



Promoting Employment of People with Mental Illness

Judge David L. Bazelon Center for Mental Health Law

Getting to work

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People with Mental Illness**

The Bazelon Center for Mental Health Law gratefully acknowledges support for the research leading to the production of GETTING TO WORK from

The Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
(under contract # 13-233-SOL-00584)

as well as additional support for this project from

The Sidney R. Baer, Jr. Foundation
The Morton K. and Jane Blaustein Foundation
The Butler Family Fund

The views expressed in GETTING TO WORK are those of the Bazelon Center and may not reflect those of these funders.

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September 2014

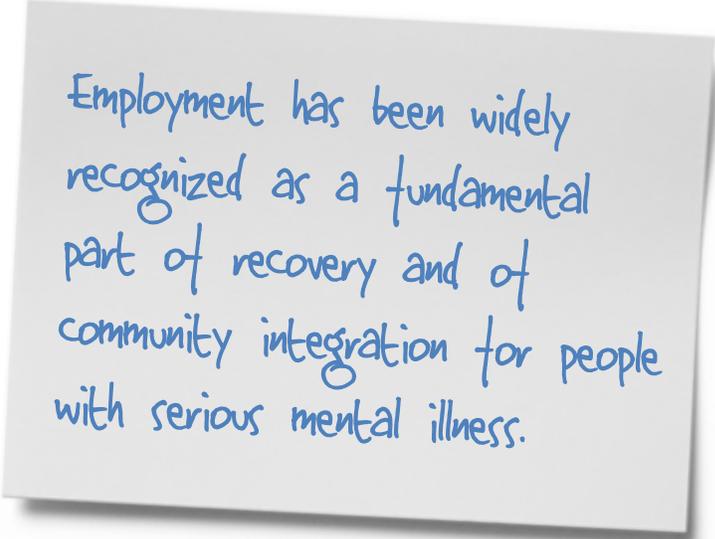
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Introduction

People with serious mental illness are employed at much lower rates than the general population. The likelihood of a person with a serious mental illness having full-time employment is approximately 1 in 10.¹ These dire statistics are not a reflection of the capacities or desire of people with serious mental illness to be a part of the workforce: at least two-thirds want to work and many have worked before. Nor does this low employment rate reflect an inability of people with serious mental illness to work. In fact, employment has been widely recognized as a fundamental part of recovery and of community integration for people with serious mental illness. Instead, the low employment rate of people with serious mental illness reflects a failure to invest in the services that many people with serious mental illness need to secure and maintain work. Mental health systems have long operated under the mistaken assumption that people with serious mental illness cannot work.

We can change this: we have services that have been enormously successful in getting people with serious mental illness into competitive employment. These services, called “supported employment,” have enabled large numbers of participating people to secure competitive employment and are cost effective compared with other alternatives.² In addition, supported employment reduces the use of hospital care and other services.³ Supported employment can be funded by Medicaid, which allows states to obtain substantial federal matching funds. Despite the success of supported employment and the financial incentives to expand these services, their availability is scarce: only 1.7 percent of people served by public mental health systems in 2012 received supported employment services.⁴ Instead, mental health systems continue to use decades-old day treatment programs that are based on the premise of life-long disability and dependence. If the funds currently used to pay for day treatment programs were reallocated to finance supported employment programs, many more people would be able to engage successfully in competitive employment.

This report describes the need for supported employment services, how these services work, the successful outcomes they secure, the cost savings that they enable states to realize, and the legal obligations that they help states fulfill. It also offers recommendations for states interested in expanding the availability of supported employment services for people with serious mental illness.



Employment has been widely recognized as a fundamental part of recovery and of community integration for people with serious mental illness.

The Vast Majority of People with Serious Mental illness Are Unemployed, Despite a Desire to Work

People with serious mental illness are employed at alarmingly low rates. In 2012, SAMHSA reported that only 16.9 percent of all people served by state mental health systems were employed.⁵ Among this group, only 5.8 percent of people with schizophrenia or related disorders living in the community were employed, and only 12.9 percent people with bipolar or other mood disorders were employed.⁶ In 2011, the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) estimated employment rates for people with serious mental illness to be “22% at any given time, with a little more than half of these individuals (12%) working full-time.”⁷ By comparison, the labor participation rate for the general U.S. population has been about three times the 22% rate.⁸

Despite their low employment rates, people with serious mental illness want to work.⁹ Studies have typically found that approximately two-thirds of people with serious mental illness express interest in working.¹⁰ These figures likely underestimate the actual number, as many people with serious mental illness have been told for years that they were not capable of working and have come to adopt this view; many others were likely unaware that supported employment services could help them to secure and maintain work. With engagement and motivational strategies, it is likely that many of these people would ultimately choose to work. Many people with serious mental illness have worked at some point in their lives,¹¹ including an estimated 99 percent of persons diagnosed with schizophrenia.¹²

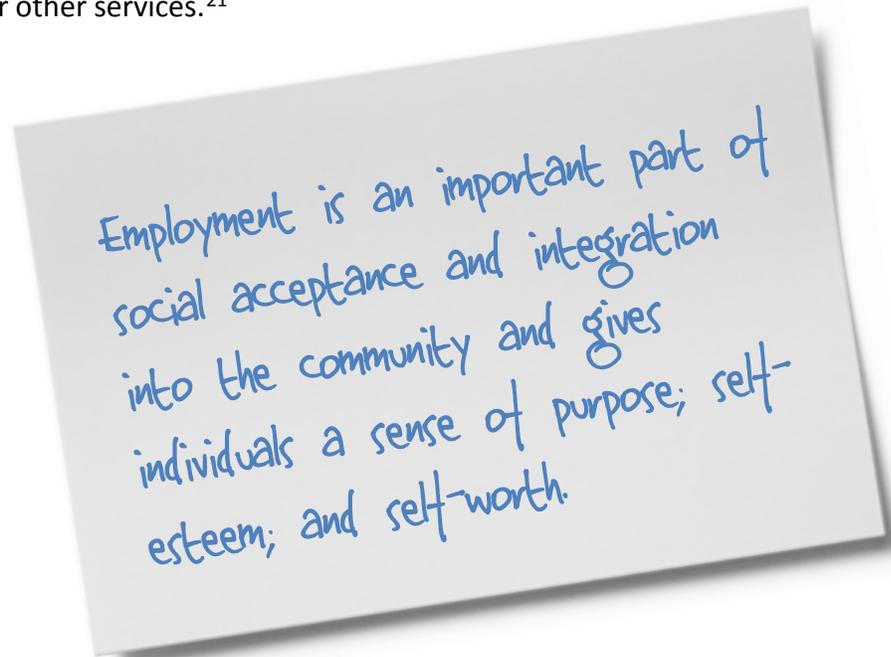
People with Serious Mental illness Can Work

While many people harbor preconceptions that people with serious mental illness cannot handle the stress of work, studies have consistently found that these assumptions are baseless.¹³ People with serious mental illness are capable of working if they are connected with appropriate jobs and receive appropriate supports.¹⁴

