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Social Security And Mental Illness: Reducing Disability With Supported Employment

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Abstract

Social Security Administration disability programs are expensive, growing, and headed toward bankruptcy. People with psychiatric disabilities now constitute the largest and most rapidly expanding subgroup of program beneficiaries. Evidence-based supported employment is a well-defined, rigorously tested service model that helps people with psychiatric disabilities obtain and succeed in competitive employment. Providing evidence-based supported employment and mental health services to this population could reduce the growing rates of disability and enable those already disabled to contribute positively to the workforce and to their own welfare, at little or no cost (and, depending on assumptions, a possible savings) to the government.

Social security administration (SSA) disability programs were originally designed for people who had no realistic chance of returning to the workforce because of age and severity of disability.¹ Since that time, numerous changes have occurred. The population deemed eligible for disability benefits has expanded dramatically, the potential of medical and vocational assistance to improve employment prospects has greatly increased, the nature of available work opportunities has changed considerably, the majority of people with serious long-term mental illnesses have consistently expressed their aspirations to work as part of recovery, the federal commitment to support people's aspirations to work and be independent has been formalized in the Americans with Disabilities Act (ADA, PL 101-336), the extent to which disability policies can themselves be disabling has been recognized, and the financial problems of Social Security have become prominent.² Together, these changes constitute a clarion call for reform.

In this paper we address these issues in relation to the largest group of Social Security beneficiaries: people with psychiatric disabilities.³ We describe and analyze the current situation for people with psychiatric disabilities; we propose providing supported employment, mental health services, and health insurance to current and potential beneficiaries; and we present the outcome of economic modeling. We conclude by recommending several specific reforms.

The Current Situation For Adults With Psychiatric Disabilities

Social Security disability system

The SSA oversees two disability programs: Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). In 1956 Congress passed legislation providing Social Security payments for workers over age fifty with severe mental or physical impairments of sufficient longevity and severity that they had no prospect of returning to substantial gainful employment. Social Security laws were subsequently amended so that SSDI included younger workers, encompassed people with impairments lasting at least one year, and provided Medicare insurance for those who were on SSDI for at least two years. In 1972 Congress established SSI, a needs-based disability program for disabled children and adults.

Beneficiaries receive financial assistance and, in nearly all cases, Medicaid insurance. Both programs have expanded over the years. Total federal and state spending for those of working age was approximately \$276 billion, or 2.7 percent of the U.S. gross domestic product (GDP), in 2002.⁴ Three-quarters of this total was for cash and health benefits related to Social Security disability programs. Further, disability programs and spending are growing at a much faster rate than the population.⁵ Current disability policies support people with disabilities but also impose major constraints. Critics argue that the policies often lead to lifelong poverty and dependency and are antithetical to the values expressed in the ADA.⁶ The majority of beneficiaries live below the federal poverty level, and very few (less than 1 percent of people with disabilities on SSI or SSDI each year) leave the programs for reasons other than aging out or death.⁷ Disincentives to return to work include fear of losing health insurance, becoming psychologically disabled by the often lengthy process of applying for and receiving benefits, unrealistic income replacement formulas (a person loses too much income support immediately upon return to work), and inability to understand the complicated regulations.⁸ Experience in European countries suggests that economic disincentives are important and that realigning incentives in disability programs can improve participation in the workforce.⁹

In addition, current policies do not address prevention. Many people with serious illnesses might avoid disability if they were able to obtain health insurance, temporary financial assistance, and help returning to work when they become injured or ill. However, Social Security currently provides no short-term disability benefit that would allow people to avoid a protracted period of separation from the workforce while establishing disabled status.

Mental illness and disability

People with psychiatric impairments constitute the largest and most rapidly growing subgroup of Social Security disability beneficiaries.¹⁰ In 1999, 34 percent of working-age adults receiving SSI, and 27 percent of SSDI recipients had a primary psychiatric impairment.¹¹ These percentages keep growing, in part because beneficiaries with psychiatric impairments are generally younger than other beneficiaries when they become ill and therefore remain on the Social Security rolls much longer.

Serious psychiatric illnesses such as schizophrenia, bipolar disorder, recurrent depression, or obsessive-compulsive disorder are characterized by fluctuating symptoms, cognitive deficits, and comorbid medical and addictive disorders. These illnesses can result in impairments to vocational functioning, interpersonal relationships, and even independent living skills.

