

**Employment and Income Supports: Issue Paper Prepared for the
President's New Freedom Commission on Mental Health**

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Introduction

This issue paper will address the topics of employment and income supports for people with severe mental health disorders. It will begin with a definition of employment and income supports, followed by descriptions and analyses of problems associated with each of these often interrelated areas. Next, youth and adults who are affected by these problems will be identified. Following that will be a discussion of innovative and effective mental health and rehabilitation services, treatments, and model programs that are evidence-based and potentially widely replicable. Next, policy recommendations will be presented to address problems with employment and income support programs, while enhancing provision of innovative services and treatments. Finally, implementation issues associated with the foregoing policy recommendations will be considered.

Employment for Mental Health Service Consumers: The Problems

Many individuals with serious mental disorders experience symptoms and/or medication side-effects that are disabling and impair their ability to work. As a result, most working-age individuals with severe mental illnesses are out of the labor force, unemployed, or underemployed. People who are not working are considered to be either "out of the labor force," if they are not seeking employment due to retirement, disability, or some other reason, or "in the labor force but unemployed," if they are seeking employment. Studies have shown how labor force participation among people with disabilities is closely tied to overall labor market

dynamics (Yelin & Katz, 1994). For example, long-term labor market trends, from 1970 through 1992, in which there was a decline in male labor force participation and an increase in female labor force participation, were mirrored in proportional labor market participation rates among men and women with disabilities. However, in the short-term, while people with disabilities experienced proportionally larger gains during periods of market expansion, they also evidenced greater losses during times of market contraction than did people without disabilities (Yelin & Katz, 1994).

Three-fifths (60%) of working age adults with mental health disabilities are out of the labor force (defined as not having a job and not having looked for work or been on payroll in the past 2 weeks), compared to less than one-fifth (18%) of their counterparts in the general population without psychiatric disabilities (Kaye, 2002, based on data from the National Health Interview Survey-Disability Supplement or NHIS-D, 1994-5). Of those American citizens with mental health disabilities who are in the workforce, 15% are unemployed, compared to only 4% unemployed in the adult working age population without disabilities (ibid.). While over three-quarters (79%) of the general adult working age population are employed, only 34% of working age adults with mental health disabilities are employed and only 17% of those with severe mental health conditions are working (Kaye, 2002). Even a college education does not appear to ameliorate the disadvantageous position of consumers in the labor market. Among college graduates, 43% of those with mental health disabilities are not working compared to only 13% of those without mental health disabilities (Kaye, 2001).

Underemployment is also a serious problem for people with severe mental illnesses. In the NHIS-D (Kaye, 2002), nearly two-fifths (38%) of workers with mental health disabilities had

near minimum wage jobs, compared with only one-fifth (20%) of people without disabilities. People with mental health disabilities earned a median hourly wage of only \$6.33 in 1995-95, versus \$9.23 for those without disabilities; and more than one-third (36%) of all workers with mental health disabilities were employed in part-time jobs, compared to only 16% of people without disabilities. Among a large group of mental health consumers receiving intensive employment support services as part of an 8-state national study called the Employment Intervention Demonstration program (EIDP) (Cook et al., 2002), a full 70% of those with college degrees (AA or higher) earned less than \$10/hour (equivalent to an annual salary of \$21,000) at their highest level job, and the majority (54%) were employed only part-time.

Given these sobering findings, it is equally problematic that most people with disabling mental illnesses receive little or no services to help them obtain or maintain employment. Among a stratified random sample of persons diagnosed with Schizophrenia in 2 states, only 23% of outpatients were receiving vocational rehabilitation services (Lehman et al., 1998). By federal legislative mandate, the Rehabilitation Services Administration (RSA), an agency of the Department of Education, funds vocational rehabilitation (VR) programs in each state to provide job placement and training services to all eligible persons with disabilities. In fiscal year 1995, 1.3 million adults were clients of state-run VR programs, accounting for 12% of all Americans estimated to have health conditions or impairments that limited their ability to work (U.S. Census Bureau, 1995). Some 2 billion in federal dollars matched by \$645 million in state and local programs are allocated annually to state VR programs (Kaye, 1998).

Researchers have studied the effectiveness of such programs over time by examining longitudinal trends in successful closure rates among state VR clients. (VR cases can be

"closed" for a number of reasons, including employment placement, transfer to other programs, or lost contact, among others.) Andrews and his colleagues (1992) examined RSA-911 data (a data base of all persons using state VR services whose cases have been closed) from 1977 through 1984. They found that the percent change in number who entered or returned to competitive employment following closure increased among individuals with severe physical disabilities, but not for those with severe psychiatric disabilities. The amount expended on case services for VR clients with psychiatric disabilities in 1986 was roughly 15% less than for clients with all other disabilities (Conley, 1999). Less than half of all people with disabilities who exited the VR system in 1995 had completed their service plan and been employed for 60 days (Kaye, 1998).

A related problem is the fact that many mental health consumers lack the necessary high-school and post-secondary education and training required to build careers. Academic underachievement begins in the early years for youth with mental disorders. Only 38% of special education students diagnosed with severe emotional disturbance (SED) graduate from high school, while another 6% receive a certificate such as a GED. The remaining 56% do not complete their schooling (Kaye, 2001). The National Longitudinal Transition Study (NLTS), a survey of young people exiting special education programs across 303 nationally representative school districts (Wagner, 1989), found that youth classified as emotionally disturbed had the highest percentage of high school noncompletion and failing grades. One to two years after exiting high school, only 18% were employed full time, while another 21% worked part time. The NLTS also found that this group had post-high school work experiences characterized by greater instability than all other disability groups (Wagner, 1993).

This situation is especially disturbing given that the Individuals with Disabilities

Education ACT (IDEA) of 1990 (PL 101-476) mandated the development of an individualized transition plan (ITP) for every young person receiving special education services by the time they reach age 16. Reauthorization of IDEA in 1997 set the age even lower at 14 years (Fitzgibbon, Cook & Falcon, 2000). One component of the ITP includes specific services and time frames for transition into the world of work. However, the promise of IDEA remains largely unfulfilled, shortchanging not only millions of children with SED but also their parental caretakers, whose labor force participation is often negatively affected as well. Numerous studies of parents of disabled children have found that both mothers and fathers have a lower likelihood of labor force participation (Acs & Loprest, 1999; Kuhlthau & Perrin, 2001), greater losses of employment income (Lukemeyer, Meyers & Smeeding, 2000), and, among low-income families, lesser likelihood of exiting welfare in order to return to work (Brandon & Hogan, 2001; Olson & Pavetti, 1996). One study of employed parents of children diagnosed with mental health problems (Rosenzweig, Brennan & Ogilvie, 2002) found that significant proportions reported adjusting their employment duties (e.g., taking a job requiring fewer hours of work or less concentration), greater need for work flexibility (i.e., working only during hours when their child was in school or when daycare was available), and negative effects of the child's condition on their daily work performance (e.g., work interruptions and repeated absences).