It is not the inability to work, but rather attitudinal barriers, service gaps, and service system barriers that make it difficult for individuals with serious mental illness to maintain

employment.¹⁵ In a national survey, people with serious mental illness reported the primary barriers to employment to be stigma and discrimination (45 percent), fear of losing benefits (40 percent), inadequate treatment (28 percent), and lack of vocational services (23 percent).¹⁶

Not only can people with serious mental illness work, but employment plays a critical role in promoting recovery.¹⁷ It promotes social acceptance and integration into the community, and gives individuals a sense of purpose, self-esteem, and self-worth.¹⁸ Work also reduces poverty and dependence, enabling people to become independent and self-sustaining, have more choices and opportunities, and live independently.¹⁹ It also improves clinical outcomes, including reducing symptoms of a person's mental illness,²⁰ and reduces the need for other services.²¹



Supported Employment Services Help People with Serious Mental Illness Secure and Maintain Work

“Supported employment” is an evidence-based practice that helps people with mental illness work in jobs that pay competitive wages in integrated settings in the community.²² Supported employment is founded on “the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found.”²³ Rather than promoting extensive prevocational training, supported employment helps people find jobs that align with their interests and strengths.²⁴

How Supported Employment Works

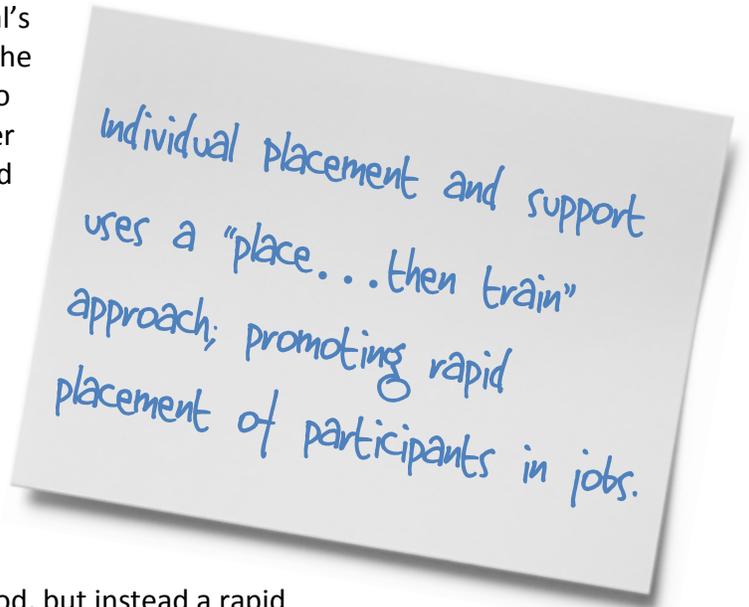
Supported employment services vary by state and by program, but at a minimum, they include:

- Identifying individuals' skills, interests, and career goals, to help match the person with a suitable job.
- Helping individuals to conduct an individualized job search.
- Providing on-the-job assistance (including, for example, counseling and interpersonal skills training) on a continuing basis to help people succeed in their jobs.
- Working with individuals and their employers to identify needed accommodations.
- Developing relationships with employers to understand their business needs and match individuals with jobs.
- Working with employers and individuals to identify ways in which jobs might be restructured or duties "carved" in order to facilitate employment of people with mental illness while at the same time meeting employers' needs.
- Providing benefits counseling to help individuals understand the impact of work on their public benefits and services as well as the details of programs that incentivize work such as the Ticket to Work program for SSI/SSDI recipients, and ensure that individuals continue to have the healthcare coverage they need while working.²⁵

The most effective approach to supported employment for individuals with serious mental illness is known as Individual Placement and Support (IPS). IPS is "[t]he one employment intervention that has been rigorously evaluated outside of [studies funded by] SSA and CMS."²⁶ IPS is defined by the following set of principles.²⁷

1. Competitive employment is the goal of IPS.²⁸ This commitment to the idea that everyone is an appropriate candidate for competitive, real-world work rejects the outmoded idea that work is harmful to individuals with serious mental illness and that many such individuals are incapable of working.²⁹
2. IPS supported employment services are coordinated with rehabilitation and clinical treatment so that an individual's other service providers are involved with and understand the individual's vocational goals.³⁰
3. All individuals are eligible for IPS services—if an individual wants to work, she is eligible "regardless of psychiatric diagnosis, symptoms, work history, or other problems, including substance abuse and cognitive impairment."³¹

4. IPS services are driven by the individual's preferences about what kinds of work he or she would like, since individuals who are interested in their work have higher levels of satisfaction with their jobs and longer job tenures.³²
5. Individuals receive personalized benefits counseling so they will understand the impact working will have on their benefits, and the impact of any changes in work status.³³
6. IPS assists individuals in seeking jobs immediately—there is no training period, but instead a rapid job search.³⁴ In doing this, IPS uses a “place, then train” approach, promoting rapid placement of participants in jobs, followed by on-the-job support and training that help participants successfully remain in those jobs.³⁵ Services include assisting participants in applying for jobs, preparing participants for interviews, providing on-the-job training, interfacing with the employer if the participant wishes, and other services that help an individual obtain and maintain a job.³⁶
7. IPS service providers “develop relationships with employers, based upon their clients’ work preferences, by meeting face-to-face.”³⁷
8. IPS is designed to be a constant support system, with services available permanently, although the goal is to help individuals become independent.³⁸ Service providers can help individuals learn job tasks or new responsibilities.³⁹ After individuals have “worked steadily (e.g., one year), they discuss transitioning from IPS.”⁴⁰



Individual placement and support uses a “place...then train” approach; promoting rapid placement of participants in jobs.

IPS Supported Employment is Extremely Effective

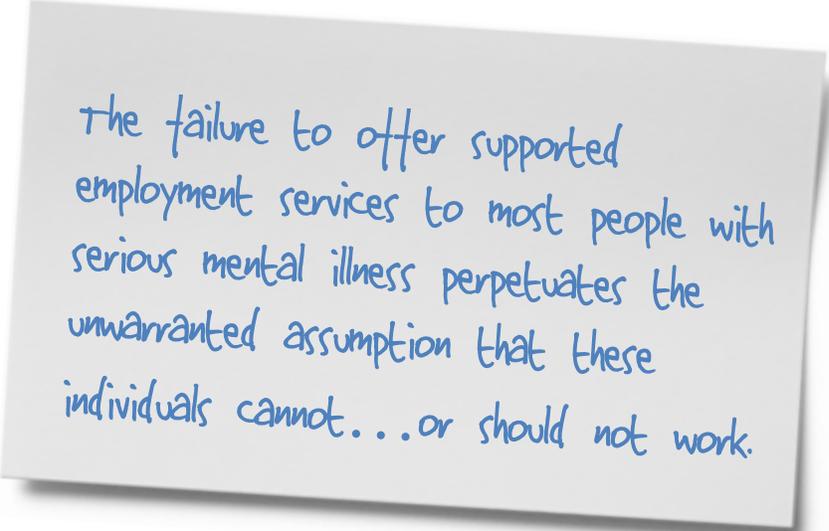
IPS is highly successful in enabling people with serious mental illness to obtain competitive, real-world employment.⁴¹ A 2008 survey of IPS research identified 11 randomized controlled trials of IPS programs serving individuals with serious mental illness, all of which concluded that vocational outcomes are consistently significantly higher with IPS: 60 percent for IPS compared to 23 percent for traditional services.⁴² The IPS supported employment results are not only better initially, but also in the long term. A ten-year follow-

up in one of the earliest studies found “the consumers in [the] study group demonstrated substantial employment rates” and that 47 percent were employed at the time of the ten-year follow-up interview.⁴³

