JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

Advances in Employment Policy for Individuals with Serious Mental Illness

Judge David L. Bazelon Center for Mental Health Law

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JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW
1101 Fifteenth Street NW Suite 1212
Washington DC 20005-5002
202.467.5730 (voice)
202-223-0409 (fax)
www.bazelon.org

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Introduction

People with serious mental illness have among the lowest employment rates in the United States. The odds of an individual with a diagnosis of schizophrenia having a job are "a little better than 1 in 5, and the likelihood of having a full-time job is approximately 1 in 8."[1] In 2015, only 21.7 percent of individuals receiving public mental health services had any form of employment (temporary or part- or full-time).[2] These low employment rates persist despite studies suggesting that nearly everyone with serious mental illness has prior work experience[3] and two-thirds want to work.[4]

This enormous gap between these employment rates and individuals' desire to work is not for want of knowledge about how to engage and support individuals with serious mental illness (SMI) in employment; yet that knowledge has not been deployed to accomplish this on a large scale. There are evidenced-based services that enable people with SMI to secure and maintain jobs. In fact, there is a robustly studied practice called "Individual Placement and Support"—a type of supported employment that has shown great success in facilitating employment of people with SMI.[5] But despite decades of evidence and recognition at the federal and state level of the need for these services, their availability remains scarce, and the vast majority of people who need them do not have access to them.

This report begins with a summary of what supported employment is, the research demonstrating its success, the legal obligations states have to ensure access to it, and its limited availability. We explore why supported employment is not more widely available. We then present strategies utilized by states when they expanded supported employment under settlement agreements; practical perspectives from employers, providers, and service users; and valuable

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[1] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, FEDERAL FINANCING OF SUPPORTED EMPLOYMENT AND CUSTOMIZED EMPLOYMENT FOR PEOPLE WITH MENTAL ILLNESSES: FINAL REPORT vii (2011) (hereinafter ASPE Financing Report). There was a more recent analysis of 2009 and 2010 National Survey on Drug Use and Health data which estimates a full-time employment rate of 38.1%. However, "the study sample did not include people in institutional settings (prisons, hospitals, treatment centers)." Alison Luciano and Ellen Meara, *The Employment Status of People with Mental Illness: National Survey Data from 2009 and 2010*, 65 Psychiatric Services 10, 1201–1209 (Oct. 1, 2014).

[2] THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): SAMHSA UNIFORM REPORTING (2015) (hereinafter SAMHSA NOMS 2015).

[3] Robert E. Drake, et al., *Social Security And Mental Illness: Reducing Disability With Supported Employment*, 28 *Health Affairs* 3, 761-770, 763 (2009) ("Surveys of adults with psychiatric disabilities consistently find that 50–70 percent of them have a strong preference to work").

[4] Gary R. Bond and Robert E. Drake, *Making the Case for IPS Supported Employment*, 41 Administration and Policy in Mental Health and Mental Health Services Research 1, 69-73 (Jan. 2014).

[5] *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.

lessons learned over the past decade. We conclude with recommendations at the federal, state, and local levels for how to ensure that this core service is widely available.

Supported employment services help people with serious mental illness re-enter or enter the work force, but despite a substantial evidence base, these services are not widely available.

Services designed to help people with disabilities secure and maintain employment are often referred to as "supported employment." The best methods for getting people with SMI back to work or into work for the first time have been studied extensively for the past several decades. Traditional strategies were typically premised on the notion that people with SMI were incapable of working without first spending months or years being "trained" in sheltered workshops[6] or other non-work settings to become ready to work (sometimes known as "train and place"). Research over the last several decades, however, consistently demonstrated that a "place and train" approach of getting people employed and training them on the job—with an understanding of the specific set of skills needed to succeed in a particular job—was more successful than traditional strategies.[7]

Research has clearly identified a particular form of supported employment that is very successful: "Individual Placement and Support (IPS) supported employment." IPS supported employment begins with "the belief that every person with SMI is capable of working competitively in the community if the right kind of job and work environment can be found."[8] This is a crucial counter to the discrimination and misunderstanding that many people with SMI face when attempting to return to or begin work. IPS supported employment then provides wraparound employment services for people with SMI. It can include many different elements, such as:

- 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.

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[6] A sheltered workshop is a segregated employment setting that primarily or exclusively employs people with disabilities, or where people with disabilities work separately from others. Workers with disabilities in these settings are typically paid sub-minimum wages through a special authority under the Fair Labor Standards Act.

[7] *See, e.g., Patrick W. Corrigan and Stanley G. McCracken,* Place First, Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation, 50 Social Work 1, 31-39 (Jan. 2005) ("train–place approach to rehabilitation is dominated by concerns about relapse if a person with mental illness is too quickly placed in a real-world setting with its commensurate demands and stresses").

[8] 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. While this toolkit does not explicitly identify IPS, the model described in the toolkit is IPS.

- 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 illnesses while at the same time addressing employers' unmet 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 Social Security Insurance (SSI)/Social Security Disability Insurance (SSDI) recipients, and ensure that individuals continue to have the healthcare coverage they need while working.[9]

IPS supported employment has been thoroughly analyzed and shown to result in substantially better employment results than other forms of vocational rehabilitation for people with SMI. IPS was developed by researchers at Dartmouth and is "[t]he one employment intervention that has been rigorously evaluated outside of [studies funded by] SSA [Social Security Administration] and CMS [Centers for Medicaid and Medicare Services]."[10] IPS is defined by the following set of principles:[11]

- First, competitive employment is the goal of IPS.[12] This commitment to the idea that everyone is an appropriate candidate for competitive, real-world work diverges from outmoded ideas that work is harmful to individuals with SMI and that many such individuals are incapable of working.[13]

- Second, IPS services are integrated and coordinated with rehabilitation and clinical treatment so that an individual's other service providers are involved with and understand

[9] *See id.*; Interview by Bazelon Center Staff with Staff at Cornerstone Montgomery, an IPS supported employment provider (May 22, 2014) (hereinafter Cornerstone Interview).
[10] 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.
[11] *See* 2011 IPS Principles), *supra* note 5; 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).
[12] 2011 IPS Principles, *supra* note 5; Bond 2004, *supra* note 11, at 352-54; and Bond 1998, *supra* note 11, at 12-14.
[13] *Id.*

the individual's vocational goals.[14]

- Third, all individuals are eligible for IPS services—if an individual wants to work, he or she is eligible "regardless of psychiatric diagnosis, symptoms, work history, or other problems, including substance abuse and cognitive impairment."[15]

- Fourth, 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.[16]

- Fifth, individuals receive personalized benefits counseling so they will understand what impact working will have on their benefits, and the impact of any changes in work status.[17]

- Sixth, IPS assists individuals in seeking jobs immediately—there is no training period, but instead a rapid job search.[18] In doing this, IPS uses a 'place, *then* train' approach, promoting rapid placement of participants in jobs, followed by on-the-job support, resources, and training that help participants successfully remain in those jobs.[19] 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.[20]

- Seventh, IPS service providers "develop relationships with employers, based upon their clients' work preferences, by meeting face-to-face."[21]

- Eighth, IPS is designed to be a constant support system, with services available permanently, although the goal is to help individuals become independent.[22] Service providers can help individual clients learn job tasks or new responsibilities.[23] After individuals have "worked steadily (e.g., one year), they discuss transitioning from IPS."[24]

The research on IPS has consistently demonstrated clear successes—there have been 14 randomized controlled studies; taken together, the studies demonstrate "1) [IPS] Supported

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[14] 2011 IPS Principles, *supra* note 5; Bond 2004, *supra* note 11, at 355; and Bond 1998, *supra* note 11, at 15-17.
[15] 2011 IPS Principles, *supra* note 5.
[16] 2011 IPS Principles, *supra* note 5; Bond 2004, *supra* note 11, at 354; and Bond 1998, *supra* note 11, at 17-18.
[17] 2011 IPS Principles, *supra* note 5 and Bond 2004, *supra* note 11, at 355-56.
[18] 2011 IPS Principles, *supra* note 5; Bond 2004, *supra* note 11, at 354-55; and Bond 1998, *supra* note 11, at 14-15.
[19] *See* Patrick W. Corrigan and Stanley G. McCracken, *Place First, Then Train: An Alternative to the Medical Model of Psychiatric Rehabilitation*, Social Work, vol. 50, no. 1, 31 (Jan. 2005).
[20] Cornerstone Interview, *supra* note 9.
[21] 2011 IPS Principles, *supra* note 5.
[22] 2011 IPS Principles, *supra* note 5; Bond 1998, *supra* note 11, at 19.
[23] Cornerstone Interview, *supra* note 9.
[24] 2011 IPS Principles, *supra* note 11.

employment increases the length and time of people's employment" and "2) People on [IPS] supported employment find jobs quicker."[25] Specifically, "IPS clients work twice as many weeks and three times as many hours per year than clients in other vocational programs."[26] In addition, "well-integrated IPS and mental health services reduce hospitalizations."[27] For people with SMI, employment, whether obtained via IPS or otherwise, results in "improved psychiatric symptoms, higher quality of life, or fewer psychiatric hospitalizations."[28]

IPS supported employment has been studied and shown to be effective for veterans,[29] individuals of a variety of racial and ethnic backgrounds,[30] and transition age youth.[31]

The success and evidence-base for IPS supported employment have been recognized at the federal, state, and local level.

The evidence base for IPS supported employment and its success in helping individuals with SMI have been widely recognized. The Federal government, states, and advocates have all taken steps to promote the use of supported employment. This section details some of those measures.

1) The Department of Health and Human Services (HHS)

In 2010, Substance Abuse and Mental Health Services Administration (SAMHSA) released an evidence-based practice toolkit for supported employment, designed to help states implement supported employment.[32] The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has also published reports on the subject: in 2011, a summary of the current research, entitled "Federal Financing of Supported Employment and Customized Employment

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[25] Yoshihiro Kinoshita, et. al, *Supported Employment for Adults with Severe Mental Illness (Review)*, 9 *Cochrane Database of Systematic Reviews* CD008297, 2 (2013) (hereinafter Cochrane Review).
[26] Alison Luciano, et. al, *Evidence-Based Supported Employment for People with Severe Mental Illness: Past, Current, and Future Research*, 40 Journal of Vocational Rehabilitation 1, 1-13, (2014).
[27] *Id*.
[28] *Id*. See also, 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); 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).
[29] U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, Mathematica Policy Research, Bonnie O'Day et al., *How the Affordable Care Act Can Support Employment for People with Mental Illness* 9 (May 2014) available at https://aspe.hhs.gov/basic-report/how-affordable-care-act-can-support-employment-people-mental-illness ("Those who received SE and obtained employment found only part-time jobs with low wages").
[30] Luciano et al., *supra* note 26, at 4.
[31] Bonnie O'Day, et al., *supra* note 29, at 15-16.
[32] See SAMHSA TOOLKIT, *supra* note 8.

[CE] for People with Mental Illness," that was designed "to identify strategies for improved access to federal financing of IPS and CE services,"[33] and in 2014, a report discussing "How the Affordable Care Act Can Support Employment for People with Mental Illness"[34] that discussed how the Medicaid program can be used to finance supported employment. While the Medicaid Rehabilitative Services option, the Targeted Case Management option, Medicaid home and community-based services waivers, and other Medicaid services are used by states to finance aspects of supported employment, the report notes the particular usefulness of the Medicaid Section 1915(i) home and community-based services option, which can be used to cover the full range of supported employment services, in expanding access to supported employment.

