IPS Supported Employment and State Vocational Rehabilitation: A Crosswalk

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Overview

The goal of this issue brief is to help inform state and local mental health leaders responsible for IPS services about the federal-state vocational rehabilitation (VR) system and to facilitate collaboration with VR administrators and counselors. Others, including VR administrators and counselors, may also find this issue brief useful.

Background

Individual Placement and Support (IPS) supported employment is an evidence-based practice that helps people with mental health conditions get and keep competitive jobs matching their preferences. Vocational Rehabilitation (VR) refers to the public vocational rehabilitation program authorized by the Rehabilitation Act (as amended by the Workforce Innovations and Opportunity Act, P.L. 114–95) and administered by states and territories in accordance with the rules and regulations of the Federal Rehabilitation Services Administration (RSA). VR assists eligible individuals with disabilities in obtaining and maintaining competitive integrated employment related to each person's strengths, resources, priorities, concerns, abilities, capacities, interests, and informed choice. People who have access to both IPS and VR benefit from the expertise and resources of both systems. Because of their different purposes, scope, missions, and history, IPS and VR have sometimes been viewed as not in synchrony with each other. This issue brief briefly describes the conceptual and historical foundations of each, the research on the effectiveness of IPS from the perspective of VR, and the integration of IPS principles with VR policy.

VR: History

In response to the many injured veterans returning home after World War I, Congress created the public VR program in 1920 with passage of the Smith-Fess Act. This legislation limited VR services to Americans with physical disabilities. In 1943 the Barden-LaFollette Act expanded the scope of VR to include people with psychiatric disabilities. Yet into the 1960s, clients with psychiatric disabilities constituted less than 5% of VR counselor caseloads (Courtney, 2005). By 2005 the proportion of VR clients with psychiatric disabilities had grown to 25%, but people with psychiatric disabilities have continued to have less access to VR services than people with other disabilities (Salzer, Baron, Brusilovskiy, Lawer, & Mandell, 2011).

The organization of VR services at the state level involves a network of local VR offices staffed by VR counselors, who determine client eligibility, develop rehabilitation plans, provide counseling, authorize services and resources, and provide a range of other services. Compared to other federal budgets, such as for Medicaid, the federal funding (along with state matching funds) allocated for VR services is modest (Hogan, Drake, & Goldman, 2014) – requiring IPS programs to access multiple funding sources. For example, an Oregon program evaluation found that VR funding accounted for 6% of the total revenue received by 13 IPS programs (Herinckx, 2011). VR funding is nonetheless a critical element in ensuring financial viability for many IPS programs.

State VR agencies are required to submit outcome data to a national data base known as RSA 911 (Rosenthal, Dalton, & Gervey, 2007). Until recently, the VR measure of a successful outcome was a successful closure, defined in part, as completing at least 90 days of stable employment. In annual reports based on the national RSA 911 data base, clients with psychiatric disabilities consistently have had lower competitive employment rates at case closure compared with those with other disabilities (Salzer et al., 2011).

The Workforce Investment and Opportunity Act mandated a new set of outcome measures called the Common Performance Measures. (www.doleta.gov/performance/guidance/tools_commonmeasures.cfm). It is too early to assess the adoption process for these new measures.

Why the Gap Between VR and Mental Health

Historically, VR and mental health professionals have had challenges coordinating services because of differing policies, practice, priorities, and service areas. For example, the diagnostic systems used by mental health and VR professionals differ sharply. Mental health professionals are not always aware of the services and expertise available through VR. In turn, VR counselors are not always informed about current treatments for mental illnesses, especially for people who have co-occurring mental health and substance use disorders.

Throughout the U.S., only a fraction of people with serious mental illness who could benefit from VR services actually do so. According to a report from Missouri, less than 7% of clients receiving services in the public mental health system in 2009 were VR clients, as shown in Figure 1. The reasons for this gap may include the limited funding for VR services and the perception that clients with psychiatric disorders are difficult to employ, which would impede successful VR closures.

IPS: History and Conceptual Foundations

IPS has its origins in the supported employment movement, which received official recognition in the Rehabilitation Act Amendments of 1986 (Courtney, 2005). This legislation defined supported employment as "…competitive work in an integrated work setting for individuals who, because of their handicaps, need ongoing support service to perform that work." Supported employment contrasts sharply with sheltered employment, which was the dominant service model at that time. Supported employment advocates hoped to shift from the "train-place" model embedded in a sheltered workshop approach to a "place-train" model, where job coaches provided direct assistance to people with severe disabilities in competitive employment settings without a period of training (Wehman & Moon, 1988).

Most initial supported employment projects were designed for and offered to people with intellectual disabilities, but soon psychiatric rehabilitation advocates began adapting supported employment for people with serious mental illness (Mellen & Danley, 1987). One early supported employment model proposed for this population was IPS developed in the 1990s in rural New Hampshire (Becker & Drake, 1993). IPS was subsequently tested in a series of randomized controlled trials throughout the U.S. and the world. It is the most extensively researched and disseminated of supported employment models (Drake, Bond, & Becker, 2012). IPS is based on eight principles:

1. Open to anyone who wants to work
2. Focus on competitive employment
3. Rapid job search
4. Systematic job development
5. Client preferences guide decisions
6. Individualized long-term supports
7. IPS integrated with treatment team
8. Benefits counseling included

Reviews of the research literature have periodically examined the empirical foundations for these principles and found moderate and strong support for each of them, though the literature continues to evolve and provide greater specificity to principles (Marshall et al., 2014; Modini et al., 2016).

