3.4 THE INDIVIDUAL PLACEMENT & SUPPORT MODEL OF SUPPORTED EMPLOYMENT FOR STREET-INVOLVED YOUTH WITH MENTAL ILLNESS

Kristin M. Ferguson

INTRODUCTION

More than two million youth in the United States are homeless at some time each year (Whitbeck, 2009). They often have histories of depression, complex trauma, substance abuse, and physical and sexual abuse—all of which make obtaining and maintaining competitive employment difficult. Epidemiologic data indicate that 26% meet the clinical criteria for major depression, 35% have attempted suicide, and 72% use illegal substances to cope (Rotheram-Borus & Milburn, 2004). Their connection to school is also irregular or non-existent, which contributes to low educational levels and limited employment skills. Several studies suggest that over one-third of youth who are homeless have dropped out of school, do not attend school regularly, or fail to earn a high-school diploma by age 18 (Thompson, Pollio, & Constantine, 2002; Whitbeck, 2009). These mental health and behavioural health challenges, combined with low educational and employment skills, contribute to high unemployment rates among youth who are homeless compared with their housed peers. Housed youth in the general population (aged 16–24) have unemployment rates ranging between 8% and 17% (U.S. Department of Labor, Bureau of Labor Statistics, 2016), whereas unemployment rates for youth who are homeless range from 39% to 71% across various samples of youth living on the street or in shelters (Courtney, Piliavin, Grogan-Kaylor, & Nesmith, 2001; Ferguson & Xie, 2008; Lenz-Rashid, 2006; Whitbeck, 2009).

Unemployment among youth who are homeless can be chronic, with many averaging more than eight months without work in any given year (Baron & Hartnagel, 1997). These young people may be unemployed according to the federal government's official definition: being jobless, having actively looked for work in the past four weeks, and currently being available for work (U.S. Department of Labor, Bureau of Labor Statistics, 2015). However, many rely on informal sources of income, both legal (e.g., selling recycled material, self-made items, blood/plasma) and illegal or legally regulated (e.g., prostitution, selling drugs, panhandling, asking people for money in public spaces). These income sources may be in addition to or a substitute for income from formal employment (Ferguson, Bender,

Thompson, Xie, & Pollio, 2011; Gaetz & O'Grady, 2002). Unemployment and illegal informal employment among young people who are homeless is associated with various antisocial outcomes, including increased substance use and criminal activity (Baron, 1999), which can lead to further societal estrangement (Johnson, Whitbeck, & Hoyt, 2005; Thompson, Rew, Barczyk, McCoy, & Mi-Sedhi, 2009).

Employment nonetheless is particularly important to young people who are homeless because it contributes to identity formation, links them to conventional institutions, and provides income that facilitates economic self-sufficiency (Gaetz & O'Grady, 2002). Through employment, these young people benefit from developing skills related to time structure, social contact, social context, and social identity (Harnois & Gabriel, 2000), which many have not had the opportunity to learn within home environments characterized by abuse and dysfunction (Tyler, Cauce, & Whitbeck, 2004). Further, since many of these youth have emancipated from the child welfare system and their biological families, they need to achieve economic self-sufficiency to survive (Mallon, 1999). Without employment opportunities combined with clinical and case management supports, youth who are homeless are at a disadvantage in achieving economic self-sufficiency and independent living in their transition to adulthood. This transition thus requires customized, long-term, and integrated employment, clinical, and case management services. Without these targeted supports, this population remains at risk for economic hardship, labour exclusion, exacerbation of mental illness, and chronic adult homelessness (Tyler & Johnson, 2006).

INDIVIDUAL PLACEMENT & SUPPORT MODEL PRINCIPLES

The individual placement and support (IPS) model is one example of a customized, long-term, and integrated model of supported employment. It is an evidence-based vocational intervention that targets individuals who have severe mental illness with customized, long-term, and integrated vocational and clinical services to help them gain and maintain competitive employment (Drake, Bond, & Becker, 2012). Originally designed for adults with severe mental illness (Drake et al., 2012), the IPS model has been implemented and adapted with multiple populations, including adult veterans with psychiatric or addiction disorders who are homeless (Rosenheck & Mares, 2007), housed young adults with first-episode psychosis (Nuechterlein et al., 2008; Rinaldi et al., 2004), and young adults with mental illness who are homeless (Ferguson, Xie, & Glynn, 2012).