The Johnson & Johnson and Dartmouth Community Mental Health Program, which has funded and implemented IPS programs across the nation since 2001, has generated a rich set of data concerning the effectiveness of IPS.⁴⁴ Today, the program includes “14 states (Colorado, Connecticut, Illinois, Kansas, Kentucky, Maryland, Minnesota, Missouri, North Carolina, Ohio, Oregon, South Carolina, Vermont, Wisconsin), the District of Columbia, and a county-level project in Alameda County, California.”⁴⁵ The Dartmouth program served more than 11,000 people, demonstrating significant increases in their rates of competitive employment.⁴⁶

A national study of IPS, funded by the Social Security Administration and completed in 2012, reported even higher success rates: 60 percent for the IPS treatment group, with higher total and consecutive amounts of work, average hours worked, and hourly wage.⁴⁷ These rates approach the labor force participation for the general population.

Give the extraordinarily low rates of employment for people with serious mental illness, the success of supported employment has the potential to bring about dramatic change. Yet supported employment is out of reach for most people who desire it.



The failure to offer supported employment services to most people with serious mental illness perpetuates the unwarranted assumption that these individuals cannot...or should not work.

Despite Its Success, Supported Employment Remains Widely Unavailable

Despite the success of supported employment services, these services are not the norm offered by state mental health systems.⁴⁸ In 2012, only 1.7 percent of individuals served by state mental health authorities receive supported employment services.⁴⁹ In the eighteen states that offer supported employment state-wide⁵⁰ and the twenty-three states that have supported employment available in part of the state,⁵¹ a total of less than 50,000 people received supported employment in 2012.⁵²

Despite the need for additional supported employment services, the percentage of mental health system clients receiving supported employment has actually decreased over the last several years. In 2009, the national usage rate of supported employment was 2.1 percent and 51,207 people with mental illness received services.⁵³ The rate remained steady in 2010 as state mental health authorities served more people and the number of people receiving supported employment increased to 56,910,⁵⁴ but over 2011 and 2012, the rate dropped to 1.7 percent, with only 50,394 people receiving these services in 2011 and 48,880 people receiving them in 2012.⁵⁵

The failure to offer supported employment services to most people with serious mental illness perpetuates the unwarranted assumption that these individuals cannot or should not work. So why has supported employment not been more widely available? Simply put, because states have invested resources in other, less effective services.

Day Treatment Continues to be the Norm... Despite Poor Outcomes

Instead of supported employment, the primary service that state mental health systems offer to people with serious mental illness during the day is “day treatment.” Virtually all states provide day treatment services, funded largely through the Medicaid program.⁵⁶ The last detailed analysis of nationwide spending on day treatment, using 2001 data, showed that state mental health systems spent \$840 million on day treatment services.⁵⁷

Day treatment services typically operate at a single site, and provide social and recreational activities, rehabilitative skills training,⁵⁸ meals, and structured social activities including parties and outings.⁵⁹ Day treatment is supposed to help individuals build life skills and live independently in the community.⁶⁰ Participants generally spend their days, however, interacting primarily with other people with disabilities.⁶¹

Day treatment services often have little focus on helping participants secure employment or develop job skills.⁶² Many involve participants spending significant amounts of time playing bingo or other games, discussing current events, or doing arts and crafts. One court observed that “attending these programs contributes to [individuals’] isolation and separation from the mainstream of community life.”⁶³ Noting that these programs have “little focus on skill development,” the court pointed to a review by a New York state agency concluding that there was “a ‘disconnect’ between participants’ life goals of gaining independent living and job skills and the goals that the programs had set for them.”⁶⁴

Day treatment programs typically have little success in enabling people with mental

illness regain or develop the skills they need to live independently and work.⁶⁵ These programs usually “employ a train-then-place approach, emphasizing prevocational training classes.”⁶⁶ With this outmoded approach, individuals rarely gain the skills they need to work or to live independent lives.⁶⁷ As one study put it in 1994, “the central concern about day treatment involves the failure to move people with psychiatric disabilities out of treatment centers into normal adult roles in the community.”⁶⁸

Part of a normal adult role in the community is having a job with competitive wages in an integrated setting. Day treatment is ineffective in helping individuals achieve this result. Studies comparing employment outcomes in day treatment with those in supported employment have consistently shown much better outcomes for the latter.⁶⁹ These dramatic differences in outcomes are not limited to individuals who spend only a short time in day treatment: in one study, people with serious mental illness who had spent 5 years in day treatment programs went from a competitive employment rate of 12.9 percent while in the day treatment program to 64.5 percent after receiving IPS supported employment.⁷⁰ Moreover, when people with mental illness spend their days in day treatment programs rather than working, they remain dependent on costly public services.

The ineffectiveness of day treatment has prompted many calls to shift from this model to offering supported employment services. In 2003, the Final Report of the President’s New Freedom Commission on Mental Health recommended that state and federal programs be restructured “to pay for evidence-based practices, such as Individual Placement and Support (IPS) that help consumers achieve employment goals rather than pay for ineffective, traditional day treatment programs that do not support employment.”⁷¹

States Can Save Money by Providing Supported Employment

Supported employment not only transitions people with serious mental illness successfully into competitive work; in doing so, it saves states money. One study projected that “wide-scale implementation and recruiting of people with serious mental illness to evidence-based supported employment and mental health care” would not only improve financial security for people with serious mental illness, but also, conservatively estimated, save the government an estimated \$368 million per year.⁷² These savings come from multiple sources: first, those individuals who use supported employment services use fewer health care services and have fewer costly hospitalizations, and second, replacing less effective day treatment services means that funds can be shifted from those services to supported employment, typically at lower cost.

