

Measuring Access to Individual Placement Support (IPS) and Employment Outcomes for Historically Underserved Groups¹

Gary Bond, PhD | Robert Drake, PhD, MD | Deborah Becker MEd | Jackie Pogue, MPH

January 2022

IPS is an evidence-based practice that helps people with psychiatric disabilities achieve competitive integrated employment regardless of background characteristics (such as age, gender, diagnosis, work history, symptoms, substance use) (Campbell, Bond, & Drake, 2011).

With the current emphasis at the federal level on diversity and inclusion (Executive Order 13985, 2021), research on IPS for historically underserved groups, including people of color and people of Hispanic heritage, is of particular interest to federal, state, and local leaders responsible for planning and implementing evidence-based services. In this brief we review the research on access to and effectiveness of IPS for historically underserved groups and suggest a standardized template for states, including those participating in ASPIRE (Advancing State Policy Integration for Recovery and Employment), to track race and ethnicity in IPS programs.

While understanding the impact of IPS through carefully designed research studies is important, state and local leaders also need information about its accessibility and effectiveness within their state or community. Few states systematically report statistics on racial and ethnic demographics of people in their IPS programs. To our knowledge, local programs rarely collect the appropriate information to determine access to IPS or its effectiveness for underserved groups. Moreover, ASPIRE states have not yet adopted a standardized template for tracking these data.

Based on federal government priorities as well as ASPIRE priorities, we recommend that ASPIRE state leaders initiate systematic data collection on race and ethnicity in IPS programs and report data in a standardized format. To aid in this process, this issue brief provides guidance to implement these recommendations. The document has four sections:

- 1. Research on Race and Ethnicity in IPS Programs.** Review of IPS research examining access and outcomes for people from underserved communities.
- 2. Template for Tracking Race and Ethnicity.** Proposed template for tracking race and ethnicity for discussion within the ASPIRE learning community.
- 3. Data Collection and Reporting Issues.** Key issues in tracking and reporting information on race and ethnicity.
- 4. Future Directions.** Issues in tracking people identifying as LGBTQ+.

1. Research on Race and Ethnicity in IPS Programs

Disparities in access to IPS

Studies show health care disparities for people of color and Latinx people (Mongelli, Georgakopoulos, & Pato, 2020). Several factors contribute to these disparities, including patient distrust and poverty, treatment expenses, and proximity of medical services to the communities where minority populations live. Although disparities are well established throughout health care, little research has examined disparities based on race and ethnicity for IPS services.

A meta-analysis of randomized controlled trials of IPS in the U.S. published between 1996 and 2012 found that the combined sample of 2,055 clients included 53% who were White, 38% who were Black and 11%

¹ This issue brief has been prepared by Westat under DOL Contract Number 1605DC-18-A-0034/1605C3-20-F-00017

who were Hispanic. These studies included a negligible percentage of Asians, Native Americans/Alaska Natives, and Native Hawaiians/Pacific Islanders, suggesting that these latter groups may be underserved in IPS programs (Metcalf, Pogue, & Drake, 2021). At the national level, U.S. Census found that, as of July 1, 2019, the U.S. population was 76% White, 19% Hispanic, 13% Black, 6% Asian, and 0.2% Native Hawaiian and other Pacific Islander (<https://www.census.gov/quickfacts/fact/table/US/PST045219>). The Black population also has been growing, increasing from 36.2 million in 2000 to 46.8 million in 2019 (Tamir, 2021). The Hispanic population has grown even more during this time period, increasing from 35.7 million in 2000 to 60.6 million in 2019 (Noe-Bustamante, Lopez, & Krogstad, 2020).

We found only two published studies examining disparities in IPS services provided to people from racial minorities and people of Latinx heritage. Using a large administrative data set, a Maryland study examined Medicaid recipients during 2001-2010 who had a diagnosis of serious mental illness (Salkever, Abrams, Baier, & Gibbons, 2017). Annually this population consisted of 20,000 to 25,000 people. Among Medicaid recipients, the proportion receiving IPS services did not differ for Black or Latinx clients compared to White clients. In other words, among Medicaid recipients, this study found no evidence of disparities in IPS access based on race or ethnicity.