Perhaps not surprisingly, by the time they reach adulthood, reading comprehension and mathematics computation levels of adult psychiatric rehabilitation populations are well below age-appropriate levels (Cook, Wessell & Dincin, 1986; Cook & Solomon, 1995). Less than 6% of all participants entering the 8-state EIDP study had a college degree (Cook et al., 2002). These gaps in education are critically important because the growth rate of occupations is fastest among those requiring an Associate's Degree (A.A.) or more advanced education. Seventy

percent of the 30 fastest growing occupations and a third of the 30 occupations with the largest anticipated numerical increase require a community college or university degree or some post-secondary training (Heckler, 2001).

Given the high level of social stigma attached to mental illness in American society, it is not surprising that people with mental disorders experience labor force discrimination (Cook & Jonikas, 2002). In employer surveys over the past five decades, employers have expressed more negative attitudes about hiring workers with psychiatric disabilities than any other group (with the occasional exception of intellectual and substance abuse disabilities) (Cook et al., 1993; Diksa & Rogers, 1996). In a national probability sample drawn from the NHIS-D (Kaye, 2001), one third (32%) of those with mental health disabilities reported having been fired, laid off or told to resign (22%), refused employment (14%), refused a transfer (6%), refused a promotion (10%), or refused a training opportunity (6%) because of their disability. Looking closer at the question of earnings, Baldwin and Johnson (1998) applied techniques used by economists to study race and sex discrimination through the development of multivariate models designed to explain wage differentials. Their analysis focused on the wages of men and women both with and without disabilities in 1984 and 1990. After accounting for productivity differentials related to functional limitations, and other productivity-related characteristics of individuals (such as education, occupational distributions, and part-time employment), large remaining unexplained variance in wage differentials suggested that those with disabilities were experiencing discrimination in the labor market. Moreover, among males with impairments thought to evoke "greater prejudice" such as mental illness and paralysis, the amount of unexplained variance attributed to discrimination and residual effects was greater than that among men with impairments evoking "mild prejudice" such as diabetes and back problems. (Small sample sizes

prevented the testing of this hypothesis among the female respondents.)

Income Support for Mental Health Service Consumers: The Problems

A series of benefits and entitlements including cash payments, vouchers, and other income support mechanisms are currently in place to assist individuals with disabilities who are unable to work. Recent concerns are that these systems (SSI, SSDI, Medicare, Medicaid), designed for other purposes in times of different population demographics, no longer are viable without significant alterations. Many individuals with serious mental disorders qualify for and receive either supplemental security income (SSI), a means-tested income-assistance program, or social security disability insurance (SSDI), a social insurance program with benefits based on prior earnings. The number of SSI and SSDI beneficiaries with psychiatric disabilities has been increasing at a higher rate than total program growth for over a decade (National Academy of Social Insurance, 1994). Individuals with severe mental illnesses represent the single largest diagnostic group on the SSI rolls -- 36% in December, 2001 (Social Security Administration, 2002). In 1999, people with psychiatric disabilities comprised over a third of working aged adults receiving SSI and over a quarter (27%) of all SSDI recipients (McAlpine & Warner, 2002).

One problem with this situation is that disability income is equivalent to poverty level income. As a national average, year 2000 SSI benefits were equal to around \$3.23/hour or almost \$2.00 less than minimum wage (Consortium for Citizens with Disabilities, 2000). On average, rental of a modest, one bedroom apartment costs 98% of year 2000 SSI benefits (ibid). Annual year 2000 SSI benefits averaged only 18.5% of the one-person median household income, dropping below 20% for the first time in over a decade (ibid). SSDI income has the capacity to provide annual income above the poverty level, but only for those with high annual

earnings for at least three eligible years. Among those with disabling mental disorders participating in the EIDP, almost three-quarters (73.9%) were at or below the poverty level: 78% of those on SSI lived in poverty, while 59% of those on SSDI, 75% of those on both, and 87% of those on neither did so. Thus, income support programs for people with mental illnesses are inadequate to help them meet basic needs, including the requisites of job training and seeking.

Even given its inadequacies, mental health consumers rely heavily on disability benefits not only for income but also for their health care and psychotropic medication coverage. This is because individuals with major mental disorders experience discrimination due to lack of parity in health and mental health care, forcing them to rely on public systems of care (Sing & Hill, 2001). In a study of individuals with schizophrenia followed for a mean of five years after their first hospitalization (Ho, Andreasen & Flaum, 1997), 56% were primarily supported by SSI, SSDI, or AFDC at one year post-discharge, and 72% relied on one or more of these public funding sources throughout much of the followup period. Thus, disability income support and health care coverage are inter-twined to the detriment of many recipients, especially those attempting to return to work.

The vulnerability of those who return to work while on the federal disability insurance (SSDI) rolls is evident in studies showing that most re-enter the labor force because of financial need rather than medical improvement (Schechter, 1997). Those who do return to work tend to be younger and better educated than those who do not. Their initial post-SSDI jobs are lower paying and for fewer hours than the job held prior to DI recipiency, and they tend not to return to their previous employer. Moreover, the first job attempt after SSDI entitlement has the greatest chance of leading to successful labor force re-entry; the likelihood of positive outcomes

decreases with subsequent job attempts (Hennessey, 1996). Finally, while workplace accommodations may extend the average duration of employment for those with disabilities (Burkhauser, Butler & Kim, 1995), there is evidence that some injured workers who receive job accommodations also receive lower wages, in essence "paying the price" of their own accommodations (Gunderson & Hyatt, 1996). Evidence that SSI/SSDI recipients with psychiatric disabilities return to jobs that do not provide health care, sick leave, or other benefits comes from the EIDP. Of all full-time jobs held by EIDP study participants over the two-year course of the study, only 24% provided medical coverage, 16% dental coverage, 8% mental health coverage, and 20% sick leave. Most SSDI recipients who re-enter the labor force do so at lower-paying jobs, for fewer hours per week, and with a different employer than the jobs they held prior to SSDI reciprocity (Schechter, 1997).

