

POLICY OPPORTUNITIES FOR PROMOTING EMPLOYMENT FOR PEOPLE WITH PSYCHIATRIC DISABILITIES

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Abstract

Employment rates among people with psychiatric disabilities lag far behind rates for the general population.

While people with psychiatric disabilities face myriad of barriers to employment, many people want and are able to work successfully. Over the past several years, national and state level policies have increasingly focused on employment of people with disabilities, laying a foundation for enhanced worked opportunities for those with disabilities. In this policy brief, we discuss the services and supports that people with psychiatric disabilities need to work and the barriers to employment that still remain. We review current legislative and policy opportunities for further promoting employment for people with psychiatric disabilities, with an emphasis on opportunities created by enforcement of the ADA's integration mandate, the Affordable Care Act, the Workforce Innovation and Opportunity Act, regulatory changes to Medicaid home and community-based services and to Section 503 of the Rehabilitation Act, state-based Employment First initiatives, and possible reforms to Social Security benefits. In addition, we offer recommendations for leveraging these opportunities to develop practice innovations as well as to expand funding for and access to employment services for people with psychiatric disabilities.

Unemployment among working-age people with serious mental illness is a significant social problem. Serious mental illnesses, or psychiatric disabilities, include mental, behavioral, or emotional disorders that may cause substantial functional impairment, interfering with major life activities such as working, completing school, or sustaining important relationships. In general, people with disabilities have much lower rates of employment than those without disabilities (33% vs. 74%) (Erickson, Lee, & von Schrader, 2014), and the rate for people with psychiatric disabilities is lower still, with estimates ranging from 10-15% among those receiving mental health services, and 20-25% among broader community samples (Bond, 2011). Significant personal and economic costs are associated with unemployment, including social isolation, poorer health, long-term dependence on public disability benefits, and a life of poverty. The magnitude of this problem is substantial; about 4% of adults in the US age 18 and older – over 10 million people – experience a serious mental illness in a given year (Substance Abuse and Mental Health Services Administration, 2014).

Their low employment rate notwithstanding, the vast majority of people with psychiatric disabilities want to work (Frounfelker, Wilkniss, Bond, Devitt, & Drake 2011; Ramsay, et al., 2011). Employment is increasingly seen as an integral part of health for people with psychiatric disabilities, with work playing a central role in providing a sense of identity and promoting recovery (Dunn, Wewiorski, & Rogers, 2008; National Alliance on Mental Illness, 2014). Beyond the economic benefits, studies show work is associated with enhanced self-esteem, life satisfaction, social functioning, and decreased symptoms (Bond, et al., 2001; Burns, et al., 2009; Kukla, Bond, & Xie, 2012), challenging the still common belief that work is too stressful for people with psychiatric disabilities.

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The last 20 years have brought major advancements in the development of effective strategies for helping people with psychiatric disabilities get and keep jobs. One major strategy – a set of services known as supported employment (SE) – assists people with psychiatric disabilities to obtain competitive jobs, i.e. jobs in mainstream, integrated settings, available to anyone, that pay a prevailing wage; the evidence for the efficacy of SE is strong (Bond & Drake, 2014; Marshall, et al., 2014; Luciano, Drake, et al., 2014). However, access to services is quite limited; only about 2% of the over 3 million people served by State Mental Health Authorities received evidence-based SE services in 2012 (www.nri-incdata.org).

People with psychiatric disabilities face myriad of employment barriers, including social environment factors (e.g. stigma, lack of transportation); policy factors (e.g. complexities of disability benefit programs); as well as a lack of access to services and supports. Over the past several years, national and state level policies have increasingly focused on employment of people with disabilities, laying a foundation for enhanced work opportunities for those with disabilities. In this policy brief, we discuss the services and supports that people with psychiatric disabilities need to work and the barriers to employment that still remain, the current legislative and policy opportunities for further promoting employment for people with psychiatric disabilities, and offer recommendations for leveraging these opportunities.

What People with Psychiatric Disabilities Need to Work

There is compelling evidence that people with psychiatric disabilities want and are able to work successfully. Critical supports include services for employment and career development, services that promote economic well-being, and access to health care services that support participation in work.