Research on Employment Outcomes for VR clients with Psychiatric Disabilities

One important strength of VR has been its emphasis on employment outcomes. In this respect, VR has been congruent with the evidence-based practice movement and with IPS. When reporting the results of IPS studies to VR professionals, a common reaction is, these findings are interesting, but how do they translate into VR's system for measuring outcomes? Surprisingly, little research has been conducted to answer this question. IPS researchers and program leaders must do a better job of translating employment outcomes into language understandable to the VR community.

Several state VR agencies have compared closure outcomes for VR clients with psychiatric disabilities receiving IPS to other types of vocational services. A program evaluation in Maryland found significantly higher VR successful closure rates for clients enrolled in high-fidelity IPS compared to those in other services (Bond, Becker, & Drake, 2011). Recently, Wisconsin's state VR agency also found higher successful VR closure rates for IPS compared to non-IPS services (Enders, K., personal communication).

More recently, VR has endorsed the use of evidence-based practices. A recent VR expert panel consisting of VR subject matter experts (from university rehabilitation counseling programs and state VR agencies) identified IPS as highly relevant to VR practice (ranked 3rd of 26 practices, behind secondary transition services and assistive technology) and strongly evidence-based (also ranked 3rd of 26 practices, behind cognitive behavioral therapy and assertive community treatment) (Leahy et al., 2018). It was the only practice that ranked high on both criteria.

Crosswalk Between IPS and VR

Although IPS and VR have historically been regarded as different systems, the features that they have in common outweigh their differences. Many of the differences are a matter of terminology; VR and IPS practitioners leaders share many common values. VR leaders in the IPS Learning Community have identified points of similarity between IPS and VR. Table 1 shows that the principles and policies of IPS and VR can be in synchrony (IPS Learning Community VR Liaisons, 2017).

State VR agencies can take critical steps to fully align their policies with IPS (Johnson-Kwochka, Bond, Drake, Becker, & Greene, 2017). Some state VR agencies have made important changes in this direction. In Maryland, the state VR and mental health agencies devised a single point of entry for VR application, referral, and eligibility determination for clients and providers requesting IPS services (Becker et al., 2007). In Missouri, the state VR agency eliminated situational assessments from its fee schedule to fit with the IPS principles of avoiding prevocational work options (Swanson et al., 2011). Several states have streamlined the VR eligibility process to align with the IPS rapid job search principle. In other states, VR administrators have incorporated IPS into their policy and procedure manuals for VR counselors. Illinois, for example, has taken this step (Oulvey, G. personal communication).

Crosswalk Between IPS and VR

Training IPS specialists and VR counselors together ensures that all practitioners have a similar understanding of the IPS approach. VR counselors also need help from VR administrators to understand how they can practice IPS without violating their agency's policies. Another important strategy is to help local VR counselors and IPS specialists build relationships so they are invested in helping each other. Examples of how some states have improved collaboration are listed below:

Frequent communication.

A representative from the state VR office had monthly phone calls with VR counselors to answer questions and talk about concerns. The calls continued during the first six months of IPS implementation in that state.

Provide cross training to enhance understanding and teamwork.

A representative from state VR and one from the state department of mental health facilitated trainings for IPS teams and VR counselors together. They discussed common goals and practices, as well as how VR counselors could adjust their practices to accommodate IPS, for example, establishing eligibility quickly to help with rapid job search. They explained what documentation VR counselors need from IPS teams.

As part of cross-training, state trainers highlight the benefits of collaborating with VR counselors when training IPS specialists. They explain that VR counselors are knowledgeable about different disabilities and chronic illnesses that may affect people with mental illness. They also describe how many VR counselors know about different employers, job types, and education/training programs that the IPS team may not know about.

Provide guidance on VR and mental health treatment team collaboration.

In one state, a VR liaison counselor was identified for each IPS program and attended IPS team meetings weekly (in the beginning) and then monthly. In another state, the expectation was for the VR counselor to attend mental health treatment team meetings, with the IPS specialist, once a month. That allowed mental health practitioners to learn about VR services, for example, to understand why everyone does not get the same services, and it helped VR counselors to understand how the team tried to help people go to work sober in spite of ongoing substance use problems.

Dedicated office space.

Some local mental health agencies reserve an office for the VR counselor so that they can meet with IPS clients onsite.

Share IPS program outcome data with VR.

At the program level, IPS supervisors sometimes share their outcomes with local VR counselors to explain benefit to VR of working with their program.

Work together to solve problems.

IPS steering committee meetings are a useful venue for VR counselors and supervisors to collaborate and problem-solve issues.

Conclusions and Practical Implications

VR professionals at every level – national leaders, state VR agencies, local VR counselors – are increasingly aware of IPS as an evidence-based practice, choosing IPS programs as VR vendors, and making referrals to IPS programs. Clarifying the congruence between IPS principles and VR policies is a critical element in advocating for IPS in states that have not yet fully embraced IPS. This document is intended to provide some guidance to IPS leaders.

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