Disability program rules and regulations constitute a considerable disincentive to work that prevents people with mental illness from realizing their full career potential. Federal regulations mandate an administrative review of disability status upon return to work, effectively "punishing" those who obtain employment. Unlike SSI, which allows recipients to retain part of their income supports after substantial gainful employment, SSDI recipients encounter an allowable income "cash cliff," whereby their cash payments cease entirely once they exceed SGA for a specified number of months. Individuals who lose disability income status because of their return to work also experience an "implicit tax" because they risk losing other unearned income such as housing subsidies, utility supplements, transportation subsidies, and food stamps (Polack & Warner, 1996). SSDI beneficiaries must undergo a two-year waiting period before becoming eligible for health coverage under Medicare, while most SSI recipients become eligible for Medicaid immediately upon receiving SSI.

Unfortunately, recent legislation designed to remediate income support disincentives is likely to have limited impact on the return to work of individuals with psychiatric disabilities. One example is the 1999 Ticket to Work and Work Incentives Improvement Act known as TWWIIA. TWWIIA was intended to increase federal disability insurance beneficiary options for obtaining rehabilitation and vocational services, remove barriers that require choosing between health care coverage and employment, and assure that more Americans with disabilities would have opportunities to participate in the workforce and lessen their dependence on public benefits. However, economists have forecasted that TWWIIA rules establishing milestone payment amounts to vocational rehabilitation providers offer too little financial incentive to serve clients with mental illnesses (Cook, 2002). By "backloading" the payment structure, TWWIIA in effect "punishes" providers who serve a clientele that takes longer to prepare for movement into competitive jobs (Salkever, 2002). Moreover, by linking financial payments to achievement of substantial gainful employment (SGA) level income, as currently structured, TWWIIA provisions are unlikely to motivate providers to serve people with psychiatric disabilities and developmental disabilities (Wehman & Kregel, 2002).

Another example of legislation with much initial promise but a largely disappointing impact is the 1990 Americans with Disabilities Act or ADA. The ADA gives civil rights protections to individuals with disabilities in employment, transportation, public accommodations, State and local government services, and telecommunications. ADA protections have become increasingly circumscribed for individuals with psychiatric disabilities (and others) as a result of recent supreme court rulings (Sutton v. United Airlines, 1999; Murphy v. United Parcel Service, 1999; Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 2002), declaring that ADA protections do not extend to workers with illnesses "controlled by

medications" and those whose limitations are not considered "central to most people's daily lives" (Mathis & Giliberti, 1999). Additional evidence of the failure of the ADA to protect workers with psychiatric disabilities has been identified in the claims adjudication process (Ullman et al., 2001). Under a policy introduced in 1995, EEOC claims are classified into three tiers by field office investigators at intake, based on the investigator's subjective judgments as to whether or not discrimination has occurred. Given the subjectivity of such judgments and the failure of EEOC to validate the accuracy of their classification system, recent research (Ullman et al., 2001) focused on whether ADA claims filed by individuals with certain disabilities, such as mental illness, are more likely to be classified as low-priority. This research also attempted to investigate the relationship between priority assignment and the likelihood that a claimant received some benefit, either in the form of an actual monetary payment (compensatory damages, back pay, remedial relief) or projected monetary benefits assumed to co-occur with hiring, promotion, or reinstatement. Results of this research revealed that the priority classification with the highest total benefit rate was significantly less likely to be assigned to claimants with psychiatric disabilities, while the category with the lowest benefit rate was significantly more likely to be assigned to those with mental illnesses. The authors of this study called into question the ability of untrained EEOC field investigators, using an un-validated classification system, to appropriately evaluate claims involving mental illness, and called for future studies of this question.

Populations Affected by these Problems

Problems with Employment. Adults with severe mental illness and youth with severe emotional disturbance (SED) are the primary groups affected by the aforementioned problems. Youth confronting employment issues are those in transition between school and work, which is

defined as children between the ages of 16 to 25 years (Davis & Vander Stoep, 1997), who meet criteria for a psychiatric disorder. Adults of working age are typically considered to be those between age 18 to 64 years.

National household probability surveys find that anywhere between 18% to 21% of children meet the diagnostic criteria for a psychiatric disorder (Cohen, Provet & Jones, 1996), while the prevalence of SED (for which criteria are more stringent than those for psychiatric disorder and require significant functional impairment) has been conservatively estimated at 5% to 9% (Friedman et al., 1996). As of the year 2000, an estimated 6.5 million children in the U.S. have an SED diagnosis and are between the ages of 16 to 25 years of age.

The latest figures on adults indicate that 21% of the U.S. adult population experiences a mental illness (Surgeon General's 1999 Report on Mental Health). Estimates are that between 4.7 million (Kaye, 2001) and 8.2 million civilian, non-institutionalized adults have a disabling mental/emotional problem (Willis et al., 1998). This means that a sizable number of working-age adults and youth are likely to be confronting one or more of the identified problems with employment.

Problems with Income Supports. As of December, 2001 (the latest date for which information is available), 4.7 million individuals were receiving SSI, with 36% of that group or approximately 1.7 million individuals having a diagnosis of mental illness (SSA, 2002). As of December, 2000 (the latest date for which information is available), 5 million individuals are receiving SSDI under the classification of disabled workers, with 27.4% of recipients or approximately 1.4 million individuals having mental disorders. This indicates the sizable nature of the population potentially affected by the aforementioned income support problems.

Evidence-Based Mental Health and Rehabilitation Services

Services for Adults. The accumulated research evidence indicates that people with severe mental illnesses can successfully participate in the labor market in a variety of competitive jobs. Competitive employment refers to jobs that are located in the so-called "regular" labor market (i.e., work settings not comprised solely of co-workers with disabilities), pay minimum wage or above, belong to the worker rather than an agency, and for which anyone in the labor market can compete. The service delivery approach with demonstrated efficacy in accomplishing this outcome is called supported employment. While a number of evidence-based supported employment models tailored specifically for people with mental illness exist in the field today, they all share a common set of features. All deliver carefully coordinated clinical and vocational services, provided by multidisciplinary service delivery teams including both mental health and rehabilitation professionals, with rapid job placement, into competitive positions, in client's preferred fields and settings, and with the availability of services and supports that are not time-limited (Cook et al., 2002). In an 8-state, multi-site, clinical trials study of supported employment for people with severe psychiatric disabilities testing models meeting these characteristics (the EIDP study), over two-thirds of participants became employed at some point during the two-year followup, earning over 3.8 million dollars and working over 850,000 hours. These results are confirmed by individual, randomized controlled trials of supported employment programs for people with severe mental illnesses (Crowther et al., 2001) which find that supported employment is more effective in achieving competitive employment than prevocational training programs or standard non-vocational community care. Another study of services used by community mental health center clients over a nine year period in a rural Midwestern area of the U.S. found that those with severe mental illness showed significantly greater improvement in role performance (including but not limited to work roles) in years when

they used supported employment than in years when they used sheltered workshops (Landis, 1999).