The Centers for Medicaid and Medicare Services (CMS) have also recognized the importance of these services and have issued guidance documents addressing states' obligations with respect to supported employment and financing of these services. In 2011, CMS issued a guidance concerning employment-related services that stated, among other things, that:

> . . . states have obligations pursuant to the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Supreme Court's *Olmstead* decision interpreting the integration regulations of those statutes. 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.[35]

Subsequently, CMS clarified that certain Medicaid authorities may be used to cover the full array of supported employment services for people with SMI. This statement came in a 2015 guidance aimed at assisting states in developing a benefit package to provide Recovery After an Initial Schizophrenia Episode (RAISE) services, including supported employment, to young adults.[36] The guidance described supported employment as follows:

> "Supported Employment Services – For young adults, first episode psychosis can impede attempts to obtain or maintain employment. Supported employment services are offered to all clients who want to work, in order to help them choose and get a job that aligns with their career goals. Supported employment emphasizes rapid job placement in the

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[33] ASPE Financing Report, *supra* note 1.
[34] Bonnie O'Day, et al., *supra* note 29.
[35] 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.
[36] U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, NATIONAL INSTITUTE OF MENTAL HEALTH, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., JOINT INFORMATIONAL BULLETIN, COVERAGE OF EARLY INTERVENTION SERVICES FOR FIRST EPISODE PSYCHOSIS , (Oct. 16, 2015) available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.

client's preferred work setting. Ongoing supports are also available to help the individual maintain employment."[37]

The guidance clarified that states could use a variety of Medicaid state plan services, including the rehabilitative services option, to cover components of supported employment. For example, under the rehabilitative services option, "a state may cover services such as individual therapy or behavior modification that help individuals manage their behavior in the work environment, develop strategies for resolving workplace issues, and address their symptoms while at work."[38] The guidance also stated that "[s]tates can implement the full breadth of the supported employment model through 1915(c) and (i) authorities," a critical point that CMS had not stated explicitly before.[39]

In addition to presenting the research and providing technical assistance on how to implement supported employment, HHS, through SAMHSA, has also awarded "Transforming Lives Through Supported Employment" grants to seven states: Alabama, Connecticut, Illinois, Kansas, Ohio, Utah, and Washington.[40] These grants are designed "to enhance state and community capacity to provide and expand evidence-based, supported employment programs to adults with SMI."[41] Following an award in 2014, the seven states have five years to utilize their funding and each has a targeted number of people with SMI to serve and some have a specific special population focus:

- Alabama: 450 total individuals, Veterans
- Connecticut: 450 total individuals, Latinos and individuals who have justice involvement
- Illinois: 350 total individuals
- Kansas: 225 total individuals, Hispanics or Latinos and refugees in a geographic region
- Ohio: 450 total individuals, Transition Age Youth
- Utah: 450 total individuals
- Washington: 450 total individuals

2) The Social Security Administration (SSA)

The Social Security Administration commissioned a large-scale study of the effectiveness of supported employment, known as the Mental Health Treatment Study. The study tested "the hypothesis that access to supported employment (SE) services and systematic medication management (SMM) services, coupled with the removal of some known programmatic

[37] *Id*. at 5.
[38] *Id*. at 8.
[39] *Id*. at 9. Due to certain aspects of its structure, the 1915(c) option tends to be used infrequently to fund community mental health services.
[40] SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., TRANSFORMING LIVES THROUGH SUPPORTED EMPLOYMENT (SE) PROGRAM (last visited Feb. 23, 2017) available at https://www.samhsa.gov/gains-center/grant-grantees/transforming-lives-through-supported-employment-program.
[41] *Id*.

disincentives, will enable Social Security Disability Insurance (SSDI) beneficiaries with schizophrenia or an affective disorder to return to work."[42] The study, conducted from November 2006 to July 2010, provided a group of SSDI beneficiaries "a comprehensive package of services and benefits, including evidence-based [IPS] SE, SMM, behavioral health and related services, and comprehensive insurance to pay for needed services and out-of-pocket expenses."[43] The study found significant increases in employment, approximately 20 percent higher than for the control group, as well as improved mental health outcomes among people who participated in these services compared with those who did not.[44] A small number of SSA disability participants (4 percent) were no longer receiving SSDI at the end of the two year study period.[45] The study also found that "[u]nder current conditions, SSDI beneficiaries lack access to evidence-based SE services in community mental health centers."[46]

The Mental Health Treatment Study also demonstrated 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."[47] The average savings due to reductions in hospital use alone was approximately $1,800 per year per person.[48] The study estimated that expanding supported employment services to cover just 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.[49]

3) Other federal agencies

As described later in this report, the Department of Justice has recognized supported employment as an effective service for individuals with SMI, and has entered a number of settlements with states requiring its expansion. The Department's *Olmstead* guidance lists this service as among the services that must be provided to avoid needless segregation.

The U.S. Equal Employment Opportunity Commission (EEOC) has also encouraged the use of supported employment. In recently promulgated regulations, the Commission stated that it "strongly endorses the use of supported employment," and listed "increased efforts to hire and retain individuals who require supported employment because of a disability" among the strategies that federal agencies may use to increase their employment of individuals with disabilities.[50]

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[42] Frey, *supra* note 28, at Ex-1.
[43] *Id*.
[44] *Id*. at 4-3, 9-5, 9-6.
[45] *Id*. at 4-29.

[46] *Id*. at Ex-13.
[47] *Id*. at EX-10.
[48] *Id*. at EX-10, 8-13.
[49] *Id*. at EX-11.
[50] EEOC Final Rule to implement Section 501 of the Rehabilitation Act; Affirmative Action for Individuals with Disabilities in Federal Employment, 89 Fed. Reg. 654, 669 (Jan. 3, 2017); 29 C.F.R. § 1614.203(d)(7)(ii)(E).

4) Congress has encouraged the expansion of supported employment.

Congress has also taken specific steps to increase access to supported employment for people with disabilities with the passage of the Workforce Investment and Opportunity Act (WIOA).

WIOA, enacted in 2014, expands opportunities for employment of people with disabilities, including people with SMI. In addition to revising and streamlining the federal job assistance programs, WIOA focuses on ensuring that people with disabilities, including psychiatric disabilities, have access to competitive integrated employment.[51] Competitive integrated employment means employment at the same wages as non-disabled peers,[52] in settings "where the employee interacts with other persons who are not individuals with disabilities (not including supervisory personnel or individuals who are providing services to such employee) to the same extent that individuals who are not individuals with disabilities and who are in comparable positions interact with other persons", and which "present opportunities for advancement that are similar to those for other employees who are not individuals with disabilities."[53] WIOA also "requires state [vocational rehabilitation] 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."[54]

WIOA also created an Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities, which was instructed to prepare and submit a Final Report to the Secretary of Labor and to Congress.[55] In the final report, issued September 15, 2016, the committee members found that while "employability of people with significant disabilities is implicit in relevant federal legislation, the current service capacity and associated federal and state policies have made it difficult to make this concept a reality."[56] The report specifically points out that "only a handful of states prioritize funding for competitive integrated employment (CIE) in a way that has translated to meaningful employment rates for people with significant disabilities."[57] The Committee specifically pointed out that while evidence-based practices do exist, they are often not incentivized by state funding streams or widely available:

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[51] See, e.g. Workforce Investment and Opportunity Act, Pub.L. 113–128, § 3(11), § 104, § 107, § 402, § 404 (2014) (hereinafter WIOA).

[52] While subminimum wage is more of an issue for people with intellectual or developmental disabilities, there are some individuals with psychiatric disabilities who work in sheltered workshops and are paid subminimum wage.

[53] WIOA, *supra* note 51, § 404(5).

[54] Alexis D. Henry, et al., Policy Opportunities for Promoting Employment for People with Psychiatric Disabilities (2016) available at http://commed.umassmed.edu/sites/default/files/publications/UMASS_Document_PolicyOppForPromEmployPPD_CHPR_2016_v5.pdf.

[55] WIOA, *supra* note 51, § 461.

[56] Advisory Committee on Increasing Competitive Integrated Employment for Individuals with Disabilities, Final Report to: The Honorable Thomas E. Perez, United States Secretary of Labor; the United States Senate Committee on Health, Education, Labor and Pensions; the United States House of Representatives Committee on Education and the Workforce 9 (Sept. 15, 2016).

[57] *Id*. at 9-10.

> The resulting service system is a mix of different services that include sheltered employment, facility-based day services, non-facility-based day services, group employment, and individual supported or customized employment. [. . .] Typically, services that lead to CIE are significantly less available than other service options.[58]

The report makes several recommendations to begin to remedy this situation some of which will be discussed in more depth below.

5) States have recognized the importance of supported employment, even though they have failed to offer it widely to people with serious mental illness.

States have recognized that low rates of employment of all people with disabilities represent a significant problem and many have started to enact "Employment First" policies through executive, legislative, or administrative action. Such policies are designed to push systemic reform of the system to ensure that people with disabilities can access competitive integrated employment services. These policies usually state that "[e]mployment in the general workforce is the first and preferred outcome in the provision of publicly funded services for all working age citizens with disabilities, regardless of level of disability."[59] Many of these policies, however, are focused not on people with psychiatric disabilities, but instead and solely on people with intellectual/developmental disabilities.[60]

Of the 34 states that have adopted an Employment First policy, only 17 have taken formal policy action to encourage cross-disability employment. Maine and Virginia have both passed legislation and the state agencies have responded with action. Alaska, Delaware, Illinois, Kansas, Utah, Wyoming, and Texas have all passed legislation. Governors in Florida, Arkansas, New Jersey, and Mississippi have all issued Employment First executive orders, as has the Mayor of the District of Columbia.[61] Administrative agencies in North Dakota, Minnesota, and Michigan have all adopted Employment First regulatory policy positions. The legislation, regulatory action, executive orders, and policy positions demonstrate some focus on the employment of people with disabilities, but does not necessarily mean that the state has focused on the employment rates of people with SMI or that the state has taken steps to ensure access to IPS. Even where Employment First policies do apply specifically to people with mental illness, these policies typically focus on broad goals and lack specific targets and implementation requirements.

6) People with disabilities, their families and advocates want supported employment expanded

Employment First policies also demonstrate clearly that state and local advocates want to see changes to the status quo. These policies have been adopted largely as a result of aggressive

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[58] *Id*. at 10.
[59] Association of People Supporting Employment First, APSE Statement on Employment First (last visited 2/23/17) available at http://apse.org/employment-first/statement/.
[60] Policy Research Brief, Employment First Across the Nation: Progress on the Policy Front (last visited 2/23/17) available at http://www.apse.org/wp-content/uploads/2014/01/activity.html.
[61] *Id*.

state-level advocacy by families, people with disabilities, and others who have made this issue a top priority.

IPS supported employment has had additional advocates pushing for its implementation including the Johnson & Johnson and Dartmouth Community Mental Health Program. The program has funded and implemented IPS programs across the nation since 2001.[62] Today, the program includes 17 states (Alabama, Colorado, Connecticut, Illinois, Kansas, Kentucky, Maryland, Minnesota, Missouri, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Vermont, Washington, Wisconsin), the District of Columbia, and one county-level project in Alameda County, California.[63] Now, the program "has evolved into a learning community in which the IPS leaders from the jurisdictions continue to meet together and identify and participate in research projects to better understand how to support people living with symptoms of mental illness in their recovery through work and school."[64] The success rate speaks for itself: "the average employment rate across 51 quarters is 43%."[65]

Advocates' focus on supported employment is also reflected in a national consensus around the need to expand supported employment. In July 2013, a coalition of national advocates, led by the Bazelon Center for Mental Health Law, issued a set of general principles that lay out a vision for people with disabilities, including a clear mandate for competitive, integrated employment. The Key Principles call for people with disabilities to "have control over their own day, including which job or educational or leisure activities they pursue"[66] and have a specific commitment to competitive integrated employment:

- Individuals with disabilities should have the opportunity to be employed in non-segregated, regular workplaces.

- Virtually all individuals with disabilities can be employed and earn the same wages as people without disabilities. When needed for such employment, they should have access to supported or customized employment. They should be afforded options other than sheltered work, day treatment, clubhouses, and other segregated programs.[67]

The Key Principles were embraced by virtually every major national disability organization, including the national associations of state mental health and developmental disabilities directors. Signatories to the Principles were: Americans Disabled Attendant Programs Today (ADAPT), American Association of People with Disabilities, American Diabetes Association, Association of University Centers on Disabilities, The Arc of the United

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[62] Johnson & Johnson – Dartmouth Community Mental Health Program, *Program Description* (2015) available at https://www.ipsworks.org/wp-content/uploads/2015/10/jj-description-10-27-15.pdf
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] Bazelon Center, Community Integration for People with Disabilities: Key Principles (July 2013), available at http://www.bazelon.org/Where-We-Stand/Community-Integration/Key-Principles-of-Community-Integration.aspx.
[67] *Id.*

States, Autistic Self-Advocacy Network, Bazelon Center for Mental Health Law, Depression and Bipolar Support Alliance, Disability Rights Education and Defense Fund, Easter Seals, International Association of Peer Supporters, Little People of America, Mental Health America, National Alliance on Mental Illness, National Association of Councils on Developmental Disabilities, National Association of Rights Protection and Advocacy, National Association of State Directors of Developmental Disabilities Services, National Association of State Mental Health Program Directors, National Coalition for Mental Health Recovery, National Council for Community Behavioral Healthcare, National Council on Independent Living, National Disability Rights Network, National Federation of the Blind, National Mental Health Consumers' Self-Help Clearinghouse, National Organization on Disability, Paralyzed Veterans of America, TASH, and United Spinal Association.[68]

This national consensus makes it clear that, like the Federal government, Congress, states, and other advocates, the mental health and disability communities strongly support increased access to supported employment and competitive integrated employment for people with psychiatric disabilities.