A British study of two IPS programs compared IPS enrollment rates for Blacks, Asians, and other racial minorities to rates of receipt of mental health services in the corresponding service areas (Perkins, Patel, Willett, Chisholm, & Rinaldi, 2021). The proportion of Asian clients accessing IPS was similar to the proportion of Asian clients receiving mental health services and did not differ from the corresponding proportion for White clients. The proportion of Black clients accessing IPS was more than 50% greater than the proportion of Black clients receiving mental health services. Overall, this study found no evidence for less access to IPS among Black or Asian service users.

Neither of these studies, however, compared these statistics to racial and ethnic statistics for adult residents of the local community. Many communities with a disproportionately high proportion of people from racial and ethnic minorities lack access to affordable outpatient mental health services (Cook, McGuire, & Miranda, 2007). The distribution of IPS programs by geographic location has not been systematically documented, but a similar pattern of poor access to IPS programs seems likely. On the other hand, the literature

provides several examples of successful IPS programs located in predominantly Black communities (Bond et al., 2007; Drake et al., 1999; Gold et al., 2006; Lehman et al., 2002).

In the U.S., some state mental health agencies collect and report data on race and ethnicity of clients receiving mental health services through the public mental health system. Unfortunately, state-level statistics on race and ethnicity of IPS clients do not appear to be publicly available, because these data are either not collected or not reported in any public websites or documents. Recently, however, the state of Tennessee prepared annual statistics for its IPS services, reporting that 1,118 people received IPS services in 2020, of whom 377 (34%) were Black and 19 (2%) were Hispanic/Latinx (Liverman, 2020). The percentage of Black IPS clients was twice the percentage of Black citizens in Tennessee in the 2010 census, which was 17% (<https://www.census.gov/quickfacts/fact/table/US/PST045219>).

Effectiveness of IPS for people from racial minorities and of Latinx heritage

IPS has been shown to be more effective than usual vocational services for Black, Asian, and Latinx clients, with significantly better outcomes for people receiving IPS than those receiving usual vocational services (Campbell et al., 2011; Metcalfe, Bond, & Drake, 2017; Metcalfe et al., 2021; Perkins et al., 2021). As shown in [Table 1](#), the results from a meta-analysis illustrate that Black and Latinx clients receiving IPS have significantly better employment outcomes than those receiving standard services. Moreover, the differences in employment outcomes between IPS and control participants are similar to those for White clients (Campbell et al., 2011). A later randomized controlled trial of IPS found that Latinx clients had significantly better employment outcomes than White clients (Metcalf et al., 2017).

2. Template for Tracking Race and Hispanic Ethnicity

In this section we outline a set of procedures suitable for (1) local IPS programs to track race and ethnicity of clients on a quarterly basis and (2) a central authority (such as an ASPIRE Point of Contact or an official from the state mental health agency) to compile and report these statistics. The logistics for collecting these data will likely vary widely, depending on the local expertise, organizational resources, and organizational policies. Some IPS programs track demographic information on clients, including data on race and ethnicity, although the proportion doing so nationwide is unknown.

IPS programs might obtain demographics from an electronic health record compiled at admission to the parent agency (usually a community mental health center), or else the IPS team leader (or someone designated by the team leader) might collect these data at enrollment into the IPS program. We use the label data manager to refer to the person responsible for collecting and compiling such data. For small programs, the IPS program leader is likely the data manager. IPS programs with access to administrative support may assign an administrative staff member to be the data manager. In large agencies, the information technology office may be able to generate the pertinent data, bypassing the manual data collection approach outlined in this issue brief.

This template describes steps for collecting and compiling data on race and ethnicity assuming that the IPS team is responsible for data collection and compilation.