The IPS model follows eight supported-employment principles, as described by Drake et al. (2012):

- Zero exclusion: all clients who want to participate are eligible.
- Integration of vocational and mental health treatment services: vocational and mental health treatment staff members are co-located and frequent communication between team members is essential.
- Competitive employment: clients get help obtaining community-based jobs at competitive wages.
- Benefits counselling: people who receive government benefits need personalized benefit planning when considering employment.
- Rapid job search: the job search process begins within one month of the client meeting with an employment specialist and beginning a career profile or vocational assessment.
- Follow-along supports: individualized assistance to working clients is available for as long as they need it.
- Preferences: client preferences influence the type of job sought and the nature and type of support offered.
- Systematic job development: employment specialists build an employer network based on clients' interests, developing relationships with local employers by making systematic contacts.

Table 3.4-1 on the next page elaborates on these eight points.

TABLE 3.4-1: PRINCIPLES OF THE INDIVIDUAL PLACEMENT & SUPPORT (IPS) MODEL

ADAPTATION	KEY MECHANISMS	OBJECTIVES
Zero exclusion		
All individuals who want to work (or look for work) are eligible to participate. No job skills or educational level screening assessments are used.		
Four grant-required screening criteria identified homeless status and mental illness. Participants were recruited from an agency for youth who are homeless. They had to meet four criteria: ■ be 18 to 24 years old ■ speak English ■ have a past-year primary clinical diagnosis of generalized anxiety, posttraumatic stress disorder, major depressive episode, mania/hypomania, antisocial personality disorder, or alcohol or other substance use disorders) ■ express a desire to work or look for work	Inclusion Focus on self-acceptance of one's job skills and experiences Strengths-based program	IPS staff makes employment accessible to all youth. IPS staff validates the diversity of youths' job skills and experiences.
Integration of vocational and mental health treatment services		
Vocational and mental health treatment staff is co-located. Frequent communication among team members is essential.		
Host agency employment specialist, case managers, clinicians, and supervisor (i.e., IPS staff) met weekly with the principal investigator using a case conference format to discuss cases. IPS staff used a spreadsheet of case notes hosted on the agency's shared server to make regular updates on client meetings and progress. Staff held biweekly telephone consultations with the principle investigator and IPS trainer to review cases and address implementation issues.	Ongoing collaboration across IPS staff with IPS participants Capacity development of IPS staff Supportive supervision of IPS staff	Host agency establishes case conferencing format. IPS staff enhances collaboration around IPS participants' work preferences and goals. IPS staff builds IPS capacity. IPS staff receives mentoring and supervision.
Competitive employment		
Clients are assisted in obtaining community-based jobs at competitive wages.		
IPS employment specialist worked with participants to obtain community-based jobs at competitive wages. The employment specialist and participants met at least weekly to identify potential places of employment, complete job applications, and prepare for interviews (or do informational interviews or mock interviews). Supported education and employment models were combined to assist participants who wanted to complete degree programs or training certificates before working or for those who wanted to work and study.	Supportive staff (access to IPS employment specialist at least weekly) Modelling job search and interviewing skills	Youth develop effective job search and interviewing skills. Youth develop trust in IPS employment specialist. Youth obtain competitive employment.

ADAPTATION	KEY MECHANISMS	OBJECTIVES
Benefits Counselling		
Participants who receive government benefits need personalized benefit planning when considering employment.		
IPS case managers worked with staff from the Department of Public Social Services and the Department of Rehabilitation to educate participants on the impact of paid employment on government assistance, including Social Security Disability Insurance, Supplemental Security Income, Supplemental Nutrition Assistance Program, and General Relief.	Service connection Financial literacy Supportive staff (access to IPS case managers at least weekly)	Youth develop skills for interacting with governmental institutions. Youth develop trust in IPS case manager. Youth receive governmental benefits when eligible.
Rapid job search		
Job search process begins within one month of the client meeting with an employment specialist and beginning a career profile or vocational assessment.		
IPS employment specialist worked with participants to begin their job search within one month of completing an IPS career profile (see IPS Employment Center: www.ipsworks.org).	Supportive staff (access to IPS employment specialist at least weekly) Strengths-based career assessment	Youth develop self-awareness of strengths and areas of growth through IPS career profile. Youth practise job search and interviewing skills. Youth obtain competitive employment.
Follow-along supports		
Individualized assistance to working clients is available for as long as needed.		
IPS staff continued to provide individualized assistance to participants who were working for as long as they wanted follow-up support. Once the young person was working, follow-along supports included weekly check-ins in person or via telephone or text message with the employment specialist, clinician, and case manager.	Supportive staff (access to IPS staff at least weekly) Modelling time management, financial literacy, independent-living, coping, and interpersonal skills	Youth continue developing trust in IPS staff. Youth learn skills to help them thrive in work and home settings.
Preferences		
Client preferences influence the type of job sought and the nature and type of support offered.		
IPS employment specialist used participants' IPS career profile to guide the job search and determine the support needed. IPS employment specialist, clinician, and case manager used a strengths-based approach by helping participants with limited employment experience and skills identify transferable "street-survival" skills that could be applied in competitive employment settings.	Strengths-based career assessment Power balance between IPS staff and participants Autonomy of decision making among IPS participants	Youth develop self-awareness of personal preferences. Youth strengthen autonomy and decision-making skills. Youth gain personal power in voicing and acting on employment preferences.