States have obligations under the Americans with Disabilities Act (ADA) and the *Olmstead* Decision to expand supported employment services.

Expansion of supported employment is not merely good policy. In many cases, the Americans with Disabilities Act (ADA) *requires* states to expand supported employment along with other community-based mental health services. The ADA's "integration mandate" and the Supreme Court's decision in *Olmstead v. L.C.* obligate state and local governments to administer services to people with disabilities, including people with mental illness, in the most integrated setting appropriate to their needs. Supported employment is among the core services needed by many people with SMI to live and work in integrated settings. State and local governments must expand supported employment, along with other community-based services, to enable these individuals to be served in the most integrated setting appropriate.

The Justice Department has recognized that widespread violations of *Olmstead* persist with respect to states' provision of day and employment services, stating:

> Nationally, millions of individuals with disabilities spend the majority of their daytime hours receiving employment and day services in . . . segregated day settings (including day treatment programs or facility-based day habilitation centers) where they are segregated from non-disabled persons. Many of these individuals are capable of working competitively and earning minimum wage or above in integrated employment and are not opposed to doing so, but they have been unable to access the services and supports that would allow them to find, obtain, and succeed in competitive integrated employment.[69]

[68] *Id*.

[69] U.S. Department of Justice, *Statement of the Department of Justice on Application of the Integration Mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. to State and Local Governments' Employment Service Systems for Individuals with Disabilities*, at 1, available at

The ADA Requires States to Offer Services to People with Disabilities in the Most Integrated Setting Appropriate

The ADA, a landmark civil rights law enacted in 1990, was intended "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[70] Among other things, the ADA prohibits discrimination based on disability by state and local government entities.[71] In the ADA's findings, Congress stated 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."[72]

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."[73] As the Department has explained, the "most integrated setting" is one that "enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible."[74]

The Supreme Court interpreted the ADA's integration mandate in *Olmstead v. L.C.*[75] In that case, two women with mental illness and intellectual disabilities 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. First, needlessly segregating individuals with disabilities "perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."[76] 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."[77]

Olmstead required states to offer services in community settings to interested people with disabilities who are needlessly segregated, unless doing so would fundamentally change the service systems by requiring the state to take away services from another group of individuals with disabilities.[78]

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https://www.ada.gov/olmstead/olmstead_guidance_employment.pdf (hereinafter "Olmstead Employment Guidance").

[70] 42 U.S.C. § 12101(b)(1).
[71] *Id.* § 12132.
[72] *Id.* § 12101(a)(2).
[73] 28 C.F.R. § 35.130(d)(7).
[74] *Id*. Pt. 35, App. A
[75] 527 U.S. 581 (1999).
[76] *Id*. at 600.
[77] *Id.* at 601.
[78] *Id*. at 604-07.

The ADA's Integration Mandate Applies to Day and Employment Service Settings

Courts as well as the Department of Justice have recognized that the ADA's integration mandate and *Olmstead* apply not just to living settings, but also to employment and other day service settings.

Courts have confirmed that the ADA's integration mandate applies to employment services and settings. 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.[79] In a case on behalf of individuals with intellectual and developmental disabilities alleging that they were needlessly segregated in institutions as well as in facility-based employment and day program settings in Ohio, another court allowed these integration mandate claims to proceed. As that court noted, "federal law has [in recent years] clarified that the integration mandate that applies to residential services applies to employment and day programs as well."[80] In New Hampshire, a court certified as a class action an integration mandate case brought by individuals with SMI seeking supported employment among other community-based services to end or prevent their needless institutionalization in a state psychiatric hospital and a state-operated nursing home.[81]

The Justice Department has similarly concluded that the integration mandate and *Olmstead* apply to employment services and employment settings. As the Justice Department states, "[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."[82] Segregated settings, by contrast, include "settings that provide for daytime activities primarily with other individuals with disabilities"[83] and "settings that are managed, operated, or licensed by a service provider to serve primarily people with disabilities."[84]

The Justice Department has explicitly stated that supported employment services are key to ensuring that individuals with disabilities have opportunities to work in the most integrated setting, stating that "[o]ver the past three decades, integrated supported employment services have emerged as a leading model for enabling persons with disabilities to work in competitive integrated employment settings."[85] The Department has made clear that these services are

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[79] *Lane v. Kitzhaber*, 841 F. Supp.2d 1199, 1202-06 (D. Or. 2012). The plaintiffs' claims were initially dismissed based on a pleading issue, but the plaintiffs later filed an amended complaint to address that issue, and the parties eventually reached a settlement.

[80] *Ball by Burba v. Kasich*, Nom2:16-cv-00282, 2017 WL 1102688 (S.D. Ohio Mar. 23, 2017), at *11.

[81] *Kenneth R. ex rel. Tri-County CAP, Inc./GS v. Hassan*, 293 F.R.D. 254 (D.N.H. 2013). The parties in this case eventually reached a settlement.

[82] *See* U.S. Department 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. (*hereinafter *"Olmstead Guidance"),* and *Olmstead Employment Guidance, supra* note 69, *Question and Answer 1*).

[83] *Id.*

[84] *Olmstead Employment Guidance, supra* note 69, at 4.

[85] *Id*. at 5.

among those that states must provide to remedy needless segregation of people with disabilities.[86]

Numerous *Olmstead* settlement agreements between states and the Justice Department settlement agreements require states to provide supported employment services. In 2014, the Department entered an agreement with Rhode Island concerning the segregation of individuals with intellectual and developmental disabilities in sheltered workshops and segregated day programs rather than offering them supported employment services.[87] 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.

In 2015, the Justice Department entered a settlement with Oregon requiring the state to provide supported employment services to enable 1115 working-age people with intellectual and/or developmental disabilities who receive or have received sheltered workshop services to obtain competitive integrated employment.[88] Among other things, the state will also reduce the current number of working age adults with Intellectual/Developmental Disabilities (I/DD) in sheltered workshops from approximately 1,926 to no more than 1,530 and decrease the number of hours adults are working in sheltered workshops by about one-third. The state will issue guidance concerning standards for implementing supported employment services—including a recommended standard of an opportunity to work at least 20 hours per week—and will make performance-based payments to providers achieving employment outcomes of at least 20 hours per week.

Justice Department settlement agreements with other states include supported employment among the remedies to address needless segregation of individuals with SMI 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/Amanda D. v. Hassan* (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).

The ADA requires state and local governments to offer community-based services, including supported employment, to individuals with SMI who need them to avoid needless

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[86] *Olmstead Guidance*, *supra* note 82, Question and Answer 15.

[87] *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.

[88] *Lane v. Brown/United States v. Oregon* (settlement approved 2015). The settlement and a fact sheet about it are available at http://www.ada.gov/olmstead/olmstead_cases_list2.htm.

segregation if: (1) they are qualified for those services, (2) they do not oppose receiving those services, and (3) providing those services would not fundamentally change the service system.[89] We explain below how the ADA would require an expansion of supported employment services in many states because (1) many people with SMI in these states are qualified for these services, (2) they are interested in these services, and (3) providing them with these services would not fundamentally change the service system. As described below, in many states there are individuals with SMI who are qualified for and interested in supported employment (particularly since IPS supported employment has a 'no reject' policy and eligibility for these services is not limited to individuals with particular skill levels). Moreover, providing them with these services would not fundamentally change the service system in states that already offer these or similar services. Because supported employment would enable individuals in or at risk of placement in institutions or other segregated treatment settings (including segregated day treatment programs) to receive services in a more integrated community setting, the ADA and *Olmstead* likely require the expansion of these services in many states.

An explanation of how the ADA and *Olmstead* apply in this area and what they require follows.

1) IPS treats all people with serious mental illness who need supported employment services as qualified to receive them.

Individuals with SMI are considered qualified for IPS supported employment services if they are enrolled in Medicaid or another program that offers IPS and need supported employment. There is no qualification requirement of being sufficiently skilled or 'ready' to receive IPS. 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."[90] This 'no reject' principle is based on the core notion that "all persons with a disability can work at competitive jobs in the community without prior training, and that no one should be excluded from this opportunity."[91] IPS requires that provider agencies "develop a culture of work so all practitioners encourage clients to consider working."[92]

The Centers for Medicare and Medicaid Services (CMS) have endorsed this view as well, stating, "[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."[93]

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[89] *Id*. at 604-07.

[90] *See* Dartmouth Psychiatric Research Center, *Practice Principles of IPS Supported Employment* (Oct. 11, 2011) (hereinafter 2011 IPS Principles), available at 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); and Gary R. Bond, *Principles of the Individual Placement and Support Model: Empirical Support,* 22 Psychiatric Rehabilitation Journal 1, 11-23 (1998).

[91] *Id.*

[92] *Id.*

[93] U.S. Dep't of Health & Human Services, Centers for Medicare and Medicaid Services, Center for Medicaid, CHIP, and Survey & Certification, *Informational Bulletin, Updates to the § 1915(c) Waiver*

2) The vast majority of these individuals desire to work, and that number would increase with appropriate engagement.

Despite their low employment rates, people with SMI want to work.[94] Studies have typically found that approximately two-thirds of people with SMI express interest in working.[95] These figures likely underestimate the actual number, as many people with SMI have been told for years that they were not capable of working, would be better off not working, and/or will lose important health benefits if they begin working. Many have come to accept these views. Many others are 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. In many or most cases, they have worked at some point in their lives.[96]

3) It would not fundamentally change the design of state service systems to offer supported employment more widely; to the contrary, doing so is consistent with the mission and purpose of these service systems, and would likely result in cost savings.

Expanding the supported employment services that a state already provides would typically not be a fundamental alteration of the state's service system.[97] Indeed, expanding these

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Instructions and Technical Guide regarding employment and employment related services, at 3 (Sept. 16, 2011), https://downloads.cms.gov/cmsgov/archived-downloads/CMCSBulletins/downloads/CIB-9-16-11.pdf.

[94] Robert E. Drake et al., *Social Security And Mental Illness: Reducing Disability With Supported Employment*, 28 Health Affairs 761, 767 (May/ June 2009).

[95] Gary R. Bond & Robert E. Drake, *Making the Case for IPS Supported Employment*, Administration and Policy in Mental Health and Mental Health Services Research, vol. 39, no. 6 (Nov. 2012), at 1; 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), available at 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 SMI es 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").

[96] *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 SMI 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).

[97] *See, e.g., Disability Advocates, Inc. v. Paterson*, 598 F. Supp. 289, 335 (E.D.N.Y. 2009) ("Where individuals with disabilities seek to receive services in a more integrated setting-and the state *already provides* services to others with disabilities in that setting-assessing and moving the particular [individuals] to that setting, in and of itself, is not a 'fundamental alteration'"); *Messier v. Southbury Training School*,

services would be entirely consistent with the mission of state mental health service systems, and would simply build on an existing commitment to promoting supported employment for individuals with SMI in those states that already offer these services.

Moreover, expanding supported employment would not generally be so costly as to take away services from other individuals. While the "fundamental alteration" analysis would depend on the specific facts in each state, given the anticipated cost savings of shifting individuals from day treatment to supported employment and the reduced healthcare costs typically associated with employment, it is unlikely that expanding supported employment would be a fundamental alteration.

Expanding supported employment services, which are typically financed by Medicaid, state, and/or vocational rehabilitation funds,[98] can be done without undue cost to state service systems, particularly because of the costs it helps offset. Expanding these services saves states money both by reducing health care costs and by eliminating the higher costs that states pay for day treatment programs (and, for individuals transitioning out of institutional settings, for the very high cost of those settings).

One study projected that "wide-scale implementation and recruiting of people with SMI to evidence-based supported employment and mental health care" would not only improve financial security for people with SMI, but also, conservatively estimated, save the government an estimated $368 million per year.[99] 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 a 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.[100] 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."[101] The average savings due to reductions in hospital use alone was approximately $1,800 per year per person.[102]

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562 F.Supp.2d 294, 345 (D. Conn. 2008) (expanding existing community services and incurring minimal additional costs does not constitute a fundamental alteration).