A major national study funded by the Social Security Administration, the Mental Health Treatment Study, estimated that expanding supported employment services to

cover 14 percent of people receiving SSI or SSDI due to a psychiatric impairment—or approximately 306,000 people—could result in a savings of \$550 million per year.⁷³ The study determined that health care spending was less for individuals receiving IPS supported employment than for individuals not receiving those services, and “[t]he treatment intervention had significant positive impacts in reducing inpatient hospital use (for both admissions and number of days) and psychiatric crisis visits.”⁷⁴ The average savings due to reductions in hospital use alone was approximately \$1,800 per year per person.⁷⁵

Similar results were demonstrated in a survey of data for individuals receiving supported employment in New Hampshire. Over ten years, the average annual cost for an individual receiving supported employment was approximately \$16,600 less than the cost of serving individuals who did not receive supported employment and worked minimally.⁷⁶ As the authors of that survey put it: “The ten-year cost reduction appears to be dramatic, certainly enough to justify offering supported employment to all persons who use high levels of services and express interest in working.”⁷⁷

Not only does the cost of services decline over time when individuals spend their days working rather than in day treatment programs, but the cost of supported employment itself is generally lower than the cost of providing day treatment services. A 2010 federal government report estimated the average yearly cost per client of supported employment services to be between \$3,500 and \$5,000.⁷⁸ Day treatment costs, while they vary by state and program, tend to be substantially higher: \$13,702 per year, per client in one study.⁷⁹ The annual cost of providing “continuing day treatment” for New Yorkers with mental illness in 2003 was \$175 million for 23,000 individuals, or an average of \$7600 per person.⁸⁰ Shifting resources from day treatment services to supported employment services would bring significant cost savings.

The ADA Requires States to Offer Supported Employment Services In Lieu of Day Treatment

The Americans with Disabilities Act (ADA), enacted in 1990, was intended “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities.”⁸¹ Title II of the ADA prohibits discrimination based on disability by state and local government entities.⁸² In the ADA’s findings, Congress recognized the longstanding problem of isolation and segregation of people with disabilities, stating that:

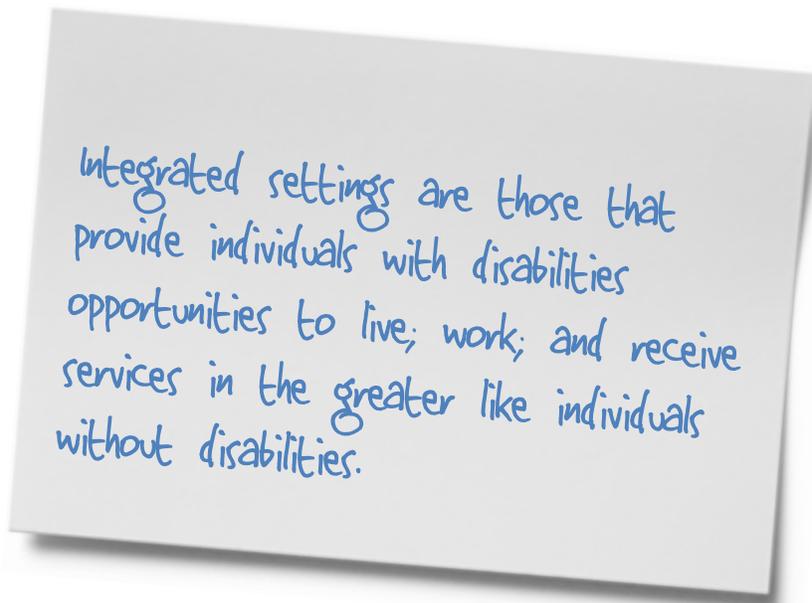
historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem.⁸³

The Justice Department's regulations implementing the ADA require states and local governments to "administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities."⁸⁴ The "most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible..."⁸⁵

In 1999, the Supreme Court interpreted the ADA's integration mandate in *Olmstead v. L.C.*,⁸⁶ a case brought by two women with mental illness and intellectual disabilities who challenged their continued confinement in a state psychiatric hospital after they had been determined ready for discharge. The Court held that needless segregation was a form of discrimination prohibited by the ADA. According to the Court, this holding reflected two evident judgments. First, needlessly segregating individuals with disabilities "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."⁸⁷ Second, "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."⁸⁸ The Court ruled that states must offer services in community settings to interested individuals who are needlessly institutionalized, unless doing so would result in money being taken from one group of individuals with disabilities to give to another.⁸⁹

The ADA's non-discrimination requirements, including the integration mandate, apply to *all* programs, services and activities of state and local government entities—including employment and other day services and not merely residential services.⁹⁰ The Justice Department's

guidance on the integration mandate and the *Olmstead* decision states that "[i]ntegrated settings are those that provide individuals with disabilities opportunities to live, work, and receive services in the greater community, like *individuals without disabilities*."⁹¹ *Segregated settings, by contrast, include "settings that provide for daytime activities primarily with other individuals with disabilities."*⁹² The guidance notes that *Olmstead* implementation efforts must include individuals in "segregated day programs."⁹³ Finally, the guidance states that "*Olmstead* remedies should include . . . supported employment."⁹⁴



Integrated settings are those that provide individuals with disabilities opportunities to live; work; and receive services in the greater like individuals without disabilities.

Similarly, the federal Medicaid agency—the Centers for Medicare and Medicaid Services—has stated that:

...states have obligations pursuant to the Americans with Disabilities Act... and the Supreme Court's *Olmstead* decision... Consistent with the *Olmstead* decision and with person centered planning principles, an individual's plan of care regarding employment services should be constructed in a manner that reflects individual choice and goals relating to employment and ensures provision of services in the most integrated setting appropriate.⁹⁵

Courts have confirmed that the ADA's integration mandate applies to employment services. In a case brought by Oregon residents with intellectual disabilities seeking supported employment services in integrated settings rather than services in segregated "sheltered workshops," the court held that the rationales for why needless segregation in residential settings is discriminatory apply equally to needless segregation in employment settings.⁹⁶

The Justice Department's settlement agreements also reflect the understanding that the ADA and *Olmstead* require states to offer supported employment services for people with disabilities. In 2014, the Department entered an agreement with Rhode Island concerning the state's needlessly segregating individuals with intellectual and developmental disabilities in sheltered workshops and segregated day programs rather than offering them supported employment services.⁹⁷ The settlement agreement obligates Rhode Island to offer supported employment to at least 700 people in sheltered workshops, at least 950 people in facility-based day programs, and approximately 350 students leaving high school. The services must be sufficient to support a normative 40-hour work week, with the expectation that individuals will work in a job with competitive wages for at least 20 hours per week on average.

Department of Justice settlement agreements with other states include supported employment among the remedies to address needless segregation of individuals with serious mental illness in institutions, including *United States v. New York*, *O'Toole v. Cuomo* (resolving *Olmstead* claims involving individuals in private adult homes; settlement approved 2014), *United States v. New Hampshire* (resolving *Olmstead* claims involving individuals in state psychiatric hospital and state-operated nursing home; settlement approved 2014), *United States v. North Carolina* (resolving *Olmstead* claims involving individuals in private adult care homes; settlement approved 2012), *United States v. Delaware* (resolving *Olmstead* claims involving individuals in psychiatric hospitals; settlement approved 2011), and *United States v. Georgia* (resolving *Olmstead* claims involving individuals in state psychiatric hospitals; settlement approved 2010).

Consigning clients to day treatment programs when they could instead be employed is as tragic and illegal as relegating people to institutions when they could instead live in the community.