ADAPTATION	KEY MECHANISMS	OBJECTIVES
Systematic job development		
Employment specialists build an employer network based on clients' interests by making systematic contacts and developing relationships with local employers.		
IPS employment specialist spent 40% of time each week in the community developing relationships with employers and connecting young people to them based on preferences. The employment specialist introduced the IPS employment program to potential employers, shared strengths-based information with them about the client population, and learned more about available positions and job duties.	Building community relationships with employers Promoting strengths of IPS participants Identifying job openings throughout the community	Host agency builds sustainable relationships with local employers. Host agency enhances reputation in local community. IPS staff increases knowledge of available positions in community and job duties. IPS employment specialist connects youth with employment based on preferences.
Clinical and case management services		
Clinical and case management services are not formally a part of the IPS model.		
Participants met with IPS clinician and case manager to identify, assess, prioritize, and treat target areas of need. Clinician and case manager used motivational interviewing, cognitive-behavioural therapy, harm reduction strategies, and referrals to psychiatrists as determined from baseline assessment and IPS career profile.	Clinical services (weekly meetings or check-ins) Case management services (weekly meetings or check-ins) Harm reduction Service connection	Clinician and youth identify clinical needs and goals. Clinician assesses and treats mental health issues. Case manager and youth identify independent living goals. Case manager and youth work toward accomplishing goals. Clinician and case manager track youths' progress.

Collectively, the eight IPS principles draw from theories of psychiatric rehabilitation and recovery with individuals who have severe mental illness (Drake et al., 2012). The theory of psychiatric rehabilitation using supported employment posits that a person's functional adjustment can be improved by creating a supportive environment and enhancing the person's skills or abilities (Anthony, Cohen, & Farkas, 1990). Likewise, the theory of recovery states that individuals can get better from their illness and pursue meaningful life goals, such as employment (Deegan, 1988). Rehabilitation and recovery are important for people with mental illness and can be supported by both mental health systems and communities. For example, mental health systems can support rehabilitation and recovery by offering services in familiar, community-based settings. Similarly, local communities can facilitate rehabilitation and recovery by developing opportunities for employment, education, housing, and social support.

Additionally, the IPS principles are consistent with the internal developmental assets identified by the Search Institute (n.d.), and include social competencies, positive values, and positive identity. The developmental assets framework is comprised of empirically grounded internal and external assets in youth that help improve positive outcomes and protect them from high-risk behaviours (Benson, 1999). The IPS components collectively aim to strengthen the internal developmental assets of youth who are homeless to enhance positive outcomes and reduce high-risk behaviours. The IPS model is designed to promote social competencies, particularly planning and decision making, by incorporating youth in the decision-making aspects of their job search and mental health treatment. For example, youth involved in IPS establish goals with the employment specialist, case managers, and clinicians related to their employment search and mental health treatment.

Further, through the IPS mental health component, clinicians work with youth on exercising positive values, such as responsibility and restraint. They work with the young people on prioritizing areas of need and taking personal responsibility for their actions. Similarly, through learning to use harm reduction strategies, youth practise the positive value of restraint. As part of the IPS model, clinicians meet weekly with the youth to identify, assess, prioritize, and treat the target areas of need. They tailor the intensity and focus of the services to the severity of the young person's presenting issues.

Finally, the IPS model is designed to promote positive identity in youth who are homeless by affirming their capacity to obtain and maintain competitive employment, which in turn strengthens their personal power. Through employment, youth identify and develop

their vocational expertise, thus enhancing their sense of purpose. Further, by combining employment and clinical services, the IPS model supports youth who are homeless in developing motivation to change in order to make better-informed life and employment choices, also enhancing their personal power.