[98] 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*, at 10 (Sept. 2011) [hereafter "NTAR Issue Brief"], available at file:///C:/Users/user/Downloads/Medicaid-Brief-pdf.pdf.

[99] Drake, *supra* note 94, at 768.

[100] Frey, *supra* note 28, at EX-11.

[101] *Id.* at EX-10.

[102] *Id*. at EX-10, 8-13.

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.[103]

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.[104] Day treatment costs, while they vary by state and program, tend to be substantially higher: $13,702 per year, per client in one study.[105] 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.[106] Shifting resources from day treatment services to supported employment services would likely bring significant cost savings.

States may cover supported employment services through the Medicaid program in a variety of ways. States can use ordinary Medicaid state plan services to cover some components of supported employment for individuals who are working or want to work.[107] For example, they can use the Medicaid "rehabilitative services" option to cover "services such as individual therapy or behavior modification that help individuals manage their behavior in the work environment, develop strategies for resolving workplace issues, and address their symptoms while at work."[108] Importantly, states can use other Medicaid authorities including the Medicaid home and community-based state plan option, to cover "the full breadth of the supported employment model."[109]

States can also use federal funds to provide supported employment services to such individuals through their vocational rehabilitation systems. Currently, few vocational rehabilitation dollars go toward providing supported employment for individuals with SMI, but the vocational rehabilitation system is nonetheless an important source of additional financing

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[103] *Id.*

[104] U.S. Dep't of Health & Human Services, Assistant Secretary for Planning & 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), available at http://aspe.hhs.gov/daltcp/reports/2010/supempLR.pdf.

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

[106] Commission on Quality of Care and Advocacy for Persons with Disabilities, *Continuing Day Treatment Review*, at 3 (Dec. 2006), available at http://www.justicecenter.ny.gov/sites/default/files/archivereports/Publications/CDTReport.pdf.

[107] Centers for Medicare and Medicaid Services, National Institute of Mental Health, Substance Abuse and Mental Health Services Administration, *Joint Informational Bulletin, Coverage of Early Intervention Services for First Episode Psychosis* (Oct. 16, 2015), at 8, available at https://www.medicaid.gov/federal-policy-guidance/downloads/cib-10-16-2015.pdf.

[108] *Id.* at 8.

[109] *Id.* at 8, 9-10. Medicaid demonstration waivers may also be used to cover the full array of supported employment services. *See* NTAR Issue Brief, *supra* note 98.

for e services.[110] A number of states have established 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 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.[111]

Because individuals with SMI are considered qualified for IPS supported employment services if they are enrolled in Medicaid or another program that offers IPS and need supported employment[112] and the great majority are interested in working,[113] and because expanding these services would typically not be unduly costly to states,[114] the ADA and *Olmstead* likely require the expansion of these services in many states. Thus, making supported employment services available on a much broader scale would not only generate good outcomes, but is critical to states meeting their obligations under the ADA and *Olmstead.*

Despite the evidence of its success and the legal mandate to expand its availability, IPS supported employment has not been widely offered by public mental health systems.

Given the clear evidence of its success, as well as the obligations of states under the ADA to expand its availability, it is surprising that IPS is not more widely available. The total estimated penetration rate of all supported employment nationally is only 2 percent—meaning that only 2 percent of individuals with SMI receiving services from the public mental health systems have access to supported employment.[115]

The chart below shows the estimates provided by state mental health agencies of the penetration rates of supported employment services and the total estimated rate for the United States over the past five years:[116]

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[110] The Vocational Rehabilitation program provides time-limited services and unlike IPS supported employment, does not presume 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.

[111] 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), available at http://www.communityinclusion.org/pdf/MH%20Case%20Studies%20Final%20Report.pdf

[112] *See supra* notes 90 and 93 and accompanying text.

[113] *See supra* notes 94-96 and accompanying text.

[114] *See supra* notes 97-111 and accompanying text.

[115] SAMHSA NOMS 2015, *supra* note 2.

[116] U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): SAMHSA UNIFORM REPORTING 2015 (2016) (hereinafter SAMHSA NOMS 2015); U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): SAMHSA UNIFORM REPORTING 2014 (2015) (hereinafter SAMHSA NOMS 2014); U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES

State	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY2016**
Alabama	0%	0%	0%	0%	0%	0%
Alaska	3.80%	2.90%	2.70%	1.80%	1%	1.20%
Arizona	24.90%	23.70%	25.30%	28.30%	24%	23.50%
Arkansas	0.30%	0.40%	0.10%	0.20%	1%	1.10%
California	0.20%	0.20%	0.20%	0.10%	0%	0.20%
Colorado	1.70%	1.70%	1.90%	2.10%	2%	0.70%
Connecticut	7.90%	7.50%	7.30%	7.10%	7%	6.30%
Delaware	1.20%	1.50%	0.70%	0.60%	0.20%	0.50%
District of Columbia	0.00%	3.60%	4.10%	4.10%	7%	5.50%
Florida	0.70%	0.50%	0.50%	0.70%	1%	1.00%
Georgia	1.80%	2.00%	2.30%	2.50%	3%	2.80%
Hawaii	0.90%	0.90%	0.70%	0.80%	2%	0.70%
Idaho	1.40%	1.40%	8.10%	3.50%	4%	3.90%
Illinois	2.80%	2.00%	2.80%	3.30%	4%	4.80%
Indiana	3.70%	1.80%	1.70%	1.70%	2%	1.80%
Iowa	0.00%	0%	0%	0.00%	0%	0%
Kansas	19.80%	16.90%	16.30%	16.10%	14%	16.10%
Kentucky	1.00%	1.10%	1.10%	1.20%	1%	1.40%
Louisiana	0.80%	0.40%	1.50%	1.00%	2%	0%
Maine	0.00%	1.80%	0.60%	1.50%	1%	1.00%
Maryland	5.00%	4.90%	4.90%	4.80%	0%	5.20%
Massachusetts	0.00%	9.90%	8.50%	9.40%	11%	8.90%
Michigan	1.80%	2.10%	2.40%	2.30%	0%	3.20%
Minnesota	0.40%	0.20%	0.40%	0.40%	0%	1.10%
Mississippi	0.00%	0.00%	0.00%	0.00%	0%	0%
Missouri	0.90%	0.90%	0.90%	0.80%	2%	1.00%
Montana	0.90%	0.70%	0.40%	0.50%	1%	0%
Nebraska	4.40%	4.70%	3.60%	6.10%	5%	5.40%
Nevada	0.00%	0.00%	0.00%	0.00%	0%	0%
New Hampshire	13%	12.10%	11.40%	11.30%	14%	19.70%

ADMIN., MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): SAMHSA UNIFORM REPORTING 2013 (2014) (hereinafter SAMHSA NOMS 2013); U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): SAMHSA UNIFORM REPORTING 2012 (2013) (hereinafter SAMHSA NOMS 2012); U.S. DEPT. OF HEALTH AND HUMAN SERVICES, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMIN., MENTAL HEALTH NATIONAL OUTCOME MEASURES (NOMS): SAMHSA UNIFORM REPORTING 2011 (2012) (hereinafter SAMHSA NOMS 2011). There are a few points about the data that should be noted—the rates here reflect the State Mental Health agency's estimate for the number of consumers in the state receiving supported employment divided by the estimated adult population serviced by the state mental health system.

New Jersey	1.80%	1.40%	1.60%	1.50%	2%	1.30%
New Mexico	0.00%	0.00%	0.00%	0.70%	0%	1.40%
New York	0.70%	0.50%	0.40%	0.40%	0%	0.50%
North Carolina	0.00%	0.00%	0.00%	0.00%	0%	0%
North Dakota	0.90%	1.20%	1.10%	2.40%	2%	1.80%
Ohio	2.60%	2.40%	2.00%	2.40%	3%	2.50%
Oklahoma	0.10%	0.20%	0.10%	0.10%	0%	0.20%
Oregon	1.30%	1.20%	1.40%	1.40%	2%	3.10%
Pennsylvania	0.00%	0.00%	0.10%	0.20%	0%	0.10%
Rhode Island	3.60%	3.30%	5.40%	4.60%	6%	12.20%
South Carolina	0.80%	0.70%	0.70%	0.70%	1%	0.70%
South Dakota	0.00%	0.00%	0.00%	0.00%	0%	0%
Tennessee	0.60%	0.60%	0.80%	0.70%	0%	0.30%
Texas	2.00%	2.00%	3.20%	4.60%	7%	4.80%
Utah	1.50%	1.60%	0.00%	0.00%	0%	0.10%
Vermont	30.50%	32.70%	31.70%	32.80%	29%	27.70%
Virginia	0.60%	0.90%	0.60%	0.70%	1%	0.70%
Washington	1.70%	0.00%	0.00%	0.00%	0%	0%
West Virginia	0.20%	0.00%	0.00%	0.00%	0%	0%
Wisconsin	1.10%	1.00%	1.40%	1.40%	3%	2.60%
Wyoming	0.00%	0.00%	0.00%	0.00%	0%	0%
United States	**1.7%**	**1.7%**	**1.9%**	**2.0%**	**2.0%**	**2.10%**

The exact number of people receiving IPS supported employment is difficult to determine, since there are other models of supported employment utilized and data does not always reflect which type of model is utilized.[117]

SAMHSA also tracks the rates of employment for all individuals receiving public mental health services to the extent that data is available:[118] These numbers include all individuals who worked for any period of time within the year, including those who only worked part time or for only a portion of the year. As such, this includes individuals who would not earn sufficient income to make a significant difference to their economic situation.

State	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY2016**
Alabama	10.90%	11.00%	11.40%	11.10%	13.10%	13.30%
Alaska	28.70%	28.60%	29.30%	30.30%	31.20%	29.60%
Arizona	16.50%	17.10%	17.70%	17.70%	18.80%	21.70%
Arkansas	20.90%	21.20%	19.70%	20.20%	19.80%	20.10%

[117] SAMHSA NOMS 2015, *supra* note 2, at 14 (noting that only 14 states measure fidelity for supported employment).

[118] SAMHSA NOMS 2015, supra note 2; SAMHSA NOMS 2014, *supra* note 116; SAMHSA NOMS 2013, *supra* note 116; SAMHSA NOMS 2012, *supra* note 116; SAMHSA NOMS 2011, *supra* note 116.

California	9.80%	10.00%	9.20%	7.90%	8.30%	9.00%
Colorado	22.00%	22.20%	22.30%	26.50%	26.50%	30.10%
Connecticut	20.20%	20.30%	20.60%	22.80%	23.70%	24.30%
Delaware	21.10%	23.10%	39.00%	19.40%	21.20%	21.00%
District of Columbia	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Florida	15.60%	15.30%	15.80%	18.40%	18.20%	20.30%
Georgia	13.20%	13.00%	13.40%	8.40%	13.60%	13.70%
Hawaii	10.40%	8.60%	9.00%	5.60%	10.60%	13.20%
Idaho	19.50%	18.70%	13.10%	11.70%	12.30%	12.20%
Illinois	19.10%	16.80%	16.30%	16.10%	17.90%	14.10%
Indiana	19.30%	19.50%	19.40%	20.90%	22.30%	23.90%
Iowa	30.90%	31.60%	42.50%	36.70%	30.10%	27.40%
Kansas	29.20%	29.80%	29.50%	28.90%	30.30%	30.00%
Kentucky	16.10%	16.10%	16.30%	16.70%	18.00%	20.30%
Louisiana	10.80%	11.70%	14.00%	13.90%	17.40%	18.00%
Maine	6.90%	7.40%	7.90%	8.40%	8.80%	9.40%
Maryland	16.80%	15.90%	19.40%	21.10%	22.70%	21.90%
Massachusetts	11.20%	10.90%	11.60%	12.00%	12.30%	21.90%
Michigan	12.10%	11.90%	12.00%	12.20%	12.50%	12.70%
Minnesota	15.00%	13.80%	15.20%	33.70%	37.40%	35.80%
Mississippi	15.00%	13.80%	13.60%	14.20%	13.60%	13.50%
Missouri	10.90%	10.90%	13.60%	11.40%	13.70%	14.90%
Montana	14.60%	13.90%	15.10%	14.80%	14.70%	16.60%
Nebraska	28.60%	29.30%	31.40%	33.10%	34.50%	32.10%
Nevada	16.40%	16.20%	15.90%	15.50%	14.90%	15.10%
New Hampshire	32.70%	32.70%	31.90%	37.70%	38.70%	38.30%
New Jersey	28.10%	27.80%	27.40%	27.20%	27.00%	26.80%
New Mexico	23.60%	24.00%	22.80%	20.40%	24.50%	26.70%
New York	22.80%	16.00%	16.00%	15.50%	15.50%	18.80%
North Carolina	17.00%	14.90%	11.90%	13.90%	14.90%	14.50%
North Dakota	37.40%	37.10%	37.00%	37.00%	38.80%	37.10%
Ohio	15.40%	16.00%	15.00%	21.30%	21.10%	25.30%
Oklahoma	19.10%	20.70%	21.30%	20.70%	21.20%	20.80%
Oregon	16.00%	12.20%	13.80%	13.70%	22.00%	38.00%
Pennsylvania*						
Rhode Island	18.60%	17.50%	17.70%	16.80%	16.20%	16.80%
South Carolina	12.50%	12.40%	12.60%	12.50%	11.70%	11.80%
South Dakota	26.60%	28.00%	29.80%	30.40%	31.40%	31.60%
Tennessee	20.90%	20.10%	20.10%	18.60%	21.50%	22.80%
Texas	18.80%	14.40%	15.00%	17.60%	18.90%	19.70%
Utah	20.00%	19.30%	20.20%	20.10%	20.90%	22.50%