While most consumers do not receive any vocational rehabilitation services at all, others receive supported employment services that are not organized or delivered according to best-practice standards. That is, they receive something called supported employment but not meeting the evidence-based standards defined above. Often, they receive vocational services from an agency or program that is separate from their clinical provider or program, with poor or non-existent coordination between the various parties. In other instances their career preferences and individual financial circumstances are not taken into account and they are offered generic job placements rather than ones tailored to their needs and career plans. In still other supported employment programs they are served by employment staff who have little or no knowledge of mental disorders, psychotropic medications and their side-effects, work-based stigma and discrimination specific to mental health conditions, and appropriate techniques for the assessment of work potential in this population. Often, so-called "ongoing" supports have an explicit or implicit time limit, after which the consumer is encouraged to "graduate" and terminated from contact. An additional problem is that State-Federal VR services are funded for time-limited periods and provide no payment mechanism for ongoing job support, other than a "post-employment services" status that is rarely used, and even less so for people with psychiatric disabilities. Similarly, most vocational rehabilitation services are not reimbursable under Medicaid, creating a funding vacuum that helps to account for the vast underserving of this population.

Services for Transition-Age Youth. A number of successful service delivery approaches have been designed to help young people with SED make the transition from high school to post-

secondary education and/or employment careers (Cook et al., 1997). Many of these approaches were identified in a national review of exemplary model programs for transition-age youth with emotional or behavioral difficulties (Clark, Unger & Stewart, 1993). These programs are built upon evidence-based principles that include early identification of emotional and behavioral difficulties and development of a individualized, coordinated service delivery plan with the parents and child at the center and active involvement of education, mental health, child welfare, and vocational rehabilitation systems (Fitzgibbon, Cook & Falcon, 2000). Other evidence-based practices include a place-then-train approach (Cook et al., 1997) in which youth work in socially integrated settings in the competitive labor market for at least minimum wage, with ongoing professional job support and natural support from employers and coworkers (Cook, Jonikas & Solomon, 1992). The importance of peer support also is acknowledged as a research-based principle that builds on the paramount importance of the peer group to transition age youth by offering valuable opportunities for positive role modeling and esteem enhancement (Farrell, 1992). The combination of vocational and supported education services is another evidence-based principle (Cook & Solomon, 1993) allowing youth to continue to work on their job skills while completing interrupted educations or acquiring college degrees necessary for career building.

As with adults, however, most youth with SED do not receive the types of transition services they need and the services they do receive seldom conform to best-practice standards. Studies continually find that these young people have lower rates of employment and productive activity than youth with other types of disabilities and challenges (Carson, Sitlington & Frank, 1995). Numerous reports have documented a lack of coordination between the various systems mandated to serve these children, as well as a concomitant lack of coordination between the

youth and adult services sectors (Vander Stoep, Davis & Collins, 2000). Often youth experience a discontinuity or even a cessation of vocational services as they "age out" of the child serving sector, since vocational rehabilitation systems tend to focus on adults and have a poor track record of serving young adults with disabilities (Bellamy et al., 1985). Young people and their families often find that there is nowhere to turn for the help they need.

Policy Options to Address Employment and Income Support Problems

This section presents courses of action that could potentially be taken by the government to address the aforementioned problems with employment and income supports, thus enhancing provision of innovative services and removing barriers and obstacles. Some of the policy recommendations apply to all (or almost all) federal agencies serving individuals with mental disorders, while others are specific to particular agencies.

Recommendations Across Agencies/Federal Programs

1. All cabinet level departments currently coordinating Olmstead implementation activities should include in those activities a focus on employment services and supports for individuals with severe mental illness, consistent with those recommended in the Olmstead Report.
2. The administration should develop and Congress enact legislation to increase the federal share of Medicaid funds for those states that implement TWWIIA-based reforms in their Medicaid systems and achieve predetermined levels of return-to-work and job retention among TWWIIA participants with psychiatric disabilities. Such efforts should include states with Medicaid Buy-In programs constructed under the Balanced Budget Act (BBA) of 1997.
3. As TWWIIA is implemented nationally, the administration should be prepared to address "creaming" (i.e., recruiting efforts or selection criteria favoring people with relatively less significant disabilities or few specialized service needs) which has the potential to result in

underserving people with psychiatric disabilities, by implementing or recommending to Congress such reforms as are necessary to remedy this situation. To this end, the SSI Adequacy of Incentives Demonstration (i.e., the federal study of potential "creaming" in TWWIIA) should include adequate study sample representation of Ticket holders with psychiatric disabilities, and targeted data analyses of potential effects on this group.

4. The administration should review and consider progress made by and initiatives recommended by the previous administration's Presidential Task Force on Employment of Adults with Disabilities.

7. The administration should promote and encourage interagency initiatives and demonstration projects designed to eliminate employment barriers and increase employment opportunities for people with psychiatric disabilities.

8. All federal agencies conducting employment-related projects should track the number of people with mental disorders that are served, along with their employment status. Such tracking should be specific to those with mental illnesses and not combine these disorders with developmental disabilities (such as mental retardation), cognitive disabilities, substance abuse, etc.

9. Rates of individuals with mental disorders served by all federal disability-related programs should be reported along with their employment outcomes, and compared to rates and employment outcomes of individuals with other types of disabilities.

10. For the next five years, every federal agency serving individuals with mental disorders, and all employment-focused disability programs, should be required to issue an annual report about this sub-group of service recipients (i.e., people with mental disorders and/or psychiatric disabilities) and how they fare in the various programs administered by these agencies.

11. All federal agencies (including DOL, SSA, USDOE [RSA & ED], and CMS) should be required to begin a data-sharing and matching initiative to learn more about employment trends of people with psychiatric disabilities and how these impact and are impacted by receipt of disability income supports. Such an initiative should include state-of-the-art access and usage safeguards to protect mental health service consumers' privacy and confidentiality, yet enable researchers to conduct sufficiently comprehensive analyses to address complex, multi-system policy questions.