The ADA's integration mandate requires states to offer supported employment services to individuals with serious mental illness. All individuals with serious mental illness are qualified for supported employment services. As the Centers for Medicare and Medicaid Services stated, "[a]ll individuals, regardless of disability and age, can work – and work optimally with opportunity, training, and support that build on each person's strengths and interests."⁹⁸ Indeed, one of the fundamental principles of IPS supported employment services is that all individuals are eligible,

"regardless of psychiatric diagnosis, symptoms, work history, or other problems, including substance abuse and cognitive impairment."⁹⁹

Consigning clients of public mental health systems to day treatment programs, when they could instead be employed, is as tragic and illegal as relegating people to institutions when they could instead live in the community if they receive needed services. State mental health systems are needlessly "segregating" people with serious mental illness by providing services at day treatment programs instead of at regular job sites, through the use of supported employment. Day treatment programs are not the "most integrated setting" in which to receive rehabilitative services.¹⁰⁰ In addition, as noted above, supported employment services help people with serious mental illness avoid needless institutionalization by reducing hospitalizations.

It would not be costly for state service systems to offer supported employment services, which are typically financed by Medicaid, state, and/or vocational rehabilitation funds.¹⁰¹ In fact, it would save states money both by reducing health care costs and by eliminating the higher costs that states pay for day treatment programs. States may cover supported employment services through the Medicaid program in a variety of ways.¹⁰² States receive at least 50% federal matching funds for services covered under the Medicaid program. For states that have adopted the Affordable Care Act's Medicaid expansion, a federal matching rate of 100%, eventually decreasing to 90%, is available for services provided to individuals covered by the expansion.

States can also use federal funds to provide supported employment services to such individuals through their vocational rehabilitation systems—and should be doing so. Currently, however, few vocational rehabilitation dollars go toward providing supported employment for individuals with serious mental illness.¹⁰³ Nonetheless, the vocational

rehabilitation system is an important source of additional financing for supported employment services. States should establish collaborations between the state mental health authority and the state vocational rehabilitation agency to coordinate the delivery of supported employment services to maximize the reach and effectiveness of these services. A number of states have begun to engage in such collaboration [for example, Delaware has had vocational rehabilitation staff working together with employment specialists on assertive community treatment (ACT) teams, a mental health intervention]. A recent publication by the Institute for Community Inclusion describes successful strategies used in eight states to coordinate funding and delivery of supported employment services between state mental health authorities and state vocational rehabilitation authorities.¹⁰⁴

Thus making supported employment services available on a much broader scale would not only generate good outcomes and save money, but is critical to states meeting their obligations under the ADA and *Olmstead*.

Recommendations

The Medicaid program is an important resource for states to expand the availability of supported employment services for individuals with serious mental illness. As we have described above, Medicaid dollars could be used to provide supported employment services to many more people with mental illnesses. Several key steps would advance this goal, including states covering a full array of supported employment services through their Medicaid programs, reallocating dollars from segregated day services to supported employment, and coordinating between mental health and vocational rehabilitation authorities to deliver supported employment services effectively.

Given the slow pace at which states have moved to expand Medicaid-financed supported employment services, Congress should incentivize the expansion of these services; it is in the federal government's interest to ensure that federal Medicaid dollars are used for services that promote employment of people with disabilities and are consistent with the ADA. Accordingly, we recommend that:

- States cover a robust package of Medicaid-financed supported employment services for people with mental illness. The best avenues for accomplishing this are:
 - Covering supported employment under the “home and community-based services” state plan option, known as the “Section 1915(i) option.” This option permits states to target a set of home and community-based services, including employment services, to a set of individuals using needs-based criteria (for example, individuals with serious mental illness who need supported employment services to secure and/or maintain work). States may choose to adopt a Section 1915(i) option for people with mental illness or for a broader group of people with disabilities including people with mental illness. This option gives states the flexibility to cover a broader array of services than other state plan options.
 - Covering supported employment through a Medicaid demonstration waiver. Since the passage of the Affordable Care Act, many states have been applying for Medicaid demonstration waivers in order to facilitate better coordination of care for people with disabilities. These demonstration waivers afford states significant flexibility in choosing what services to cover, and may be used to cover a full array of supported employment services.
- States reallocate Medicaid and mental health funds from segregated day treatment services to pay for supported employment services instead.
- States coordinate the delivery of supported employment services between the state mental health authority and the state vocational rehabilitation agency.
- Congress amend the Medicaid statute to include incentives for states to expand their supported employment programs. For example, enhanced federal matching rates could be offered for states that expand the number of individuals with mental illness who receive supported employment services by a certain percentage.

Conclusion

People with serious mental illness are unemployed in extremely high numbers and exist largely outside of the workforce. Mental health service systems have continued to operate based on the premise that most people with serious mental illness do not work. They have invested heavily in day treatment as the primary service offered to people during the day. Despite the tremendous successes of supported employment, its importance to recovery, and its cost-saving potential, it has been largely unavailable in public mental health systems. It is time for that to change. The Medicaid program provides ample opportunities for states to cover supported employment services—opportunities that are even more valuable in states that have adopted the Medicaid expansion. Reallocating funds from day treatment services to support individuals in employment would bring vast improvements to the lives of individual with serious mental illness, affording them opportunities for independence and self-sufficiency and enhancing individuals' sense of purpose and self-worth. It would also save states money and help them comply with their legal obligations under the ADA and *Olmstead*. Expanding supported employment is not just a good idea—it is a necessity.

¹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, *Federal Financing of Supported Employment and Customized Employment for People with Mental Illness: Final Report* vii (Feb., 2011) (hereinafter ASPE Supported Employment Report) available at <http://aspe.hhs.gov/daltcp/reports/2011/supempFR.pdf>.

² See, e.g., Eric A. Latimer, *Economic impacts of supported employment for persons with severe mental illness*, 46 *Canadian Journal of Psychiatry* 496 (Aug. 2011); David Salkever, *Social costs of expanding access to evidence-based supported employment: concepts and interpretive review of evidence*, 64 *Psychiatric Services* 111 (Feb. 2013).

³ See Robert E. Drake et al., *Social Security And Mental Illness: Reducing Disability With Supported Employment*, 28 *Health Affairs* 761, 763 (May/ June 2009) (hereinafter Drake 2009); Tom Burns et al., *The Impact of Supported Employment and Working on Clinical and Social Functioning: Results of an International Study of Individual Placement and Support*, 35 *Schizophrenia Bulletin* 5, 949-58 (Sept. 2009); Philip W. Bush et al., *The Long-Term Impact of Employment on Mental Health Service Use and Costs for Persons With Severe Mental Illness*, 60 *Psychiatric Services* 1024 (Aug. 2009); WILLIAM D. FREY ET AL., WESTAT, MENTAL HEALTH TREATMENT STUDY, FINAL REPORT (July 2011).

⁴ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *2012 CMHS Uniform Reporting System Output Tables 1* (2012) (Hereinafter 2012 URS).

⁵ 2012 URS, *supra* note 4, at Table 1.

⁶ 2012 URS, *supra* note 4, at 3.

⁷ ASPE Supported Employment Report, *supra* note 1, at vii. ASPE's estimates are derived from historical data. The SAMHSA data reflect the actual rates of employment of people served by state mental health agencies in 2012.