Vermont	22.00%	25.30%	25.70%	26.30%	25.20%	25.80%
Virginia	18.70%	19.70%	19.70%	19.60%	20.00%	19.00%
Washington	9.10%	13.10%	8.60%	10.60%	14.80%	20.00%
West Virginia	17.20%	8.20%	15.50%	12.10%	20.80%	20.10%
Wisconsin	24.40%	22.80%	21.50%	24.40%	23.60%	23.50%
Wyoming	43.90%	43.90%	43.60%	46.90%	49.90%	47.90%
United States	**18.10%**	**16.90%**	**17.00%**	**17.90%**	**21.70%**	**24.50%**

*We have excluded Pennsylvania's reported data from this chart due to apparent differences in reporting methodology that may prevent meaningful comparisons with other states.

These numbers demonstrate the dramatic difference between employment rates for people with SMI and those for the general population. The employment-population ratio for those without a disability was 65.0 percent for Fiscal Year (FY) 2016, and was similar over past five years.[119] By contrast, the national average for people with mental illness served by the state mental health systems over the past six years has hovered between 17 and 22 percent—a full 43 to 48 percent below the national average.

Why has supported employment not been more widely adopted?

Despite several decades of proven success, supported employment has remained scarce for a number of reasons, including the difficulty of overcoming assumptions that have been prevalent for decades that most individuals with SMI are incapable of work, poor understanding of the financing mechanisms for supported employment, provider incentives to focus on site-based day treatment programs, and lack of coordination between different state and federal agencies and programs.[120]

1. Attitudinal Barriers

One of the most commonly recognized barriers is that widespread negative attitudes about the capabilities of people with SMI persist, particularly with respect to their ability to work.[121] State mental health service systems offering employment services and employment

[119] BUREAU OF LABOR STATISTICS, PERSONS WITH A DISABILITY: LABOR FORCE CHARACTERISTICS SUMMARY (June 21, 2016) available at https://www.bls.gov/news.release/disabl.nr0.htm. See also, BUREAU OF LABOR STATISTICS, TABLE A. EMPLOYMENT STATUS OF THE CIVILIAN NON-INSTITUTIONAL POPULATION BY DISABILITY STATUS AND AGE, 2014 AND 2015 ANNUAL AVERAGES (Jun. 21, 2016) (finding a rate of 64.6 in 2014 and a rate of 65.0 in 2015) available at https://www.bls.gov/news.release/disabl.a.htm.

[120] Valerie A. Noel *et al*., *Barriers and Facilitators to Sustainment of an Evidence-Based Supported Employment Program*, 44 Administration and Policy in Mental Health & Mental Health Services 331 (May 2017).

[121] *See e.g*., Patrick W. Corrigan, *Mental Health Stigma as Social Attribution: Implications for Research Methods and Attitude Change*, 7 Clinical Psychology 1, 48-67 (Mar. 2000); Patrick W. Corrigan et al, *How Does Stigma Affect Work in People With Serious Mental Illnesses?,* 35 Psychiatric Rehab. Journal 381- (Sept. 2012). *See also* Deborah R. Becker & Robert E. Drake, A Working Life for People with Severe Mental Illness (2003); Written Testimony of Dr. Gary Bond, Professor of Psychiatry, Dartmouth Psychiatric Research Center, for U.S. Equal Employment Opportunity Commission public meeting on

service providers must overcome the effects of decades of assumptions that people with SMI could not or should not work.[122] The notion that people with SMI cannot or should not handle the "stress of work" continues to be pervasive at all levels of service systems, although studies have found this notion to be baseless.[123] One study found that people with psychiatric disabilities who wanted to work were frequently not referred to services, even if they asked.[124] Similarly, employers are less likely to hire someone whom they believe has a mental illness.[125] Perhaps most significantly, many people with mental illness have internalized these views themselves, losing confidence in their own value and abilities.[126]

2. Lack of Understanding of Financing Mechanisms

Another barrier to expansion of supported employment is the lack of understanding about funding streams available to finance these services.[127] As noted above,[128] states can utilize a variety of Medicaid waivers and state plan options to finance supported employment—including rehabilitative services, targeted case management, and home and community-based services waivers and options, yet confusion about financing supported employment continues to be common, perhaps due to the different funding streams available for different elements of this

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Employment of People with Mental Disabilities (May 15, 2011), http://www.eeoc.gov/eeoc/meetings/3-15-11/bond.cfm (in a national survey, most commonly cited barrier to employment of people with SMI was stigma and discrimination).

[122] *See* SAMHSA Toolkit, *supra* note 8, The Evidence, at 9 ("Administrators who do not have information about evidence-based practices may not value their outcomes or believe that they are possible (49). Administrators, especially those who received training and professional experience in an earlier era, may hold negativist attitudes about the feasibility of work—for example, "Schizophrenia is a chronic disease with little hope of recovery . . . work is a source of unnecessary stress" [. . .] [l]ike administrators, clinicians often view clients as too unmotivated to work (97) and often underestimate the need for vocational services (98,99)."); *see also* Terri K. Pogoda, et al., Qualitative Analysis of Barriers to Implementation of Supported Employment in the Department of Veterans Affairs, 62 Psychiatric Services 11, 1289-95 (Nov. 2011).

[123] Christine Besse *et al, Changes in the nature and intensity of stress following employment among people with severe mental illness receiving individual placement and support services: an exploratory qualitative study, Journal of Mental Health (Jun. 27, 2016).*

[124] Edward S. Casper & Cynthia Carloni, *Assessing the underutilization of supported employment services*, 30 Psychiatric Rehabilitation Journal 182-188 (2007).

[125] N.L. Berven & J.H. Driscoll, The effects of past psychiatric disability on employer evaluation of a job applicant, *Journal of Applied Rehabilitation Counseling*, 12, 50-55 (1981); H.W. Tsang *et al*., A cross-cultural study of employers' concerns about hiring people with psychotic disorder: Implications for recovery. *Social Psychiatry and Psychiatric Epidemiology*, 42, 723-733 (2007).

[126] *See* Corrigan, *Mental Health Stigma As Social Attribution*, *supra* note 121; Corrigan et al., *How Does Stigma Affect Work in People With Serious Mental Illnesses?*, *supra* note 121.

[127] See Noel, *supra* note 120.

[128] *See supra* note 38 and accompanying text. *See also* Webinar slides of John O'Brien, Centers for Medicare and Medicaid Services, in *Road To Recovery: Best Practices and Financing Strategies for Supported Employment: Medicaid and Behavioral Health – New Directions* (2014), Slides 46 and 47, available at https://www.aahd.us/wp-content/uploads/2014/07/NAMI-on-IPS-Supported-Employment-Presentation+7-8-14.pdf (identifying states that have covered IPS supported employment using the Section 1915(i) home and community-based services option, Section 1915(c) home and community-based services waivers, Section 1915(b) managed care waivers, and Section 1115 demonstration waivers).

service. While some options, such as the rehabilitative services option, may be used to cover only certain components of supported employment, others, such as Section 1915(c) home and community-based services waivers and Section 1915(i) home and community-based state plan, may be used to pay for the full array of supported employment services.[129] The federal government's publicizing of these changes has had limited reach, and many policy makers remain unaware of the extent to which Medicaid may be used to finance IPS supported employment.[130] The number of states utilizing Medicaid to finance IPS is relatively small, although that number is increasing.[131]

3. Provider Incentives

There are also barriers to expansion of supported employment in the provider sector and related to workforce.[132] Service providers have developed business models around providing segregated day treatment, and consequently resist adopting supported employment.[133] State reimbursement structures may make it easier for providers to receive payment for site-based programs instead of supported employment.[134] Most state Medicaid plans include unnecessary limitations on covered services involving vocational activities.[135] In addition, guaranteed payment for units of service provided at a day treatment site, with no expectation of particular outcomes, may be viewed as easier to obtain than payment for services provided at various job sites or elsewhere and that are expected to assist individuals secure employment.[136] Furthermore, supported employment services are sometimes delivered together with site-based rehabilitation programs, with significant reimbursement for rehabilitative services such as classes and little reimbursement for supported employment activities away from the program site.[137] This

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[129] See *supra* note 39 and accompanying text.

[130] Robert E. Drake et al., *Individual Placement and Support Services Boost Employment for People with Serious Mental Illnesses, but Funding is Lacking*, 35 Health Affairs 1098 (June 2016), available at http://content.healthaffairs.org/content/35/6/1098.short.

[131] See webinar slides of John O'Brien, *supra* note 128 (identifying which states used Medicaid to finance IPS in 2014). Since then, additional states such as Ohio, Indiana and New York have covered IPS through their Medicaid programs. Others, including Illinois, have applications pending with the Centers for Medicare and Medicaid Services to cover IPS.

[132] Noel, *supra* note 120.

[133] SAMHSA Toolkit, *supra* note 8, The Evidence, at 10 ("Resistance to change is a barrier in any organization. In the mental health field, professional identities are defined by what practitioners do—methods employed, program name, and the like—or by their discipline, not by the outcomes sought. Program changes sometimes are introduced as externally imposed ideas rather than resulting from a process that includes the participation of the clinicians and supervisors, who are ultimately responsible for implementing the desired change (103). In such circumstances, practitioners perceive change efforts as a criticism and devaluing of their work").

[134] *Id.* at 9 ("Fee-for-service systems of reimbursement for units of service, regardless of outcomes, have created incentives to perpetuate services that are not evidence based, such as day treatment (92). Some commentators have concluded that financing of supported employment programs within managed care systems will not be any easier (93)").

[135] *Id.*

[136] *Id.*

[137] *See, e.g.*, New York Office of Mental Health, *Personalized Recovery Oriented Services, Clarification 14*, available at https://www.omh.ny.gov/omhweb/PROS/Clarification/Clarification14.pdf (describing provision of IPS by site-based mental health treatment teams in PROS program). The statewide rate for

structure may also make it harder to encourage an expectation that participants will work, given the other rehabilitative services that are provided by these programs.

4. Lack of Coordination Between State and Federal Agencies

Coordination with other programs designed to help people with disabilities with work, including the Vocational Rehabilitation Program and the Social Security Ticket to Work program, is often poor and as a result these programs provide IPS supported employment on a smaller scale than what is needed.[138]

Strategies for increasing access to supported employment and to jobs

The federal government, states, localities, providers, consumers, and employers all have roles to play in expanding access to supported employment and increasing employment among people with SMI. Strategies for expanding access include expanding the availability of supported employment services as well as ensuring that supported employment is delivered in a manner that maximizes engagement of individuals and most effectively links them with employment.

This section of the report provides on-the-ground perspectives of employers, users of supported employment services, and supported employment providers concerning what works and does not work to engage individuals and to increase employment rates. This section also describes examples of strategies used in some states to expand the availability of supported employment services.

1. The perspectives of people who receive supported employment, those who provide it, and those who welcome it in their workplaces, offer valuable insights concerning practices that increase access to and effectiveness of supported employment.