To date, there is strong research evidence for using supported employment models, such as the IPS model, with adults who have severe mental illness (Drake et al., 2012). Four initial trials evaluating IPS effectiveness with young adults with early psychosis also show promising results (Bond, Drake, & Campbell, 2012). One key feature of programs with demonstrated efficacy in establishing competitive employment is the integration of clinical and vocational services (Cook et al., 2005). Evidence indicates that clients who participate in vocational rehabilitation with integrated and coordinated clinical services report improvements in relationships, self-esteem, hope, and life satisfaction, in addition to gains in employability, work functioning, work hours, and income (Drake et al., 2012; Mueser et al., 2004; Salyers et al., 2004). Findings also reveal that clients who receive more employment-specific vocational services and who remain for longer durations in vocational programs achieve significantly better outcomes than those who receive fewer vocational services for shorter durations (Cook, 2006). Additionally, using more vocational services has been found to have a positive impact on employment outcomes, whereas using more clinical services is associated with poorer employment outcomes (Cook, 2006). These findings suggest that enhancing the amount of vocational services to clients with mental illness to complement or exceed their existing levels of clinical services may benefit them in obtaining and maintaining competitive employment.

IPS ADAPTATION & PILOT STUDY

Despite the origins of the IPS intervention with housed adults with severe mental illness, the eight IPS supported-employment principles have been adapted to work with young adults (aged 18–24) with mental illness who were receiving services from a non-profit youth homelessness agency (Ferguson et al., 2012). In this 10-month adaptation study, researchers recruited 20 young adults with mental illness who were homeless from a host agency. A control group consisted of 16 young adults with mental illness who were homeless and who attended services at another agency. Researchers relied on host-agency staff members, who were already known and trusted by the study participants, to implement the IPS model. One host-agency employment specialist, three case managers,

and two clinicians were assigned 20 cases among them for the pilot study. The Supported Employment Fidelity Scale suggests a maximum caseload of 20 clients per employment specialist to achieve high fidelity (Swanson, Becker, Drake, & Merrens, 2008). Case managers and clinicians had smaller caseloads given the mental health and other life challenges common among young people who are homeless (Whitbeck, 2009). All IPS participants met individually with the employment specialist, one case manager, and one clinician at least weekly. The IPS clinicians and case managers held their meetings within the host agency, whereas the employment specialist held agency- and community-based meetings. Regarding job development in the community, the IPS employment specialist also spent about 40% of each week out in the community, building relationships with new and existing employers. IPS studies with adults, which have high reported fidelity, indicate that employment specialists should spend 60%–70% of their time in job development in the community (Swanson et al., 2008).

IPS principles

The following section outlines how the eight IPS principles were adapted in this pilot study to work with young people with mental illness who are homeless and how such adaptations helped staff overcome common barriers to IPS implementation and sustainability. Table 3.4-1 outlines the eight IPS principles, their characteristics, specific adaptations that were made, mechanisms of influence, and objectives. The implementation and sustainability of the IPS model in a host agency likely will require considerable changes in staff duties and organizational culture and processes. As such, Table 3.4-1 is designed to serve as a guide for administrators and practitioners seeking to implement the IPS intervention in their agency to overcome implementation barriers. For more information on the full adaptation study of the IPS model with young adults with mental illness who are homeless, see Ferguson et al. (2012).

Zero exclusion

All young adults who met the study's screening criteria were eligible. Eligibility criteria were developed because this was the first pilot adaptation study of the IPS model with young adults with mental illness who are homeless and limited grant funding prevented the inclusion of all clients from the host agency. In the adaptation study, participants had to meet four screening criteria:

- Be aged 18–24;
- Speak English;

- Have received a primary clinical diagnosis in the past year for one of six mental illnesses (generalized anxiety, posttraumatic stress disorder, major depressive episode, mania/hypomania, antisocial personality disorder, and alcohol or substance use disorders}; and
- Express a desire to work or to look for work.

When implementing the IPS intervention as an agency-wide program, all staff can be trained in the IPS model to create a culture of supported employment throughout the agency. This allows staff to overcome the challenges related to implementing an evidence-based program with only a small segment of the client population.

Integrated vocational and mental health treatment services

The host agency's employment specialist, case managers, clinicians, and supervisor began meeting weekly with the principal investigator using a case-conference format to openly discuss active client cases. This integrated approach helped IPS staff overcome the barrier of staff from different fields working in a siloed manner. To facilitate more frequent internal communication among agency IPS staff, the employment specialist developed a spreadsheet of IPS client case notes and hosted the document on the agency's shared computer drive. Each staff member who met individually with study participants updated the case notes following the weekly meetings. To further promote collaboration, both the clinical and vocational staff also attended biweekly consultations with an IPS trainer to review cases and problem solve implementation issues.

