Implementing Individual Placement and Support in Rural Communities: Barriers and Strategies[1]

ASPIRE

Advancing State Policy Integration for Recovery and Employment

Gary R. Bond | Monirah Al-Abdulmunem | Deborah R. Becker | Robert E. Drake

June 2022

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 address these barriers. This brief draws primarily on a qualitative interview study of 27 key informants in 15 states with successful IPS programs in rural communities. (Al-Abdulmunem et al., 2021).
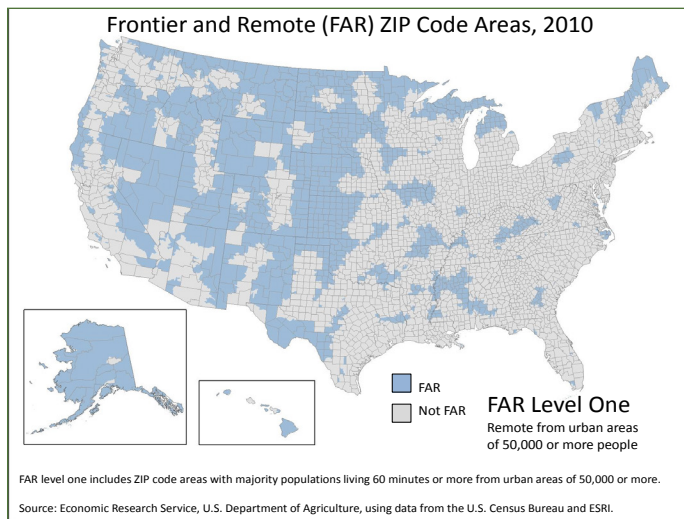
What is Rurality?

Federal agencies and researchers have developed many definitions of rurality, based on administrative, land-use, economic, and other factors, using a variety of measures to define gradations of rurality. For example, the Economic Research Service (ERS) within the United States Department of Agriculture maintains a set of Rural-Urban Commuting Area (RUCA) codes to classify U.S. census tracts (and zip codes) on a 10-point scale (https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/). An area classified as rural by one definition may not be by another, leading a 2008 report to note that "The share of the U.S. population considered rural ranges from 17 to 49 percent depending on the definition used" (Cromartie & Bucholtz, 2008). The Office of Management and Budget advises against using the term rurality but instead defines two broad categories: *metropolitan and non-metropolitan* (Bennett et al., 2019). The most remote type of rural area is termed *frontier*, defined (by Frontier and Remote Area Codes) as an area "at least fifteen minutes away from a city or town of 2,500–9,999 people and an hour or more away from a city or town of 50,000 or more people" (Bennett et al., 2019). In this issue brief we will not delve into the complicated technical details of the various definitions but instead assume that an area is rural if identified as such by local residents.

Rural communities vary widely in economies, culture, demographics, and geography. Rural regions include areas in Northern New England, Appalachia, the Southeast, the Great Plains (parts of Montana, North Dakota, South Dakota, Wyoming, Nebraska, Kansas, Colorado, Oklahoma, Texas, and New Mexico), the Rocky Mountains, the Southwest, and Alaska. All states have rural communities, but the noncoastal Western states
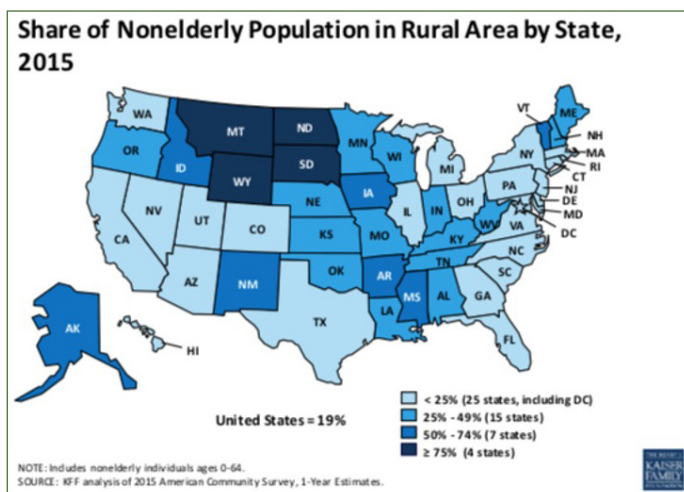
have the largest concentration of rural regions (See Figure 1). In 26 states, a quarter or more of the land area is considered rural, as shown in Figure 2 (Foutz et al., 2017). Therefore, implementation of IPS in rural communities is a national issue.