As part of this report, we interviewed people with disabilities who had utilized supported employment, employers of individuals utilizing supported employment services, and providers of supported employment services. Here we describe what those individuals had to say about their experiences and what these on-the-ground participants in the system think are the most important practical strategies to ensure that supported employment is effective. The people we interviewed

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competitive integrated employment for individuals in the PROS program was 9.9%, with rates ranging from 5.5% in New York City to 13.7% in Western New York. New York Office of Mental Health, *Statewide PROS Performance Packet*, at 16, available at https://www.omh.ny.gov/omhweb/pros/performance/statewide.pdf.

[138] SAMHSA Toolkit, supra note 8, The Evidence, at 9 ("Vocational rehabilitation expenditures apparently have been disproportionately devoted to administration and to assessment and other preemployment activities (89). Compounding the problem is the fact that persons with severe mental illness fail to complete the vocational rehabilitation eligibility process twice as often as people with physical disabilities (90). Nevertheless, vocational rehabilitation agencies continue to allocate minimal funding for supported employment services (91)").

sounded many of the same themes, whether they were employers, service users, or service providers. Key themes that emerged were:

- Perhaps the most important thing for supported employment to be successful is that the service provider must believe that each person who comes to them is capable of working. As one provider put it, the provider must have faith in the clients and be willing to listen to and assist them at all times, rather than seeing them as a paycheck. Providers described clients who had repeatedly been told by others that they were unable to work – and individuals described their own experiences of being told this – and yet those individuals were able to maintain consistent and long-term employment once working with a provider that believed in them.

- The service provider's belief in, and knowledge of, the capacity of the individuals using supported employment is critical to the provider's ability to help the person believe in himself or herself, and the provider's ability to convey with authenticity to employers the provider's confidence in the individual's capabilities.

- Relatedly, at the state level, leadership is needed to build a "culture of employability" within programs and within the service system, by educating employers, providers, and individuals with disabilities about what is possible when using practices that work.

- A good, detailed vocational profile of the individual—and not simply a short intake conversation—is essential. Key to the success of supported employment is listening carefully to the individual to help identify jobs in which the person has an interest, and to help the individual translate what he or she is good at to jobs that would be a good fit (by eliciting from the individual what he or she has done in the past, and what he or she has enjoyed and/or been good at).

- Listening carefully to the employer as well, to understand and observe the employer's unmet needs, is also critical.

- Another critical element is the patience and persistence to help the individual find a job that motivates him or her. Rather than losing faith in the individual when some jobs do not work out and concluding that the problem lies with the individual, an effective provider will continue working with the person to try to find a more appropriate job. One provider described his experience with a client who went through approximately ten jobs in a period of five months; the person wanted to try various different types of jobs, but discovered with each that he didn't like the job. The provider finally helped the person find a job that worked, and the person has been there for more than four years; as the provider noted, both he and the client learned something about the client through this experience. Often individuals are blamed for sabotaging their jobs when in fact what is happening is that the person does not want the job.

- To effectively engage a person who is uncertain about either working or about using supported employment, the provider must have the patience and skill to allow the person to build a relationship with the provider. Often this takes time, and often it requires the person to overcome a significant history of having been told that he or she is incapable of working and/or having bad work experiences.

- In addition, engaging a person who is uncertain may require using a variety of tools and seeing what works most effectively for each person; no one formula works well for everyone. Helping individuals understand all of the positive aspects of being employed is critically important. One provider noted, however, that for many individuals who have an employment history that does not match with the picture being described (for example, a history of losing jobs, of getting sick on the job, of not getting along with an employer, or other bad work experiences), "all of this preaching has no place inside that person to connect—no context. You can't make yourself a cheerleader for employment." Another approach that often works is helping individuals think about the effects of poverty and what their life may look like in two years, or five years, and how it may impact their ability to accomplish the things they care about. One individual talked about a peer who initially decried the idea of work, wanting instead to live alone in a house in the woods where people would not bother him; when he realized that he would not be able to afford such a house without a paycheck, however, he began exploring what skills he could use and decided that working with cars might enable him to obtain the house he wanted.

- Individualizing and customizing on the front end to ensure that an individual is matched with a job that will likely work for him or her can often save a lot of money and grief on the back end, where the provider and employer may otherwise have continuous challenges supporting the person in a job he or she does not want.

- For people with disabilities, finding the right job often becomes the key to recovery and to resolving other important issues in their lives. We heard from both providers and individuals using supported employment about how work that motivated them had made individuals' home lives and other aspects of their lives more stable, and individuals who had experienced repeated hospital stays ended that pattern as the job became the center of their new life.

- Providers should not try to 'sell' the supported employment program to employers. Rather, the provider's goal should be to be as invisible as possible, while being present to support both the individual and the employer and helping the relationship unfold in a way that works for both.

- Employers often benefit more broadly from the advice and assistance they receive when they employ individuals who use supported employment; many of the strategies used to support an individual using supported employment at work (for example, transparency, flexibility, expecting the best of people, individualization,

good communication, setting clear expectations, being willing to change practices that don't work) are consistent with best practices in organizational management, and help the employer address the needs of many other employees as well.

These interviews confirm the central importance of provider and state-level efforts to overcome attitudinal barriers; strategies aimed at addressing those barriers emerged as the most common theme in the interviews.

2. Strategies that states have used to meet requirements to expand the availability of supported employment, including as part of Olmstead settlements, also provide a useful learning tool.

It is also useful to examine the strategies that some states have chosen to employ in order to meet requirements to expand supported employment services as part of *Olmstead* settlements. Those measures offer some guidance for other states making efforts to expand the availability of supported employment outside the context of a lawsuit or settlement.

Supported employment has been a part of the remedy in many Justice Department settlement agreements addressing the needless segregation of individuals with SMI in institutions, including *United States v. New York, O'Toole v. Cuomo* (resolving *Olmstead* claims involving individuals in private adult homes; settlement approved 2014);[139] *United States v. New Hampshire* (resolving *Olmstead* claims involving individuals in state psychiatric hospital and state-operated nursing home; settlement approved 2014);[140] *United States v. North Carolina* (resolving *Olmstead* claims involving individuals in private adult care homes; settlement approved 2012);[141] *United States v. Delaware* (resolving *Olmstead* claims involving individuals in psychiatric hospitals; settlement approved 2011);[142] and *United States v. Georgia* (resolving *Olmstead* claims involving individuals in state psychiatric hospitals; settlement approved 2010).[143] Some of these states, such as Delaware, have significantly increased the access to supported employment as part of the settlement agreement. Others have begun taking steps to broaden access, such as Illinois.

1) Delaware has almost tripled the employment rate for the target population in its Olmstead settlement.

Following the settlement with DOJ, Delaware identified a challenge: while the state's mental health and vocational rehabilitation agencies had done some work to increase employment before the settlement "result[ing] in solid employment rates among individuals

[139] U.S. v. New York – 13-cv- 4165 – (E.D.N.Y. 2013), available at https://www.ada.gov/olmstead/olmstead_cases_list2.htm#ny.
[140] *Amanda D., et al. v. Hassan, et al.; United States v. New Hampshire*, No. 1:12-CV-53 (SM), available at https://www.ada.gov/olmstead/olmstead_cases_list2.htm#wood.
[141] *U.S. v. North Carolina*, No. 5:12-cv-557 – (E.D.N.C. 2012), available at https://www.ada.gov/olmstead/olmstead_cases_list2.htm#NC.
[142] *U.S. v. Delaware*, No. 11-CV-591 – (D. Del. 2010), available at https://www.ada.gov/olmstead/olmstead_cases_list2.htm#de.
[143] *U.S. v. Georgia*, No. 10-CV-249 – (N.D. Ga. 2010), available at https://www.ada.gov/olmstead/olmstead_cases_list2.htm#georgia.

served in the DSAMH [Division of Substance Abuse and Mental Health] system of care," these gains had begun to slip.[144] Partially due to the settlement and partially due to the particular focus from state leadership,[145] the state hired an individual "whose sole responsibility will be the development and support of employment services, particularly within DSAMH provider organizations that support individuals on the US DOJ Target population."[146] This Target population consisted of individuals with serious and persistent mental illness who are at the highest risk of unnecessary institutionalization, including individuals in the state psychiatric hospital or who had recently experienced an emergency room admission, criminal justice system encounters, or homelessness.[147] The state "pursu[ed] changes in its Medicaid plan which will expand coverage for services such as supported employment and care management"[148] and worked towards having "one dedicated employment counselor for each [ACT] team."[149] Due to all of these changes, Delaware's numbers improved rapidly:

[144] Delaware Health and Social Services, Division of Substance Abuse and Mental Health, *Second Progress Report on Implementation of the Settlement Agreement Between the U.S. Department of Justice and the State of Delaware*, 15 (Dec. 15, 2013) (hereinafter *Second Progress Report*) available at http://dhss.delaware.gov/dhss/admin/files/dsamhsecondannualprogressreport.pdf. *See also, Third Report of the Court Monitor on Progress Towards Compliance with the Agreement: US v. State of Delaware, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS* (Mar. 8, 2013) ("In contrast to the important benchmarks reflecting the development of a new service (e.g., the number of ICM teams), in a very real sense, stable mainstream housing and employment are the fruits of the State's new service array") (hereinafter *Third Court Monitor's Report*).

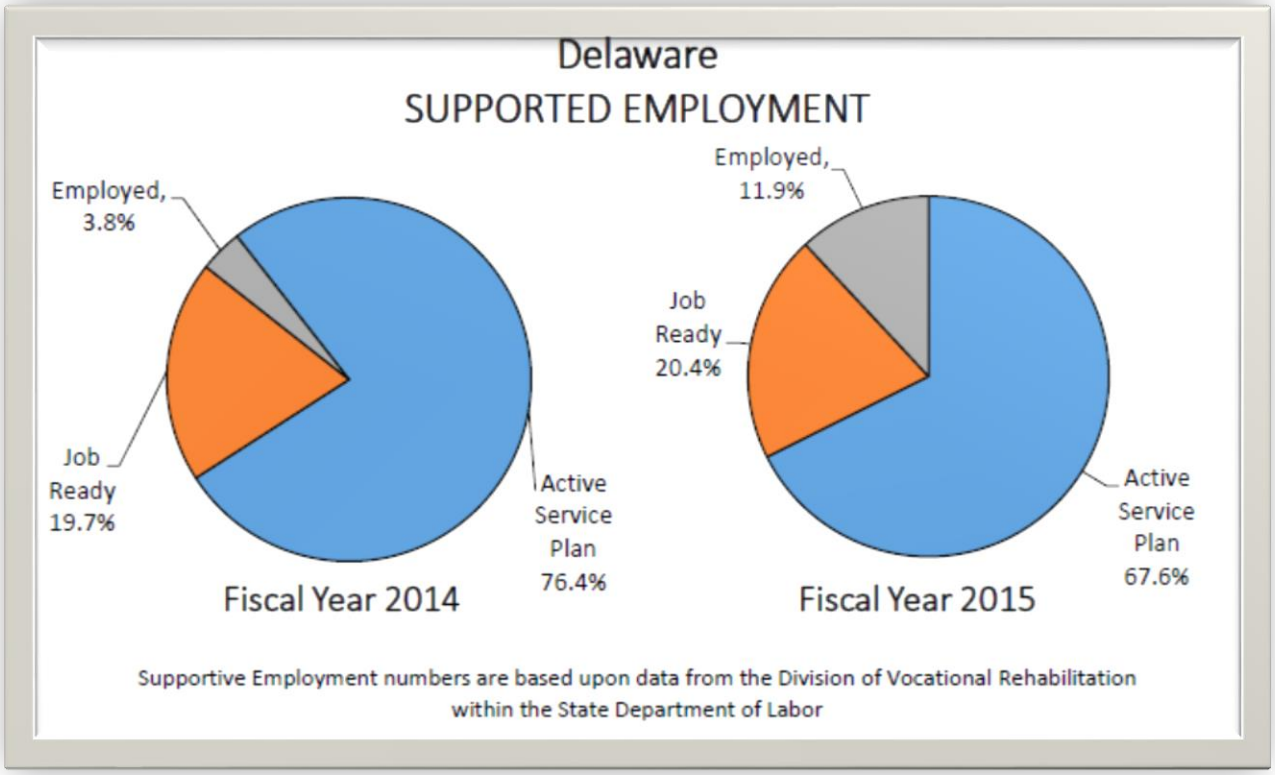
[145] *Third Court Monitor's Report*, *supra* note 144, 15 (Governor Markell, "both in his Delaware role and as Chair of the National Governor's Association, has launched initiatives to promote the employment of people with disabilities").

