ISSUE BRIEF

# State-Level Barriers and Facilitators to Individual Placement Support (IPS) Implementation[1]

ASPIRE

Advancing State Policy Integration for Recovery and Employment

Gary Bond, PhD | Jackie Pogue, MPH | Monirah Al-Abdulmunem, MS | Deborah Becker, MEd | Robert Drake, PhD, MD

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## Overview

This issue brief uses the findings from a 2019 national survey of state mental health and vocational rehabilitation (VR) leaders to help state leaders to identify common barriers and facilitators to implementing IPS supported employment and strategies to overcome the barriers, leading to successful implementation, maintenance, and growth of IPS programs (Pogue, Bond, Drake, Becker, & Logsdon, 2021). This brief also examines whether these issues differ among:

1. States and counties that have joined the IPS Learning Community, an organization devoted to promoting the growth and quality of IPS services (Drake, Becker, & Bond, 2020);
2. States implementing IPS, but not part of the learning community; and
3. States that have no IPS services.

Figure 1 is a map showing 23 states and 2 counties in the IPS Learning Community and the year that they joined. At the time of the survey, New Hampshire had not yet joined, so it is not classified as a learning community state in this issue brief.

## Methods

In 2019, the IPS Employment Center completed a follow-up national survey examining the spread of IPS services (Pogue et al., 2021). The 2019 survey was a follow-up of a 2016 survey with similar data collection procedures and survey questions (Johnson-Kwochka, Bond, Drake, Becker, & Greene, 2017). The 2019 survey instrument is shown in the Appendix.

The research team conducted telephone interviews with representatives from state mental health and VR agencies in 50 states, the District of Columbia, and county leaders in two counties (Alameda County, California, and Broward County, Florida, both of which are part of the IPS Learning Community). In total, the sample included 53 governmental entities.

In each state, respondents reported the number of IPS programs and estimated the number of IPS clients served during a recent three-month period. Respondents identified critical barriers and facilitators to implementing IPS and the main funding sources for IPS services in their state. The research team analyzed the open-ended responses qualitatively through an iterative coding process with three researchers. After achieving consensus on research codes, the research team aggregated them to identify the key thematic findings.

The survey also asked respondents to indicate which of three well-established strategies were used in their state to facilitate implementation of IPS:

- Close collaboration between mental health and VR agencies,
- Regular independent fidelity reviews, and
- Ongoing IPS technical assistance and training.

The survey included questions about these three strategies because states and counties joining the IPS Learning Community are expected to adopt them.

## Findings

### Availability of IPS Services in the U.S.

The growth in IPS programs in the U.S. between 2016 and 2019 is shown in Figure 2. In 2019, 41 (80%) of 50 states and the District of Columbia offered IPS services consisting of 857 IPS programs serving an estimated 43,209 clients. Although the number of states (or equivalent entities, such as the District of Columbia and large counties in Florida and California, which

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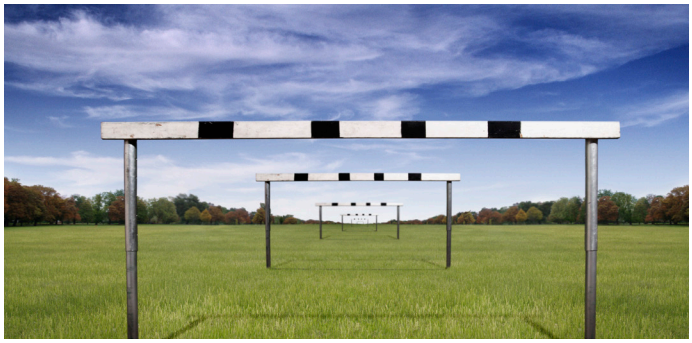
are hereafter referred to as states) with IPS programs increased only slightly from 2016 to 2019 (from 38 to 41), the number of programs grew by 64% (from 523 to 857). In other words, IPS expansion during this three-year period was mostly growth in IPS services within states, not expansion to new states.

While IPS expansion has been widespread, learning community states have increased IPS services more rapidly. Between 2016 and 2019, the number of IPS programs expanded from 272 to 486 in the learning community, and from 251 to 371 in 18 states outside the learning community. Thus, the rate of IPS expansion was much greater within the learning community than outside (79% vs. 48%).

The per capita number of IPS programs and IPS clients served were both substantially higher in learning community states than in non-learning community states in 2019. Despite a total population of 20 million fewer residents, learning community states reported 115 more IPS programs than non-learning community states (486 vs. 371) and served 58% more IPS clients (nearly 10,000 more people) than non-learning community states (26,522 vs. 16,687).