Frontier Areas of the U.S.

Frontier and Remote (FAR) ZIP Code Areas, 2010

FAR
Not FAR

FAR Level One
Remote from urban areas of 50,000 or more people

FAR level one includes ZIP code areas with majority populations living 60 minutes or more from urban areas of 50,000 or more.

Source: Economic Research Service, U.S. Department of Agriculture, using data from the U.S. Census Bureau and ESRI.

Source: Downloaded from: https://www.ers.usda.gov/webdocs/DataFiles/51020/52626_farcodesmaps.pdf?v=483.4

FIGURE 2 **How Rural is Each State**

Share of Nonelderly Population in Rural Area by State, 2015

United States = 19%

< 25% (25 states, including DC)
25% - 49% (15 states)
50% - 74% (7 states)
≥ 75% (4 states)

NOTE: Includes nonelderly individuals ages 0-64.
SOURCE: KFF analysis of 2015 American Community Survey, 1-Year Estimates.

Source: Foutz, J., Artiga, S., & Garfield, R. (2017). *The Role of Medicaid in Rural America*. Menlo Park, CA: Kaiser Family Foundation. Available at: https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/

IPS Fidelity and Outcomes in Rural Areas

IPS is based on eight principles that distinguishes it from other employment models: a) focus on the goal of competitive employment (IPS programs help clients obtain regular jobs in the community); b) zero exclusion (every client who wants to work is eligible for services regardless of "readiness"); c) attention to client preferences (services align with clients' choices, rather than practitioners' judgments); d) rapid job search (IPS specialists help clients look for jobs soon after they express interest, rather than providing lengthy pre-employment preparation); e) targeted job development (based on clients' interests, IPS specialists build relationships with employers through repeated contact); f) integration of employment services with mental health treatment (IPS programs closely integrate with mental health treatment teams); g) personalized benefits counseling (IPS specialists help clients obtain personalized, understandable, and accurate information about how working may impact their disability insurance); h) individualized long-term support (follow-along supports, tailored for the individual, continue for as long as the client wants and needs support). To facilitate implementation and sustainment of programs that follow IPS principles, Becker et al. (2019) 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 the standard IPS fidelity scale, is the single best measure of the quality of IPS implementation. Fidelity ratings using the standard 25-item IPS fidelity scale, the IPS-25, are associated with better employment outcomes (Bond et al., 2012).

Mental health leaders sometimes assume that IPS fidelity standards are not appropriate in rural areas because it is not feasible to implement IPS to the same level of fidelity in rural communities as in more populous areas. However, Luciano et al. (2014) found no differences in overall fidelity scores between 23 rural and 56 urban programs. This report then explored whether rural and urban programs differed on any individual fidelity item, finding no differences on 15 of the 25 items. Table 1 shows fidelity items on which urban and rural programs differed most. On balance, both urban and rural IPS programs face challenges in implementing IPS to high fidelity, but each area has its unique disadvantages and advantages. Functioning as a vocational unit and ensuring diversity of employers

TABLE 1   **Urban and Rural Differences on IPS Fidelity (Luciano et al., 2014)**

	Urban (N=56)	Rural (N=23)
IPS-25 total	100±14	104±12
mean team caseload	66.0	42.0
	Item score (range 1-5)	
1. Caseload size	4.6	5.0
2. Exclusively vocational services	4.8	4.5
4. Integration with treatment team	4.1	4.7
5. Contact with treatment team	3.6	4.5
7. Vocational unit	4.2	3.0
12. Benefits counseling	3.9	4.4
13. Disclosure	3.8	4.3
14. Individualized assessment	3.8	4.2
20. Employer diversity	4.4	3.8
22. Individualized supports	4.1	4.5

are two fidelity items on which rural IPS teams most often struggle, consistent with what IPS team leaders report. On the other hand, rural programs generally have smaller caseloads and closer coordination with treatment teams than urban programs, which 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, employment outcomes are similar in rural and urban IPS programs (Haslett et al., 2011; Luciano et al., 2014). Taken together, similarities in fidelity and outcomes in rural and urban areas should encourage rural mental health agencies to implement IPS.