[146] *Second Progress Report*, *supra* note 144, at 15.

[147] For a precise definition of the Target population, see Section II.B. of the Settlement Agreement, https://www.ada.gov/delaware.htm.

[148] *Corrected Fourth Report of the Court Monitor on Progress towards Compliance with the Agreement: U.S. v. State of Delaware, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS*, at 11 (Sep. 24, 2013), available at http://www.dhss.delaware.gov/dhss/dsamh/files/usdoj_courtmonitorreport4_2013_09_24.pdf.

[149] *Id*. at 27.



For additional context, the state utilizes IPS supported employment and these percentages reflect that "1,326 members of the target population were receiving Supported Employment Services in the fiscal year by that date."[150] These numbers exceed the targets set by the Settlement Agreement for supported employment, by approximately 20 percent.[151] Unfortunately, this progress is not reflected in the SAMHSA National Outcomes Measurement System (NOMS) data for Delaware in 2015, which reports that four individuals were receiving supported employment services.[152] The chart above depicts only the population of people with SMI who were part of the settlement agreement and thus had access to IPS supported employment, not all people with SMI in the state who may or may not be provided supported employment.

2) Illinois is also increasing access to supported employment.

As part of its implementation of two *Olmstead* class action settlements with private plaintiffs, Illinois developed a plan in April, 2015 that includes some of the steps taken by Delaware: a specific individual to head up state efforts and an effort to increase Assertive

[150] *Id.*
[151] *Report of the Court Monitor on Progress towards Compliance with the Agreement: U.S. v. State of Delaware, U.S. District Court for the District of Delaware, Civil Action No: 11-591-LPS, at* 26 (Dec. 26, 2015).
[152] SAMHSA NOMS 2015, *supra* note 2, at 1.

Community Treatment (ACT) team capacity to provide IPS.[153] In addition, the state planned to conduct broad outreach, education, and technical assistance and training on IPS; build the capacity of existing providers to provide employment engagement activities and strategies; and develop quality and data metrics.[154] The state has used drop-in centers as a hub for outreach to *Olmstead* class members concerning IPS supported employment.[155] The drop-in centers host various employment-related events and report weekly to the state mental health authority concerning participation in their employment engagement activities such as resume writing, mock interviews, employment-related guest speakers, job search help, job club, and benefits information. These steps have resulted in improved access to supported employment for class members and within a year, Illinois had utilized supported employment to raise the employment rates of people with SMI. An IPS Action Plan for *Olmstead* class members was developed in April 2015 and a full-time manager of this initiative was hired in October 2015. By July 2016, the number of individuals in the *Williams* class participating in IPS had reached 306 (a little more than 10 percent of the class), up from 73, with 52 having worked and an additional 35 working at that time. By May 2017, participation of the class in IPS was up to 386, with 74 having worked and an additional 54 working at that time.

The experience with implementation of these *Olmstead* settlements offers guidance to states about how to increase the availability of supported employment quickly and successfully. Recommendations for the future are discussed more below, but it is important to note that fast and successful expansion of IPS supported employment is possible.

3) New Jersey has begun to take specific steps to expand supported employment in the second phase of its Olmstead implementation for individuals with serious mental illness.

While New Jersey's *Olmstead* settlement did not contain specific requirements concerning employment services, the state has begun to explore strategies for expanding supported employment now that it has achieved a significant service system transformation in terms of living settings for people with SMI. New Jersey dramatically increased its supportive housing capacity, enabled nearly 1500 individuals to transition from state psychiatric hospitals to supportive housing under the settlement, reduced its state hospital census by approximately one-third, and developed the capacity to serve people with a variety of significant challenges in supportive housing.

In its next phase of *Olmstead* implementation, the state is setting specific targets for employment of individuals receiving ACT, and increased employment among individuals receiving "Community Support Services." The state plans to add performance indicators for Community Support Services providers relating to employment of individuals served. The state mental health authority is also planning to include Vocational Rehabilitation staff in quarterly supported employment provider meetings.

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[153] STATE OF ILLINOIS, ILLINOIS INDIVIDUAL PLACEMENT AND SUPPORT (IPS) ACTION PLAN TO ENHANCE THE AVAILABILITY OF IPS TO WILLIAMS AND COLBERT CLASS MEMBERS 5-6 (Apr. 2015).
[154] *Id*.
[155] *Id*. at 6.

New Jersey also established a pilot program in July 2015 to provide in-reach concerning supported employment services to individuals in state psychiatric hospitals who are expected to be discharged soon. The community agencies providing supported employment along with consumers and their families receive training from the Employment Institute at Rutgers School of Health Related Professions concerning benefits, the career interest inventory, barriers to employment, and engagement.

4) States are also focusing on expanding access to supported employment through funding changes.

Another major change in Delaware was how supported employment was financed. As discussed above, there are several different financing methods for supported employment. In 2014, Delaware sought and obtained an amendment to its 1115 research and demonstration waiver to include 1915(i)-like services, including supported employment.[156] There are several states that utilize Medicaid to reimburse for all elements of the supported employment service, although in different ways. Iowa utilizes a 1915(i) state plan amendment.[157] Connecticut and Montana both cover supported employment via a Section 1915(c) waiver.[158] Vermont, Arizona, Delaware, New York and Hawaii all utilize an 1115 research and demonstration waiver.[159] Michigan, Iowa, and North Carolina all also provide some supported employment services via the 1915(b) managed care authority, which enables states in some instances, to "use savings from managed care program and reinvest in other services."[160] Ohio similarly just received approval for a 1915(i) state plan amendment.[161]

Recommendations for Increasing the Availability of Supported Employment for People with Psychiatric Disabilities

Expanding access to supported employment is feasible. As discussed above, several states have substantially increased access to supported employment services and many other states have shown great success with these services and could expand them dramatically. Both attitudinal barriers and other service system barriers must both be addressed. As highlighted in the sections above, there are strategies that have been successfully utilized to address these

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[156] STATE OF DELAWARE, 1115 DEMONSTRATION AMENDMENT FOR STATE OF DELAWARE PROMISE (PROMOTING OPTIMAL MENTAL HEALTH FOR INDIVIDUALS THROUGH SUPPORTS AND EMPOWERMENT) PROGRAM CHANGES 1 (Aug. 22, 2014) ("The PROMISE program seeks authority to target individuals with behavioral health needs and functional limitations in a manner similar to an Home and Community-Based Services (HCBS) 1915(i) State Plan authority") available at http://www.dhss.delaware.gov/dsamh/files/1115_waiver_amendment081214.pdf

[157] O'Brien, *supra* note 128.

[158] *Id*.

[159] *Id*.; State of Delaware, *supra* note 156; State of New York, Department of Health, New York 1115 Medicaid Waiver Information Page (last visited 2/23/17) available at https://www.health.ny.gov/health_care/medicaid/redesign/medicaid_waiver_1115.htm.

[160] O'Brien, *supra* note 128.

[161] State of Ohio, Department of Medicaid, 1915(i) Specialized Recovery Services Program (formerly known as the Program for Adults with Severe and Persistent Mental Illness in Ohio) (last visited 2/23/17) available at http://www.medicaid.ohio.gov/RESOURCES/PublicNotices/1915i.aspx.

barriers and expand supported employment. Recommendations are offered below to facilitate expanding access to IPS supported employment.

1. **Addressing Attitudinal Barriers.** The following recommendations are offered to help overcome longstanding assumptions at all levels of a service system that individuals with SMI cannot or should not work:

   - Changing attitudes among policymakers, providers, and employers requires a strong message from mental health system leadership to all parts of the service system, with specific activities and goals to make employment the expectation for individuals with SMI.[162]

   - Creating a "culture of employment", where employment is the expectation and goal for all individuals with SMI, requires more than merely an "Employment First" policy that applies to people with mental illness. Concrete and specific expectations to ensure that employment of people with SMI is prioritized are critical--for example, specific requirements and performance measures in provider and managed care contracts, and concrete action steps to meaningfully expand the availability of supported employment. Employment should be explicitly considered the goal for all individuals with SMI receiving any other mental health system services, such as supported housing and ACT, and providers of those services should be expected to develop partnerships to ensure that employment services are available to their clients who need them.[163]

   - Creating a dedicated position within the state mental health authority to promote the development and support of employment services can be a very useful mechanism to enable leadership to convey to all parts of the mental health system the expectation of employment for people with SMI. Delaware and Illinois are examples of states that have created such a position and used it to begin shifting expectations throughout the service system.

   - Using peer support specialists to engage individuals in IPS and to serve as employment specialists on IPS teams are particularly promising strategies to help overcome attitudinal challenges among provider staff.[164] A consistent theme of our interviews above was the importance of IPS providers believing that each person who comes to them is capable of working. As employment specialists, individuals who

[162] *See, e.g.*, Marrone, *supra* note 111, at 10 (identifying as a common theme in promoting supported employment the importance of "Top administration leadership in creating and sustaining partnership activities such as agreements to jointly fund high level staffing positions or funding and Memoranda of Understanding that identify specific activities rather than just statements of mutual values").
[163] *See, e.g.*, Heartland Alliance, *Integrating Rapid Re-Housing and Employmen*t (March 2017) (identifying importance of rapid re-housing providers for homeless individuals prioritizing and valuing employment, making it a stated goal for participants, and developing necessary partnerships to make sure appropriate employment services are delivered).
[164] Deborah R. Becker, *Hiring Peers as Vocational Specialists*, 66 Psychiatric Services 337 (April 2015), available at http://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.660402.

have served as peer specialists are particularly suited to counteract assumptions that people with SMI are not capable of working, or are capable of performing a very narrow range of jobs. Delaware, Vermont, and Oregon are examples of states where peer specialists have served as IPS employment specialists.[165] Peer specialists can provide important perspective in many aspects of the IPS supported employment process. For example, their personal experience and journey to employment, and the unique relationships of trust that they can build with others navigating the mental health system, can facilitate engagement of people with SMI in IPS.[166]

- Conducting affirmative outreach or "in-reach" to individuals with SMI who are not working and not receiving supported employment is a critical step to begin engaging them in IPS. As described in the report, effective engagement is crucial to overcome the misperceptions that individuals have had instilled in them concerning their own capabilities and the potential impact of work on their benefits, and to help those who have not worked before envision a life of employment. Reaching individuals at critical junctures and in appropriate environments is important. New Jersey's pilot program to conduct in-reach and engage individuals preparing to transition out of the state hospitals is an innovative program to reach people at the earliest possible point as they transition to community life. Illinois' engagement efforts targeted at individuals using popular drop-in centers for people with SMI are a useful example of conducting such efforts in a positive environment conducive to engagement.

- Independent fidelity reviews of IPS supported employment help ensure that the service is being implemented in accordance with the principles of IPS—for example, that all individuals who need these services should have the opportunity to receive them, no one should be considered unemployable, the services should be driven by the individual's preferences, the services should be coordinated with rehabilitative and clinical services, and IPS should function as a constant support system. Studies have consistently found that programs with higher fidelity to IPS principles have better employment outcomes.[167]

- Along with fidelity reviews, frequent training and technical assistance to providers should be done concerning the expectations for how supported employment should be

[165] See, e.g., Abby Levinsohn, *Using the Fidelity Scale in a Peer-Run Center*, Employment Works! Newsletter at 5 (Dartmouth Psychiatric Research Center, Winter 2016), available at https://www.ipsworks.org/wp-content/uploads/2016/02/employment-works-winter-2016-2-5-16.pdf (describing IPS conducted by the peer-run wellness center operated by Pathways Vermont); Crystal McMahon & Jeff Krolick, *IPS Learning Community in Oregon*, Employment Works! Newsletter at 3 (IPS Employment Center, Rockville Institute, Fall 2016), available at https://www.ipsworks.org/wp-content/uploads/2016/11/IPS_NL_Fall_2016.pdf (describing initiative to add more peer specialists to IPS teams in Oregon).

[166] Margaret Swarbrick, Webinar Slides, *Peer Roles in Supported Employment* (2015), available at https://www.ipsworks.org/wp-content/uploads/2015/09/peer-roles-in-se-2015.pdf (describing advantages of, and various roles for, peer specialists in supported employment services).

