TASC Training & Advocacy Support Center

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FACT SHEET

The Value and Role of Work During Recovery From Mental Illness

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I. Introduction

Among adults living with mental illness, the unemployment rate is three to five times higher than the general population (National Alliance on Mental Health, 2010). Yet most individuals with mental illnesses want to work (Provencher, Gregg, Mead, & Mueser, 2002). Additionally, research studies show that even individuals with serious mental illness have the ability to successfully work, even after extended work interruptions (Russinova, Bloch, & Lyass, 2007), and that competitive employment has proven to be valuable to the mental illness recovery process.[1]

This Fact Sheet (1) provides information on evidence-based practice regarding work and its role in recovery; (2) reviews the literature to identify principles of supported employment that help facilitate positive employment experiences for individuals in recovery and reentry to work and community; and (3) seeks to inform and reinforce the practice and advocacy of Protection and Advocacy systems (P&As).

Definitions for 'work' and 'recovery' vary greatly across stakeholder groups. The definitions used in this paper are adapted primarily from federal legislation and emphasize inclusiveness and the importance of work in the recovery process. As used in this report:

- "Work" is competitive and enables the individual to earn at least minimum wage in an integrated work setting.[2] This definition of work does not include sheltered

[1] This Fact Sheet does not attempt to address the issue of whether competitive employment is appropriate for all individuals recovering from mental illness at every stage of recovery.

[2] The definition of work included in the Rehabilitation Act 7(35) – Supported Employment (Office of Law Revision Counsel of the House of Representatives, 2001, p. 4389) is as follows:

or other non-integrated or non-competitive employment;

- "Recovery" is holistic, focused on self-direction, and stresses the connections between recovery, work, and psychiatric rehabilitation;[3] and
- "Supported employment," is defined by the Centers for Medicare and Medicaid Services (CMS), as "assistance in obtaining and keeping competitive employment in an integrated setting."[4] .

The sections below provide background on federal legislation and current programs, examine the value of work and access to work opportunities, suggest best practices, and explore policy ideas that incorporate best practices. The final section proposes ways that P&As may advance supported employment for clients in recovery from mental illness.

(i) Competitive employment in integrated work settings; or
(ii) Employment in integrated work settings in which individuals are working toward competitive work; and,
(iii) Is consistent with the strengths, resources, priorities, concerns, abilities, capabilities, interests, and informed choice of the individuals.

[3] The Substance Abuse and Mental Health Services Administration (SAMHSA) delineates the new working definition of recovery as:
(i) The process of psychiatric rehabilitation "through which individuals improve their health and wellness,
(ii) live a self directed life; and
(iii) strive to reach their full potential. (2011, p.1)

For the purpose of this paper, work during recovery is further defined from language in the definition included in the Rehabilitation Act 7(35) – Supported Employment (Office of Law Revision Counsel of the House of Representatives, 2001, p. 4389):
"(ii) for whom competitive employment has not traditionally occurred; or for whom competitive employment has been interrupted or intermittent as a result of a significant disability…"

The following definition of "psychiatric rehabilitation" was adopted by the US Psychiatric Rehabilitation Board in 2007:

> Psychiatric Rehabilitation promotes recovery, full community integration and improved quality of life for persons who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Psychiatric rehabilitation services are collaborative, person directed and individualized. These services are an essential element of the health care and human services spectrum, and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.

[4] For definition and other CMS initiatives that promote employment, please visit: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Grant-Programs/Employment-Initiatives.html.

