ISSUE BRIEF

ASPIRE

Advancing State Policy Integration for Recovery and Employment

Implementing Individual Placement and Support in Rural Communities: Barriers and Strategies

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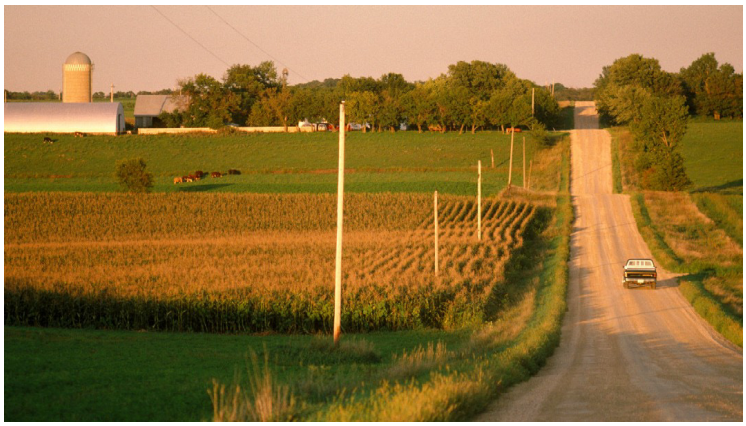


Individual Placement and Support (IPS) is an evidence-based practice that helps people with mental health conditions achieve competitive integrated employment. This issue brief describes barriers that program leaders face in implementing IPS in rural communities and the range of strategies used to eliminate these hurdles. The brief draws primarily on a qualitative study involving interviews with 27 IPS specialists in 15 states with successful IPS programs in rural communities.[1]

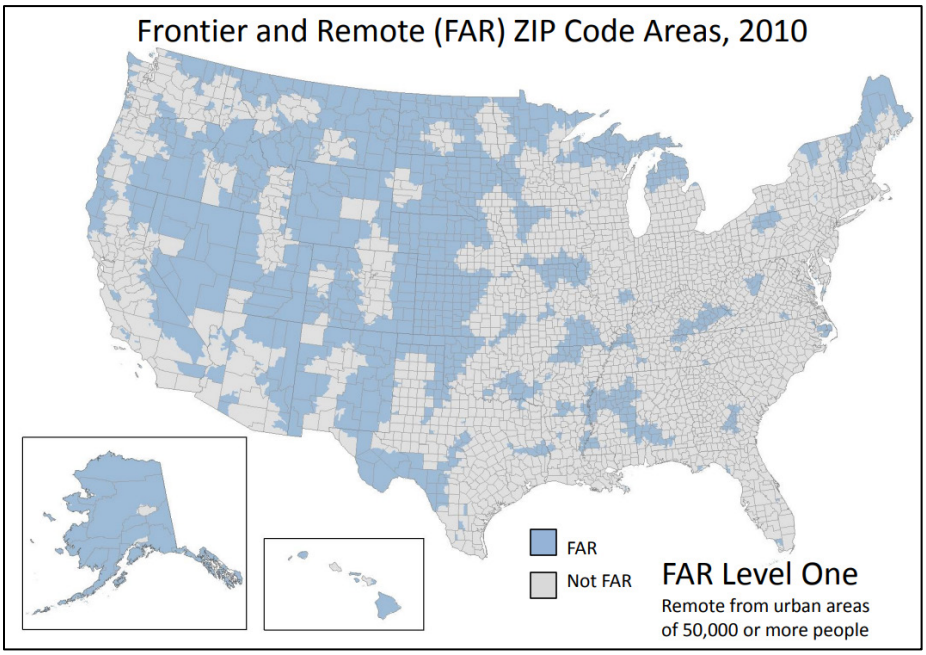
Key Points

- Throughout the U.S., rural communities face a variety of barriers to IPS implementation. The approaches used to address barriers in one community may not work in all communities, and program leaders must tailor their strategies to address the unique characteristics of their communities and local resources.
- High fidelity to IPS is a key component of successful IPS implementation; however, research shows that certain adjustments to IPS implementation in rural environments do not compromise the approach's basic principles.
- Areas that are most remote, such as frontier areas, face greater challenges in implementing IPS than small towns.