What accounts for the greater number of IPS programs and larger increase in programs in learning community states? What can be learned from the state leaders who responded to the survey about strategies? The next sections elaborate on barriers and facilitators to IPS development as described by state leaders. In the next two sections, we discuss the barriers and facilitators to implementing IPS identified by state leaders. We present barriers first, because many facilitators expressly address the identified barriers.



## Barriers

The most common barriers to implementing IPS identified by state leaders were *funding*, *lack of prioritization*, *systems barriers*, and *workforce issues*, as shown in Table 1. Learning community and non-learning community states reported similar barriers, except for more frequent reports of workforce issues in non-learning community states. In states with no IPS programs, *a lack of awareness about IPS* and *community factors* were more salient. Community factors refer to characteristics of the state – its population density, economy, etc. The most common community factor mentioned was *geography*, with state leaders from predominantly rural states expressing concern about how to implement IPS.

Examples of specific barriers within the broad barrier categories were as follows:

**Funding.** Respondents from 37 (74%) states identified *funding* as a challenge. They indicated that no single source of funding for IPS was sufficient to cover the cost of IPS services, suggesting that to sustain IPS services, an agency must secure funding from multiple sources. They noted the difficulty of *accessing funding* from multiple sources (such as Medicaid and Vocational Rehabilitation [VR]), because each funder sets limits on the amount that an IPS program can bill, has restrictive rules regarding services IPS programs can bill for, and often makes unpredictable changes from year to year. These challenges create a precarious environment for maintaining and expanding IPS services. In addition, state leaders identified gaps in funding for specific components of the IPS service model, frequently mentioning job development and job retention as the most difficult to fund. Other challenges included the *lack of targeted funding* for program start-up costs and fidelity reviews.

**Prioritization.** *Lack of prioritization* of IPS was the second most common barrier, identified by respondents in 25 (50%) states. Respondents reported that key stakeholder groups often did not believe in recovery; instead, many stakeholders assumed that people with serious mental illness were unable to work competitively. Some state and local mental health officials regarded employment as outside the scope of mental health treatment and their agency's mission. A few providers and advocacy groups promoted outdated (and non-evidence-based) services such as sheltered workshops and day treatment. Respondents noted their struggles with stakeholders at various levels who were unwilling to actively endorse employment as a priority for people with serious mental illness or to support implementation of IPS.

**Systems barriers.** State leaders identified several *systems barriers* to IPS implementation, including *decentralized mental health systems*, *lack of collaboration between state mental health and VR*, and *policy challenges*. In several states with decentralized decision-making (that is, having a county-level mental

health authority), leaders in the central office described their challenges with cultivating buy-in from local stakeholders. Decentralized services also interfered with providing technical assistance resources statewide. A few respondents acknowledged collaboration difficulties between state mental health and VR. In some states, formal responsibility for employment services for people with serious mental illness was unclear or in the process of shifting between agencies. Some states experienced diffusion of responsibility for employment services for people with serious mental illness with no single state agency providing oversight or leadership. Another challenge was coordination between the state mental health agency and the state Medicaid office to ensure that the state Medicaid plan included employment services as an authorized service.

**Workforce issues.** Respondents in 17 (34%) states cited *workforce issues* as major barriers. In most states, IPS specialists are poorly paid. Some states struggle to pay IPS specialists beyond entry-level rates due to low reimbursement rates for employment services, which makes it hard to recruit and retain staff. Not surprisingly, IPS specialist positions have frequent turnover and high vacancy rates. A respondent from a state with a long and stellar record of implementing IPS statewide noted a 40% IPS specialist turnover rate over the last year.

## Facilitators

As shown in Table 2, the most common facilitators to IPS development were *leadership*, *funding*, *quality improvement, building awareness*, and *government actions and programs*. Other facilitators included *buy-in from stakeholders*, *collaboration between state and local mental health and VR agencies*, *cultural factors*, *peer-to-peer learning*, and *past success with IPS*. *Government actions and programs* were noted more often as a facilitator in learning community states than non-learning community states, while *building awareness* was mentioned more often as a facilitator in non-learning community states than in learning community states.

**Leadership.** In 26 (52%) states, respondents noted the critical role of leaders from both state agencies (VR and mental health) and non-governmental organizations in promoting IPS and articulating the role of employment in the recovery process. One essential leadership role for ensuring IPS development is advocating for expanded funding for IPS. Governors and legislatures in several states promoted IPS through executive orders and other policy directives related to employment, such as for people affected by the opioid epidemic.