Competitive employment

The IPS employment specialist worked with study participants to obtain community-based jobs at competitive wages. He met with participants at least weekly to identify potential places of employment, complete job applications, and prepare for interviews (or in some cases, informational interviews). To overcome the barrier of incompatible work and school schedules in participants' lives, supported education and employment models were combined to assist participants who wanted to complete degree programs or training certificates prior to working or for those who wanted to both work and study. Previous studies combining supported education and employment with housed young adults with first-episode psychosis have shown success (Nuechterlein et al., 2008; Rinaldi et al., 2004).

Benefits counselling

IPS case managers worked closely with the Department of Public Social Services and the Department of Rehabilitation to educate IPS participants on the impact of paid employment on their governmental assistance, including Social Security Disability Insurance, Supplemental Security Income, Supplemental Nutrition Assistance Program, and General Relief. By coordinating IPS services with governmental benefits counselling, IPS staff was able to overcome the challenge of encouraging participants to work without fully understanding the impact of employment on benefits. This way, IPS participants were able to make more informed choices about both their employment and public benefits.

Rapid job search

The IPS employment specialist worked with participants to begin their job search within one month of completing an IPS career profile (for the IPS career profile and other IPS-related materials, see the IPS Employment Center at www.ipsworks.org). The IPS model suggests that the best employment training is on-the-job training; as such, the job search process began right away with IPS participants and did not include any pre-employment training or preparation classes (Drake et al., 2012). By focusing on rapid job placement in the community, IPS staff was able to overcome the barrier of operating lengthy and costly job training programs housed within organizations for homeless youth that often fail to result in formal job offers for participants.

Follow-along supports

Host-agency IPS staff continued to provide individualized assistance to participants who were working for as long as they wanted follow-up support. Once the young person was working, follow-along supports generally took the form of weekly check-ins in person or via telephone or text message with the employment specialist, clinician, and case manager. By using varied contact methods, IPS staff was able to overcome the barrier of high drop-out rates from agency services common among youth who are homeless.

Preferences

The IPS employment specialist used participants' IPS career profiles to guide the job search in terms of the type of job sought and the nature of support the youth would need. The profile is a strengths-based vocational assessment that asks participants about their work goals, work experience, educational and vocational training, military experience, physical health, cognitive abilities, substance use, and government benefits. Use of this strengths-based career profile enabled IPS staff to better support and encourage young adults and to overcome the challenge of working with a population with limited employment experience and skills.

Systematic job development

The IPS employment specialist spent 40% of his time each week in the community developing relationships with local employers and connecting young people to employers based on their identified interests. The employment specialist introduced the IPS supported employment program to potential employers, shared strengths-based background information with them about the client population, and learned more about available positions and job duties. By committing regular time each week to developing relationships with employers in the community, IPS staff was able to overcome the barrier of employer stigma toward young adults experiencing homelessness and mental illness.

MENTAL HEALTH TREATMENT COMPONENTS & OUTCOMES

The IPS clinicians and case managers participating on the IPS team developed various mental health treatment components to accompany the employment specialist's work. First, for participants experiencing depression, mania/hypomania, or anxiety disorders, the clinicians on the IPS team used cognitive behavioural therapy, coupled with referrals to collaborating psychiatrists for medication. For those experiencing trauma symptoms, clinicians provided individual and group trauma intervention services (e.g., cognitive behavioural therapy and referrals for medication). To address high-risk sexual and substance use behaviours, clinicians used motivational interviewing to identify high-risk behaviours and to help the young adults move toward change. Clinicians also used various harm-reduction strategies (e.g., safe-sex practices, prevention of sexually transmitted diseases, HIV testing/counselling, substance abuse referrals) to reduce harmful behaviours associated with substance abuse and high-risk sexual activity through small achievable steps. This integrated employment–clinical–case management approach enabled IPS staff to overcome the challenge of working with a population with multiple and complex psychosocial needs.

The study hypothesized that youth in the IPS group would have greater improvement compared with the control group in five areas: (1) ever worked rate, (2) working at follow-up rate, (3) monthly work rate, (4) weekly work hours, and (5) weekly income (Ferguson et al., 2012). The study found that IPS participants were more likely than the control group to have worked at some point during the study (85% vs. 38%). Working at follow-up was reported by 67% of the IPS group and 25% of the control group.

For the monthly work rate, IPS participants worked a significantly greater number of months over the 10-month study (5.2 months vs. 2.2 months). Moreover, 45%–70% of IPS participants and 19%–31% of the control group were working during any one month of the study. There were no significant differences between the IPS and control groups on weekly work hours or weekly income. With respect to type of employment, IPS young adults worked in retail, restaurants, supermarkets, airports, janitorial services, and security services. Control group participants worked in retail, janitorial services, construction, and supermarkets.