What Is Rurality?

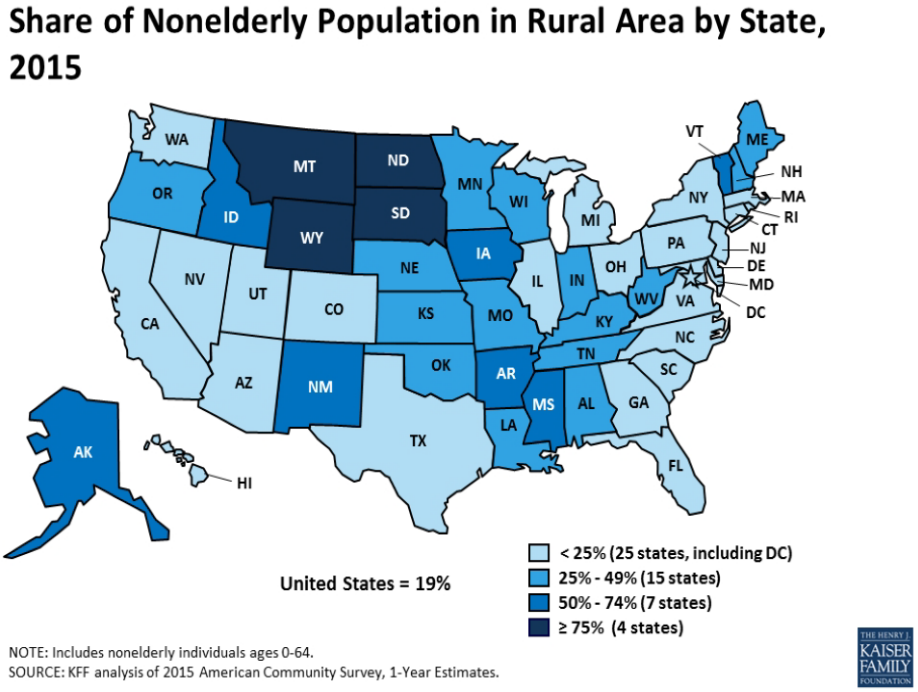
Federal agencies and researchers use many definitions of rurality, based on administrative, land-use, economic, and other factors, utilizing a variety of measures to define gradations.[1-4] Rural communities vary widely in economics, culture, demographics, and geography. Rural regions include areas in Northern New England, Appalachia, the Southeast, the Great Plains, the Rocky Mountains, the Southwest, and Alaska. All states have rural communities, but the noncoastal Western states have the largest concentration of rural regions (see Figure 1).[4] In 26 states, a quarter or more of individuals ages 64 or under live in a rural area, as shown in Figure 2.[5] Like the urban and suburban populations, the significant portion of individuals and families living in these rural areas deserve access to good jobs and financial security and well- being. Therefore, implementation of evidence-based employment services in rural communities is a national issue.

FIGURE 1: Frontier Areas of the U.S.[4]



Source: FARcodesZIPdata2010WithAKandHI.xlsx (live.com)

FIGURE 2: Share of the Population Ages 64 or Under in a Rural Area by State[5]



Source: The Role of Medicaid in Rural America - Appendix - 9017 | KFF

Individual Placement and Support (IPS): An Evidence-Based Model of Supported Employment

IPS is an evidence-based model of supported employment for people with serious mental illness.[6] It is based on the eight principles below:

1) **Focus on the goal of competitive integrated employment** – IPS programs help clients obtain good jobs in the community.

2) **Zero exclusion** – Every client who wants to work is eligible for services regardless of "readiness."

3) **Attention to client preferences** – Services align with clients' choices, rather than practitioners' judgments.

4) **Rapid job search** – IPS specialists help clients look for jobs soon after they express interest, rather than providing lengthy preemployment preparation.

5) **Targeted job development** – Based on clients' interests, IPS specialists build relationships with employers through repeated contact.

6) **Integration of employment services with mental health treatment** – IPS programs integrate with mental health treatment teams.