**Funding.** State leaders mentioned the importance of diverse funding to facilitate IPS service development, including local or state funds, grants, and Temporary Assistance for Needy Families. A few respondents indicated that grant funding for homelessness initiatives helped support new programs. One respondent mentioned access to startup funding for IPS pilot programs. Respondents mentioned the availability of policy documents providing concrete guidance to IPS teams for billing Medicaid.

**Quality improvement resources.** Respondents from eight (16%) states emphasized the importance of access to training and regularly scheduled fidelity reviews, especially when the state had an infrastructure that included permanent staff positions for experienced trainers. Access to technical assistance was also valued by state leaders. Informing potential adopters of IPS of the training and technical assistance availability has helped expand IPS to new sites. Two respondents noted that consistency in tracking data and outcome monitoring also helped state leaders monitor program quality and identify improvement needs. Both states used a common data collection tool statewide and shared results with providers.

**Building awareness.** Respondents described how they built awareness for IPS using multiple strategies, including conferences, client employment celebration events, newsletters, sharing back-to-work stories, and presentations. Some state leaders mentioned actively educating providers and sending comparison reports to them with the hope that the information would encourage them to adopt IPS. Positive messages from providers currently offering IPS have also helped its spread.

**Government actions and programs.** Government policies, legislative mandates, and various programs related to employment services increased the adoption of IPS and helped in prioritizing supported employment. For example, legislative mandates to provide evidence-based practices resulted in implementing IPS services. Respondents from six (12%) states mentioned the Employment First initiative supported by the U.S. Department of Labor, Office of Disability Employment Policy (www.dol.gov/agencies/odep/initiatives/employment-first), which promotes competitive integrated employment for all people with disabilities, as being a driving force for providing IPS services.

Other facilitators included increased buy-in among governmental, provider, and employer stakeholders due to a growing understanding of the IPS model and belief in employment as part of mental health treatment. Two respondents mentioned that IPS being an evidence-based practice has given it a good standing and encouraged new agencies to adopt IPS.

*Past success with IPS*, especially when state and local leaders document high rates of competitive integrated employment for IPS clients, can be a powerful facilitator of IPS adoption and growth in both new locations and in new populations. *Collaboration between VR and state mental health* has helped reinforce consistent messaging about employment. *Cultural factors* included a shift in agency culture toward employment for marginalized groups. Another shift in agency culture was adopting the guiding principle that "work is an outcome of care." *Peer-to-peer learning* took the form of advisory board meetings that included program managers and other meetings for IPS specialists, in addition to a learning collaborative across the state.

## State-Level Strategies for Maintaining and Expanding IPS Services

Learning community states were far more likely than non-learning community states to use each of three well-established strategies to implement IPS (collaboration between state mental health and VR agencies, provision of training and technical assistance, and regular independent fidelity reviews). In fact, 20 (83%) of the learning community states used all three key strategies, while only one of the 18 states (6%) outside the learning community provided all three. Outside the learning community, state mental health and VR agencies were rarely reported as collaborating closely; this collaboration can be challenging because of differences in organizational mission, target client groups served, and even terminology used to describe processes and outcomes. However, a strong partnership between these two agencies has many benefits for IPS, including greater opportunities to diversify funding for IPS.

While all the learning community states conduct external fidelity reviews on a regular basis, less than half of the non-learning community states do so. This produces problems because, without fidelity reviews, the quality of the employment services was uncertain and necessary information for technical assistance was unavailable. The history of large-scale efforts to disseminate evidence-based practices includes many examples in which planners have fallen short of their goals because they did not have an adequate mechanism to monitor quality of services (e.g., Rosenheck & Mares, 2007).

Learning community states were also more successful in obtaining funding for IPS services through multiple sources, including Medicaid, VR, state budgets, and federal grants. Nearly twice the percentage of learning community states used VR funding for IPS as non-learning community states (83% versus 44%), which is consistent with the greater collaboration between state mental health and VR agencies in learning community states. Both learning community states and non-learning community states typically used state or local funds (71% versus 72%) and to a lesser extent Medicaid (63% versus 56%). Of the possible funding sources for IPS, Medicaid may be the most underutilized.

## Discussion and Recommendations

IPS services are available throughout the U.S., including all but ten states. Nationwide, the reported number of IPS programs was over 850 in 2019 and growing (not including programs provided throughout the U.S. Department of Veterans Affairs), documenting the widespread acceptance of IPS as a valued service model.