IMPLEMENTATION CONSIDERATIONS

There are several important considerations when implementing the IPS model with youth with mental illness who are homeless. First, IPS is an evidence-based intervention that has demonstrated high fidelity and effectiveness with adults with mental illness who are homeless. When implementing IPS with youth and young adults who are homeless, it is important to solicit buy-in from a host agency, where young people who are homeless already congregate and feel safe. It is also important to secure the participation of the necessary IPS staff: employment specialist, clinician, and case manager. The greater the level of rapport and trust between host-agency staff and participating youth, the greater the engagement and retention of youth in the IPS program will be. In addition to implementing the IPS intervention, it is vital to have a host-agency supervisor involved in its implementation and oversight to support and mentor staff alongside the principal investigator and IPS trainer. The IPS Employment Center has IPS trainers and materials for training host-agency staff to ensure fidelity to the IPS model (www.ipsworks.org).

In the adaptation study, the principle investigator and the IPS trainer introduced evidence-based IPS materials to staff during the two-day training held in the host agency. Subsequently, IPS staff held weekly meetings with the principle investigator and biweekly phone calls with the IPS training consultant to discuss specific cases and to troubleshoot issues that arose during the 10-month pilot. Throughout the study, the principal investigator and the IPS trainer observed and provided feedback to staff on inter-staff and staff–client interactions. Integrating IPS experts from around the country in the design, implementation, and evaluation of IPS studies provides needed guidance to researchers and practitioners who are adapting this model to new populations within a host-agency setting.

A second important consideration for implementing IPS involves the host agency's involvement with the intervention. When introducing the IPS program into a host agency that has an existing employment program, it is important to honour the staff's practice wisdom by incorporating them into all levels of the intervention adaptation, implementation, and evaluation. In the IPS adaptation study, we used a seasoned employment specialist with over two years of experience working with youth with mental illness who are homeless. It was necessary for the employment specialist to work at a very basic level with many of the participants, since they had never held a job and had limited educational attainment. Strengths-based tools such as the IPS career profile and career mapping (Shaheen & Rio, 2006) were instrumental in helping participants begin to identify and market their employment interests, skills, and experiences. The employment specialist also found creative ways to stay in contact with a highly transient population; this included using cellphones, texts, emails, and regular visits to the study participants' job sites (when approved by the young adults). Further, the IPS employment specialist understood the common employment preferences in this young adult population and developed strong relationships with local employers in areas including retail, restaurant, and supermarket work, and janitorial and security services. This enabled IPS staff to build a job bank of available positions to match with IPS participants' preferences.

Another consideration for implementing IPS involves integrating educational programming into employment. When working with youth and young adults who have not yet completed their required education and have not been socialized fully to the workforce, it is important to integrate evidence-based educational programming (e.g., supported education) into employment services. It is common for emerging adults to study and work concurrently, as well as to pursue educational degrees or technical certificates prior to entering the workforce (Arnett, 2004). Combining supported employment and supported education thus allows IPS staff to further honour participants' career and academic aspirations and to reinforce that these two can be blended. In the IPS adaptation study, several participants sought technical training offered through local community colleges (e.g., pharmacy technician certificate), Job Corps (e.g., culinary arts' certificate), and Goodwill Industries International (e.g., forklift training program certificate) prior to securing competitive employment. Other participants worked and studied concurrently to finance their education. Service providers working with this population can offer educational scholarships, academic mentoring, and tutoring programs that help support young adults' educational pursuits. Likewise, employment specialists can work with young adults and employers to identify employment options (or tailor existing work schedules) that support young adults' educational goals, since both academic certificates and technical training can enhance their competitiveness and productivity in the workplace.

When working with young people experiencing homelessness and housing instability, it is also important to incorporate housing options into employment services. To date, evidence-based housing approaches include rapid rehousing and permanent supportive housing that emphasizes housing first (Padgett, Henwood, & Tsemberis, 2016). These approaches follow the principle that flexible psychosocial and vocational interventions must accompany housing supports (National Alliance to End Homelessness, 2012). In the adaptation study, the IPS model was implemented in a host agency that had a drop-in centre, an emergency (30-day) shelter, a long-term shelter, and permanent supportive housing (apartments) with an emphasis on housing first. Housing options for IPS participants were varied, as housing stability is often fluid in this population. For example, while only one IPS participant reported living on the streets at baseline, others initially reported precarious housing situations (e.g., living with abusive parents, with a partner's family, with friends). Still others abandoned shelters for the streets during the study or lost their permanent supportive housing due to relapse and lack of commitment to residential drug treatment. Involvement in the IPS intervention (and in competitive employment specifically) for many young people sensitized them to the importance of safe, stable, and supportive housing as a prerequisite to accomplishing their work goals. IPS case managers worked with participants to tailor housing options as part of their IPS case plan. IPS clinicians worked with participants on mental health issues (e.g., depression, substance abuse, posttraumatic stress disorder) that can hinder success in gaining and maintaining both employment and housing (Whitbeck, 2009). The integration of housing, employment, clinical, and case management services not only honours young people's preferences and life goals; it also is consistent with the best evidence for addressing youth homelessness.