Services for Employment and Career Development

Across multiple well-controlled studies, SE, particularly the Individual Placement and Support (IPS) model of SE, has been shown to be superior in helping people with psychiatric disabilities to obtain and retain jobs, have higher earnings and work more hours in comparison to a variety of other approaches (Luciano, Drake, et al. 2014). IPS services are individualized, and emphasize a rapid search for competitive jobs consistent with individuals' goals, interests, and experiences. Services are available to anyone who wants to work without consideration of diagnosis, past work history, or an assessment of readiness. Key features of IPS include time-unlimited supports as necessary, work incentives counseling services so that people can understand the impact of earnings on disability benefits, and integration of IPS with other mental health services (Swanson, Becker, Drake, & Merrens, 2008).

IPS has been shown to be quite effective in helping people with psychiatric disabilities to work. However, in order to maximize the economic benefits of work for participants, IPS may need to be enhanced with additional strategies to address underlying barriers (e.g. limited education) to obtaining higher wages and/or full-time jobs. As is true for the general population, higher wages are associated with higher levels of education among SE participants (Burke-Miller, et al., 2006; Henry, Hashemi, & Zhang, 2014; Rosenheck, et al., 2006; Salkever, et al., 2007). Because the typical age of onset of serious mental illness is late adolescence or early adulthood, disruptions in education are common among people with psychiatric disabilities. In recent years, experts have proposed an integration of SE and supported education (SEd) to promote career development for people with psychiatric disabilities, particularly for young people who may have decades of work participation ahead of them (Burke-Miller, Razzano, Grey, Blyler, & Cook, 2012; Luciano, Drake, et al., 2014; Manthey, Rapp, Carlson, Holter, & Davis, 2012).

SEd assists students to pursue education consistent with their interests and career goals (Mowbray, et al., 2005). Services include career counseling; assistance with financial aid, course selection, and registration; training in skills needed in an academic setting (e.g. study skills); information about student rights and campus resources; and mentorships. Services may be provided on- or off-campus by college mental health or disability services staff, or by specialized staff from a psychiatric rehabilitation agency. There is evidence that SEd assists people to identify education goals, access resources, and cope with barriers to education, and may be associated with increased educational attainment (Rogers, Kash-MacDonald, Bruker, & Maru, 2010). While programs combining SE and SEd have been described (Hutchinson, Anthony, Massaro, & Rogers, 2007; Rudnick, Gover, & Pearson, 2009), more research is needed examining the impact of SEd on work outcomes (Ringeisen, Ryder-Burge, Ellison, Biebel & Alikahn, 2015; Rogers, et al., 2010).

States use a variety of mechanisms to fund SE and SEd services, including Medicaid and state Vocational Rehabilitation (VR) dollars, SAMHSA Mental Health Block Grants, Ticket-to-Work payments, state general funds, and other resources (Bazelon Center for Mental Health Law, 2010; Luciano, Drake, et al., 2014; Karakus, Frey, Goldman, Fields, & Drake, 2011). Some states have developed partnerships across mental health and VR agencies to create braided funding for SE (Marrone, Cala, Haines, Boeltzig-Brown, & Foley, 2013). Some SE programs include SEd (Becker, Drake, & Bond, 2014), but states typically offer little direct funding for these services. As discussed later, many states are not taking full advantage of Medicaid financing for SE services.

Services to Promote Economic Well-Being

For decades, public mental health systems have prioritized assisting people with psychiatric disabilities to enroll in the Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) programs (as well as Medicare and Medicaid), which require people to demonstrate that they cannot work at substantial levels. While many people with psychiatric disabilities necessarily rely on SSDI and SSI for critical income support, the reality is that to be dependent on disability benefits for income is to live in poverty. In 2015, the average monthly SSDI benefit was \$1,165 and the federal SSI benefit was \$733 (many states supplement the federal benefit) (Social Security Administration, 2016). As mental health services have become increasingly recovery-oriented, emphasis has shifted to supporting people with psychiatric disabilities to work and to improve their economic well-being. However, the complexities of the rules governing disability benefit programs mean that many people with psychiatric disabilities, as well as many providers, lack an understanding of how work and earnings will impact these benefits. In a national survey, 40% of people with serious mental illnesses identified fear of losing disability benefits as a primary barrier to employment (Hall, Graf,

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Fitzpatrick, Lane, & Birkel, 2003). Consequently, people may decide not to work or keep earnings low because they fear losing benefits (Gettens, Henry, Laszlo, & Himmelstein, 2012).