⁸ U.S. DEP'T OF LABOR, BUREAU OF LABOR STATISTICS, EMPLOYMENT PROJECTIONS — 2012-2022, Table 2 (Dec. 19, 2013) available at <http://www.bls.gov/news.release/pdf/ecopro.pdf>.

⁹ Drake 2009, *supra* note 3, at 767.

¹⁰ Written Testimony of Dr. Gary Bond, Professor of Psychiatry, Dartmouth Psychiatric Research Center, for U.S. Equal Employment Opportunity Commission public meeting on Employment of People with Mental Disabilities (May 15, 2011) (hereinafter Bond Testimony), <http://www.eeoc.gov/eeoc/meetings/3-15-11/bond.cfm>. See also Michael McQuilken et al., *The Work Project Survey: Consumer Perspectives on Work*, 18 *Journal of Voc. Rehab.* 59, 60 (2003) ("most studies suggest that a majority of people with severe mental illness want to work. . . . [citing one survey finding that 71 percent of respondents, individuals with serious mental illnesses receiving case management services, who were not employed indicated that they wanted to become employed, and one study finding that 53 to 61 percent of participants, individuals with schizophrenia spectrum disorders following a symptom relapse, who were not working reported an interest in working] . . . Other studies have found similar results.").

¹¹ See, e.g., Nancy M. McCrohan, et. al, *Employment Histories and Expectations of Persons with Psychiatric Disorders*, 38 *Rehab. Counseling Bulletin* 59 (Sep 1994) (finding that nearly 100% of the individuals surveyed had a work history). When Oregon instituted a supported employment program, 67 percent of individuals with serious mental illness being served by the state had worked at least one quarter in the past six years. HEIDI HERINCKX, REGIONAL RESEARCH INSTITUTE FOR HUMAN

SERVICES PORTLAND STATE UNIVERSITY, OREGON SUPPORTED EMPLOYMENT CENTER FOR EXCELLENCE: FINAL EVALUATION REPORT (Jul. 2011).

¹² Mark Salzer, *Beyond Supported Employment: Meaningful Career Development Initiatives During the Next Decade* (Powerpoint presentation) (2012).

¹³ Alexis D. Henry et al., *Inpatient Hospitalizations and Emergency Service Visits Among Participants in an Individual Placement and Support (IPS) Model Program*, 6 *Mental Health Services Research* 227, 234 (Dec. 2004) and Patrick W. Corrigan and Stanley G. McCracken, *Place First, Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation*, 50 *Social Work* 31, 33 (2005). See also Kelly A. Allot et al., *Relationship Between Vocational Status and Perceived Stress and Daily Hassles in First-Episode Psychosis: An Exploratory Study*, 48 *Social Psychiatry and Psychiatric Epidemiology* 1045 (Jul. 2013)

¹⁴ Bond Testimony, *supra* note 10.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Sandra Moll et al., *Supported Employment: Evidence for a Best Practice Model in Psychosocial Rehabilitation*, 70 *Canadian Journal of Occupational Therapy* 298, 298 (Dec. 2003).

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.* See also Morris D. Bell et al., *Clinical Benefits of Paid Work in Schizophrenia*, 22 *Schizophrenia Bulletin* 57 (1996) and Laura Blankertz and Susan Robinson, *Adding a Vocational Focus to Mental Health Rehabilitation*, 47 *Psychiatric Services* 1216 (1996).

²¹ Corrigan and McCracken, *supra* note 14, at 36; Deborah Becker et. al, *Long-Term Employment Trajectories Among Participants With Severe Mental Illness in Supported Employment*, 58 *Psychiatric Services* 922, 927 (Jul. 2007); Burns, *supra* note 4, at 955-56.

²² Supported employment services are also used by people with other disabilities—most frequently people with intellectual disabilities. See e.g. DAVID BRADDOCK, ET AL., *THE STATE OF THE STATES IN DEVELOPMENTAL DISABILITIES* 35-41 (2011), <http://www.stateofthestates.org/documents/SOS%20FINAL%20REVISED%20EDITION2011.pdf>

²³ U.S. DEP'T OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, CENTER FOR MENTAL HEALTH SERVICES, *SUPPORTED EMPLOYMENT: BUILDING YOUR PROGRAM 3* (2009) (hereinafter SAMHSA TOOLKIT), <http://store.samhsa.gov/shin/content/SMA08-4365/BuildingYourProgram-SE.pdf>.

²⁴ *Id.*

²⁵ See SAMHSA TOOLKIT, *supra* note 24; Interview by Bazelon Center Staff with Staff at Cornerstone Montgomery, an IPS supported employment provider (May 22, 2014) (hereinafter Cornerstone Interview).

²⁶ David Wittenburg et al., *The Disability System and Programs to Promote Employment for People with Disabilities*, 2 *IZA Journal of Labor Policy* 17 (2013). For a survey of other forms of supported employment, see Bond, *An Update on Supported Employment for People with Severe Mental Illness*, 48 *Psychiatric Services* 335 (1997). As Bond explains, the primary difference is the use of pre-vocational training before job placement. Other forms of supported employment have not been as rigorously studied as IPS supported employment, but studies indicate better results for IPS supported employment.

²⁷ See Dartmouth Psychiatric Research Center, *Practice Principles of IPS Supported Employment* (Oct. 11, 2011) (hereinafter 2011 IPS Principles), <http://www.dartmouth.edu/~ips/page48/page79/files/ips-practice-principles-002880029.pdf>; Gary R. Bond, *Supported Employment: Evidence for an Evidence-Based Practice*, 27 *Psychiatric Rehabilitation Journal* 4, 345-59 (2004) (hereinafter Bond 2004); and Gary R. Bond, *Principles of the Individual Placement and Support Model: Empirical Support*, 22 *Psychiatric Rehabilitation Journal* 1, 11-23 (1998) (hereinafter Bond 1998).

²⁸ 2011 IPS Principles, *supra* note 27; Bond 2004, *supra* note 27, at 352-54; and Bond 1998, *supra* note 27, at 12-14.

²⁹ *Id.*

³⁰ 2011 IPS Principles, *supra* note 27; Bond 2004, *supra* note 27, at 355; and Bond 1998, *supra* note 27, at 15-17.

³¹ 2011 IPS Principles, *supra* note 27.

³² 2011 IPS Principles, *supra* note 27; Bond 2004, *supra* note 27, at 354; and Bond 1998, *supra* note 27, at 17-18.

³³ 2011 IPS Principles, *supra* note 27 and Bond 2004, *supra* note 27, at 355-56.

³⁴ 2011 IPS Principles, *supra* note 27; Bond 2004, *supra* note 27, at 354-55; and Bond 1998, *supra* note 27, at 14-15.

³⁵ See Corrigan and McCracken, *supra* note 13.

³⁶ Interview by Bazelon Center Staff with Staff at Cornerstone Montgomery, an IPS supported employment provider (May 22, 2014) (hereinafter Cornerstone Interview) (on file with the Bazelon Center).

³⁷ 2011 IPS Principles, *supra* note 27.

³⁸ 2011 IPS Principles, *supra* note 27; Bond 1998, *supra* note 27, at 19.