However, the symptoms and the related impairments tend to fluctuate, and the great majority of people with serious mental illnesses, even those with the most severe and persistent illnesses such as schizophrenia, tend to improve over time.¹² Further, most people with these illnesses tend to respond well to evidence-based treatments and rehabilitative interventions.¹³ Although people with psychiatric disabilities are the largest subgroup of beneficiaries, mental health has never been in the mainstream of disability policy. Disability policies were designed for people

with permanent impairments or lethal illnesses, not for those with fluctuating, gradually improving illnesses that respond well to treatment. Although Social Security policies do allow for continuing disability reviews, very few beneficiaries leave the rolls.

The goal of increasing employment among people with psychiatric disabilities is not solely the result of altruism or projected budget deficits: the economic loss due to reduced productivity is enormous. A national survey conducted in 2001–2003 estimated an annual loss of \$193.2 billion to the U.S. economy in reduced earnings attributable to serious mental illness.¹⁴

Supported employment

Surveys of adults with psychiatric disabilities consistently find that 50–70 percent of them have a strong preference to work.¹⁵ The first highly effective approach to employment services, known as “evidence-based supported employment” or “individual placement and support,” was developed in the early 1990s.¹⁶ The term *supported employment* has been used to refer to different models, but evidence-based supported employment entails a specific, well-researched approach: a team of employment specialists and mental health workers helps clients identify what kind of work they would like to do, find a job as quickly as possible, and succeed on the job or move to another job, while avoiding the lengthy assessments and prevocational training of traditional approaches. As a typical example, consider a young man with schizophrenia who feels paranoid and fearful around people, has little work history, and expresses a desire to work with animals. Members of the treatment team network with pet stores, veterinary clinics, and farms. They locate several possible jobs, and within a week the client starts working five hours a week taking care of animals housed overnight at a local veterinary clinic. The employment specialist makes sure the client can do all aspects of the job and checks in with the employer by phone. The job goes well, and within two months the client is working twenty hours a week, feels confident about the job, and is making friends at the clinic. This simple and direct approach has been standardized and studied extensively using a fidelity scale to ensure adherence to the specific program model.¹⁷ As in the example, supported employment participants typically begin working at low levels and increase their hours over several months.

Evidence-based supported employment is robustly validated by research. Across eleven randomized controlled trials, about two-thirds of supported employment enrollees become competitively employed, compared to less than one-fourth of those in other active vocational interventions.¹⁸ For example, Kim Mueser and colleagues compared three approaches to vocational services with an ethnically and culturally diverse group of clients in Hartford, Connecticut.¹⁹ They randomly assigned 204 clients with serious mental illnesses (46 percent African American, 30 percent Latino, and 24 percent Caucasian) to supported employment, a psychosocial rehabilitation program, or a vocational training program and followed them for two years. Clients in the supported employment program became competitively employed at a much higher rate (80 percent versus 18 percent versus 28 percent) and worked more hours than clients in the other vocational interventions. The three ethnic/cultural groups had equally good outcomes in supported employment.

In addition to greater rates and amounts of competitive employment, several related findings have emerged in this literature. Working steadily confers other benefits such as greater income, enhanced self-esteem, improvements in quality of life, and reductions in mental health service use.²⁰ Long-term follow-ups show that work outcomes improve despite minimal vocational services after the first year.²¹ Evidence-based supported employment is effective for older and younger working-age clients, for those with different diagnoses and levels of severity, for those with substance abuse comorbidities, for those with different disability statuses, and for those with different work histories.²² For example, one critical finding is that younger clients experiencing a first episode of illness have very high rates (85–95 percent) of returning to

competitive school work or a job.²³ To produce the best results, evidence-based supported employment services should be integrated with mental health interventions.²⁴

One important caveat, related to the current health insurance environment, is that most of these employees adjust their employment to about twenty hours per week to prevent loss of Social Security and health insurance.²⁵ Nevertheless, as we show below, part-time employment can reduce disability costs in two ways: by displacing disability payments, and by decreasing mental health service use.