Work incentives counseling is a critical element of evidence-based SE (Swanson, et al., 2008). Nationally, 95 Social Security Administration (SSA)-funded Work Incentives Planning and Assistance (WIPA) programs provide individualized counseling to working-age SSDI and SSI beneficiaries to help them understand the impact of earnings on disability benefits, to advise on the use of SSA and other work incentives (e.g. Trial Work Period or Medicaid Buy-in programs), and to make a plan to return to work or increase earnings. Receipt of work incentives counseling is associated with higher earnings among people with disabilities, including people with psychiatric disabilities (Livermore, Prenovitz, & Schimmel, 2011; Tremblay, Smith, Xie, & Drake, 2006). However, WIPA programs serve about 46,000 beneficiaries annually, a fraction of the almost 13 million working-age SSA beneficiaries, and funding for these services is limited (Livermore, et al, 2011).

Beyond the critical need for work incentives counseling, several authors have identified a broader need for financial planning and asset development education to help promote economic well-being and financial security among people with psychiatric disabilities. A few financial education approaches have been described in the literature (Burke-Miller, et al, 2010; Cook, Burke-Miller, Jonikas, & Swarbrick, 2010; Elbogen, Tiegreen, Vaughan, & Bradford, 2011); however such approaches have not been extensively researched.

Health Care Services that Support Participation in Work

People with disabilities have a critical need for health care services, and the ability to access health insurance through Medicare and Medicaid is one factor motivating applications for disability benefits, which qualify beneficiaries for these insurance programs. While access to disability benefits requires people to demonstrate that they cannot work, health care services, particularly the disability-related services covered by Medicare and Medicaid, can be a vital employment support. People with psychiatric disabilities who work identify mental health services, medications, and other support services as vital to helping them work (Gettens & Henry, 2014; Henry, Long, Zhang, & Himmelstein, 2011). A recent demonstration funded by the Centers for Medicare and Medicaid Services (CMS) examined the effects of early intervention programs providing health care and support services to working people whose disability had not yet caused them to turn to public benefits, and found that services helped to forestall or prevent receipt of SSA benefits (Whalen, Gimm, Ireys, Gilman, & Croake, 2012).

As with cash benefits, concerns about the impact of earnings on health insurance benefits can limit participation in employment among people with disabilities. Given the traditional model of benefits, this concern is understandable, but it is misplaced. Medicaid Buy-in programs, which exist in 38 states, allow working people with disabilities with higher income to purchase access to Medicaid services (Kehn, 2013). Unfortunately, many people with disabilities are unaware that Buy-in programs can allow

them to continue receiving health benefits if they return to work. As with SSDI and SSI, work incentives counseling can help people with psychiatric disabilities understand and take advantage of such programs. In addition, under the Affordable Care Act (ACA), people with disabilities have increased access to insurance coverage through Medicaid expansion (currently underway in 25 states and DC) and through subsidized and non-subsidized plans purchased through state marketplaces (Gettens, Henry, & Himmelstein, 2012; Smith, Gifford, Ellis, Rudowitz, & Snyder, 2013), which may have the effect of reducing the need to apply for disability benefits to obtain health insurance.

Barriers to Employment Remain

If people with psychiatric disabilities want to and can benefit from work and much is known about effective strategies for helping people to work successfully, why are so few working? In part, the problem may stem from continued low expectations for people with psychiatric disabilities and misunderstanding about what is possible in mental health service systems.

Misperceptions about Work for People with Psychiatric Disabilities

For decades, people with psychiatric disabilities were either believed to be unable to work, or it was believed that, for their own good, they should not work. This notion was based on the assumption that people with psychiatric disabilities were unable to handle the “stress of work” – an assumption that studies have consistently found to be baseless (Luciano, Bond, & Drake, 2014). These misperceptions created substantial attitudinal barriers that unfortunately remain prevalent. Studies show that many providers do not believe that people with psychiatric disabilities can work (Braitman, et al., 1995; West, et al., 2005). One study found that people with psychiatric disabilities who wanted to work were frequently not referred to services, even if they asked (Casper & Carloni, 2007). These ingrained beliefs must change if real progress is to be made; people with psychiatric disabilities, providers, and state policy makers must be educated that work is not harmful, but in fact is a critical part of mental health recovery.