Data collection. The most rudimentary method for collecting data is for the data manager to maintain an excel spreadsheet (or other database) of all active IPS clients, manually entering pertinent data for each client at the time of enrollment into the IPS program. Admission forms vary widely in data definitions for race and ethnicity. We recommend that IPS programs use the terminology and categories listed in the Race and Ethnicity Data Collection Template shown in [Table 2](#). This template uses standard data definitions used by the U.S. Census. These definitions follow guidance on collecting information on race and ethnicity as issued in Section 4302 of the Affordable Care Act.

Data compilation. To be of use, merely collecting data is insufficient; data must be compiled and reported. To start, the IPS team must identify the reporting time frame. Many agencies are required to report annual statistics based on a fiscal year defined by their budget cycle. IPS programs may also compile and report data on a quarterly basis for some purposes. The principles are the same regardless of the reporting cycle. This brief describes the procedures for a quarterly reporting cycle, but ASPIRE states may choose a longer time frame.

One specific reason for using a quarterly reporting cycle is that the IPS Learning Community produces the Quarterly Employment Outcome Report, using data that IPS programs compile using the IPS Quarterly Employment Outcome Form, shown in [Table 3](#). IPS Learning Community programs complete this form after the end of each calendar quarter (January 1–March 31, April 1–June 30, etc.). Completing the employment outcome form requires the data manager to identify

all clients who have been enrolled at least one day during the three-month period in order to determine the total number served; the data manager needs this information as well for the race and ethnicity statistics. For these reasons, we recommend synchronizing the collection and reporting of race and ethnicity data with any employment outcome reports.

To collect data on race and ethnicity, the data manager follows Steps 1-3 in [Table 2](#). The schedule of data compilation is determined by the end of each calendar quarter and in conjunction with completing the IPS Quarterly Employment Outcome Form. The deadline for completing the latter is typically within 30 days after the end of the quarter.

Data reporting. The frequency counts by race and ethnicity are then forwarded to the central data manager, that is, the person who is responsible for the overall database (for example, the database consisting of data from all IPS programs in the state). In ASPIRE, the state Point of Contact should designate the central data manager. In the IPS Learning Community the central data manager often is either a state trainer or a state IPS liaison (or designated staff person) from the state mental health or vocational rehabilitation agency.

The central data manager is responsible for aggregating the data at the state level and calculating totals and percentages, completing Steps 4 and 5 shown in [Table 2](#). A software program may facilitate the file management (including calculations) for the overall database. The central data manager then prepares and distributes a summary report. [Table 4](#) provides a draft template for such a report.

Summary. We recommend that state IPS leaders collect and report statistics on race and ethnicity, using standard data definitions used by the U.S. Census. To achieve this, the leaders and local programs should all agree on the goal of collecting and reporting these data, agree on the schedule for reporting these statistics (for example, quarterly), identify a data manager for each IPS program, designate a central data manager, and establish procedures for tracking client-level data, transmitting aggregated program-level data (frequency counts) to the central data manager, and compiling the data.

3. Data Collection and Reporting Issues

This section identifies several issues that need addressing before collecting any data.

1. To what populations will the IPS statistics be compared? One possible first step could be comparing state-level statistics for IPS to U.S. Census data for each state (<https://www.census.gov/quickfacts/fact/table/US/PST045219>).

The state-level comparisons, of course, do not address disparities at the local level. The racial and ethnic diversity of the local community affects how we interpret statistics on race and ethnicity in IPS programs. At the local level, one option for providers is to compare statistics on race and ethnicity for their IPS program to those for clients enrolled in mental health services. Several factors affect the feasibility and utility of this option: (1) the data management and data reporting capacity of the local provider, (2) the number of clients served, and (3) the degree of disparity for clients enrolled in mental health services.

2. What is the optimal time cycle for the collection and reporting of data? Although this brief describes a three-month data collection and reporting cycle, a longer time period would reduce the burden on both local and state agencies, and for that reason may be preferred.