Limited adoption of supported employment

Evidence-based supported employment has proved to be remarkably easy to implement, inexpensive, successful, and durable in several states in which it has been disseminated as part of a public-private-academic partnership.²⁶ Nevertheless, it has not been widely adopted across the United States primarily because of financing difficulties. Mental health agencies typically draw on a combination of sources to finance supported employment, including the state-federal vocational rehabilitation system, Medicaid, and state mental health dollars. Each source is constrained and unpredictable, and government regulations and policies are not aligned with evidence-based mental health and supported employment.²⁷ Mental health programs often eliminate vocational services when funding fluctuates because they are not easy to apply for and are not considered “medically necessary.” For example, when the Massachusetts Department of Mental Health was confronted with a state budget shortfall in late 2008, it completely eliminated all funding for the supported employment and education programs that had been built up over several years.²⁸

Potential Impact Of Implementing Supported Employment

In estimating the potential monetary costs and benefits of implementing evidence-based mental health treatments and supported employment over five years, we assumed that four distinct groups of people would be eligible for both evidence-based supported employment and mental health treatments (hereafter, the “intervention”) (Exhibit 1).²⁹ In these calculations, we focused on two outcome measures for this group: government costs and the change in private earnings of participants. The first group consists of the annual flow of new applicants to SSDI/SSI. The major saving from providing the intervention is to keep a fraction of potential entrants (estimated to be approximately 173,000 people per year) from enrolling in SSDI/SSI by helping to get them back to work. Of course, there are costs inherent in both recruiting participants and the supported employment programs, but these costs are offset by a cumulative decline in SSDI/SSI payments because of the resulting smaller size of the program, equal to an estimated annual saving of \$48 million (in 2006 dollars), with an assumed 30 percent enrollment rate into evidence-based supported employment.³⁰ Even when the enrollment rate is just 20 percent, savings still total \$27 million. We also estimate that personal earnings would be \$107 million higher as a result of the supported employment program.

The additional groups consist of the 3.3 million people currently enrolled in either SSI or SSDI because of mental illness (excluding mental retardation). Because of the considerable heterogeneity in this population, we consider three tertiles of 1.1 million people each within the SSI/SSDI program distinguished by low, moderate, and high severity of mental illness. The division into tertiles is an arbitrary statistical convenience, although the group labels correspond roughly to commonly used definitions of severity in the mental illness literature. A key question regarding supported employment is how many might participate. Previous studies have shown that many people in the low-severity group do not want services and will be less likely than others to enter supported employment; we therefore assume a participation rate of 30 percent.³¹ On the other hand, people who are now participating in mental health

treatment (the medium- and high-severity groups) are often far more likely to enter supported employment, and for these groups we assume a participation rate of 40 percent.

For those who participate, we used evidence from randomized controlled trials designed to measure the impact of individual placement and support on employment outcomes (see the online Appendix): estimated changes in work hours were much higher among lower-severity enrollees than among high- or medium-severity enrollees. We assumed a wage rate of \$8.50 for the lowest-severity group (and for those not yet enrolled in SSDI or SSI), and the 2006 federal minimum wage of \$5.85 for all other groups. A key component of savings comes from the observed reduction in Medicaid treatment costs following the transition into work; one naturalistic study estimated this to be as much as \$150,000 per client over a ten-year period, although we assumed a more conservative savings of \$5,000 annually, just for the most severely ill group.³² Another source of savings arises because as enrollees transition to sponsored employment, SSI scales back benefits.

The bottom line is that under our assumptions regarding participation rates and other key variables, a national program emphasizing evidence-based supported employment and treatment is predicted to save a small amount of money for the U.S. government—several hundred million dollars. This result, of course, is quite sensitive to assumptions about parameter values regarding enrollment probabilities, wage rates, and treatment effectiveness, and it is not difficult to transform the savings into a net loss. But the point of the program is not just to save money but to improve the quality of life for the millions who are enrolled in SSDI/SSI or who might become eligible in the future. Thus, the projected increase in earnings—\$1.6 billion—dwarfs the projected revenue savings, leading to larger improvements in personal incomes, work experience, and quality of life.

Policy Recommendations

Survey research indicates that more than half of people with psychiatric disabilities want to work and that a sizable proportion would become steady workers if they received mental health care and evidence-based supported employment. Furthermore, our review of the literature and economic modeling suggest that providing health insurance and evidence-based supported employment and mental health care to people with serious mental illnesses could prevent disability for many, allow a large proportion of disabled people to contribute to the workforce, and save millions of dollars in disability payments and public mental health costs. Because Social Security, Medicaid, and Medicare are federal programs, the full force and leadership of the federal government need to be behind these changes.