Despite this, the number of people served in IPS programs falls woefully short of the optimal capacity to serve the target population in need. According to annual surveys compiled by the Substance Abuse and Mental Health Services Administration (SAMHSA), only 2% of working-age adults with serious mental illness receiving community mental health services enroll in any type of supported employment (Bruns et al., 2016), even though surveys consistently find that 60% or more of this population indicate that they would like to work in competitive integrated employment (Bond, Drake, & Becker, 2020).

The barriers to implementing IPS are well known and similar across all regions of the U.S. With some caveats, the barriers are similar in states that have made progress implementing IPS as in states that have few if any IPS programs. The main exceptions to this conclusion are that *rurality* appears to be a specific barrier impeding uptake of IPS in some Western states that contain large frontier regions; conversely, *populous states with decentralized mental health services* appear to face logistical challenges in managing statewide IPS initiatives. Even so, some rural states and some large, populous states have implemented IPS widely.

While the barriers do not explain why some states successfully expand IPS services and others do not, several facilitators and strategies appear to be the key. Strong, tenacious leaders who champion IPS overcome obstacles, even formidable ones like fragmented funding, are essential. States that have attained a shared vision among key stakeholders on the importance of employment and the role of IPS are also more likely to overcome barriers. Certainly, the work of implementing IPS does not stop with stakeholder agreement on values. States that have implemented and expanded IPS have taken concrete steps to establish new IPS programs, building an infrastructure to support these efforts.

The learning community states already have the highest per capita availability of IPS services in the U.S., and IPS services are growing more rapidly in the learning community. While many factors may contribute to this success, the national survey documents several areas in state-level implementation support that distinguish the learning community: close collaboration between state agencies responsible for IPS services, external fidelity reviews, training and technical assistance, and diversified funding. Based on the national survey findings and experiences of IPS Employment Center trainers, these recommendations are made to state IPS leaders:

1. **Incorporate IPS services as a priority in state planning.** State leaders should use every opportunity to publicize that *employment is a critical mental health intervention* (Drake & Wallach, 2020). The goal is to create and articulate a vision of IPS for all stakeholders. People with behavioral health issues should have the same opportunities to work competitively. Recovery regularly involves employment, and IPS is the evidence-based strategy to facilitate employment. The U.S. Department of Justice interprets the Americans with Disabilities Act as conferring a right to community-based services, including IPS (Burnim, 2015). Leaders should incorporate this vision into their strategic plans, state Medicaid plans, grant applications, and legislation.

2. **Maximize funding options for IPS through multiple sources**. States that have successfully implemented and expanded IPS have combined funding streams that permit community mental health agencies to fully fund IPS services (Herinckx, 2011; Johnson-Kwochka et al., 2017). State leaders should examine and plan for funding that covers the core aspects of IPS, including outreach and engagement, vocational assessment, job development, job retention, and supported education. A planning worksheet can be found at https://ipsworks.org/wp-content/uploads/2018/02/State-Plan-to-Support-IPS-Services.pdf. If startup funding for IPS is short-term, such as a federal grant, the implementation team and state steering committee should work on securing long-term funding from the start. Securing funding usually involves aligning policies and standards (e.g., VR creating a separate fee schedule for IPS) and training (e.g., helping agencies learn to bill Medicaid for some IPS services). Some states have established higher reimbursement rates for IPS teams achieving high fidelity (Karakus, Frey, Goldman, Fields, & Drake, 2011).

   Given that funding is the greatest barrier to implementing IPS services, state leaders should continuously look for new funding opportunities to implement and sustain IPS. When state Medicaid plans are under review, state leaders should advocate for policies that align with IPS services. Similarly, state leaders can seek changes to VR payment structures that are compatible with IPS services. In some states, IPS programs are underutilizing existing funding sources; educating IPS team leaders may be another way to maximize funding.

3. **Cultivate strong collaborations between key state agencies, including mental health, VR, and Medicaid.** Most states that have had success implementing and expanding IPS services have built strong collaborations among key state agencies. These collaborations can be formalized in Memoranda of Understanding (See Selleck & Luecking, 2018). Also important is developing a shared understanding of the roles of different agencies and how the mission of each agency fits with the IPS model. For example, while the terminology used in VR differs from that in IPS, over time, state leaders can develop a shared vision regarding compatibility (See: IPS Supported

Employment and State Vocational Rehabilitation: A Crosswalk. https://ipsworks.org/wp-content/uploads/2017/09/IPS-VR-Crosswalk-July-2017wfooter-margins.pdf).