CONCLUSION

Despite its origins with adults with severe mental illness, IPS is adaptable to work with youth with mental illness who are homeless or street involved and is associated with successful retention and employment outcomes. The eight IPS principles of supported employment can be adapted to better support these young people in obtaining and maintaining competitive employment. Staff from agencies that serve youth who are homeless can learn more about the IPS model through the IPS Employment Center, as well as obtaining training, implementation, and evaluation materials to administer the IPS program in their agency. To administer an IPS program with high fidelity, at minimum, the host agency should have a supervisor and at least three staff to form an IPS team (i.e., employment specialist, clinician, and case manager) for every 20 youth participants. IPS

staff should make every effort to implement the intervention according to the guidelines outlined in the Supported Employment Fidelity Scale. Through adopting an individualized and long-term approach of integrating employment and clinical services, providing follow-along supports, and honouring client preferences, services for youth who are homeless will have greater success in socializing these young people to the workforce, increasing their access to competitive employment, and improving their employment skills and outcomes.

REFERENCES

Anthony, W., Cohen, M., & Farkas, M. (1990). *Psychiatric rehabilitation*. Boston, MA: Center for Psychiatric Rehabilitation.

Arnett, J. J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties*. Cary, NC: Oxford University Press.

Baron, S. W. (1999). Street youths and substance use: The role of background, street lifestyle, and economic factors. *Youth & Society, 31*, 3–26.

Baron, S. W., & Hartnagel, T. F. (1997). Attributions, affect, and crime: Street youths' reactions to unemployment. *Criminology, 35*, 409–434.

Benson, P. L. (1999). *A fragile foundation: The state of developmental assets among American youth*. Minneapolis, MN: Search Institute.

Bond, G. R., Drake, R. E., & Campbell, K. (2012, October). *The effectiveness of the Individual Placement and Support model of supported employment for young adults: Results from four randomized controlled trials*. Paper presented at the IEPA 8th Conference on Early Psychosis, San Francisco, CA.

Cook, J. A. (2006). Employment barriers for persons with psychiatric disabilities: Update of a report for the President's Commission. *Psychiatric Services, 57*, 1391–1405.

Cook, J. A., Lehman, A. F., Drake, R. E., McFarlane, W. R., Gold, P. B., Leff, H. S., . . . Grey, D. D. (2005). Integration of psychiatric and vocational services: A multisite randomized, controlled trial of supported employment. *American Journal of Psychiatry, 162*, 1948–1956.

Courtney, M. E., Piliavin, I., Grogan-Kaylor, A., & Nesmith, A. (2001). Foster youth transitions to adulthood: A longitudinal view of youth leaving care. *Child Welfare, 80*, 685–717.

Deegan, P. E. (1988). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11*(4), 11–19.

Drake, R. E., Bond, G. R., & Becker, D. R. (2012). *Individual placement and support: An evidence-based approach to supported employment*. New York, NY: Oxford University Press.

Ferguson, K., Bender, K., Thompson, S., Xie, B., & Pollio, D. (2011). Correlates of street-survival behaviors in homeless young adults in four U.S. cities. *American Journal of Orthopsychiatry, 81*, 401–409.

Ferguson, K., & Xie, B. (2008). Feasibility study of the Social Enterprise Intervention with homeless youth. *Research on Social Work Practice, 18*, 5–19.

Ferguson, K., Xie, B., & Glynn, S (2012). Adapting the Individual Placement and Support model with homeless young adults. *Child & Youth Care Forum, 41*, 277–294.

Gaetz, S., & O'Grady, B. (2002). Making money: Exploring the economy of young homeless workers. *Work, Employment & Society, 16*, 433–456.

Harnois, G., & Gabriel, P. (2000). *Mental health and work: Impact, issues and good practices*. Geneva, Switzerland: World Health Organization & International Labour Organisation.

Johnson, K. D., Whitbeck, L. B., & Hoyt, D. R. (2005). Substance abuse disorders among homeless and runaway adolescents. *Journal of Drug Issues, 35*, 79–816.

Lenz-Rashid, S. (2006). Employment experiences of homeless young adults: Are they different for youth with a history of foster care? *Children and Youth Services Review, 28*, 235–259.