7) **Personalized benefits counseling** – IPS specialists help clients obtain personalized, understandable, and accurate information about how working may impact their disability benefits.

8) **Individualized long-term support** – Tailored, follow-along supports continue for as long as the client wants and needs them.

IPS Effectiveness and Cost-Effectiveness

IPS was first developed in two rural community mental health centers in New Hampshire in the 1990s. The outcomes from this initial project showed that IPS helped people with mental health conditions gain competitive integrated employment.[7] Subsequently, researchers have evaluated IPS in 32 randomized controlled trials throughout the U.S. and worldwide, in diverse communities, including both urban and rural areas. These studies have shown that IPS participants gain employment at more than twice the rate of participants receiving standard employment services.[6] Compared to control participants, IPS participants gain employment faster, maintain employment four times longer, earn three times the amount

from employment, are three times as likely to work 20 hours or more per week, and report greater job satisfaction.[6] Long-term studies have found that IPS helps people with mental health conditions become lifelong workers and taxpaying citizens.[6] Many studies have shown the beneficial effects of employment on mental health recovery. Gaining employment increases self-esteem and life satisfaction while reducing mental health symptoms.[8] Finally, cost-effectiveness studies have found that IPS is worth the effort. Not only is IPS more effective than any other vocational program, but IPS costs also are less than or equal to costs for usual services in 8 of 10 rigorous cost-effectiveness studies.[9]

IPS Fidelity and Outcomes in Rural Areas

To facilitate implementation and sustainability of programs that follow IPS principles, Becker et al.[10] developed a 25-item fidelity scale to measure specific features of a well-implemented IPS program, such as staffing and caseload size, and specific IPS specialist interventions, such as making frequent face-to-face contacts with hiring managers and identifying jobs that match client preferences and skills. IPS fidelity, as measured by this standard scale (commonly called the IPS-25), is the single best measure of the quality of IPS implementation. Fidelity ratings using the IPS-25 are associated with better employment outcomes.[11]

Mental health agency leaders sometimes assume that it is not feasible to implement IPS to the same level of fidelity in rural communities as in more populous areas and that IPS fidelity standards are thus not applicable to rural areas. However, Luciano et al.[12] found no statistically significant differences in overall fidelity scores between 23 rural and 56 urban programs. This study also explored whether rural and urban programs differed on any individual fidelity item, finding no statistically significant differences on 15 of the 25. Table 1 lists the 10 fidelity items on which urban and rural programs differed. On balance, the study found that both urban and rural IPS programs face challenges implementing IPS to high fidelity, but that each has its unique disadvantages and advantages. For example, rural IPS team leaders reported that their greatest challenges include functioning as a vocational unit and ensuring diversity of employers, as also shown in Table 1. Rural programs also generally had smaller caseloads and closer coordination with treatment teams than urban programs, factors that may allow rural IPS specialists to provide more personalized help.

Despite these minor differences in strengths and weaknesses in implementation between rural and urban programs, two studies have found similar employment outcomes for rural and urban programs.[12,13] Taken together, similarities in fidelity and outcomes in rural and urban areas should encourage rural mental health agencies to implement IPS.

TABLE 1: Urban and Rural Differences in IPS Fidelity[12]

	Urban (N=56)	**Rural** (N=23)
Fidelity Item	Item score (range 1-5)	
Caseload size	4.6	5.0
Exclusively vocational services	4.8	4.5
Integration with treatment team	4.1	4.7
Contact with treatment team	3.6	4.5
Vocational unit	4.2	3.0
Benefits counseling	3.9	4.4
Disclosure	3.8	4.3
Individualized assessment	3.8	4.2
Employer diversity	4.4	3.8
Individualized supports	4.1	4.5
IPS-25 total (Mean, standard deviation)	**100±14**	**104±12**

Notes:

Average IPS team caseload size was 66 clients in the urban programs and 42 clients in the rural programs.

IPS-25 scores range from 25 to 125. Scores of 100 or higher are consider good fidelity.