General Barriers to Services in Rural Communities

Rural service providers face many barriers to providing high quality services. In addition to a shortage of professionals (Thomas et al., 2012), rural providers must cope with poverty, limited educational opportunities, job loss due to economic shifts, high levels of community unemployment, family stress, substance abuse, and social isolation (Case & Deaton, 2020). For these reasons,

rural mental health service areas often lack evidence-based practices (Parsons et al., 2003). Furthermore, some evidence-based practices, such as assertive community treatment, do not transfer easily from urban to rural mental health service areas. Even practices that are widely used in rural areas must adapt to local contexts, which vary considerably from one area to the next (Allan, 2010; Andrilla et al., 2020; Perkins et al., 2019; Sawyer et al., 2006).

Barriers and Strategies to 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 educated workforce, and a smaller client base. Rural centers with low referral rates have difficulty sustaining team-based services such as IPS. Such concerns may explain why leaders hesitate to start new IPS programs. Put simply, leaders may decide against establishing a new program because the financial risks are too great.

One way to mitigate risk is for state or federal agencies to provide seed money to local providers to start up IPS services. While this does not address sustainability, it does provide an opportunity to test out the viability of IPS within a particular region. Most commonly state mental health agencies provide funding of this kind, but other state agencies may offer help. State legislators sometimes authorize funding for innovative IPS projects, for example, in Minnesota (Courtney, 2019). In Iowa, county funds recently were used to fund a pilot IPS project in two rural communities. Federal funding opportunities such as Community Mental Health Services Block Grant and various SAMHSA initiatives (such as SAMHSA, 2020) are other possibilities for start-up funding. One innovative project, funded by the Centers for Medicare and Medicaid through the Balancing Incentives Program, enabled several rural communities to start up IPS services for transitional age youth (Noel et al., 2018).

State mental health 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 as well as other stakeholders can emphasize that employment is a valued outcome, an effective mental health treatment, and a high priority (Gowdy et al., 2004).

If a rural agency does implement an IPS program, it may be limited to a single IPS specialist, or in frontier areas, to a part-time staff person. Rural agencies often de-emphasize specialization and ask staff to serve in multiple roles. Rural agencies also commonly employ paraprofessionals and less credentialed professionals to fill professional roles, or they expand job descriptions, asking mental health workers to share tasks (Kirby et al., 2019) and to be generalists with diverse duties that multiple specialists are responsible for in urban areas (Hoeft et al., 2018). 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 center) to a far greater extent than do their urban counterparts (Rapp & Goscha, 2011).

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

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 4-county region staffed their IPS team with one IPS specialist in a satellite office in each county located at some distance from the central office. They used videoconferencing as an alternative to face-to-face vocational unit meetings. Telehealth grew in popularity during the COVID-19 pandemic and may have reduced the percentage of clients with mental health conditions who cancel appointments (Eyllon et al., 2022). To our knowledge, however, 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.

The lack of adequate public transportation is a barrier for clients both in the job search and at the workplace once hired. Where public transportation is available, it is sometimes unreliable, often not reaching clients' residences, or with limited hours of operation. While the use of technology might seem to be an ideal solution (Fortney et al., 2015), IPS clients may lack internet connectivity or needed technological tools. One encouraging recent development is the passage of the Infrastructure Investment and Jobs Act, which allocated $65 billion to improving internet access (H.R. 3684, 2022).

To travel to and from work, IPS clients rely on natural supports, such as family members, church members, and carpooling with co-workers. Sometimes IPS

programs help clients purchase bikes and purchase or repair cars. In some instances, they help clients to become drivers to transport other clients for pay. Sometimes IPS specialists transport their clients temporarily to start jobs until the clients arrange rides with co-workers. Some clients find remote jobs; others move closer to their workplace, walk long distances, or ride a bike. When clients need to apply to jobs online but lack a computer and internet connection to do so, they apply with the help of their IPS specialist using a computer available at the health center or library.

- **The limits of job opportunities and closeness of business ownership affect job development and follow-along supports.**