3. For state-level reporting, how will data be transmitted? We have outlined above one set of options. ASPIRE learning community state leaders may have other suggestions. Regardless of the data collection method, we recommend that ASPIRE states seek consensus on standard data definitions and a standardized data collection template, which all states then adopt.

4. Who will have access to the data? The primary audience for these data consists of state and local leaders in each state collecting these data, to inform their own state policies for engaging historically underserved communities. The learning community would decide by consensus whether these data would be shared within the ASPIRE learning community.

5. Protected Health Information status. Data collection and reporting guidelines will need to address concerns about reporting protected health information; specifically, reports should avoid indicating the number of people in specific racial or ethnic groups if that number falls below 10. One way to allay concerns about protected health information is to restrict access to data. For reports shared more broadly, aggregated data at the state level are more likely to exceed the minimum threshold; in addition, racial and ethnic groups with less than ten people can be aggregated and reported as “other.”

4. Future Directions

In addition to groups defined by race and ethnicity, Executive Order 13985 (2021) identifies several other underserved groups, including “lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons.” The LGBTQ+ community is diverse. To correctly identify gender and sexual orientation, the Human Rights Campaign, a LGBTQ+ advocacy group (www.hrc.org), suggests these three demographic questions:

Would you say you are male, female, or another gender? OR What gender best describes you right now?

- Male
- Female
- Another gender

Do you consider yourself to be transgender, non-binary, or another gender? Please pick the option that best describes how you think of yourself.

- No, I am not transgender
- Yes, I am a transgender woman (assigned male at birth and identify myself as a woman)
- Yes, I am a transgender man (assigned female at birth and identify myself as a man)
- Yes, I identify as non-binary, genderqueer, or another term
- Not sure whether I am transgender
- Not sure what this question means

Sexual orientation- which of the following best represents how you think of yourself?

- Lesbian or gay
- Heterosexual or straight
- Something else
- Not sure about my sexual orientation

If asked to track the responses to these questions, data managers would need to track 14 data elements. Following the data collection template outlined in [Table 1](#) would require data managers to track 28 variables consisting of both the frequency and the employment rate for each of the 14 data elements. The data collection and data management burden for compiling these are substantially greater than that for race and ethnicity.

TABLE 1 Employment Outcomes for White, Black and Latinx Clients in Meta-analysis of 4 IPS Controlled Trials (Campbell et al., 2011)

	Job Acquisition		Weeks Worked over 18 Months	
	IPS	Control	IPS	Control
White, not Latinx (N=265)	76%	32%	25.0	8.7
Black (N=311)	67%	19%	17.4	2.9
Latinx (N=85)	59%	19%	17.7	2.8

TABLE 2 Race and Ethnicity Data Collection Template (Quarterly Reporting Version)

Step 1. For each IPS client enrolled at least one day in the last 90 days, identify ethnicity and race, as follows:

1. Is client of Hispanic, Latino, or Spanish origin?

- No, not of Hispanic, Latino, or Spanish origin
- Yes, Mexican, Mexican American, Chicano, Puerto Rican, Cuban, or another Hispanic, Latino, or Spanish origin

2. What is client's race? Check as many as apply:

- White
- Black or African American
- American Indian or Alaska Native
- Asian (including Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or Other Asian American)
- Native Hawaiian, Samoan, Chamorro, or Other Pacific Islander
- Other Race

Step 2: Determine totals in each category for the entire caseload of the IPS program.

How many clients did the IPS program serve over the 90-day reporting period? _____

Of these, **how many self-identify with the following ethnic and racial categories:**

Hispanic ethnicity:

Number of clients of Hispanic, Latino, or Spanish origin

Race:

Number of clients in each racial category. A client can identify with one or more races.

Step 3. Determine number employed during quarter by ethnicity and race:

For each ethnic and racial category, report the number employed at least one day during the last quarter.

Step 4. Calculate percentage of clients on total caseload by ethnicity and race. (This statistic to be calculated externally by state technical assistance center or IPS Employment Center.)

Step 5. Calculate percentage employed within each ethnic and racial category. (This statistic to be calculated externally by state technical assistance center or IPS Employment Center.)