4. **Fund technical assistance and an external fidelity review process.** As suggested by the survey findings, securing permanent funding for a technical assistance capacity is crucial for ensuring quality of services and sustainment of programs over time. We recommend that states build this capacity within the state and not outsource technical assistance to an out-of-state training center, for several reasons. First, by committing to and providing funding for a local trainer (or technical assistance center), state leaders help ensure local buy-in and ownership of the technical assistance. Second, establishing a position of a local trainer is more sustainable over time; technical assistance from outside experts is often viewed as temporary and too costly to maintain. Third, local trainers are familiar with the local community – its history, culture, and politics. Fourth, local trainers are more able to provide hands-on consultation and field mentoring, which are the most effective strategies for ensuring high quality services (Rapp et al., 2008). Conversely, out-of-state trainers mostly provide help through remote consultation, which is less impactful than face-to-face contact (Bond, 2007). State leaders should ensure that the technical assistance resource is adequately sized for the number of IPS programs; as more programs develop, more trainers will be needed to ensure ongoing quality. State-funded technical assistance centers have promoted growth of IPS services (Salyers et al., 2007).

5. **Capitalize on governmental policies that favor IPS adoption.** As the survey respondents noted, the research showing the effectiveness of IPS is an important selling point. State leaders should draw on this strength. The ASPIRE website provides information on the effectiveness of IPS suitable for different audiences (including legislators, advocacy groups, and policy planners). In many states, leaders have an opportunity to use state and federal policies favoring evidence-based practices to advocate for IPS adoption and expansion. Some states have statutes that mandate state agencies to ensure that the programs and services within their purviews are evidence-based (Pew-MacArthur, 2015). In Oregon, for example, the state legislature passed a bill requiring that several state agencies allocate 75% of their state budget to evidence-based practices. This legislation has promoted the adoption of IPS throughout the state.

6. **Align policies and standards to support IPS.** Of course, governmental policies and IPS principles, and legal coverage do not always align perfectly. In these cases, IPS advocates should work toward modifying policies that are contrary to the evidence and to IPS principles, even where disability status is not clear. For example, state and local VR offices sometimes have interpreted VR policies to mean that clients who are actively using drugs or alcohol are ineligible for IPS services. However, research shows that remissions and relapses are part of the recovery process, and that people with active use enrolled in IPS programs have employment outcomes similar to people who are not active users. Moreover, employment often facilitates recovery. Ensuring that the formal state VR policy is that active substance use does not disqualify any applicant from receiving VR services would be an example of aligning policies to the evidence. A second example is a state VR agency that changed their milestone payments by eliminating payments for a practice that was not evidence-based (situational assessments) and redirected these funds to ensure enhanced rates for job placement and retention. After initially resisting this change, counselors and agency staff adopted it and ultimately increased competitive employment outcomes (Swanson et al., 2011).

7. **In states without IPS (or only a few IPS programs), start with a small number of early adopter sites and invest adequate resources to ensure successful implementation.** This recommendation is based on the notion that early success is crucial to long-term growth. Put simply, success breeds success. As survey respondents noted, *past success with IPS* is a valuable motivator of IPS expansion. Sharing client stories from early adopter sites with state department administrators and legislators can be a powerful strategy for eliciting support for IPS. Anecdotally, we know of several states in which leaders chose to implement IPS after seeing its impact in a neighboring state. One state, which had not previously offered IPS anywhere in the state, recently launched an IPS pilot program after a local program leader recognized the astonishing success of an IPS program just across the state border (Bond et al., 2021).

   In most states, state mental health and VR agency administrators responsible for employment services for people with serious mental illness are aware of IPS. Even so, misconceptions about IPS are still an issue, so education remains an important element in an implementation strategy, especially in a pilot phase.

We also recommend against launching a large statewide initiative without an initial early adopter phase. Our experience is that *rapid expansion risks compromising quality of implementation*. It is much easier to take lessons learned from a pilot phase and scale up IPS services versus doing a large-scale implementation right away. States bypassing an early adopter phase often end up with inadequate training and fidelity review resources, troubles collecting accurate data, and other problems. In these instances, leaders must go back later and realign services that did not fully implement IPS.

## Conclusions

IPS continues to grow in the U.S. and the IPS Learning Community is one effective strategy that promotes statewide growth of services. Federal agencies, including the U.S. Department of Labor, U.S. Department of Justice, Social Security Administration, National Institute of Disability, Independent Living, and Rehabilitation Research, and SAMHSA have also contributed. This issue brief identifies many barriers and facilitators to IPS development that may assist state leaders seeking to expand IPS. Barriers to IPS growth were similar across states: funding, lack of prioritization, system-level challenges, and workforce issues. Strong leadership is the linchpin facilitator of IPS development, as leaders garner resources to address barriers over time.