II. Background

Over the last 40 years, federal legislation, initiatives and appropriations have supported the choice of individuals in recovery from work-disrupting mental illnesses to work by mitigating traditional barriers including discrimination, loss of benefits, and inflexible work environments. Federal legislation seeking to remove many barriers to work and/or encourage employment includes:

- 1973 - Section 504 of the Rehabilitation Act of 1973, the first legislative breakthrough, makes it illegal for public entities and those receiving federal funding to discriminate against individuals with disabilities.
- 1986 - The Rehabilitation Act Amendments of 1986 includes supported employment to assist persons with the most significant disabilities to achieve and retain competitive employment.
- 1990 – The Americans with Disabilities Act makes it illegal for any employer to discriminate or directly harass on the basis of disability. The Act requires reasonable accommodations for the disability unless doing so causes undue hardship to the employer. Title II of the ADA requires that governmental services, including employment programs, not discriminate.
- 1992 - The Rehabilitation Act Amendments of 1992 mandated that individual rehabilitation plans for adults with disabilities are co-developed with the consumer. The amendments also required Centers for Independent Living to deliver consumer-directed services that represent different disability groups (*e.g*. not just individuals with physical disabilities) (Shreve, n.d.).
- 1998 - The Workforce Investment Act was designed to provide occupational training and education to develop the nation's workforce. This included the creation of centers to help people with disabilities access programs to enhance their ability to gain or retain jobs.
- 1999 - The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) protects medical benefits for some recipients of Medicare and Medicaid when they return to work (Timeline, n.d.).
- 2000 – Executive Order 13163 was supposed to increase by 100,000 persons the number of individuals with disabilities employed in the federal workforce, but few steps were taken and little progress was made. 65 Fed. Reg. 46563 (Executive Office of the President, 2000).
- 2010 - Executive Order 13548 -- Increasing Federal Employment of Individuals with Disabilities, delineates specific steps to achieve the goals of Executive Order 13163. 76 Fed. Reg. 52845 (Executive Office of the President, 2011).
- 2011 - Affordable Care Act Provisions – Home and Community-Based Services 1915(i) allows states to cover Supported Employment and other "habilitation" services under this Medicaid waiver; and 1915(k) increases the federal match for this waiver by 6% (specific match percentages vary by state). To many

advocates, these provisions not only support employment, but also promote integrated community-based services over institutional programs (ADAPT, 2011).

The Office of Disability Employment Policy (ODEP), the Social Security Administration (SSA), and CMS have programs, policies and initiatives that encourage employment and support individuals who want to work. ODEP, housed within the United States Department of Labor, was established in 2001, in response to "the need for a national policy to ensure that people with disabilities are fully integrated into the 21st Century workforce…" (ODEP, n.d.). ODEP has many new and emerging policies to support employment and remove barriers to work.[5]

SSA Demonstration Projects

Recent SSA demonstration projects that assess interventions that encourage work for recipients include (1) the Mental Health Treatment Study, (2) the Accelerated Benefits Demonstration, and (3) the Benefit Offset National Demonstration. They are described in the following paragraphs.

From 2006 to 2010 the Mental Health Treatment Study (MHTS) demonstration project provided both supported employment and systematic medication management services to SSDI beneficiaries with serious mental illnesses. Over 2,000 beneficiaries were recruited and integrated services were provided at 23 sites throughout the country. The evaluation of this study found that the MHTS treatment group improved both employment and health outcomes (Frey, Drake, Bond, Miller, Goldman, Salkever … Collins, 2011).

The Accelerated Benefits Demonstration included 2,000 participants across 53 metropolitan areas who were randomized into three groups in 2008. Two groups both received accelerated health care benefits at least 18 months before Medicare eligibility, and one of the two also received telephone services that promote work. The control group (the third group) received no accelerated benefits or telephone services. Initial one-year findings show that access to health care and health improvements are significant, but additional research is needed to determine impact on employment outcomes (Mann & Wittenburg, 2012).

In 2005, four states implemented a pilot to prepare for the Benefit Offset National Demonstration that is now in progress. Every state has now recruited between 250 and 600 participants who were randomly assigned to control or treatment groups. As an alternative to the standing policy of losing all financial benefits at sustained earnings levels of substantial gainful activity (SGA)[6], the treatment group's benefits are reduced

[5] Current ODEP policies include the Inclusive Federal Contractor Requirements and Small Business Tax Credits (IRS Code Section 44, Disabled Access). Detailed descriptions of all of ODEP initiatives and policies may be found at http://www.dol.gov/odep/about/.

