Introduction

Supported employment typically is used to help people with severe mental illness and disabilities obtain and retain jobs, but could this model be expanded to new populations? Could supported employment be adapted to help people with common mental disorders that do not qualify as disabilities? Could new strategies help reach the most vulnerable groups affected by health disparities?

The Centers for Medicare & Medicaid Services (CMS) recently allowed states to enact work and community engagement requirements for certain Medicaid beneficiaries, which has put an emphasis on the value of work. These new requirements are designed to improve health and well-being by helping beneficiaries achieve economic self-sufficiency. While these work requirements do not apply to disabled individuals, they may affect people with common mental health conditions who do not meet Medicaid’s disabled criteria or who have not applied for disability status. As states contemplate potential employment benefits for these populations, they may be interested in new, effective models that help individuals achieve the goals and benefits of employment.

Working in partnership with the Massachusetts General Hospital (Mass General) Disparities Research Unit, the National Academy for State Health Policy (NASHP) conducted a focus group and interviewed key state health officials in five states to explore how these states’ supported employment programs could address racial and ethnic inequities in mental health treatment and outcomes. They also explored strategies to meet the needs of those with common mental health concerns, as well as people with serious mental illnesses. This brief examines whether states could apply supported employment strategies to other subpopulations, including those who do not qualify as disabled, in order to reach the most vulnerable populations and close treatment disparities.
Background

People with mental illness generally die 10 years earlier than those without mental illness, and in the United States, people with serious mental illness die 25 years earlier. Mental illness is the leading cause of disability in the United States, and a variety of state and federal initiatives are spearheading efforts to address the impact of mental illness on health and well-being and reduce its associated costs. The CMS Medicaid Innovation Accelerator Program (IAP) and the Substance Abuse and Mental Health Services Administration (SAMSHA)-supported behavioral health homes initiative support states that are working to improve care for Medicaid beneficiaries with complex care needs and high costs, promoting community support structures, and integrating primary care and behavioral health care. Despite these varied investments in health care services, there is an outstanding need to improve the quality of programs that support people with mental health diagnoses.

One Solution: Supported Employment

Addressing health-related social needs, such as employment, income, educational attainment, and housing, can improve mental health and, in some cases, result in cost savings. Supported employment is an effective, evidence-based approach to employment for people living with mental illness and other severe disabilities who might not otherwise be able to obtain and retain real jobs. Supported employment services can include:

- Assistance with locating and obtaining a job;
- Coaching on job duties;
- Supporting job retention;
- Benefits counseling; and
- Other forms of support that generate a successful employment experience.

Individual Placement and Support (IPS) is an evidence-based practice model of supported employment used for people with serious mental illness. IPS programs provide individualized supports that help individuals find jobs in the community that are aligned with their preferences, and these support services are not time-limited. Research has shown that the IPS model can provide therapeutic benefits for individuals with serious mental illnesses, in addition to addressing economic and community inclusion goals.

While supported employment is an effective approach for individuals with mental illness, services are typically targeted to people with serious mental illnesses and other significant disabilities. State officials explored whether this model could be expanded or adapted to serve new subpopulations, such as those with more common mental disorders who do not qualify as disabled. Or, could they serve racial and ethnic minorities who experience a lower prevalence of mental illness than whites, but whose symptoms are more likely to go untreated, leading to possibly more severe and chronic outcomes. This is especially true for African-American and Latino/Hispanic populations. Is it possible to identify gaps in the availability or use of supported employment to address these disparities?

Focus Group with Leading States

NASHP and Mass General conducted a focus group and interviews with key state health officials from Connecticut, Oklahoma, Tennessee, Utah, and Washington State to discuss supported employment strategies. The officials represented departments of health services, Medicaid agencies, substance abuse and mental health, and social service agencies. NASHP looked for examples of how states used supported employment programs to address racial and ethnic inequities in mental health outcomes and service utilization. Policymakers explored opportunities to meet the needs of those with common mental health concerns as well as people with serious mental illnesses.
Financing Strategies

In order to provide supported employment programs and related services, state officials draw on and coordinate a variety of state and federal programs, resources, and services across multiple funding streams and systems, including vocational rehabilitation and Medicaid agencies and mental health authorities. Vocational rehabilitation has been a major source of funding for states’ supported employment programs. Some states, such as Maryland, braid funding -- vocational rehabilitation funds employment supports and Medicaid and mental health funds complementary supports. Tennessee, for example, has an interagency agreement between its departments of Mental Health and Substance Abuse Services and Human Services to fund IPS Supported Employment Programs across the state.

States may use grants to fund supported employment programs. Connecticut, Utah, and Washington State use non-competitive Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Block Grants (MHBG) that fund substance abuse and mental health services for their supported employment programs.\(^1\) SAMHSA requires states to set aside 10 percent of the grant for evidence-based practices for early interventions to address early serious mental illness.\(^1\) Utah uses its 10 percent set-aside to contract with four mental health authorities to deliver the First Episode Psychosis program, which provides IPS as an evidence-based supported employment intervention for those recently diagnosed with an early psychotic episode.\(^1\) Connecticut’s Social Innovation Fund (SIF) grant is examining its return on investment for services that include housing subsidies and employment supports.\(^2\)