Mallon, G. P. (1999). *Let's get this straight: A gay- and lesbian-affirming approach to child welfare*. New York, NY: Columbia University Press.

Mueser, K. T., Clark, R. E., Haines, M., Drake, R. E., McHugo, G. J., Bond, G. R., . . . Swain, K. (2004). The Hartford study of supported employment for persons with severe mental illness. *Journal of Consulting and Clinical Psychology, 72*, 479–490.

National Alliance to End Homelessness. (2012). *An emerging framework for ending unaccompanied youth homelessness*. Washington, DC: Author. Retrieved from www.endhomelessness.org/library/entry/an-emerging-framework-for-ending-unaccompanied-youth-homelessness

Nuechterlein, K. H., Subotnik, K. L., Turner, L. R., Ventura, J., Becker, D. R., & Drake, R. E. (2008). Individual placement and support for individuals with a recent-onset of schizophrenia: Integrating supported education and supported employment. *Psychiatric Rehabilitation Journal, 31*, 340–349.

Padgett, D. K., Henwood, B. F., & Tsemberis, S. J. (2016). *Housing First: Ending homelessness, transforming systems, and changing lives*. New York, NY: Oxford University Press.

Rinaldi, M., McNeil, K., Firn, M., Koletsi, M., Perkins, R., & Singh, S. P. (2004). What are the benefits of evidence-based supported employment for patients with first-episode psychosis? *Psychiatric Bulletin, 28*, 281–284.

Rosenheck, R. A., & Mares, A. S. (2007). Implementation of supported employment for homeless veterans with psychiatric or addiction disorders: Two-year outcomes. *Psychiatric Services, 58*, 325–333.

Rotheram-Borus, M. J., & Milburn, N. (2004). *Project I: Pathways into homelessness*. Los Angeles, CA: University of California, Los Angeles, Center for Community Health.

Salyers, M. P., Becker, D. R., Drake, R. E., Torrey, W. C., & Wyzik, P. F. (2004). A ten-year follow-up of a supported employment program. *Psychiatric Services, 55*, 302–308.

Search Institute. (n.d.). Developmental assets: Preparing young people for success. Retrieved from www.search-institute.org/what-we-study/developmental-assets

Shaheen, G., & Rio, J. (2006). *Career mapping for chronically homeless job seekers*. New York, NY: Chronic Homelessness Employment Technical Assistance Center. Retrieved from Corporation for Supportive Housing website: www.csh.org/wp-content/uploads/2011/12/Report_CHETA_Careermapping1.pdf

Swanson, S. J., Becker, D. R., Drake, R. E., & Merrens, M. R. (2008). *Supported employment: A practical guide for practitioners and supervisors*. Kearney, NE: Morris Publishing.

Thompson, S. J., Pollio, D. E., & Constantine, J. (2002). Short-term outcomes for youth receiving runaway and homeless shelter services. *Research on Social Work Practice, 12*, 589–603.

Thompson, S. J., Rew, L., Barczyk, A., McCoy, P., & Mi-Sedhi, A. (2009). Social estrangement: Factors associated with alcohol or drug dependency among homeless, street-involved young adults. *Journal of Drug Issues, 39*, 905–929.

Tyler, K. A., Cauce, A. M., & Whitbeck L. B. (2004). Family risk factors and prevalence of dissociative symptoms among homeless and runaway youth. *Child Abuse & Neglect, 28*, 355–366.

Tyler, K. A., & Johnson, K. A. (2006). Pathways in and out of substance use among homeless-emerging adults. *Journal of Adolescent Research, 21*, 133–157.

U.S. Department of Labor, Bureau of Labor Statistics. (2016, October 7). Labor force statistics from the current population survey: (A-10) Unemployment rates by age, sex, and marital status, seasonally adjusted [Table]. Retrieved from www.bls.gov/web/empsit/cpseea10.htm

U.S. Department of Labor, Bureau of Labor Statistics. (2015, October 8). Labor force statistics from the current population survey: How the government measures unemployment. Retrieved from www.bls.gov/cps/cps_htgm.htm#unemployed

Whitbeck, L. B. (2009). Mental health and emerging adulthood among homeless young people. New York, NY: Psychology Press.

ABOUT THE AUTHOR

Kristin M. Ferguson, PhD, MSW, is an associate professor at the Arizona State University School of Social Work. Her research aims to mitigate the environmental and psychosocial factors contributing to youth homelessness. She designs, implements, and evaluates interventions for youth who are homeless that integrate employment and clinical services, including supported employment and social enterprises.