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

The lack of available opportunities affects frontier areas more severely than more populous and less remote areas. Rural towns at least have a few employers and perhaps are near to a large factory or distribution center, but more remote frontier areas have almost no employers. The employment choices in remote areas 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 "everybody knows everybody." The lack of anonymity has advantages and disadvantages, sometimes increasing bias against hiring people with mental health conditions, substance abuse, or justice system involvement, and sometimes leading to helping neighbors. Relationships with employers are critical. IPS specialists report greater success developing jobs at locally owned businesses; chain stores with distant owners and headquarters are more challenging, especially for clients who do not wish to disclose their mental health condition. The lack of anonymity can potentially offset the disadvantages of social judgment, stigma and preconceived notions about individuals locally known to have a mental or substance use condition. One way that IPS specialists develop relationships with local employers and enhance awareness of recovery potential is to network regularly with employers 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 with low pay and in areas with few professionals. Funding regulations through managed care have resulted in serving some clients without reimbursement, thereby stressing mental health agency budgets. Waiting lists result in clients in rural areas receiving fewer services than those who live near towns. Strategies to overcome these challenges and improve retention include equalizing pay between care managers and IPS specialists, having strong leadership support, and providing excellent training. Hiring local residents who lack professional education requires more training, but these IPS specialists value the jobs and have longer tenure.

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

Culture varies from one rural area to the next. For example, local culture may emphasize welcoming or discriminating against immigrants, trying to replace a declining industry such as mining or attracting new businesses, or understanding Native American governance structures or new immigrant or refugee groups. Adaptations also are varied. For example, in five states with Native American reservations, IPS specialists have adjusted to local business ownership by the tribal council; local values, such as maintaining strong family ties; and local regulations, such as one reservation prohibiting the hiring of any members with a substance use disorder (Al-Abdulmunem et al., 2021).

Once again, relationships are critical in rural communities. IPS specialists are more effective when they have been local residents themselves, know the local families and culture, can relate to local employers, and are able to navigate local intricacies.

Key Points

- **Throughout the U.S., rural communities face a variety of barriers to IPS implementation. The creative strategies used to overcome barriers in one community may not resonate in other communities. Program leaders must tailor their strategies to address the unique characteristics of their communities and their local resources.**

- **The diverse local adjustments to rural environments have not compromised basic IPS principles, such as service integration, following client preferences, rapid job search, and follow-along support. These principles are equally applicable to rural and urban areas. High fidelity to IPS is equally important in both rural and urban communities.**

- **Because of remoteness, the challenges discussed throughout this issue brief are even greater in a frontier area than in a small town.**

Conclusions

Rural communities across the U.S. must navigate limited public transportation, poor internet connectivity, scarce employment opportunities, and other challenges. Nevertheless, IPS can be effective in rural areas. While these communities contain different cultures and have varying adjustments to IPS, successful implementations of IPS preserve the principles of the model. IPS should be a core behavioral health service in rural America.

References

Al-Abdulmunem, M., Drake, R. E., & Carpenter-Song, E. (2021). Evidence-based supported employment in the rural United States: Challenges and adaptations. *Psychiatric Services*, 72, 712-715. https://doi.org/10.1176/appi.ps.202000413

Allan, J. (2010). Determinants of mental health and well-being in rural communities: do we understand enough to influence planning and policy? *Australian Journal of Rural Health*, 18, 3-4. https://doi.org/10.1111/j.1440-1584.2009.01121.x

Andrilla, C. H., Garberson, L. A., Patterson, D. G., Quigley, T. F., & Larson, E. H. (2020). Comparing the health workforce provider mix and the distance travelled for mental health services by rural and urban Medicare beneficiaries. *Journal of Rural Health*, 37, 692-699. https://doi.org/10.1111/jrh.12504

Becker, D. R., Swanson, S., Reese, S. L., Bond, G. R., & McLeman, B. M. (2019). *Supported employment fidelity review manual* (4th ed.). IPS Employment Center.

Bennett, K. J., Borders, T. F., Holmes, G. M., Kozhimannil, K. B., & Ziller, E. (2019). What Is rural? Challenges and implications of definitions that inadequately encompass rural people and places. *Health Affairs*, 38, 1985-1992. https://doi.org/10.1080/15487768.2011.598106

Bond, G. R., Peterson, A. E., Becker, D. R., & Drake, R. E. (2012). Validation of the revised Individual Placement and Support Fidelity Scale (IPS-25). *Psychiatric Services*, 63, 758-763. https://doi.org/10.1176/appi.ps.201100476

Case, A., & Deaton, A. (2020). *Deaths of despair and the future of capitalism*. Princeton University. https://doi.org/10.1515/9780691199955

Courtney, C. (2019). Individual Placement and Support for persons with serious mental illness in Minnesota. Report to the legislature as required by Minn. Stat. §268a.15. In: Minnesota Employment and Economic Development, Vocational Rehabilitation Services.