State Medicaid programs ordinarily cannot pay for vocational or educational services due to a requirement that allows these programs to pay for services only when other funding sources are not available.\(^3\) However, states have identified ways to fund some employment supports under their state plans and finance vocational services under their Medicaid waivers. The state plan rehabilitation option allows states to support employment-related mental health treatment and support services, such as mental health assessment and counseling, medication management, case management, and other mental health services. Waivers, including 1915(i), 1915(b), 1915(c), and 1115, can cover the above as well as supported employment services such as vocational skills assessment and job development, placement, and coaching.\(^4\) Oklahoma uses a 1915(c) waiver to provide job development skills training to help Medicaid beneficiaries maintain integrated employment. Utah has a 1915(b)(3) Non-Medicaid Services Waiver that uses cost savings to pay for psychoeducational assistance for beneficiaries. These psychoeducational services make up most of the state’s supported employment services.\(^5\) Washington State also uses its 1115 waiver to create new targeted benefits to assist the most vulnerable beneficiaries to obtain and keep stable employment, in support of their broader health needs.\(^6\)

Addressing Racial and Ethnic Disparities

Racial and ethnic disparities occur across a variety of health services and programs, and supported employment is no different. Some states currently leverage supported employment to address racial and ethnic disparities in mental health outcomes and service utilization. The Connecticut Department of Mental Health and Addiction Services used its SAMHSA Transforming Lives through Supported Employment Program grant to better serve its Hispanic community.\(^7\) Recognizing its lack of bilingual staff, the department partnered with a community organization, the Hispanic Health Council, and a local mental health authority to expand IPS supported employment. Similarly, the Utah Division of Substance Abuse and Mental Health (DSAMH) collaborates with

“If we pay more attention to the whole-person, [then] housing and employment is part of that. Without those supports, people remain isolated and are at risk for substance use, which has a long-term impact on behavioral and overall health.”

- State official
Latino Behavioral Health, a peer-run organization, to offer IPS training and resources at its annual Peer Support Conference. DSAMH’s Supported Employment IPS (SE/IPS) program has partnered with the Hispanic Chamber of Commerce to provide SE/IPS resources to Hispanic communities. The DSAMH also works to reach Native American communities through rural and frontier local mental health authorities that offer IPS services.

Other states have identified opportunities to address racial and ethnic disparities in mental health outcomes and service utilization. For example, Washington State is using its 1115 waiver to strengthen collaborations with, and develop resources and training opportunities for, Native American and Alaskan Native provider networks. Washington State also examined demographic data from its Supported Employment Pilot, which was designed to support its Temporary Assistance for Needy Families (TANF) population, to better understand the needs of its diverse populations.

During interviews, policymakers discussed data collection requirements associated with their respective supported employment programs. States regularly collect and report supported employment data to Medicaid agencies and mental health and vocational rehabilitation systems. States also report this data to federal agencies as part of waiver (CMS) or grant program (SAMHSA) requirements. Measures can include the number of people served, demographic information, employment outcomes, and the competitive nature of employment, among others. Policymakers shared that despite collecting supported employment demographic information, they did not look for racial and socioeconomic disparities, although Utah, as part of its SAMHSA grant requirement, tracked racial and ethnic mental health outcomes and service utilization disparities.

**Barriers Policymakers Face**

Policymakers often cited cost and sustainability as barriers to supported employment expansion. However, they reported they develop inter-agency partnerships to sustain supported employment services. For example, Utah’s Division of Substance Abuse and Mental Health vocational rehabilitation counselors received vocational rehabilitation training and an Association of Community Rehabilitation Educator certification, a state-mandated competency for employment support specialists. By doing this, the IP services provided by their staff became eligible for payment through vocational rehabilitation milestones, which will help sustain the state’s supported employment efforts after SAMHSA funding ends in 2019.

Eligibility requirements, funding, and sustainability challenges impede opportunities to expand supported employment to people with general mental health concerns. As policymakers work to lower health care costs, they have historically prioritized meeting the needs of those with serious mental illness over the needs of those with common mental health disorders. Some programs are designed only to serve individuals who qualify as disabled, and common mental concerns may not qualify for this coverage.

Many policymakers cited cultural barriers as obstacles to expanding supported employment efforts. Some identified a stigma that can prevent employers from hiring people with mental illness or substance use disorder needs, thus preventing organizations from developing resources for people to engage in meaningful employment, assist their communities, and strengthen skills for mental health resilience. Some states have addressed this stigma by educating the public through materials such as videos that showcase success stories and possible benefits for employers, such as increasing workforce diversity and companies’ commitment to social justice. Other policymakers expressed a desire to change the culture within state health agencies to better understand and advocate for the effectiveness of supported employment and to collect data that would substantiate its return on investment.
Conclusion

States use a variety of strategies to advance supported employment in their states. However, they face financing, data, and cultural barriers that may pose challenges as they work to expand the scope of services to support people with common mental health needs and reduce racial and ethnic disparities in mental health outcomes. Examining trends in supported employment data by race and ethnicity may identify opportunities to reduce health disparities and other barriers to care.

Untapped opportunities can include leveraging data that states are already collecting, and implementing performance-incentive payment mechanisms that can help to better serve racial and ethnic minorities. Some states incentivize their supported employment providers by paying for milestones, such as placing people in jobs and keeping them employed for a certain length of time -- rather than paying for services. States could consider the diversity of population served as another aspect of performance. States can partner with local mental health authorities to reach racial and ethnic minorities, develop and implement cultural competence training, and to ensure their programs are maximizing their impact.

Endnotes


16. For a detailed explanation of funding sources that can be used for various components of IPS, please see Table 1a. “Components of IPS and CE and Possible Medicaid Funding Sources” and Table 1b, “Components of IPS and CE and Possible Medicaid Funding Sources” here.


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