[6] In 2014, SGA for persons receiving Social Security Disability Insurance benefits is $1,070 per month for non-blind individuals and $1,800 for blind individuals (Social Security Administration, n.d.)

by $1 per $2 of additional earnings. Both the control and treatment groups are offered additional vocational counseling services. This project has not yet been evaluated (Mann & Wittenburg, 2012).

In addition to the Ticket to Work Act referenced above, CMS provides states with the option to offer Medicaid recipients supported employment services through Home and Community Based Services under the provisions of Section 1915(c)(5)(C) or 1915(i) waivers. These services, defined as "assistance in obtaining and keeping competitive employment in an integrated setting," and peer support services that deliver "counseling and other support services to Medicaid eligible adults with mental illnesses…" (CMS, n.d.), are more comprehensive than those available through federal-only Medicaid programs.

III. Value of work

There is a wide array of significant benefits to competitive employment during recovery. First-person accounts often cite the importance of work during recovery because it enhances connections with others, self-esteem, self-sufficiency, personal responsibility, stress management, and views of self-worth by contributing to society (Dunn, Wewiorski, & Rogers, 2008). People with a mental health diagnosis who work feel that they are more respected, are more financially independent, and have more meaningful relationships (McGurk, Mueser, DeRosa, & Wolfe, 2009).

In 2008, Dunn, et al., performed a qualitative study interviewing individuals with serious mental illness who have been successful working during recovery. The study, which included 23 interviews, concludes that 'significant benefits' are realized during the recovery process from work. One common theme among participants was the value of employment at promoting recovery through supporting confidence and self-pride. One study participant shared that "at (one) point I felt like work was the only thing in my life that had any value (p. 61)." Other themes were the importance of establishing daily routines through employment, distraction from negative thoughts, overcoming symptoms of isolation, and achieving financial self-sufficiency. Previous studies corroborate these results (Honey, 2004; Provencher et al. 2002).

A. Employment not only promotes recovery, but it has also been shown to decrease long-term service use and costs.

Bush, Drake, Xie, McHugo, and Haslett (2009) published a rigorous 10-year study of utilization and cost that followed 187 individuals in recovery. Minimum- and steady-work groups that controlled for education, work history, psychiatric diagnosis, and severity of psychopathology were compared and longitudinal patterns of work, utilization and cost outcomes were established. The conclusion of the study was that "highly significant reductions in service use were associated with steady employment." (p. 1024).[7]

[7] The literature cited in the paper also suggests that the significant benefits of work in recovery include the potential to combat depression, mend personal identity, develop and recover skills,

B. Competitive employment has been shown to benefit individuals with different recovery experiences.

According to a qualitative study by Provencher et al., individuals with different recovery experiences all realized benefits from work. People who viewed their recovery as uncertain benefitted from developing structure to fill free time, building secure environments, and having distractions from their worries; those who experienced recovery as self-empowering benefitted from regaining pride and connecting with others; those who felt recovery was challenging gained from feeling that they were meeting their potential. The study findings provided support for the theory that employment has positive effects on other aspects of recovery, such as creating a secure base, supportive relationships, and coping mechanisms (2002).

C. Working in an integrated setting influences every dimension of recovery.

Along with education and housing, one of three functional recovery factors defined by Whitley and Drake is employment, with "obtaining and maintaining employment" as the measurable outcome. And functional recovery is linked to the other four dimensions of recovery (clinical, existential, physical and social). For instance, "employment (functional recovery) may lead to inclusion in positive social networks (social recovery), which might enhance hope and responsibility (existential recovery). These factors may work together to reduce symptoms (clinical recovery)." (2010, p. 1250). Consumer movements often also focus on the participation in self-directed employment as a marker of recovery.

D. All of the literature promotes work.

In the entire literature review, not one negative effect of employment during recovery was mentioned. An academic search for "detrimental effects of employment during recovery from mental illness" and related topics and key words revealed that the only negative references pertained to barriers to employment including the impact of stigma, self-disclosure, and lost productivity from mental illness. All of these negative associations between employment and mental illness are unrelated to negative effects of work during recovery.