TABLE 3 IPS Quarterly Employment Outcome Form

IPS Supported Employment Sites – Quarterly Outcomes Report for the IPS Learning Community

Report Period (check one): January–March 2021 July–September 2021
 April–June 2021 October–December 2021

Agency Name:	Agency Person Reporting:	Date:	
<p>Total Number of People on Caseload of IPS Supported Employment Staff. Include total number of clients that are on the assigned caseload of the IPS supported employment staff <u>at anytime during the reporting quarter. Only include</u> those people (unduplicated) who received at least one employment service.</p>	<input style="width: 50px; height: 20px;" type="text"/>	<p>Number of New Enrollees Admitted to the IPS Supported Employment Program During this Reporting Quarter. This number is a subset of total number served on IPS supported employment caseload this quarter.</p>	<input style="width: 50px; height: 20px;" type="text"/>
<p>Number of People (unduplicated) from IPS Supported Employment Caseload Working Integrated Competitive Employment at Anytime During the Quarter. Integrated competitive employment is defined as a community-based job that pays at least minimum wage, is available to any person, belongs to the worker and does not have time limits determined by the rehabilitation/mental health agency.</p>	<input style="width: 50px; height: 20px;" type="text"/>	<p>Number of New Job Starts for All IPS Supported Employment Participants During the Quarter. Include all job starts. For example, one person starts three new jobs, which equals three job starts.</p>	<input style="width: 50px; height: 20px;" type="text"/>
<p>Total Number of People on IPS Supported Employment Caseload Enrolled in Education Programs During this Quarter. “Education” is defined as a “credit-bearing educational program”— such as a technical school, college — for which the person will receive documentation upon completion. Include GED prep classes.</p>	<input style="width: 50px; height: 20px;" type="text"/>	<p>Number of People of IPS Supported Employment Caseload who Enrolled in Education Programs During This Quarter. This number will be a subset of the total number enrolled in a credit-bearing education program this quarter.</p>	<input style="width: 50px; height: 20px;" type="text"/>
<p>Total Number of People Working Successfully in Integrated Competitive Employment who Transitioned off the IPS Supported Employment Caseload during this Quarter.</p>	<input style="width: 50px; height: 20px;" type="text"/>	<p>Number of People Not Working Who Transition Off the IPS Supported Employment Caseload during the Quarter.</p>	<input style="width: 50px; height: 20px;" type="text"/>

Staffing: Complete this section for the majority (over half) of the quarter.

- Number of People who are Employment Specialists with an IPS Caseload (excluding the supervisor.)**
- Total FTE Employment Specialists (excluding the supervisor) with an IPS Caseload** – (FTE = full-time equivalent). Includes full-time and part-time positions. For example, 2 employment specialists working 20 hrs/week= 1 FTE.
- Number of IPS Clients on Supervisor’s Caseload (if any).**

December 21, 2020 Note: Individual Placement and Support (IPS) is the evidence-based approach to supported employment.

TABLE 4 **Summary Report: Quarterly Statistics for Race and Ethnicity**

Ethnic and racial statistics for total caseload

- ___ N (%) of Hispanic ethnicity
- ___ N (%) White
- ___ N (%) Black or African American
- ___ N (%) Indian or Alaska Native
- ___ N (%) Asian (including Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or Other Asian American)
- ___ N (%) Native Hawaiian, Samoan, Chamorro, or Other Pacific Islander
- ___ N (%) Other

Employment rates for ethnic and racial subgroups

- ___ N (%) employed among people of Hispanic ethnicity
- ___ N (%) employed among White clients
- ___ N (%) Black or African American
- ___ N (%) employed among Indian or Alaska Native clients
- ___ N (%) employed among Asian clients (including Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or Other Asian American)
- ___ N (%) employed among Native Hawaiian, Samoan, Chamorro, or Other Pacific Islander
- ___ N (%) employed among Others

Notes: This form uses the categories for race and Hispanic ethnicity as defined by the U.S. Census Bureau in the American Community Survey. It follows the guidance on collecting information on race and ethnicity as issued in Section 4302 of the Affordable Care Act.