FIGURE 1 **IPS Learning Community**

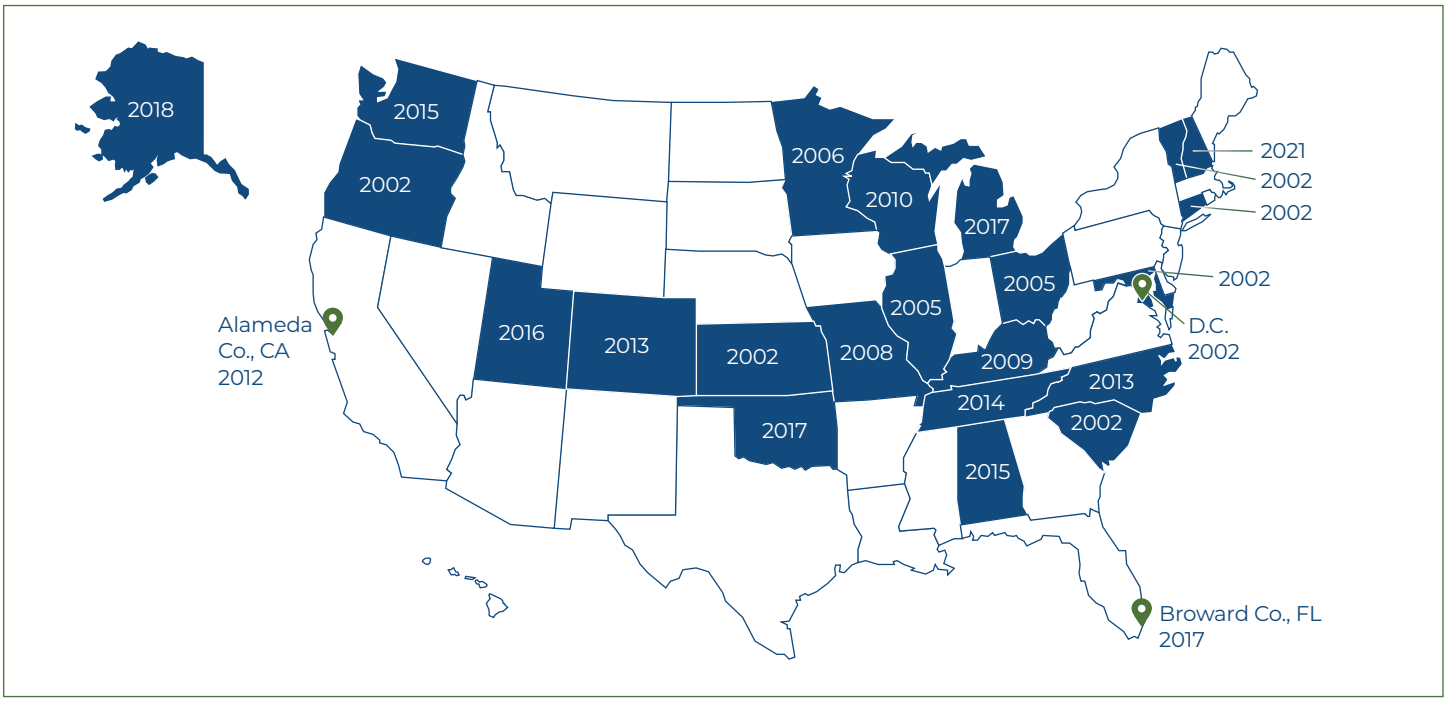



FIGURE 2 **Growth of the Number of IPS Programs in the United States, 2016–2019**