Delink health insurance from disability status

Delinking health insurance from disability status would encourage more people with serious mental illnesses to work. Many people with psychiatric disabilities who are unemployed cite losing health insurance as the primary barrier to working; others who are employed part time cite fears of losing health insurance as the primary barrier to full-time employment. Most Americans believe that health care should be a right for all, and national health insurance would of course accomplish this goal.³³ Short of that, people with serious mental illnesses could receive federal insurance, without being required to claim total disability, until they qualify for private insurance and could be allowed to return to federal insurance automatically if they lose private insurance. Denying insurance or requiring continued disability is even more costly than providing insurance for this population, and the cost is borne by individuals, families, and society.

Link supported employment services to mental health services

Linking supported employment to mental health services could enable a sizable proportion of people with serious mental illnesses to become employed. The evidence we reviewed strongly supports combining these. Aligning Medicaid and Medicare with these services could ameliorate the problem of limited adoption of evidence-based practices. Congress could decide which agencies should pay for the services, mandate the services, and allocate sufficient funds to serve the population. States could be mandated to monitor implementation, organization, quality, and outcomes. Valid monitoring will require attention to electronic records, quality of services, and outcomes.

Align incentives for people who qualify for disability (SSI or SSDI)

An alignment of incentives could help beneficiaries move as rapidly as possible back into the workforce. The rules for disability payment reductions in relation to work could be more gradual, and people could be allowed to return to disability payments easily when they encounter difficulties. The goal should be to help people return to work, not necessarily to leave the SSA rolls.

Provide supported employment and mental health services early in the course of mental illness

Doing this could help many people avoid entering the disability system. International early intervention studies, including one in the United States, support this proposal.³⁴ Early insurance provision or universal health care, combined with evidence-based practices for early episodes of serious mental illnesses, would move the mental health system toward preventing disability, with state mandates to encourage the provision of such services.

Our benchmark estimates suggest that wide-scale implementation and recruiting of people with serious mental illnesses to evidence-based supported employment and mental health care would improve financial security for participants and could even save the government money. Our economic model is, however, clearly sensitive to assumptions, and we are making educated estimates regarding many key assumptions. This weakness points to the need to conduct research to answer key questions, such as the following: How many clients would participate in supported employment if the incentives were different? How much would they work, and what would they earn, if regulatory constraints were lessened? To what extent could we prevent disability status by providing insurance and prevention services? That these services could be provided with cost-neutrality or, more likely, with cost savings is a secondary benefit but a finding that should encourage health and disability policy officials to act.

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EXHIBIT 1
Estimated Costs And Benefits Of A National Program To Implement Supported
Employment And Evidence-Based Treatments For Mental Illness

Categories of people	Government savings from a supported employment (SE) program	Costs of SE program	Annual change in personal income (\$ millions)	Net government savings (\$ millions) ^a
For people not yet enrolled in SSDI or SSI				
	Reduction in percent of new SSDI/SSI enrollees, with large long-term gains	SE and recruitment costs	107	48
For people currently enrolled in SSDI or SSI				
Low severity of mental illness	Estimated 200 additional hours of work for those who receive SE; more earnings but only a small cut in SSDI/SSI costs	SE and recruitment costs, which generally exceed the potential SSDI/SSI	679	-124
Moderate severity of mental illness	Estimated 167 additional hours of work for those who receive SE; more earnings but only a small cut in SSDI/SSI costs	savings per worker (leading to net losses per worker)	466	-262
High severity of mental illness	Reduction in treatment costs and savings to the Medicaid program; major cost savings (from current high spending levels); very modest employment gains		343	706
Total			1,596	368

SOURCE: Authors' calculations, drawn from sources described in the text and Appendix (available online at <http://content.healthaffairs.org/cgi/content/full/28/3/761/DC1>).

NOTES: SSDI is Social Security Disability Income. SSI is Supplemental Security Income.

^a All estimates annualized, expressed in 2006 dollars, and averaged over a five-year period. See Appendix for details of estimates.