Funding for Employment Supports Is Available, But Poorly Understood

Until recently, Medicaid funding for SE services for people with psychiatric disabilities has been limited. The Medicaid authority that has historically funded SE for other disabilities populations, the 1915(c) Home and Community Based Services Waiver, has had limited applicability to people with psychiatric disabilities who typically do not meet the “institutional level of care” or “cost neutrality” required for the 1915(c) waiver eligibility. Instead, services for people with psychiatric disabilities have mainly been funded through Medicaid state plan rehabilitative services option. While some employment supports can be funded under this option (Crowley & O’Malley, 2007), the option can fully fund non-work day services, which has led public mental health systems to prioritize options like day treatment instead of employment services. However, because of changes to Medicaid law under ACA, options for fully funding SE for people with psychiatric disabilities may be easier and more available than ever. We discuss these options below.

Early Interventions Are Needed

While much progress has been made in helping people with psychiatric disabilities to work, additional changes are needed. One particular challenge is the lack of early intervention services that provide education, career development and employment supports to people early in the course of illness, before they experienced prolonged disengagement from productive activities like school and work. The current trajectory for most people with a psychiatric disability is to apply for disability benefits to get access to services; most people then are pushed into day services rather than supported to work. However, if early interventions can help people with psychiatric disabilities stay connected to school and work, services may have the effect of preventing or forestalling application for disability benefits (Whalen, et al., 2012). Dedicated efforts to develop and provide early intervention services are critically needed.

Legislative and Policy Opportunities

Over the past several years, national and state-level policies have increasingly focused on employment of people with disabilities, in part as an outgrowth of efforts to enforce and implement the integration mandate of the Americans with Disabilities Act (ADA), which requires states to administer services to people with disabilities in integrated settings. While initial efforts focused on shifting state systems away from providing care in institutional and large congregate settings towards providing services to people in integrated housing in the community, more recent efforts have focused not only on where people live but also how they spend their days. These efforts have required states to expand access to employment services for people with disabilities. Simultaneously, federal policy – including recent legislation passed by Congress and actions by executive branch agencies – has prioritized and expanded employment opportunities. Some states are taking action through “Employment First” initiatives. These steps have laid a foundation to enhance work opportunities for people with disabilities.

Enforcement of the ADA’s Integration Mandate

Title II of the ADA prohibits discrimination against people with disabilities by state and local governments, and regulations require governments to administer services to people with disabilities “in the most integrated setting appropriate to their needs” (General Prohibitions Against Discrimination, 1991). The Department of Justice (DOJ) has stated that an integrated setting “provide[s] individuals with disabilities opportunities to live, work, and receive services in the greater community, like individuals without disabilities” (2011, pg. 2). In its 1999 decision in *Olmstead v. L.C.*, the Supreme Court held that Title II of the ADA prohibits states from needlessly institutionalizing people with disabilities and requires them to offer services in integrated settings, unless doing so would fundamentally alter disability service systems (*Olmstead v. L.C.*, 1999). Since the *Olmstead* decision, there have been significant enforcement activities on behalf of people with psychiatric disabilities, as well as voluntary ADA compliance efforts by states. Initial *Olmstead* litigation focused on people needlessly (or at risk of being) institutionalized and resulted in settlement agreements requiring states to develop more comprehensive community mental health services and thousands of scattered supported housing sites for people with psychiatric disabilities. These efforts have helped many people with psychiatric disabilities move into their own homes, maximizing their independence. More recently, *Olmstead* enforcement efforts have recognized that SE services are critical to helping people with psychiatric disabilities live successfully in the community, and settlement agreements have included SE among the required services to assist people who are transitioning from institutions and other large congregate settings to the community (US Department of Justice, nd.). There also has been recent *Olmstead* litigation focused exclusively on states’ non-residential services, challenging the provision of services to people with disabilities in segregated settings, such as sheltered workshops and day habilitation programs. For example, in Oregon, a class of people with intellectual and developmental disabilities (ID/DD) sued the state seeking SE services in integrated settings rather than in sheltered workshops. The federal court held that the ADA’s prohibition on needless segregation in residential settings applies equally to segregation in employment settings (*Lane v. Kitzhaber*, 2012). Similarly, DOJ recently reached a settlement with Rhode Island in a case brought on behalf of individuals with ID/DD who were needlessly segregated in workshops and day programs, obligating the state to offer SE services to people in or at risk of placement in these settings. In addition, DOJ has stated that states’ voluntary *Olmstead* planning should include expanding SE for people in day programs (US Department of Justice, 2011). Implementation of the ADA’s integration mandate has enormous potential to shift resources from institutional care and segregated day programs to fund SE services.