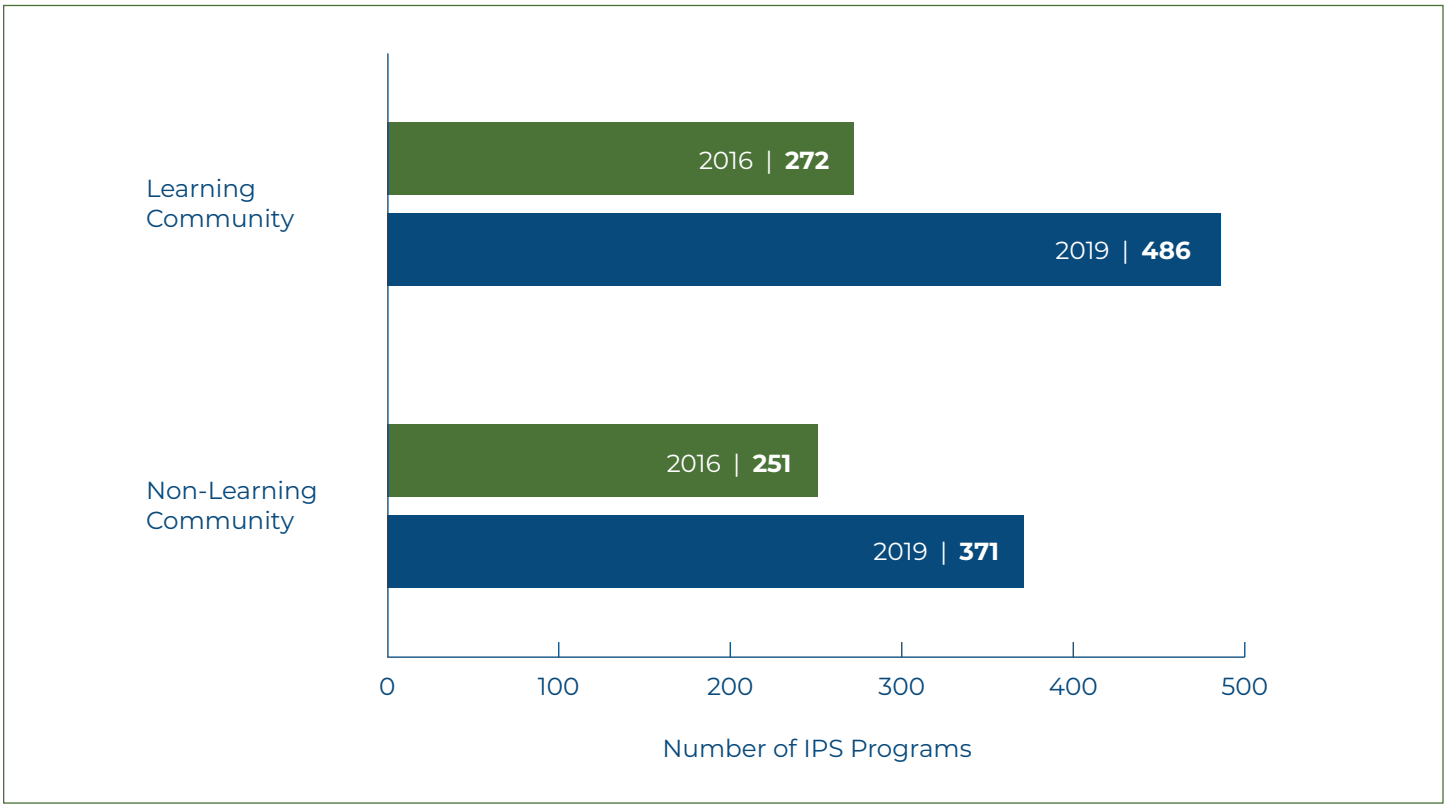


TABLE 1 **Barriers to Implementing IPS Identified by State Leaders in 48 States and 2 Counties**

| Barrier | Learning Community (N=22 states and 2 counties) | % | Non-Learning Community (N=18) | % | States without IPS (N=8) | % | Total, all three groups (N=50) | % |
|---|---|---|---|---|---|---|---|---|
| Funding | 16 | 67% | 16 | 89% | 5 | 63% | 37 | 74% |
| Prioritization | 11 | 46% | 10 | 56% | 4 | 50% | 25 | 50% |
| Systems barriers | 8 | 33% | 9 | 50% | 1 | 13% | 18 | 36% |
| Workforce Issues | 6 | 25% | 10 | 56% | 1 | 13% | 17 | 34% |
| Awareness | 5 | 21% | 2 | 11% | 3 | 38% | 10 | 20% |
| Infrastructure | 6 | 25% | 2 | 11% | 1 | 13% | 9 | 18% |
| Leadership | 3 | 13% | 4 | 22% | 1 | 13% | 8 | 16% |
| Community Factors | 1 | 4% | 3 | 17% | 3 | 38% | 7 | 14% |
| Client Factors | 1 | 4% | 3 | 17% | 1 | 13% | 5 | 10% |

Note: We list Broward County, Florida, and Alameda County, California, with the Learning Community States because they are large counties the size of some states. We consider the rest of Florida and California as outside of the Learning Community.