References

- Bond, G. R., Salyers, M. P., Dincin, J., Drake, R. E., Becker, D. R., Fraser, V. V., & Haines, M. (2007). A randomized controlled trial comparing two vocational models for persons with severe mental illness. *Journal of Consulting and Clinical Psychology, 75*, 968-982.
- Campbell, K., Bond, G. R., & Drake, R. E. (2011). Who benefits from supported employment: A meta-analytic study. *Schizophrenia Bulletin, 37*, 370-380.
- Cook, B. L., McGuire, T., & Miranda, J. (2007). Measuring trends in mental health care disparities, 2000-2004. *Psychiatric Services, 58*, 1533-1540.
- Drake, R. E., McHugo, G. J., Bebout, R. R., Becker, D. R., Harris, M., Bond, G. R., & Quimby, E. (1999). A randomized clinical trial of supported employment for inner-city patients with severe mental illness. *Archives of General Psychiatry, 56*, 627-633.
- Executive Order 13985. (2021). Advancing racial equity and support for underserved communities through the federal government *Federal Register, 86*(14), 7009-7013.
- Gold, P. B., Meisler, N., Santos, A. B., Carnemolla, M. A., Williams, O. H., & Kelleher, J. (2006). Randomized trial of supported employment integrated with assertive community treatment for rural adults with severe mental illness. *Schizophrenia Bulletin, 32*, 378-395.
- Lehman, A. F., Goldberg, R. W., Dixon, L. B., McNary, S., Postrado, L., Hackman, A., & McDonnell, K. (2002). Improving employment outcomes for persons with severe mental illness. *Archives of General Psychiatry, 59*, 165-172.
- Liverman, M. (2020). The year in numbers: Tennessee's IPS program: FY21 review. https://www.tn.gov/content/dam/tn/mentalhealth/documents/TN_FY21_IPS_Data.pdf.
- Metcalfe, J. D., Bond, G. R., & Drake, R. E. (2017). Predicting employment in the Mental Health Treatment Study: do client factors matter? *Administration and Policy in Mental Health and Mental Health Services Research, 44*, 345-353. doi:10.1007/s10488-016-0774-x
- Metcalfe, J. D., Pogue, J. A., & Drake, R. E. (2021). A brief assessment of race and ethnicity in individual placement and support studies in the United States. *Psychiatry Research, 301*, 113981 <https://doi.org/10.1016/j.psychres.2021.113981>.
- Mongelli, F., Georgakopoulos, P., & Pato, M. T. (2020). Challenges and opportunities to meet the mental health needs of underserved and disenfranchised populations in the United States. *Focus, 18*, 16-24. doi:10.1176/appi.focus.20190028
- Noe-Bustamante, L., Lopez, M. H., & Krogstad, J. M. (2020). *U.S. Hispanic population surpassed 60 million in 2019, but growth has slowed: Pew Research Center* (<https://www.pewresearch.org/fact-tank/2020/07/07/u-s-hispanic-population-surpassed-60-million-in-2019-but-growth-has-slowed/>).
- Perkins, R., Patel, R., Willett, A., Chisholm, L., & Rinaldi, M. (2021). Individual placement and support: cross-sectional study of equality of access and outcome for Black, Asian and minority ethnic communities. *BJPsych Bulletin, doi:10.1192/bjb.2021.9*.
- Salkever, D. S., Abrams, M., Baier, K., & Gibbons, B. (2017). Impacting entry into evidence-based supported employment: a population-based empirical analysis of a statewide public mental health program in Maryland. *Administration and Policy in Mental Health and Mental Health Services, 45*, 328-341.
- Tamir, C. (2021). *The growing diversity of Black America: Pew Research Center* (<https://www.pewresearch.org/social-trends/2021/03/25/the-growing-diversity-of-black-america/>).