New Legislation

Recent legislation, including ACA and the Workforce Investment and Opportunity Act, has also created opportunities to promote employment of people with disabilities.

Affordable Care Act (ACA). Enacted in 2010, ACA gives states the option to extend Medicaid eligibility to all people with income at or below 133% of the federal poverty level, with the federal government paying almost all of the costs of their care (Musumeci, 2014). The expansion covers a substantial number of people with serious mental illness – approximately 7% of the 18 million or so people newly eligible for Medicaid in states adopting the expansion (Substance Abuse and Mental Health Services Administration, 2013). Coverage through the Medicaid expansion must include mental health services offered at parity with medical services; that is, they may not have higher co-pays or other financial requirements or more restrictive treatment limitations (US Department of Health and Human Services, Centers for Medicare and Medicaid Services, 2013). Such coverage will make it easier for people to transition from unemployment to work without the fear of losing Medicaid for jobs that may not offer health insurance, or offer insurance that does not meet their needs. Additionally, rehabilitative services available as part of the ten essential health benefits required of both Medicaid expansion and health plans offered through states' and the federal marketplaces (www.healthcare.gov) should cover psychiatric rehabilitation services, including SE.

ACA also makes it easier for states to cover SE services through the Medicaid program. For example, the 1915(i) State Plan option allows states to target an array of home and community-based services, including employment services, to a group of individuals using needs-based criteria; states may use the option for people with psychiatric disabilities or a broader group of people with disabilities (Bazelon Center for Mental Health Law, 2014b). While previously, states could only use Medicaid's state plan rehabilitative services option to cover limited employment supports, the 1915(i) option allows the provision of more comprehensive employment services (Bazelon Center for Mental Health Law, 2014a). Although the option has been available since 2007, ACA made significant improvements to the authority, and CMS issued implementing regulations in 2014. States are now becoming more interested in the 1915(i) option. Currently 12 states have active 1915(i) options, and an additional four states are planning to apply for the option (Smith, et al., 2013). Because of a lack of awareness of this option's reach, few states have used the option to offer employment services, and only one state so far has included SE services as a benefit (O'Brien, 2014). Several other states have chosen to cover SE services under Medicaid Demonstration Waivers, known as 1115 waivers. Change has been slow, however, and there is a critical need for more states to be made aware of the ability to cover a full range of SE under the 1915(i) option or an 1115 waiver.

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Workforce Innovation and Opportunity Act (WIOA). Passed in 2014, a major goal of WIOA is to promote competitive employment for people with the most significant disabilities (Workforce Innovation and Opportunity Act, 2014). Among other things, the law requires state VR agencies to offer SE services to people with disabilities for longer periods of time than before, expanding the period from 18 months to up to 24 months if needed. WIOA also specifically addresses the needs of the students with disabilities after they leave high school, allowing for up to 4 years for youth age 24 and under with the most significant disabilities. WIOA requires states to provide pre-employment transition services to young people, including job exploration counseling; integrated, work-based learning experiences; instruction in self-advocacy; and peer mentoring. WIOA also prohibits employers from hiring people with disabilities at subminimum wages after the effective date of the law, except in very limited circumstances (Workforce Innovation and Opportunity Act, 2014).

Finally, WIOA created the Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities. The Advisory Committee is charged with making recommendations to Congress and the Labor Secretary on ways to increase competitive integrated employment for people with significant disabilities and on the use and oversight of subminimum wage certificates under Section 14(c) of the Fair Labor Standards Act. In its September 2015 Interim Report, the Advisory Committee made a number of recommendations relevant to employment of people with psychiatric disabilities, including issuing guidance

regarding Medicaid coverage of supported employment for people with psychiatric disabilities under different authorities, funding mechanisms to incentivize competitive integrated employment over other day services, and strategies for addressing real and perceived disincentives to employment caused by concerns about loss of healthcare and/or cash benefits. (Sept. 15, 2015 Advisory Committee Report, available at <http://www.dol.gov/odep/pdf/20150808.pdf>)