[167] Gary Bond, *Why Assess Fidelity*?, Employment Works! Newsletter at 3 (Dartmouth Psychiatric Research Center, Winter 2016), available at https://www.ipsworks.org/wp-content/uploads/2016/02/employment-works-winter-2016-2-5-16.pdf

provided, to whom, and how outreach and engagement should be conducted, and how to create a culture of employment and employability.

2. **Addressing Confusion about Financing Mechanisms.** The following recommendations are offered to help clarify for policymakers the financing mechanisms available to support IPS supported employment:

- It is important to ensure that different components of state service systems (including agencies or agency components focusing on mental health, Medicaid, vocational rehabilitation, and workforce development) are aware of the need for a sustainable funding source and are collaborating to seek coverage of the full range of IPS supported employment services and to make them widely available. As with addressing attitudinal barriers, a strong message from mental health system leadership about available options and the importance of developing a clear and straightforward financing structure, combined with collaboration between the mental health system leadership and the state Medicaid agencies and other relevant state components, is crucial.

- Establishing or expanding collaborations between state and regional leaders, such as the Individual Placement and Support (IPS) Learning Community, would allow more states to draw on the experiences of other states in implementing and financing supported employment.[168] The Learning Community provides training and consultation to state leaders and trainers regarding funding mechanisms, policies and procedures to adopt IPS, program implementation and monitoring, and tracking outcomes.[169] Sites in the IPS Learning Community have demonstrated success with fidelity and quality monitoring, and, crucially, sustainability—a recent study found that 96 percent of sites participating in the learning collaborative remained active after two years.[170]

- Conveying to all stakeholders, including individuals with disabilities, advocates, family members, and providers, information about supported employment would help to build momentum for expanding its availability. For example, Ohio's Department of Mental Health and Addiction Services has an entire webpage devoted to IPS Support Employment, which targets not only providers, with Frequently Asked Questions and other technical assistance materials, but also family and consumer advocates, with lists of certified providers and links to a state advocate coalition.[171] The page also details

[168] Gary R. Bond, et al, *The IPS Learning Community: A Longitudinal Study of Sustainment, Quality, and Outcome* 67 Psychiatric Services 8, 864-9 (Aug. 2016).
[169] Deborah Becker et al., *The IPS Supported Employment Learning Collaborative*, Psychiatric Rehabilitation Journal, vol. 37. No. 2, at 79 (June 2014).
[170] *Id.* This rate is significantly higher than the 80% rate over a two-year period following the end of the initial implementation phase in a national study of 49 sites implementing a new evidence based practice in mental health with systematic technical assistance. *Id*.
[171] Ohio Dept. of Mental Health and Addiction Services, Meaningful Employment Can Enhance a Person's Recovery (last viewed May 12, 2017) available at http://mha.ohio.gov/Default.aspx?tabid=260.

Ohio's recent SAMHSA grant and the state's goals related to expanding IPS supported employment statewide, making it clear that IPS supported employment is a priority and that there are financing options available, to both providers and advocates. This publicity and promotion ensures that stakeholders are aware of these changes and are a part of building sustainability of these financing mechanisms.

- Pursuing increased availability of supported employment as part of other financing changes, such as a shift to managed care or to outcome-based payment methods, is an important strategy for states. For example, all contracts with providers and managed care entities could incorporate employment outcomes achieved through the provision of IPS supported employment services. These performance measures would enable states to hold providers accountable for getting a desired percentage of people with serious mental illness engaged in IPS services and/or a desired percentage working (at a minimum number of hours, minimum amount of wages, or other relevant criteria).[172] This would allow states to consider results as a factor in renewing contracts, determining reimbursement rates, incentives, and other future decisions.

- Guidance that helps states understand and make full use of Medicaid authorities, such as the Home and Community-Based Services Option, would help ensure that the tools are in place to significantly expand the availability of supported employment for individuals with SMI. For example, this could include issuance of federal guidance on which elements of IPS supported employment can be covered by the Medicaid rehabilitation option and other Medicaid state plan options, as well as Medicaid waivers to implement managed care as well as home and community-based services. It could also include the creation of model waivers or state plan options for states who express interest in changing their systems.

- Issuing federal grants that assist states to "establish robust supported employment programs" and "secure sustainable funding for on-going community [supported employment] services," such as the recent SAMHSA Mental Health Transformation Grant Program: Transforming Lives through Supported Employment, would be useful in helping states develop necessary infrastructure to expand the availability of supported employment.[173]

3. **Addressing Provider Incentives to Focus on Segregated Options.** The following recommendations are offered to help eliminate incentives to develop site-based day programs rather than supported employment:

[172] *See, e.g.*, Deborah Becker et al, *Critical Strategies for Implementing Supported Employment*, 27 Journal of Vocational Rehabilitation 13 (2007) (describing Kansas's system of measuring client outcomes for supported employment and using the measures to set goals for supervisors to improve program performance).

[173] SAMHSA, Grant Announcement: Transforming Lives Through Supported Employment (Jan. 15, 2015) available at https://www.samhsa.gov/grants/grant-announcements/sm-14-011 (last visited May 10, 2017).

- Limiting the duration and scope of Medicaid coverage of site-based day treatment and rehabilitative services would help to overcome current incentives to focus on such programs over supported employment.

- Setting specific annual goals for making supported employment available to a target number of individuals with SMI, and using existing solicitation processes to ensure that that capacity is developed, is critical to changing the status quo.

- As described above, creating a culture where employment is the expectation and goal for all individuals with SMI throughout the service system is important. Concrete and specific expectations should be set out at the provider level as well as the service system level, including performance measures in provider and managed care contracts. Performance measures should include expectations for factors such as how quickly someone is placed in a job once referral to employment services is made, longevity in a job and how closely the job opportunities sought reflect individuals' desires and preferences. Such performance measures must also be imposed for site-based day programs; these programs should also be expected to offer IPS supported employment among their services and demonstrate similar employment outcomes, or to transition individuals promptly to supported employment services.

- Using Medicaid to cover the full range of supported employment services would simplify funding prospects for providers. As discussed above, various Medicaid authorities enable states to secure federal matching funds for the provision of IPS supported employment via Medicaid. The Medicaid program can be used to cover the full array of IPS services. Vocational Rehabilitation system funds and other funds can be used to supplement funding for IPS—for example, by using time-limited Vocational Rehabilitation funding to cover these services initially and then using Medicaid funding after that.

- Creating a clear and straightforward guide for service providers on how IPS supported employment services can be billed and reimbursed is a useful strategy. It is important for states to ensure that providers are aware that supported employment is a reimbursable service and that its availability is a priority for the state. A state publication for providers, detailing the reimbursement structure and details and articulating the state's focus on ensuring that people with SMI who need this service have access to it would be beneficial.[174]

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[174] *See, e.g.*, Oregon Health Authority, Health Systems Division, *Memorandum to Oregon Supported Employment Center for Excellenc*e, HCPCS H2023 and H2023TG frequently asked billing questions (Sept. 10, 2015), available at http://osece.org/wp-content/uploads/2015/10/H2023-billing-questions-for-OSECE.pdf; North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, *State-Funded Individual Placement and Support (IPS-SE) for AMH/ASA* (Jan. 1, 2016), available at https://www.trilliumhealthresources.org/contentassets/6daf55f6397a493b82836704839373d7/trillium/state-funded-se-service-definition.pdf.

4. **Addressing Lack of Coordination.** The following recommendations are offered for addressing the lack of coordination among state and federal agencies and programs:

   - If expansion of IPS supported employment is needed to prevent public mental health system clients from being served in institutions or segregated day treatment programs, it is important that such expansion be part of any *Olmstead* and "Employment First" planning and compliance efforts. Those efforts reflect actions that states have identified as priorities in order to meet their legal obligations to administer services to people with disabilities in the most integrated setting appropriate. Hence items that are part of these planning efforts are more likely than purely discretionary items to be funded and accomplished. As discussed above, many state *Olmstead* and "Employment First" plans lack concrete goals or targets. In addition to ensuring that the plans include and focus on employment services, states should establish specific targets for 1) outreach and engagement of individuals with SMI, 2) participation in IPS supported employment, and 3) employment rates for people with SMI.

   - Each state has a workforce development plan pursuant to the Workforce Investment and Opportunity Act (WIOA), and those plans should incorporate goals for expansion of supported employment for individuals with SMI. Maryland's WIOA state plan, for example, describes the collaboration between the mental health agency and the vocational rehabilitation agency in providing supported employment services and in working with the University of Maryland to promote training in evidence-based supported employment, and the collaboration between the vocational rehabilitation agency and the education department to provide supported employment and other services to students with disabilities. The plan sets a target of 775 individuals with significant disabilities achieving a supported employment outcome during FY2017.[175]

   - Ensuring that the provision of other mental health services, including ACT, case management, and supported housing, is coordinated with the provision of IPS is a useful step so that individuals receiving these services also get evidence-based employment services.[176] In particular, the relationship between an ACT team and the employment service can be made needlessly complicated. For example, in one state with IPS supported employment that had shown very successful outcomes for individuals with SMI, no individuals who received ACT were permitted to receive IPS. This situation arose because of the state's belief that the two could not be simultaneously provided since ACT team staff, including the employment specialist, must report to and be supervised by the ACT team leader, whereas IPS requires that staff report to and be supervised by the IPS team leader. In addition, employment had become a low priority of ACT teams as a result of other crisis situations arising for

[175] WIOA State Plan for the State of Maryland, at 184, available at https://www2.ed.gov/about/offices/list/osers/rsa/wioa/state-plans/md.pdf.

[176] *See, e.g.*, Heartland Alliance, *supra* note 163 (explaining the importance of coordination of rapid rehousing services with supported employment services, including to help ensure that individuals have a means of continuing to support themselves in housing when their housing subsidies disappear at some point in the future).

clients. As a result of concerns raised about this situation, the state began ensuring among other things that ACT team employment specialists received regular IPS training along with IPS staff. In Delaware, the state is working toward ensuring that each ACT team has a dedicated IPS employment specialist. As noted above, Illinois has used its drop-in centers for individuals with mental illness as hubs for activities designed to engage people in IPS.

- The provision of supported employment should also be coordinated with the Social Security Administration's (SSA's) Ticket to Work program, which is designed to assist individuals with disabilities receiving Social Security Disability Insurance or Supplemental Security Income in returning to or joining the workforce. The Ticket to Work program uses entities called Employment Networks, which enter agreements with the Social Security Administration to provide or coordinate the delivery of employment services to SSA beneficiaries. State mental health authorities can become an Employment Network in order to coordinate delivery of supported employment to SSA beneficiaries with SMI. In Oregon, for example, the state vocational rehabilitation agency serves as an Employment Network and partners with the state mental health agency to provide supported employment to individuals with SMI.[177]

- Ensuring that the Vocational Rehabilitation program and Medicaid, Social Security Disability Insurance and Supplemental Security Income program efforts to assist individuals in returning to or joining the workforce all coordinate is also important. The relevant Federal agencies could issue joint guidance about how states can best coordinate their systems to ensure that supported employment is available to many more individuals with SMI. Technical assistance to help all relevant state agencies and officials plan and implement system-wide IPS supported would also be beneficial.

Conclusion

People with SMI overwhelmingly want to work and can do so. Evidence-based supported employment services have been shown to be highly successful in enabling individuals with SMI to secure and maintain employment. These services should be brought to scale. This report has laid out recommendations for doing that.

While research continues to explore additional improvements to IPS supported employment, including the development of a supported education service encompassing components such as career planning, academic survival skills, help with enrollment and financial aid, and outreach to campus resource people,[178] and techniques to maximize the effectiveness of

[177] Oregon WIOA Plan, at 186, available at https://www2.ed.gov/about/offices/list/osers/rsa/wioa/state-plans/or.pdf
[178] Bonnie O'Day, et al., *supra* note 29, at 18-19.

IPS for individuals involved with the criminal justice system,[179] IPS boasts far better results than day treatment and traditional vocational rehabilitation services for people with SMI.

With political will, a significant expansion of these services to become widely available to those who need them can be accomplished. Such an expansion would make a tremendous difference in the lives of people with SMI, would conserve state resources, and would help states comply with their legal obligations. The intent of this report is to provide a roadmap for this progress.

[179] SAMHSA's GAINS Center for Behavioral Health and Justice Transformation, Gary R. Bond, *Supported Employment for Justice-Involved People with Mental Illness* (Aug. 2013).