12. All federal disability programs (including State-Federal VR, Department of Labor One-Stops, TWWIIA Benefits Planning and Outreach Centers, the TWWIIA ticket program) should be required or have as a goal, to achieve representation of individuals with mental disorders proportionate to their current representation on SSA's SSI disability rolls (36% as of 12/01).

13. In the Re-authorization of the Rehabilitation Act, Congress should expand eligibility for benefits now limited solely to TWWIIA Ticket holders, to include Benefits Planning, Assistance, and Outreach (BPAO) services, Work Incentives protection and advocacy (P&A) services, and services from SSA Employment Supports representatives (ESRs). This could be done by expanding BPAO provisions (as proposed in H.R. 4070) to include employment rights protection and career-oriented financial planning, expanding TWWIIA P&A access, and/or by expanding the role of the ESRs.

Federal Agency/Program Specific Recommendations

Social Security Administration

1. Given its decision not to conduct a national demonstration of SSDI "cash cliff" removal (i.e., the \$1-for-\$2 demonstration), SSA should move forward with all expediency to implement the state by state demonstrations it has proposed instead. The large proportional representation of

people with psychiatric disabilities on SSDI means that many with this disability are faced with the potential loss of as much as \$1200 per month in SSDI dollars. Since the "cash cliff" is one of the most serious work disincentives for people with psychiatric disabilities, SSA should make the roll-out of these demonstrations a top priority for 2003.

2. SSA should revise the provider payment structure of TWWIA in accordance with recommendations made by labor force economists (Rupp & Bell, forthcoming) to allow the Ticket provider payment incentive structure to more closely mirror research-documented labor force participation patterns of people with psychiatric disabilities.
3. SSA should reconsider the classification of psychiatric disabilities as those falling into the "Medical Improvement Expected" category, which under current TWWIA rules requires those with psychiatric disabilities to undergo a disability determination review before becoming eligible for a ticket.
4. At least three experts on psychiatric disability (including but not limited to mental health consumers) should be included on the SSA Work Incentives Advisory Panel, in proportion to their representation in the SSA working-age population.
5. Consideration should be given to granting individuals with severe mental illness a life-time eligibility for easy re-entry to SSI/SSDI in recognition of the well-documented unpredictable course of major mental disorders.
6. In line with SSA's "Vision's 2010" long-range plan, the agency's existing web-based, automated system (SSA On-Line) should be expanded to allow beneficiaries to report changes in employment and earnings in a manner that "immediately" alters their next monthly payment, in order to prevent SSA overpayments and the need for consumers to repay them.
7. As part of TWWIA implementation, a Report Card system for Employment Networks (ENs)

should be established through the work of a multi-stakeholder task force including consumers, families, providers, and state agency personnel. The purpose of the Report Card will be to enable TWWIIA ticket holders to judge an EN's effectiveness, defined as the number and proportion of clients with psychiatric disabilities served by each EN, along with the employment outcomes achieved for this group of clientele, compared to outcomes achieved by the EN clients with other types of disabilities.

Centers for Medicare and Medicaid Services

1. Extend the Medicaid buy-in (both the TWWIIA-Buy-Ins and the BBA Buy-Ins) for which TWWIIA ticket holders and others in selected BBA Buy-In states are now eligible to all individuals with psychiatric disabilities who exit the SSI/SSDI rolls due to employment.
2. Expand the availability of funding for psychiatric rehabilitation services, to mirror the availability of funding for rehabilitation services that already are covered under Medicaid for individuals with physical and cognitive disorders. Encourage states to use already-existing flexibility in including evidence-based psychiatric rehabilitation services in Medicaid state plans.
3. CMS should encourage Home and Community Based Services (HCBS) Waiver Program submissions that would study and evaluate home and community based waiver services provided to employed people with psychiatric disabilities. Early intervention should be conceptualized to include both clinical care and psychosocial supports related to employment, job retention, and swift return to work. CMS should solicit Independence Plus Waiver Initiatives from states aimed at demonstrating the effectiveness of providing HCB waiver services (including evidence-based supported employment services) to employed persons with severe mental illnesses.
4. Alter medical necessity restrictions that currently limit Medicaid reimbursement for rehabilitation services to individuals with psychiatric disabilities.

5. Expand Medicaid coverage for services beyond the acute stages of mental illness.
6. Since Medicaid covers day treatment, which has proven inferior to supported employment in promoting mental health consumer employment, change standards for day treatment to include evidence-based supported employment services.
7. CMS should prioritize development of clear and comprehensive guidance on the Medical Improvement Group (MIG) of the TWWIIA Medicaid Buy-In options. Designed to provide Medicaid coverage to individuals who, because of therapies and medications, etc., no longer meet the disability test but continue to have "a severe medically determinable impairment," absence of such guidance from CMS has limited state selection and use of this option which now applies to many individuals with severe mental illnesses.
8. CMS should establish a special initiative on the organization and delivery of personal assistance services (PAS) or PAS-type services to individuals with mental illnesses who are working or attempting to return to work.
9. Given the potential of Section 1619(b) work incentive (which provides for continued access to Medicaid following cessation of SSI cash benefits), CMS and SSA should launch a national campaign to expand states' use of this powerful incentive. Such an initiative should address previously-identified barriers to use of Section 1619(b) (such as the need for communication and coordination between SSA and state Medicaid agencies reduction of burden from dual application processes, and education of former SSI recipients about their continued Medicaid eligibility). This initiative should be designed to improve SSA and Medicaid agency communication, as well as promote education and outreach to consumers, families, VR counselors, and community rehabilitation programs.

Department of Labor

1. In recognition of the role of mental disorders as the leading cause of disability worldwide, the newly created Office of Disability Employment Policy (ODEP) should highly prioritize psychiatric disabilities in all of its activities, policy development, and programs, and should closely coordinate its efforts with other DOL efforts that address psychiatric disability as well as with outside agencies' (e.g., RSA, SSA, SAMHSA, CMHS, CMS, HHS) activities for people with mental disorders.
2. Working with the Bureau of Labor Statistics (BLS), ODEP and BLS should develop a valid and reliable system to track the employment status of Americans with mental illnesses at least annually. Such tracking should be specific to those with mental illnesses and not combine these disorders with developmental disabilities (such as mental retardation), cognitive disabilities, substance abuse, etc.
3. One-Stop Career Centers established through the Workforce Investment Act (WIA) of 1998 should be surveyed to determine the proportion of clients served who have psychiatric disabilities as well as the outcomes of these individuals. DOL, with ODEP in the lead, should work with other agencies to increase One-Stop Center physical and program access and services for people with psychiatric disabilities, including those transitioning to the community from institutions or those at risk of placement in residential facilities. ODEP should pursue regulatory changes that ensure collaboration between these Centers and the VR system through formalized agreements.
4. ODEP should ensure that psychiatric disability is addressed with appropriate consumer representation and best-practice employment models in its WorkFORCE Coordinating Grants and Action Grants. Two types of grants have been awarded under this program for the Olmstead-covered populations: one to assist states to coordinate the delivery of necessary

employment-related services (Coordinating Grants) and the second to demonstrate how these services can be delivered (Action Grants). These grants are to be awarded to states that (a) develop in their Olmstead Plans an employment focus and activities to promote employment for persons with disabilities, and (b) coordinate employment and related supports at the state and local levels.