Regulatory Changes

Medicaid Home and Community-Based Services (HCBS). CMS recently finalized new rules defining home and community-based settings that are eligible for funding under Medicaid's HCBS programs (Medicaid Program; State Plan Home and Community-Based Services, 2014). The rules require states to transition away from providing day services in segregated settings and to expand integrated services like SE, and provide that HCBS settings must be chosen by the individual from among various options, including settings that are not disability-specific. Settings must support full access to the community, including integrated employment settings; ensure the rights of privacy, dignity, respect, and freedom from coercion and restraint; optimize independence in conducting daily activities and making life choices; and facilitate choice regarding services. Certain settings, including those that may isolate people from the broader community, are presumed not to be community-based. To the extent that states are using HCBS funding for services for people with psychiatric disabilities, many settings in which services are delivered likely will not meet the requirements of the new regulations. The regulations allow states a transition period to come into compliance and create incentives for states to invest more heavily in SE services.

Section 503 of the Rehabilitation Act. Section 503 of the Rehabilitation Act of 1973 requires that federal contractors avoid disability-based discrimination and take affirmative action to advance employment of people with disabilities. In 2011, the Department of Labor (DOL) announced that Section 503 regulations had "resulted in little improvement in the unemployment and workforce participation rates of individuals with disabilities" (pg. 77069) and that new rules would be promulgated (Affirmative Action and Nondiscrimination Obligations of Federal Contractors; Notice of Proposed Rulemaking, 2011). New regulations issued in 2013 set a goal for large federal government contractors to have 7% of the employees in each part of their workforce be people with disabilities. This goal is significant; for the first time, federal contractors will be held to the kind of benchmarks that have been imposed for years for employment of women and racial and ethnic minorities. The new regulations also require large contractors to report data on their efforts to recruit, hire and retain people with disabilities, allowing contractors and the government to measure the effectiveness of such efforts. Further, the regulations require contractors to invite job applicants and employees to voluntarily self-identify their disability status for purposes of furthering affirmative action efforts, and to periodically review physical and mental job qualifications to ensure they do not screen out qualified people with disabilities (Affirmative Action and Nondiscrimination Obligations of Federal Contractors, 2013). As federal contractors employ nearly one-quarter of the national workforce, these new regulations have great potential to increase employment rates for all people with disabilities.

State "Employment First" Initiatives

Some states have begun to take action to expand employment opportunities for people with disabilities through "Employment First" initiatives. While there is not one governing set of Employment First principles, and state approaches have varied, guidelines issued by the Association of People Supporting Employment First (nd.) emphasize two important elements to Employment First efforts: 1) recognition that employment in the general workforce is the first and preferred outcome of publicly funded services for working-age people with disabilities; and 2) that employment means a competitive job in an integrated setting that pays at least minimum wage. Many states have included these principles in their Employment First initiatives (Nord & Hoff, 2014) which have been driven in large part by advocacy organizations. Technical assistance for state-level efforts has been supported by DOL's Office of Disability Employment Policy, as well as by national associations for state mental health and developmental disabilities programs (e.g. State Employment Leadership Network, National Association of State Mental Health Program Directors).

One challenge with Employment First is that people with psychiatric disabilities are often not included in states' initiatives. Most state initiatives are focused on people with ID/DD; of the 32 states that have taken formal policy action to promote Employment First, only about half had cross-disability policies. Another 14 states have initiatives underway, again with most focused on people with ID/DD (Nord & Hoff, 2014). Advocacy efforts are needed to ensure that Employment First initiative address the

needs of people with psychiatric disabilities. There are additional challenges associated with getting states to make the systemic changes necessary to implement Employment First. While having an Employment First policy helps to shift public perception away from the idea that people with disabilities cannot work, change will only be possible if there is an accompanying system change that ensures that people with disabilities have access to effective SE services. Employment First has great potential to increase the number of people with disabilities working in competitive employment, but only if these challenges are met.

SSDI and SSI Reforms

SSDI and SSI are major programs that provide income support for people with significant disabilities, and people with mental illnesses comprise a significant (and growing) percentage of the people on these benefits. SSDI and SSI have been criticized for creating disincentives for people with disabilities to work. The arduous process of applying for benefits requires people to prove that they are unable to work. Often people become disconnected from employment during this process, and by the time they begin receiving benefits, find it difficult to re-enter the workforce. Additionally, the complexity of the regulations governing both the cash and health insurance benefits make people hesitant to risk benefits by increasing their earning, even when they want to work (Gettens, et al., 2012). As previously discussed, work incentives counseling is a critical service for people receiving benefits, but is limited across the country.