General Barriers to Services in Rural Communities

Rural mental health service providers face many barriers to providing high-quality services. In addition to a shortage of professionals,[14] they must cope with poverty, limited educational opportunities, job loss due to economic shifts, and high levels of community unemployment and substance use, among other barriers.[15] Given these challenges, rural mental health service providers may lack the time and resources to learn about new evidence-based practices.[16] Furthermore, some evidence-based practices, such as assertive community

treatment,[17] do not transfer easily from urban to rural mental health service areas. Even practices that are widely used in rural areas must be adapted to local contexts, which often vary considerably from one area to another.[18-21]

Barriers and Strategies for Implementing IPS in Rural Areas

- **A small population base, lack of funding, professional shortages, and competing service priorities impede decisions by local leaders to initiate IPS services.**

Compared with their urban counterparts, rural mental health agency administrators have smaller budgets, a less credentialed workforce, and a smaller client base.[14] Rural centers with low referral rates also have difficulty sustaining team-based services such as IPS. Such concerns may explain why rural mental health service providers hesitate to start new IPS programs: Local and regional leaders may decide against establishing a new program because the financial risks are too great.

One way to mitigate risk for rural mental health service providers is for state or federal agencies to provide seed money to start up IPS services. While this type of assistance does not address sustainability, it does provide an opportunity to test the viability of IPS within a particular region. State mental health agencies often provide this kind of funding, but other state agencies may help as well.

State legislators and local governments sometimes authorize funding for innovative IPS projects. For example, in Minnesota, family advocates successfully lobbied the state legislature to provide annual funding for IPS.[22] In Iowa, county officials funded a pilot IPS project in two rural communities after seeing successful IPS services in neighboring Minnesota.[23] Federal funding opportunities include the Substance Abuse and Mental Health Services Administration's (SAMHSA) Community Mental Health Services Block Grant and other transformation initiatives, such as the Transforming Lives through Supported Employment program.[24] One innovative project, funded by the Centers for Medicare and Medicaid (CMS) through the Balancing Incentives Program, enabled several rural communities to start up IPS services for transition-age youth.[25]

State mental health agency leaders can enhance employment expectations, services, and outcomes through several strategies: policies, plans, trainings, meetings, presentations, newsletters, and other communications. Similarly, rural mental health agency leaders and other stakeholders can emphasize the value of employment as a high-priority outcome and how it can be facilitated by effective mental health treatment.[26]

If a rural agency does implement an IPS program, it may be limited to a single IPS specialist or, in frontier areas, a part-time staff person. Given limited staff, rural agencies often de- emphasize specialization and ask employees to serve in multiple roles. Rural agencies also commonly employ paraprofessionals and other less credentialed professionals to fill professional roles.[27] In addition, agency leaders may expand job descriptions, asking employees to share tasks and serve as generalists with diverse duties that would be handled by multiple specialists in urban areas.[28] IPS specialists and care managers in rural areas also rely on natural community resources (that is, family members and other community members not employed by the mental health agency) to a far greater extent than their urban counterparts.[29]

- **Long distances, lack of public transportation, and a lack of internet connectivity require creative strategies for job development and travel.**

Rural IPS specialists often need to travel long distances to meet with clients, employers, clinicians, and local VR counselors. One strategy to reduce travel time is videoconferencing. For example, a Colorado mental health agency serving a large four- county region staffed its IPS team with four IPS specialists, one serving each county. They used videoconferencing as an alternative to face-to-face vocational unit meetings. We know that the use of telehealth during the COVID-19 pandemic may have helped reduce the percentage of clients with mental health conditions who canceled appointments,[30] but to our knowledge, no IPS research has carefully examined whether virtual alternatives to face-to-face interactions are equally effective for client contacts, job development, and/or treatment team meetings. Of course, if agencies pursue this strategy, they will need to ensure the technology used is accessible to individuals with disabilities.

The lack of adequate public transportation in many rural areas is an additional barrier for clients, both in the job search and at the workplace once hired. Even when public transportation is available, it is sometimes unreliable, often not reaching clients' residences or offering only limited hours of operation. To travel to and from work, IPS clients often rely on natural supports, such as family members, congregation members, or coworkers who can carpool. Some clients find remote jobs; others move closer to their workplace, walk long distances, or ride a bike. Sometimes IPS programs help clients purchase bikes or buy or repair cars. In some instances, IPS programs help clients become drivers to transport other clients for pay. Sometimes IPS specialists transport their clients temporarily to start jobs until they have arranged rides with coworkers or found other transportation solutions.