³⁹ Cornerstone Interview, *supra* note 36.

⁴⁰ 2011 IPS Principles, *supra* note 27.

⁴¹ Robert E. Drake, et. al, *Rehabilitative Day Treatment vs. Supported Employment: I. Vocational Outcomes*, 30 *Community Mental Health Journal* 519, 528 (Oct. 1994)(hereinafter Drake 1994)(“This study indicates that eliminating day treatment services in favor of a supported employment program can produce competitive jobs in the community. This effect occurred in a group of persons with severe mental disabilities that was not selected for vocational potential”); Deborah R. Becker, *Converting Day Treatment Centers to Supported Employment Programs in Rhode Island*, 52 *Psychiatric Services* 351 (Mar. 2001) (“There is little evidence that rehabilitative day treatment—an expensive service—either promotes rehabilitation or protects clients from poor outcomes. Furthermore, it seems clear from interviews and ethnographic studies that clients experience day treatment as demeaning and would prefer competitive employment as an alternative. It may be that keeping people in segregated, low-expectation settings such as day treatment centers has the unintended effect of socializing them into disability, just as long-term hospitalization did earlier this century”) (citations omitted); Moll, *supra* note 19, at 306 (“[IPS] appears to be significantly more effective than traditional prevocational training and day treatment in terms of achieving competitive employment. The documented successes have provided new hope for individuals with severe and persistent mental illness who may have been previously labeled as unemployable. Evidence shows that there are improved vocational outcomes even for individuals who have been long-term consumers of mental health services, who have high levels of disability, and who have a limited

employment history”) (citations omitted); Bond 2004, *supra* note 27, at 348 (summarizing four studies: “the percentage of consumers obtaining competitive jobs nearly tripled after conversion of day treatment to supported employment, while competitive employment rates in nonconverting sites remained virtually static”).

⁴² Gary R. Bond et al., *An Update on Randomized Controlled Trials of Evidence-Based Supported Employment*, 31 *Psychiatric Rehabilitation Journal* 280, 284 (2008) (hereinafter Bond 2008).

⁴³ Michelle P. Salyers et al., *A Ten-Year Follow-Up of a Supported Employment Program*, 55 *Psychiatric Services* 302, 305 (2004) (“Almost all the consumers reported that they were employed at some point during the ten-year follow-up period, and 17 consumers (47 percent) were employed at the time of the ten-year follow-up interview ... These rates of employment are very high given the nature of the study group—high users of day treatment in the original conversion study.”)

⁴⁴ Johnson & Johnson – Dartmouth Community Mental Health Program, *Program Description*, available at <http://sites.dartmouth.edu/ips/j-j-dartmouth-community-mental-health-program/> (last visited Jun. 9, 2014) (hereinafter Johnson and Johnson and Dartmouth Program Description).

⁴⁵ *Id.*

⁴⁶ Deborah R. Becker et al., *The IPS supported employment learning collaborative*, 37 *Psychiatric Rehabilitation Journal* 79 (Feb. 2014).

⁴⁷ Robert E. Drake et al., *Assisting Social Security Disability Insurance beneficiaries with schizophrenia, bipolar disorder, or major depression in returning to work*. 170 *American Journal of Psychiatry* 1433 (Dec. 2013).

⁴⁸ Drake 2009, *supra* note 3, at 764-65.

⁴⁹ 2012 URS, *supra* note 4, at 1.

⁵⁰ NASMHPD RESEARCH INSTITUTE, INC., STATE MENTAL HEALTH AGENCY PROFILING SYSTEM: SYSTEM: 2012, ARE SUPPORTED EMPLOYMENT SERVICES CURRENTLY AVAILABLE STATEWIDE? (last visited June 9, 2014) available at http://www.nri-inc.org/projects/Profiles/ProfilesRevExpReport.cfm?Variable=S_11b3&State=AZ&Year=12&Description=Are%20Supported%20Employment%20services%20currently%20available%20statewide?&PTable=P12Services2.

⁵¹ NASMHPD RESEARCH INSTITUTE, INC., STATE MENTAL HEALTH AGENCY PROFILING SYSTEM: SYSTEM: 2012, ARE SUPPORTED EMPLOYMENT SERVICES CURRENTLY AVAILABLE IN PARTS OF THE STATE? (last visited June 9, 2014) available at http://www.nri-inc.org/projects/Profiles/ProfilesRevExpReport.cfm?Variable=S_11b2&State=AZ&Year=12&Description=Are%20Supported%20Employment%20services%20currently%20available%20in%20parts%20of%20the%20state?&PTable=P12Services2.

⁵² NASMHPD RESEARCH INSTITUTE, INC., STATE MENTAL HEALTH AGENCY PROFILING SYSTEM: SYSTEM: 2012, NUMBER OF PERSONS SERVED BY SUPPORTED EMPLOYMENT (last visited June 9, 2014), http://www.nri-inc.org/projects/Profiles/ProfilesRevExpReport.cfm?Variable=S_13b2&State=AZ&Year=12&Description=Number%20of%20persons%20served%20by%20Supported%20Employment.&PTable=P12Services2b

⁵³ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *2009 CMHS Uniform Reporting System Output Tables 1*.

⁵⁴ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *2010 CMHS Uniform Reporting System Output Tables 1*.

⁵⁵ U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *2011 CMHS Uniform Reporting System Output Tables 1*.

⁵⁶ U.S. DEP'T OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, GAIL ROBINSON ET. AL, STATE PROFILES OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES IN MEDICAID (2005) ("As of July 2003, among the 51 State Medicaid agencies profiled (Figure 8), 45 (88 percent) covered the service for those with a mental health condition").

⁵⁷ NASMHPD RESEARCH INSTITUTE, INC., FUNDING SOURCES AND EXPENDITURES OF STATE MENTAL HEALTH AGENCIES: FISCAL YEAR 2001 (May 2003).

⁵⁸ Drake 1994, *supra* note 41, at 520.

⁵⁹ See William C. Torrey et. al, *Addressing the Social Needs of Mental Health Consumers When Day Treatment Programs Convert to Supported Employment: Can Consumer-Run Services Play a Role?*, 22 *Psychiatric Rehabilitation Journal* 73-75 (1998).

⁶⁰ Drake 1994, *supra* note 41, at 521 (discussing the services provided in day treatment programs).

⁶¹ *Id.* at 520.

⁶² *Id.* at 521.

⁶³ *Disability Advocates, Inc. v. Paterson*, 653 F. Supp.2d 184, 212 (E.D.N.Y. 2009), vacated on other grounds, *Disability Advocates, Inc. v. New York Coalition for Quality Assisted Living, Inc.*, 675 F.3d 149 (2d Cir. 2012).

⁶⁴ *Id.*

⁶⁵ Drake 1994, *supra* note 1, at 521 ("a central concern about day treatment involves the failure to move people with psychiatric disabilities out of treatment centers into normal adult roles in the community").

⁶⁶ Elizabeth W. Twamley et. al, *Work Rehabilitation for Middle-Aged and Older People With Schizophrenia*, 193 *The Journal of Nervous and Mental Disease* 596, 596 (2005).