5. ODEP should work with other DOL agencies and the U.S. Department of Education on activities that promote the transition of youth with SED from school to post-secondary opportunities and/or employment. This should include researching, demonstrating, and disseminating successful strategies for transitioning young adults with SED into employment, and initiation of policy actions and regulatory changes ensuring that such strategies are utilized within DOL activities and programs.

6. For individuals at risk of institutionalization or segregation in restricted environments, as well as those transitioning from institutions to their communities, ODEP should expand self-employment, small business, micro-enterprise development, and other entrepreneurial opportunities for people with psychiatric disabilities.

7. Demonstration grants and research focused on people with psychiatric disabilities should be funded to link One-Stops Centers to mental health consumer and provider groups.

8. Demonstration grants and research focused on people with psychiatric disabilities should use ITAs to focus on training, support, and accommodations for people with psychiatric disabilities, using "customized employment" strategies to help unemployed and underemployed people with psychiatric disabilities achieve competitive employment that is based on individual choice, provides increased earnings, benefits and career development, and uses technology to promote employment.

9. People with psychiatric disabilities should be prioritized in ODEP's new and existing grant initiatives, including Customized Employment Innovative Demonstration Grants for Youth with Disabilities, Telework/Telecommuting, Technical Assistance for Providers, and Grassroots Community Action.
10. ODEP should conduct "listening sessions" with stakeholders that include people with psychiatric disabilities (e.g., CMHS-funded Consumer Technical Assistance Centers and Consumer Supporter Centers), advocacy organizations (e.g., NAMI, NMHA, Bazelon Center for Mental Health Law), and providers (e.g., International Association of Psychosocial Rehabilitation Services) in the mental health services area.
11. ODEP should expand funding of its Customized Employment, Innovative Demonstration Grants for Youth, and Olmstead Initiatives prioritized for people with psychiatric disabilities.

Department of Commerce

1. Improve psychiatric disability related data collected in all Bureau of the Census (BOC)-sponsored surveys, especially the Current Population Survey, through addition of questions allowing identification of respondents with mental disorders. Such identification should be specific to those with mental illnesses and not combine these disorders with developmental disabilities (such as mental retardation), cognitive disabilities, substance abuse, etc.

U.S. Department of Education, RSA

1. OSERS should continue to enforce the new VR regulation that eliminates extended employment (i.e., sheltered workshops) as a final employment outcome under the State Vocational Rehabilitation Services Program, so that an employment outcome may only be counted if an individual with a disability (including a psychiatric disability) is working in an integrated setting in the community.

2. Given evidence that ongoing employment supports are often needed to ensure job retention of individuals with psychiatric disabilities, current policies and practices regarding case closure and re-opening should be reexamined. Especially important is the RSA "Post-Employment Services" category authorizing the re-opening of cases previously closed "status 26" for provision of services to obtain or maintain employment. Post-employment services should be provided with greater frequency and to a higher percentage of individuals with psychiatric disabilities who experience job loss as a result of the worsening of their disorders, economic downturns in the labor market, and for other reasons.
3. Given evidence of the low educational attainment of many individuals with psychiatric disabilities, Federal-State VR planning should make greater use of post-secondary education services for those with psychiatric disabilities in college, university, and vocational/trade school settings. Such efforts should include evidence-based practices such as supported education models and approaches that have been specially designed for students with psychiatric disabilities.
4. All VR counselors should receive training on the recently revised (2002) RSA disability classification system (including new codes for individuals with psychiatric disabilities).
5. In all instances where Federal-State VR agencies serve as ENs under TWWIIA, they should participate in a Report Card system for Employment Networks by reporting the number and proportion of Ticket holders with psychiatric disabilities served, the employment outcomes achieved for this clientele, and comparing these to EN clients with other types of disabilities.
6. A limited number of demonstration projects should be funded to determine the efficacy of performance-based contracting between State VR agencies and the community employment service providers with whom they contract, especially for services to mental health consumers.

7. Federal-State VR funding of services for clients with psychiatric disabilities should be restricted to only those community providers using evidence-based, supported employment models developed specifically for people with severe mental illnesses.

U.S. Department of Education, Special Education

1. OSERS should institute a limited number of demonstration programs to address problems with and ameliorate the low high school completion rate of youth with emotional disturbance (ED). These should include demonstration projects that fully involve parents and other family members and include placement of mental health professionals within schools, especially those with high drop-out rates and high rates of failing grades among students with ED.
2. Given the legislative mandate of the Individuals with Disability Education Act (IDEA), requiring local State Departments of Education to ensure that schools develop and carry out Individualized Transition Plans for all special education students, USDOE should require States to report the number and proportion of children with ED served, document the rate of compliance with IDEA's transition planning requirements, and report the transition outcomes of all special education students with ED on an annual basis.
3. In recognition of the critical importance of parents and other family members in the development and implementation of successful ITPs, USDOE should require States to assess and report the level of parent involvement in and satisfaction with their child's transition planning, implementation, and outcomes for all special education students with SD on an annual basis.
4. OSERS should initiate a series of demonstration programs designed to evaluate the integration into special education curricula of evidence-based, best-practices for transitioning students with ED into post-secondary education and career-building employment.
5. Small demonstration grants should be established to link community colleges and universities

with State multi-stakeholder networks of providers described in the SAMHSA recommendation regarding its Youth Systems of Care mandate.

6. OSERS should encourage post-secondary educational institutions to adopt policies allowing "dual enrollment," so that students with ED can simultaneously earn their high school diplomas at the same time they complete work toward earning their associate's degrees.