Cromartie, J., & Bucholtz, S. (2008). *Defining the "rural" in rural America*. Economic Research Service, U.S. Department of Agriculture. Available at: https://www.ers.usda.gov/amber-waves/2008/june/defining-the-rural-in-rural-america/

Eyllon, M., Barnes, J. B., Daukas, K., Fair, M., & Nordberg, S. S. (2022). Telehealth on visit adherence in mental health care: An interrupted time series study. *Administration and Policy in Mental Health and Mental Health Services Research*, 49, 453-462. https://doi.org/10.1007/s10488-021-01175-x

Fortney, J. C., Pyne, J. M., Turner, E. E., Farris, K. M., Normoyle, T. M., Avery, M. D., Hilty, D. M., & Unutzer, J. (2015). Telepsychiatry integration of mental health services into rural primary care settings. *International Review of Psychiatry*, 27, 525-539. https://doi.org/10.3109/09540261.2015.1085838

Foutz, J., Artiga, S., & Garfield, R. (2017). *The role of Medicaid in rural America*. Kaiser Family Foundation (https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/)

Gowdy, E. A., Carlson, L. S., & Rapp, C. A. (2004). Organizational factors differentiating high-performing from low-performing supported employment programs. *Psychiatric Rehabilitation Journal*, 28, 150-156. https://doi.org/10.2975/28.2004.150.156

H.R. 3684. (2022). Infrastructure Investment and Jobs Act. Available at: https://www.epw.senate.gov/public/_cache/files/e/a/ea1eb2e4-56bd-45f1-a260-9d6ee951bc96/F8A7C77D69BE09151F210EB4DFE872CD.edw21a09.pdf

Haslett, W. R., Bond, G. R., Drake, R. E., Becker, D. R., & McHugo, G. J. (2011). Individual placement and support: Does rurality matter? *American Journal of Psychiatric Rehabilitation*, 14, 237-244. https://doi.org/10.1080/15487768.2011.598106

Hoeft, T. J., Fortney, J. C., Patel, V., & Unützer, J. (2018). Task-sharing approaches to improve mental health care in rural and other low-resource settings: a systematic review. *Journal of Rural Health*, 34, 48-62. https://doi.org/10.1111/jrh.12229

Kirby, J. B., Zuvekas, S. H., Borsky, A. E., & Ngo-Metzger, Q. (2019). Rural residents with mental health needs have fewer care visits than urban counterparts. *Health Affairs*, 38, 2057-2060. https://doi.org/10.1377/hlthaff.2019.00369

Luciano, A. E., Bond, G. R., Becker, D. R., & Drake, R. E. (2014). Is high fidelity to supported employment equally attainable in small and large communities? *Community Mental Health Journal*, 50, 46-50. https://doi.org/10.1007/s10597-013-9687-2

Noel, V. A., Oulvey, E., Drake, R. E., Bond, G. R., Carpenter-Song, E. A., & DeAtley, B. (2018). A preliminary evaluation of Individual Placement and support for youth with developmental and psychiatric disabilities. *Journal of Vocational Rehabilitation*, 48, 249-255. https://doi.org/10.3233/JVR-180934

Parsons, J. E., Merlin, T. L., Taylor, J. E., Wilkinson, D., & Hiller, J. E. (2003). Evidence-based practice in rural and remote clinical practice: Where is the evidence? *Australian Journal of Rural Health*, 11, 242-248. https://doi.org/10.1111/j.1440-1584.2003.00527.x

Perkins, D., Farmer, J., Salvador-Carulla, L., Dalton, H., & Luscombe, G. (2019). The Orange Declaration on rural and remote mental health. *Australian Journal of Rural Health*, 37, 374-379. https://doi.org/10.1111/ajr.12560

Rapp, C. A., & Goscha, R. J. (2011). *The strengths model: a recovery-oriented approach to mental health services* (2nd ed.). Oxford.

SAMHSA. (2020). *Transforming Lives Through Supported Employment (SE) Program* (https://www.samhsa.gov/criminal-juvenile-justice/grant-grantees/transforming-lives-through-supported-employment-program). Substance Abuse and Mental Health Services Administration.

Sawyer, D., Gale, J. A., & Lambert, D. (2006). *Rural and frontier mental and behavioral health care: Barriers, effective policy strategies, best practices*. National Association of Rural Mental Health.

Thomas, D., MacDowell, M., & Glasser, M. (2012). Rural mental health workforce needs assessment: A national survey. *Rural and Remote Health*, 12, 2176. Available at: www.rrh.org.au/journal/article/2176