The SSDI program is projected to have a financial shortfall starting in 2016; without reforms or other action, the program will not be able to fully pay the claims of current beneficiaries (Faler, 2012). This has led to a renewed urgency to consider reforms to the program. Many reforms being discussed have focused on changing the programs to incentivize and support people with disabilities to work (Congressional Budget Office, 2012). For example, proposals include providing supports to individuals to keep them connected with employment at the onset of disability, helping them to continue working and be diverted from benefit programs (Whalen, et al., 2012). Other proposals include reforming the system from one that is an “all or nothing” program to one that provides partial benefits depending on the limitations imposed by the person’s disability and ability to continue working (even if part-time) (Congressional Budget Office, 2012). These conversations around SSI/SSDI reform have led to a renewed focus on how to help people with disabilities work, particularly people with psychiatric disabilities.

Recommendations

Develop Guidance and Incentives for Medicaid Coverage of SE

One key to increasing employment among people with psychiatric disabilities is for more state Medicaid systems to offer SE to these individuals. While there are a number of Medicaid authorities available to pay for SE services – including a Section 1915(i) state plan amendment, a Section 1115 demonstration waiver, managed care authorities (such as Section 1915(b)), as well as benefit plans available through the Medicaid expansion – many state officials are unaware of what may be covered under each option. CMS should ensure that states, as well as consumers and advocates understand the opportunities to use Medicaid to fund SE by publicly clarifying (via guidance or other technical assistance documents) how SE services, and particularly the critical components of IPS, can be covered under different authorities. Guidance should also describe how to coordinate the funding and delivery of SE between state mental health and VR agencies, as well how to use other Medicaid programs, such as the Balancing Incentive Program, to fund services. In addition, CMS should engage in a coordinated outreach and technical assistance effort to encourage states to use Medicaid to provide SE to people with psychiatric disabilities. Finally, Congress should consider creating incentives for states to provide SE in their Medicaid programs, such as an enhanced federal reimbursement rate for SE services. Congress has taken similar steps to promote the adoption of other Medicaid options, like the Section 1915(k) Community First Choice Option.

Maximize Opportunities in the Affordable Care Act

ACA provides another opportunity to support employment among people with disabilities. In states undertaking Medicaid expansion, lower income individuals with psychiatric disabilities who want to work or are working will have access to health insurance without needing to apply for disability-based Medicaid; efforts should be made to ensure that people are aware of this option. Additionally, CMS should clarify that mental health parity applies to all ten essential health benefits specified through the ACA, in particular the rehabilitation and habilitation benefits. Under these benefits, psychiatric rehabilitation services, including SE, should be covered to the same degree as physical rehabilitation services (e.g. physical and occupational therapy) in plans available through state health insurance marketplaces, as well as through www.healthcare.gov.

Continue Service Innovations

There are opportunities to improve on current evidence-based SE practices, especially to address the educational and career development needs of younger people with psychiatric disabilities. Early intervention supported employment may divert people from a lifetime of disability benefits and poverty. Disability employment researcher as well as funding agencies, such as National Institute on Disability and Rehabilitation Research and National Institute of Mental Health should prioritize the development and testing of innovations to current approaches. Additionally, as part of an early intervention strategy, the Social Security Administration should proactively make available information about and encourage the use of employment support services and work incentives counseling when people first apply for DDSI and SSI to help people stay connected to the labor force and reduce the need for long-term disability benefit support.

Include People with Psychiatric Disabilities in Federal and State Employment Initiatives

There are a number of federal and state initiatives to expand employment opportunities for people with disabilities that could significantly benefit people with psychiatric disabilities if they are included as a focus. At the federal level, DOL should ensure that covered entities include people with psychiatric disabilities as part of their outreach, recruitment, and retention efforts under Section 503. As efforts proceed, DOL should track the rates of employment for people with psychiatric disabilities and take action if such individuals are not benefitting from the regulations. At the state level, Employment First initiatives should be expanded to include not only individuals with ID/DD, as is the case in most states, but also people with psychiatric disabilities. In addition, expansion of SE for people with psychiatric disabilities should be part of states' affirmative strategies for achieving compliance with Olmstead and with the new HCBS regulations. Advocates should encourage states to take these actions, including by pushing for cross-disability Employment First initiatives, raising employment as part of states' Olmstead efforts, and engaging with states as they develop transition plans for their HCBS programs.

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