State leaders from three states without IPS did not respond to this survey question.

TABLE 2 **Facilitators to Implementing IPS Identified by State Leaders in 48 States and 2 Counties**

| Facilitator | Learning Community (N=22 states and 2 counties) | % | Non-Learning Community (N=18) | % | States without IPS (N=8) | % | Total, all three groups (N=50) | % |
|---|---|---|---|---|---|---|---|---|
| Leadership | 12 | 50% | 10 | 56% | 4 | 50% | 26 | 52% |
| Quality Improvement | 6 | 25% | 7 | 39% | 1 | 13% | 14 | 28% |
| Buy-in from Stakeholders | 8 | 33% | 4 | 22% | 1 | 13% | 13 | 26% |
| Funding | 6 | 25% | 5 | 28% | 2 | 25% | 13 | 26% |
| Government Actions and Programs | 8 | 33% | 3 | 17% | 2 | 25% | 13 | 26% |
| Building Awareness | 5 | 21% | 7 | 39% | -- | -- | 12 | 24% |
| Past Success with IPS | 5 | 21% | 4 | 22% | -- | -- | 9 | 18% |
| Interagency Collaboration | 5 | 21% | 3 | 17% | 1 | 13% | 9 | 18% |
| Cultural Factors | 2 | 8% | -- | | 2 | 25% | 4 | 8% |
| Peer-to-Peer Learning | 2 | 8% | 2 | 8% | -- | -- | 4 | 8% |

Note: We list Broward County, Florida, and Alameda County, California, with the Learning Community States because they are large counties the size of some states. We consider the rest of Florida and California as outside of the Learning Community.

State leaders from three states without IPS did not respond to this survey question.

# Appendix

## 2019 National Survey

**State:**

Your answer

**Number of IPS Programs (agencies)**

Your answer

**Number of IPS Teams**

Your answer

**Number of IPS clients served during recent three-month period**

Your answer

**Number of IPS clients who were competitively employed during same three-month period**

Your answer

**Number of IPS clients who were in education programs during same three-month period**

Your answer

**How many IPS providers have both mental health and employment services within their agency?**

Your answer

**How many IPS providers are clubhouses?**

Your answer

**How many IPS providers are stand-alone employment agencies that partner with mental health OR traditional rehab agencies (like Goodwill, Easterseals)?**

Your answer

**How many IPS providers are first episode psychosis programs?**

Your answer

**How many IPS providers are WIOA-sponsored young adult programs?**

Your answer

**Any other IPS provider program types, including #?**

Your answer

**IPS funding (Primary sources and "any funding")**

- ☐ Medicaid (Add which category in add'l notes)
- ☐ VR
- ☐ State or local general funds
- ☐ Federal Block Grant
- ☐ Ticket to Work
- ☐ SAMHSA grant
- ☐ Other grants
- ☐ Other: _____

**Additional notes on IPS funding**

Your answer

**How is IPS fidelity measured?**

- ☐ Independent fidelity reviews with enhanced funding
- ☐ Independent fidelity reviews informational only
- ☐ Self-assessed fidelity
- ☐ No fidelity measurement
- ☐ Other: _____

**Percentage of programs that have independent fidelity reviews with enhanced funding**

Your answer

**Percentage of programs that have independent fidelity reviews that are informational only**

Your answer

**Percentage of programs that have self-assessed fidelity**

Your answer

**Percentage of programs that have no fidelity monitoring of any kind**

Your answer

**IPS technical assistance**

- ☐ State-funded technical assistance specifically for IPS
- ☐ More general technical assistance (e.g., voc rehab)
- ☐ Agency-funded technical assistance specifically for IPS
- ☐ None
- ☐ Other: _____

**Do IPS programs take the IPS Center's online courses? (If yes, add % of staff in other box)**

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Other: _____

**Which state agency leads IPS implementation in your state?**

- ☐ Active and positive collaboration between MH and VR
- ☐ MH leads IPS implementation, VR generally not involved
- ☐ VR leads IPS implementation, MH not involved
- ☐ Neither state agency involved
- ☐ Other: _____

**3 factors promoting IPS**

Your answer

**Factors promoting IPS (go through and check if not mentioned above):**

- ☐ Member of IPS Learning Community
- ☐ Olmstead or related legal action (add which one in other box)
- ☐ State legislation (evidence-based policies, e.g., Oregon)
- ☐ Champion/leadership

**3 barriers to implementing IPS**

Your answer

**Final notes and comments**

Your answer

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