Marrone and Golowka performed an extensive literature search as well and found no clinical research studies regarding ill effects of employment on people with mental health disabilities. Rather, the authors stress that the benefits of employment far outweigh the stresses of employment on mental health. In addition, they noted the benefits of realizing a role other than "consumer," decreasing stress from being on public benefits, developing possibilities for romantic relationships, and increasing the meaning of leisure time (1999).

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expand social networks and support systems, decrease long-term reliance on benefits, better achieve long-term goals, and increase structure in ways that promote recovery.

IV. Supported Employment

In a qualitative study by Dunn et al. (2010), seven themes emerged as important to helping individuals in recovery return to work and stay employed. These themes are "having the confidence to work, having the motivation to work, possessing work-related skills, assessing person–job fit, creating work opportunities, receiving social support, and having access to consumer-oriented programs and services." (p. 185).

Evidence-based research indicates supported employment is the intervention that most effectively optimizes employment outcomes for individuals in recovery from mental illness who are returning to work. A 2012 SAMHSA training teleconference discusses Individual Placement and Support (IPS) Supported Employment as a "new" tool backed by decades of research.

This evidence-based practice model has five defining features:

- The approach leads to a mainstream job in the community.
- The job pays at least minimum wage.
- The work setting includes people who are not disabled.
- The service agency provides ongoing support.
- This type of employment is intended for people with the most severe disabilities.

"The Role of Employment in Recovery and Social Inclusion: An Integrated Approach" August 14, 2012 (available at www.promoteacceptance.samhsa.gov).

Supported employment differs from other models in that it: emphasizes choice, encourages rapid entry/reentry into the labor force over prevocational assessment and training programs; and provides supports and assistance to find and keep competitive jobs in the community (Center for Evidence-Based Practices, n.d.).

In 2008, Bond, Drake, and Becker summarized results from 11 studies in the employment outcome areas of "employment rates, days to first job, annualized weeks worked, and job tenure in the longest job held during the follow-up period." (p. 280). The conclusion was that the Individual Placement and Support Model for supported employment (IPS) had the best work outcomes as compared with other vocational rehabilitation models. Most significantly, the competitive employment rate for IPS was 61% vs. 23% for controls.

Additional research corroborates these findings. Bush, Drake, et al., researchers affiliated with the Dartmouth Psychiatric Research Center, a leading national center on mental health and employment policy, state that "a specific vocational intervention—supported employment— has been demonstrated over the past 20 years to be an evidence-based practice for persons with serious mental illnesses. Methodologically rigorous studies show that supported employment is nearly three times as effective as other interventions for helping persons with psychiatric disabilities to achieve

competitive employment, increases the number of hours worked, and accomplishes other vocational outcomes." (2009, p. 1024) Research by Bond and others show similar impacts, and sustained or increased long-term employment outcomes despite less reliance on vocational services. (Becker, Whitley, Bailey,& Drake, 2007; Bond, 2004; and Cook, Leff, Blyler, Gold, Goldberg, Mueser, …Burke-Miller, 2005).

V. Best practices

A. Supported employment stands alone in the research as the best practice for supporting recovery through work for individuals with serious mental health conditions.

The following basic principles of Individual Placement and Supported Employment (IPSE) are advanced by the IPS Supported Employment Center at Dartmouth. They are similar to the principles delineated by McGurk et al. (2009, p. 5).

1. **Focus on Competitive Employment:** Agencies providing IPS services are committed to competitive employment as an attainable goal for clients with serious mental illness seeking employment.
2. **Eligibility Based on Client Choice:** Clients are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement.
3. **Integration of Rehabilitation and Mental Health Services:** IPS programs are closely integrated with mental health treatment teams.
4. **Attention to Client Preferences:** Services are based on clients' preferences and choices, rather than providers' judgments.
5. **Personalized Benefits Counseling:** Employment specialists help clients obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements.
6. **Rapid Job Search:** IPS programs use a rapid job search approach to help clients obtain jobs directly, rather than providing lengthy pre-employment assessment, training, and counseling.
7. **Systematic Job Development:** Employment specialists build an employer network based on clients' interests, developing relationships with local employers by making systematic contacts.
8. **Time-Unlimited and Individualized Support:** Follow-along supports are individualized and continued for as long as the client wants and needs the support.