General Accounting Office

1. In accordance with Section 303 of TWWIIA, the GAO is launching a study of tax incentives designed to enhance the employment of persons with disabilities, in order to determine which of these are outdated and in need of modification. Some incentive programs, such as the work opportunity tax credit (WOTC), are unnecessarily restrictive (e.g., the WOTC is available only to those who have received SSI, but not SSDI, within the past two months) or apply to a very limited population (e.g., the WOTC applies only to those who have completed a federal-State VR program). The GAO study should address the manner in which the design of these tax incentives impacts on their use and effectiveness for individuals with psychiatric disabilities.

Health and Human Services

1. HHS should propose statutory improvements to create a ten-year Home and Community-Based Services demonstration as an alternative to Medicaid-funded psychiatric residential treatment centers. This demonstration should be designed to allow States to set up home and community-based alternatives to placement of children with SED into psychiatric residential treatment facilities. Such alternatives should be designed to promote the transition-to-work of youth with SED.

2. HHS should issue non-discriminatory guidance for the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) that unequivocally protects the rights of TANF

recipients with mental disorders, given that studies of adult recipients have revealed a prevalence rate of DSM-IV disorders in TANF populations of 20%-30%.

3. HHS and OPM should create a federal interagency, cross committee Mental Health and Substance Treatment Work Group (with representation from each of the 18 member agencies) in order to evaluate and monitor implementation of parity for mental health coverage in the federal Employees Health Benefits Plan (FEHB).

Substance Abuse and Mental Health Services Administration

1. In line with its mandate to provide support and technical assistance to state mental health authorities, SAMHSA's Center for Mental Health Services (CMHS) should provide grants for each State to establish interagency coordination directed specifically at improving the employment rate of its citizens with psychiatric disabilities. Links should be made between state or county mental health authorities and Welfare-to-Work, Department of Labor One-Stop Centers, State-Federal Vocational Rehabilitation authorities, Workforce Investment Boards, Business Leadership Networks, SSA BPAO programs and TWWIA providers, State Medicaid Offices, and others.

2. As part of its children's mental health System of Care initiative, CMHS should direct additional funding to its Youth Transition program, to help youth with SED make the transition to employment, postsecondary education, and independent living. The relatively modest funding level of this program should be expanded, and increased collaboration with USDOE, SSA, and CMS should be fostered.

3. An initiative to encourage further development of entrepreneurial models of vocational rehabilitation should be encouraged, based on feedback from mental health consumers confirming both the effectiveness and a high level of demand for this type of service, including

small business initiatives, self-employment, consumer-run businesses, and micro-enterprises. This initiative should include grants to develop, establish, and formally evaluate the effectiveness of such initiatives.

4. TWWIIA Community Mental Health Participation Incentive Grants should be provided to encourage community-based mental health organizations with VR expertise to participate as TWWIIA EN providers. Given their lack of ready capital for start-up costs associated with Ticket participation, these agencies report being unable to afford the upfront costs associated with operating Ticket programs for mental health consumers. This is due to the relatively slower pace of entry into the labor force and achievement of SGA-level employment among mental health consumers, as demonstrated in the EIDP. This would also enhance the likelihood of use of evidence-based practices for Ticket holders with psychiatric disabilities.

5. Given that employment status data are collected as part of the SAMHSA National Household Survey on Drug Abuse, which currently includes a limited number of mental disorders (e.g., depression, generalized anxiety disorder, agoraphobia, panic disorder), the survey's target population should be expanded to include all mental disorders, with such expansion overseen by CMHS.

6. As part of its children's mental health System of Care initiative, CMHS should fund and evaluate a series of pilot projects designed to ameliorate the deleterious effects of caring for children with SED on the labor force participation of parents.

Office of Personnel Management

1. The Office of Personnel Management (OPM) should revise its Employment Guide for People with Disabilities in the Federal Government to incorporate regulatory changes that allow individuals with psychiatric disabilities to become permanent federal employees.

2. OPM should report to Congress and the public on the results of two federal government programs designed to broaden employment opportunities for people with psychiatric disabilities.

The first is a government-wide excepted appointing authority for people with psychiatric disabilities which provides them with opportunities already available to people with mental retardation or significant physical disabilities. The second is the Olmstead Report measures to increase employment opportunities in the federal government and create uniformity in provisions applicable to people with psychiatric and physical disabilities.

3. OPM should assess and report to Congress and the public the level of awareness of personnel officers in the federal government of issues related to reasonable accommodations for federal workers with psychiatric disabilities. OPM also should conduct a campaign to disseminate widely to federal employers information about hiring, retaining, and working with individuals with psychiatric disabilities.

Equal Employment Opportunity Commission

1. The EEOC should commission a rigorously designed evaluation study of the validity and reliability of its current three-tier classification of ADA and other employment discrimination complaints, and make any adjustments determined to be necessary as a result of the evaluation findings.

2. The EEOC should provide training to all field investigators regarding the frequency and types of employment discrimination experienced by workers with psychiatric disabilities, as well as reasonable accommodations appropriate for workers with mental disorders.

Centers for Disease Control and Prevention

1. The National Health Interview Survey (NHIS), a national household probability survey conducted by the Bureau of the Census under the mandate of the National Center for Health

Statistics of CDC, should include, on a regular basis, a topical module on disability similar to the Disability Supplement last conducted in the 1994-5 NHIS. This module should define respondents with psychiatric disabilities separately from those with developmental disabilities (such as mental retardation), cognitive disabilities, substance abuse, etc. Consideration should be given to including disability and employment questions (allowing separate analysis of respondents with psychiatric disabilities) as part of the basic module of the NHIS.

Business Community

1. Representatives of high-growth industries, in partnership with federal agencies (such as Departments of Labor, Education, Health and Human Services, and Commerce) should develop a coordinated, nationwide plan for increasing participation of individuals with psychiatric disabilities in high-growth industries and expanding sectors of the economy.
2. Nationwide, local Chambers of Commerce and community Business Councils should become involved in education and outreach campaigns to inform employers about the untapped human resource potential of individuals with mental disorders as dependable, productive workers.
3. Initiatives should be encouraged among private sector, small business associations and organizations to assist people with psychiatric disabilities in developing self-employment, small businesses, micro-enterprises, and other entrepreneurial opportunities.
4. Based on the demonstrated efficacy of a model tested in the federal multi-site EIDP study, a pilot program should be launched to establish "Employer Consortia" composed of local businesses and not-for-profit employers with the intention of encouraging the hiring, retention, and promotion of workers with psychiatric disabilities. This initiative should be coordinated by CMHS-SAMHSA with the participation of DOL and SSA.