⁶⁷ Corrigan and McCracken, *supra* note 13, at 35.

⁶⁸ Drake 1994, *supra* note 41, at 521.

⁶⁹ See, e.g., Deborah R. Becker, *Converting Day Treatment Centers to Supported Employment Programs in Rhode Island*, 52 *Psychiatric Services* 3, 351-357 (Mar. 2001) (rates of employment among participants in community mental health centers that shifted from providing day treatment to providing supported employment rose to between 44.2 and 56.7 percent, as compared with 19.5 percent at a community mental health center offering traditional day treatment); Robert Drake, *Rehabilitative Day Treatment vs. Supported Employment: I. Vocational Outcomes*, 30 *Community Mental Health Journal* 519 (1994) (employment rates in program that shifted from day treatment to supported employment rose from 25.4% to 39.4%, while rates in day treatment program declined slightly from 13.4% to 12.5%; among individuals previously unemployed, 28.3% of supported employment group obtained competitive jobs, compared with 8.2% of day treatment group).

⁷⁰ Edward L. Bailey et. al, *Do Long-Term Day Treatment Clients Benefit from Supported Employment?*, 22 *Psychiatric Rehabilitation Journal* 24 (1998)

⁷¹ U.S. NEW FREEDOM COMMISSION ON MENTAL HEALTH, FINAL REPORT 41 (2003), See also Bailey et al.,

supra note 70, at 24 (“We conclude that long-term day treatment involvement may prevent rather than facilitate return to normal working lives”); Drake 1994, *supra* note 41, *Rehabilitative Day Treatment vs. Supported Employment*, at 520 (“These results indicate that eliminating day treatment and replacing it with a supported employment program can improve integration into competitive jobs in the community”).

⁷² Drake 2009, *supra* note 3, at 768.

⁷³ *Id.* at EX-11.

⁷⁴ FREY, *supra* note 3, at EX-10.

⁷⁵ *Id.* at EX-10, 8-13.

⁷⁶ *Id.*

⁷⁷ *Id.*

⁷⁸ U.S. DEP’T OF HEALTH AND HUMAN SERVICES, ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, OFFICE OF DISABILITY, AGING AND LONG-TERM CARE POLICY, TOWARD A SOCIAL COST-EFFECTIVENESS ANALYSIS OF PROGRAMS TO EXPAND SUPPORTED EMPLOYMENT SERVICES: AN INTERPRETIVE REVIEW OF THE LITERATURE (Dec. 2010), <http://aspe.hhs.gov/daltcp/reports/2010/supemplR.pdf>.

⁷⁹ Robin E. Clark, *Supported Employment and Managed Care: Can They Coexist?*, 22 *Psychiatric Rehabilitation Journal* 62 (1998).

⁸⁰ COMMISSION ON QUALITY OF CARE AND ADVOCACY FOR PERSONS WITH DISABILITIES, CONTINUING DAY TREATMENT REVIEW 3 (Dec. 2006), <http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/CDTReport.pdf>.

⁸¹ 42 U.S.C. § 12101(b)(1).

⁸² *Id.* § 12132.

⁸³ *Id.* § 12101(a)(2).

⁸⁴ 28 C.F.R. § 35.130(d).

⁸⁵ *Id.* Pt. 35, App. A

⁸⁶ 527 U.S. 581 (1999).

⁸⁷ *Id.* at 600.

⁸⁸ *Id.* at 601.

⁸⁹ *Id.* at 604-07.

⁹⁰ 42 U.S.C. § 12132.

⁹¹ See U.S. Dept. of Justice, *Statement of the Department of Justice on Enforcement of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C., and Questions and Answers on the ADA’s Integration Mandate and Olmstead Enforcement*, Question and Answer 1, available at http://www.ada.gov/olmstead/q&a_olmstead.pdf.

⁹² *Id.*

⁹³ *Id.*, Question and Answer 12.

⁹⁴ *Id.*, Question and Answer 15.

⁹⁵ U.S. DEP’T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, CENTER FOR MEDICAID, CHIP, AND SURVEY & CERTIFICATION INFORMATIONAL BULLETIN, UPDATES TO THE §1915 (c) WAIVER

INSTRUCTIONS AND TECHNICAL GUIDE REGARDING EMPLOYMENT AND EMPLOYMENT RELATED SERVICES 5 (Sept. 16, 2011), <http://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf> (hereinafter “CMS BULLETIN”).

⁹⁶ *Lane v. Kitzhaber*, 841 F. Supp.2d 1199, 1202-06 (D. Or. 2012). While the plaintiffs’ claims were dismissed based on a pleading issue, the plaintiffs later filed an amended complaint to address that issue, and the court ultimately certified the case as a class action. *Lane v. Kitzhaber*, 283 F.R.D. 587 (D. Or. 2012).

⁹⁷ *United States v. Rhode Island* (settlement approved 2014). A fact sheet describing the settlement agreement, as well as the agreement itself, can be found at http://www.ada.gov/olmstead/olmstead_cases_list2.htm.

⁹⁸ CMS BULLETIN, *supra* note 95, at 3.

⁹⁹ IPS Principles 2011, *supra* note 27.

¹⁰⁰ This is true even for members of the group or class that may not want to or be capable of working fulltime. These class members would seek, in addition to supported employment, rehabilitative services that are provided in settings more integrated than traditional day programs.

¹⁰¹ National Technical Assistance and Research Center to Promote Leadership for Increasing the Employment and economic Independence of Adults with Disabilities, Issue Brief Number 8, *Using Medicaid Funding to Support the Employment of People with Disabilities* 10 (Sept. 2011) (hereinafter NTAR Brief) available at http://www.dol.gov/odep/pdf/NTAR_IB8.pdf.

¹⁰² Some supported employment services may be covered under the “rehabilitation option,” 42 U.S.C. § 1396d(a)(13) and other Medicaid options. Other Medicaid authorities can be used to cover a full range of supported employment services, including the home and community-based state plan option (the “Section 1915(i) option”), home and community-based waivers (“Section 1915(c) waivers”), and demonstration waivers (“1115 waivers”). See NTAR Brief, *supra* note 105.

¹⁰³ The Vocational Rehabilitation program provides time-limited services and is not built on the presumption that all individuals can work; many individuals do not receive vocational rehabilitation services because they are deemed by state vocational rehabilitation agencies to be unable to work.

¹⁰⁴ JOSEPH MARRONE ET AL., INSTITUTE FOR COMMUNITY INCLUSION, REHABILITATION RESEARCH AND TRAINING CENTER ON VOCATIONAL REHABILITATION, VOCATIONAL REHABILITATION AGENCIES HELPING PEOPLE WITH PSYCHIATRIC DISABILITIES GET EMPLOYED: HOW FAR HAVE WE COME? HOW FAR DO WE HAVE TO GO? CASE STUDIES OF PROMISING PRACTICES IN VOCATIONAL REHABILITATION (April 2013), <http://www.communityinclusion.org/pdf/MH%20Case%20Studies%20Final%20Report.pdf>.