While the use of technology might seem to be an ideal solution,[31] IPS clients may lack internet connectivity or other needed technology. When clients need to apply to jobs online (as many now require) but lack a computer and/or internet connection to do so, they can apply with the help of their IPS specialist using a computer at the mental health center or library. One encouraging recent development was the passage and ongoing implementation of the Infrastructure Investment and Jobs Act, which allocated $65 billion to improving internet access.[32]

- **Limited job opportunities and lack of anonymity among local communities and businesses affect job development and follow-along supports.**

The limited number of available jobs presents a challenge for many rural IPS providers. Most jobs in these areas depend on local industries, which vary from state to state (e.g., factories in rural Ohio or farms in rural North Dakota).[1] To match clients' preferences and skills with a job, IPS specialists sometimes collaborate with employers to carve out part-time positions or work with clients to start their own businesses.

The lack of available employment opportunities affects frontier areas more severely than more populous, less remote areas. Rural towns tend to have at least some employers and are often located near one or more large factories or distribution centers. However, frontier areas often have almost no employers, and the choices for job seekers are stark: work on the local farm or ranch, work remotely (often impossible due to lack of internet access), or move to a more populous area.

A common refrain in rural areas is that "everybody knows everybody." The lack of anonymity has advantages and disadvantages. It can increase bias against hiring people with known mental health conditions, substance use, or justice system involvement, but it can also lead to neighbors helping neighbors. Relationships with employers are critical. In rural areas, IPS specialists report greater success developing jobs at locally owned businesses than with chain stores with distant owners and headquarters, especially for clients who do not want to disclose their mental health condition.[1] The lack of anonymity can potentially offset the disadvantages of social judgment, stigma, and preconceived notions about individuals locally known to have a mental health or substance use condition. One way that IPS specialists develop relationships with local employers and enhance awareness of recovery potential is to network regularly in restaurants, coffee shops, or business group meetings.

- **Limited workforce availability and funding require training and support.**

Hiring and retaining IPS specialists in rural areas can be difficult, especially in mental health agencies that offer low pay and are located in areas with few professionals. Funding

regulations through managed care have resulted in mental health agencies serving some clients without reimbursement, further stressing agency budgets.[23] In rural areas, there are also waiting lists for services, resulting in clients receiving fewer services than those who live near towns. Strategies to overcome these challenges and to improve retention include paying care managers and IPS specialists equally, offering strong leadership support, and providing high-quality training. Local residents who lack professional education can also be trained to become IPS specialists. This strategy requires increased investment in training, but these locally hired IPS specialists frequently value their jobs and have longer tenures.

- **Local culture requires local knowledge and familiarity.**

Local culture varies from one rural area to another, determining, for example, how people may treat immigrants or refugee groups, how the community may feel about replacing a declining industry such as mining or attracting new businesses. Another example could be whether local groups are willing to learn about and work with Native American and Tribal governance structures. Adaptations can also vary. For example, in five states with Native American and Tribal reservations, IPS specialists adjusted their approach based on local business ownership by the tribal council; local values, such as maintaining strong family ties; and local regulations, such as a reservation prohibiting the hiring of any members with a substance use disorder.[1]

Again, relationships are critical in rural communities. IPS specialists are more effective when they live in the community themselves, know the local families and culture, can relate to local employers, and are able to adapt to unique local circumstances.

Conclusion

Mental health agencies in rural communities across the U.S. contend with limited public transportation, poor internet connectivity, scarce employment opportunities, and other challenges, which can make it difficult to implement the IPS model of supported employment for people with mental health conditions. However, IPS programs can adapt to the local community culture, while still maintaining high fidelity of implementation and achieving positive outcomes for individuals. IPS is an evidence-based approach to employment, and rural communities should consider which adjustments are needed for successful implementation and make it a core part of behavioral health services in their areas.

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