5. The nature and outcomes of activities to increase the employment of individuals with disabilities conducted by the U.S. Chamber of Commerce and the Society for Human Resource Management should be examined for their potential targeting to individuals with psychiatric disabilities.
6. The feasibility of public-private initiatives involving the AFL-CIO to hire and retain workers with psychiatric disabilities should be explored.
7. Opportunities for public-private initiatives to promote the employment of individuals with psychiatric disabilities involving the Business Roundtable should be examined.

Other Private Sector Entities

1. Collaboration at the federal level should be encouraged with private sector mental health and advocacy organizations that are currently operating employment initiatives (e.g., the National Alliance for the Mentally Ill, the National Mental Health Association, the Bazelon Center for Mental Health Law, National Organization on Disability) as well as trade organizations with such initiatives (e.g., the International Association for Psychosocial Rehabilitation Services, Association for Persons in Supported Employment, American Psychological and Psychiatric Associations).

Overarching Policy Recommendations

We recommend the creation of a National Leadership Initiative on Employment for Youth and Adults with Mental Health Disabilities involving all levels of government, provider and professional associations, consumers, and the private sector.

- This would include a Business Roundtable on Employment, which would focus on creating opportunities and developing accommodations for this segment of the labor force.

- Also needed is a Federal-State Interagency Collaboration to reduce fragmentation and enhance service penetration into diverse groups of mental health service consumers.

The Business Roundtable would involve the business community, in partnership with local agencies (such as schools, rehabilitation programs, self help organizations, mental health service providers, and others) and with the support of relevant federal agencies (such as DOL, HHS, Commerce, USDOE, CMHS-SAMHSA, and others) should develop a coordinated, national plan for increasing participation of individuals with psychiatric disabilities in high-growth industries and expanding sectors of the economy.

A Federal-State inter-agency initiative, led by SAMHSA, should involve all federal agencies charged with addressing mental health, employment, and/or disability issues engaged in a collaborative effort to inventory and assess existing federal programs. Procedures to enhance the efficiency and effectiveness of these programs for people with mental health disabilities should be formulated and implemented. This should include educating multiple stakeholders about under-utilized programs in an effort to enhance enrollment, elimination of unnecessarily restrictive eligibility requirements to extend services to a broader population in need, and greater levels of inter-agency coordination in the administration of similar programs.

Potential Implementation Issues of Policy Recommendations

This section will deal with ease of implementation, barriers and solutions, and changes in federal, state, or local legislation, rules and regulations required for implementation. Also discussed will be the primary stakeholders involved in implementation, although it should be noted that individual stakeholders associated with specific recommendations are named above, along with each recommendation.

Cost Neutrality of Proposed Policy options. With few exceptions, many of these

recommendations would be low-cost or no-cost (i.e., budget neutral) in nature. Many involve minimal additional financial outlays or reallocation of existing budgetary funds. The cost-neutrality of these proposals also may be enhanced to the extent that duplication of effort is reduced through interagency coordination and elimination of overlapping programs.

Stakeholders Involved in Implementation. These policy recommendations make significant demands on staff time and resources, and require tremendous planning, coordination and administrative time investments on the part of the agencies involved. The primary stakeholders involved in implementation of these recommendations include the administration, Congress, federal agencies, state agencies, the private-sector business and nonprofit employer community, the mental health consumer community and consumer supporter organizations, the mental health and rehabilitation advocacy communities, and mental health and rehabilitation service providers.

Changes in Legislation and Regulations. Regarding legislative changes required by the recommended policy options, in most cases, the necessity of enacting new federal, state, or local legislation is yet to be seen. In some cases this need will depend on future developments such as how effectively and how equitably existing legislation is being enacted (ADA, TWWIA, WIA), what evaluations discover about how people with mental disorders fare under these laws, and other competing legislative imperatives on which attention must be focused. Certainly, a host of changes in rules and regulations would be required to implement the proposed policy options, considering that many of the options involve reviewing and sorting out a number and variety of federal programs to encourage employment among people with disabilities, and studying their use by this population. In the ideal, unnecessarily restrictive and conflicting rules and regulations would be identified, evaluated, streamlined, updated, and in some cases eliminated,

in favor of other approaches such as blended funding through interagency financial transfers, expanded eligibility, and combination of similar programs across departments and agencies.

Conclusion

It is essential to consider the occupational context within which job training and placement will be occurring over the coming decades. Labor market projections and trends indicate that both population growth and labor force participation are expected to continue increasing in the early decades of the 21st century. Between 2000 and 2010 it is estimated that the labor force will increase by 12% to a total of 158 million U.S. citizens (Fullerton & Toossi, 2001), and contain a greater proportion of women and Hispanics than the current workforce. Total employment is expected to increase by 22.2 million jobs over the years 2000-2010, and 35.8 million job openings will result from replacement needs (Hecker, 2001). The growth rate of occupations is fastest among those requiring an Associate's Degree (A.A.) or more advanced education. The occupations with the largest job growth are expected to be retail trade, business services (including computer-related), health services, and public and private education (including health care providers, teacher aides, teachers and professors). Also, the self-employed are expected to increase by almost 15%, including a 10% increase projected for self-employed professional and related occupations (Hecker, 2001). This last projection has particular relevance for the development of VR models that promote self employment among people with disabilities (Arnold & Seekins, 1994; Arnold, Seekins & Raveslout, 1995).

Numerous research studies have indicated that individuals with serious mental disorders want to work and consider themselves able to work, although most feel that they need training, services, and supports. Opinion surveys repeatedly find that the majority of mental health service consumers say that they desire paid employment, and want to receive vocational

rehabilitation services and supports (Rogers et al., 1991; Campbell, Schraiber & ten Tusser, 1989). In a national household probability survey, half of all working-age adults with mental health disorders considered themselves able to work if supported adequately (NHIS-D, 1994-1995).

Given these developments, the stage is now set for recommendations from the President's New Freedom Commission on Mental Health. Key to the likelihood of change will be the willingness and ability of the federal government to take the lead in two major efforts. The first involves identifying, evaluating, and reforming a multiplicity of sometimes duplicative and often unnecessarily restrictive disability and employment policies and programs. The second consists of forging collaborative relationships between multi-stakeholder federal agencies and their state partners, mental health service consumers and their supporters, employer and business communities, service provider communities and related trade associations, and advocates as well as watchdog agencies. However, the challenges inherent in such an undertaking are more than outweighed by the potential for a more productive, more diverse, better prepared, and more highly motivated and supported workforce. The enhancement of our country's economy and its human capital that could result from such an undertaking can benefit all American citizens, not just those with psychiatric disabilities.

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