Bond (2004) finds that evidence-based research shows the strongest support for principles one (competitive employment), two (client choice) and six (rapid job search). Rapid reentry into employment has also been shown to increase the probability of employment leading to a career rather than just planning for employment (Marrone &

Golowka, 1999; Bond et al. 1995). Bond goes on to discuss moderately strong evidence in support of principles three (integrating rehabilitation and mental health teams) and four (honoring client preferences).

Additional research supports principle three. In the SSA Mental Health Treatment Study discussed above in Section II, Frey, et al., found that this 2,238-participant demonstration project combining supported employment and systemic medication management services improved employment and health outcomes for treatment group members. At the end of the 24-month study, 61% of the treatment group was employed vs. 40% of the control group. However, average earnings for both groups were well below SGA ($251 per month) and not significantly different between the groups. Notably, hospitalizations and psychiatric treatment visits decreased in frequency and length for treatment group beneficiaries (Frey et al., 2011). A different study by McGurk et al. (2009) found that the combination of supported employment and cognitive remediation services enhanced employment outcomes and increased cognitive recovery more than supported employment alone.

B. In addition to the basic principles of IPSE, the ideal relationship between work and the recovery process based on our research might include the following provisions:

1. Attainable intermediary outcomes: *Taking client preferences into account, goals and outcomes should be realistic, incremental and flexible.* Defined goals, outcomes, and timetables for securing employment are critical to progress. Development and evaluation of progress markers should take into consideration that recovery is not always a linear process. For example, an individual may have excelled at a full-time position prior to a relapse of mental illness, but in early recovery this person may not be able to work full time or be competitive at the same level of employment prior to relapse. Rather, his goals may begin with satisfactorily holding a half-time entry level position that later leads to full employment in his previous field.

2. Redefining success: *Individualized client supports that define and celebrate every new vocational success as a milestone of recovery.* Throughout the recovery process and particularly in early recovery, every accomplishment is significant and often formative. Employment specialists should emphasize each new milestone that is crossed, and never take an achievement for granted. In early recovery, successes may include regular attendance, notifying the employer if absent, and passing probationary review; intermediate successes may include consistent attendance, increasing hours worked, and less reliance on benefits; and advanced successes may include a month of perfect attendance, securing a full-time position within the individual's previous field, and financial independence.

3. The evolving personal value of work: *Employment specialists and counseling services that emphasize the individual reasons to work and the progressing value of work.* As discussed in the 'Value of Work' section, not every person in recovery works for the same reasons or benefits from work in the same ways. The value derived

from work often changes as a person recovers. Supports that emphasize current reasons to work and benefits of employment, in addition to past successes attributable to work, best incentivize future employment. An individual may begin working for self-esteem and to establish daily routines. As self-esteem builds and routines become easier, he may continue to work to increase his personal responsibility and social circle. In later recovery, his value of work may build to include financial independence.

VI. Implications for P&As

The research is uncontroverted that competitive work throughout the recovery process is proven to be valuable to people needing mental health services, with no known disadvantages. Furthermore, employment is a critical factor not only in the recovery process but as an essential feature of integration into the community. It is imperative that the P&As advocate for strategies that promoting competitive employment opportunities and programs.

P&As should consider how they can advocate for the funding of Individual Placement and Supported Employment, and programs based on similar principles, which are shown to be the most effective evidence-based program interventions. At the state level, it is possible to address the importance of work in a number of ways. First, focus on the importance of work and supported employment in individual advocacy for individuals with mental illness. Second, advocate for the creation and expansion of supported employment services for individuals in the mental health system and promote increased awareness and the utilization of benefits counseling to understand how work incentives can be used to enhance opportunities for stable employment. P&As should also advocate for the inclusion of supported employment initiatives in Olmstead Plans. Finally, consider forming alliances with stakeholders, such as consumer groups, to devise strategies for promoting employment.

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