



# A Model for Supported Employment Services for Individuals Receiving Time-Limited Disability Benefits

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## INTRODUCTION

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Some policy experts have proposed that the Social Security Administration (SSA) award disability benefits for a time-limited period. For some Social Security Disability Insurance (SSDI) applicants, time-limited benefits could be paired with the requirement that they participate in supported employment to potentially increase their likelihood of returning to employment. Participation in supported employment may forestall long-term disability for people with fluctuating medical or psychiatric conditions and potentiate the positive impacts of employment. We propose a mobile, team-based intervention to accompany and assure the success of time-limited benefits in terms of promoting return to work. Our model combines principles of multidisciplinary care with evidence-based approaches to increasing employment and reducing the biopsychosocial components of disability.

## BACKGROUND

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Commentators and policymakers have proposed that SSA should test a new policy of awarding time-limited benefits (perhaps for 2 to 5 years) to some SSDI applicants whose impairments are expected to improve (Hildred, Mazerski, Krent, & Christian, 2016; Stapleton, Ben-Shalom, & Mann, 2019a). These proposals reflect several empirical findings. First, many applicants have fluctuating conditions, such as anxiety, depression, and musculoskeletal disorders, which may improve markedly over time. Even people with life-threatening recurrences of cancer may now respond to new therapies with complete remissions. Second, long-term benefits often consign people to a lifetime of separation from the workforce because people who can and want to work do not do so out of fear of losing their benefits and health insurance. Furthermore, unemployment leads to a host of secondary harms, including problems with self-esteem, family relations, social isolation, homelessness, and substance use. Third, research continues to accumulate that evidence-based supported employment can substantially promote competitive work for people with a disability. Findings from more than two dozen randomized controlled trials show that many people with a disability can become successfully employed (Modini et al., 2016). Although these trials began with people with a serious mental illness, positive outcomes have extended to people with spinal cord injury, post-traumatic stress disorder, anxiety/depression, substance use disorder, and mixed physical and mental conditions (Bond, Drake, & Pogue, 2019).

## BACKGROUND (cont'd)

The Committee for a Responsible Federal Budget sponsors the McCrery-Pomeroy SSDI Solutions Initiative, a bipartisan project commissioned to identify potential policy reforms meant to improve the SSDI program. As part of this initiative, several researchers have proposed specific models for time-limited benefits. Hildred et al. (2016) proposed a transitional benefits program, and Stapleton et al. (2019b) proposed an employability/eligibility service system. Both plans emphasize the provision of benefits for an impermanent period of time (between 2 and 5 years) for some portion of currently eligible SSDI recipients, mainly those deemed most likely to see medical improvements in their health status. Both models also link payment of benefits to some form of vocational rehabilitation intervention. We propose in this paper that for any given model that links transitional or time-limited benefits with the provision of employment services, the intervention should use a mobile, team-based approach with evidence-based supported employment as its foundation.

Time-limited benefits are common among U.S. private disability programs, but rarely studied (Bond, Lerner, & Drake, 2017). Several studies outside the United States have evaluated return-to-work programs for people on leave of absence for medical reasons. Two main findings from these studies are: (1) the longer people are out of

the workforce, the less likely they will return to work; and (2) return-to-work programs that provide an integrated package of evidence-based interventions (including cognitive-behavioral therapy and workplace accommodations) accelerate return to work (Cullen et al., 2018; Joyce et al., 2016; Nieuwenhuijsen et al., 2014).

In the near future, SSA plans to conduct new demonstrations that will test substantive changes to SSDI program rules to support beneficiaries' return-to-work efforts. Given the amount of interest in the concept of time-limited benefits, SSA may decide to test one or more time-limited benefits approaches with new SSDI beneficiaries. We strongly support such a demonstration, but we argue that time-limited benefits should be paired with empirically based interventions (i.e., based on rigorous research) to help these beneficiaries complete their recovery, secure and maintain employment, as well as mitigate biopsychosocial risk factors that may undermine employment efforts.

A key element in the two suggested models is the link between time-limited benefits and participation in vocational rehabilitation services (Sevak & Rosenbluth, 2017). Linking the receipt of continued benefits to participating in evidence-based supported employment has been effective in helping people who receive

Temporary Assistance for Needy Families to work competitively (Chandler, 2017; Danielson, Mayfield, Lucenko, Fan, & Felver, 2019). Other job-training approaches have been far less successful (Pavetti, 2016).

A critical component of a successful strategy to incentivize returning to work during a period of medical recovery is coverage for health care, in addition to the provision of cash benefits. Natural experiments comparing work outcomes for people with disabilities in Medicaid expansion states suggest that access to medical insurance promotes increased rates of employment, as compared to non-expansion states, where researchers find no such increases (Hall, Shartzter, Kurth, & Thomas, 2017, 2018). In effect, Medicaid expansion coverage facilitates employment support for people with disabilities.

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## FOUNDATIONAL SHIFT IN THINKING ABOUT DISABLEMENT

The SSA definition of disability drives what is essentially an all-or-none policy. At a particular point in time, SSA determines whether an individual is disabled or not disabled. Practically speaking, this definition of disability refers to an individual's ability to engage in Substantial Gainful Activity (i.e., the ability to earn a specified dollar amount per month). Recognizing that individuals who are determined to be disabled might improve medically or improve in terms of work-related functioning, SSA assesses whether their impairments are expected to improve, likely to improve, or not expected to improve. This rubric forms the basis for subsequent redeterminations, called Continuing Disability Reviews.

Disability-related research conducted over the past 45 years indicates that disability is a dynamic phenomenon dependent upon a variety of individual and environmental circumstances, not just the nature of the qualifying medical condition. Recent studies conducted by SSA further challenge the static view of disability. For instance, findings from the Mental Health Treatment Study (MHTS) reveal that many individuals determined to be disabled by SSA can and do work (Drake et al., 2013).

The critical developments in understanding disability and its determinants include the following issues.

### **Disability is a functional outcome resulting from a combination of a chronic medical condition(s), social determinants, and social and behavioral risk factors.**

A determination of disability by SSA requires the presence of a medically determinable impairment. The emphasis is, first, on medical conditions. Then, the determination often focuses on functional limitations. For example, a person develops a serious injury or disease that affects functioning. SSA determines the severity of the impairment and the degree of functional limitation. However, people with the same injury or illness severity have very different functional outcomes. According to the World Health Organization, social determinants of health are “the conditions in which people are born, grow, live, work, and age” (World Health Organization, n.d.). While some of these determinants are static, such as race or ethnicity, others are dynamic. Social determinants powerfully affect health but so do social, environmental, and behavioral risk

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factors. Social and environmental risk factors are specific conditions, such as poverty, isolation, unemployment, housing instability, and access to health care, which can influence health. Behavioral risk factors include smoking, alcohol or drug use, lack of exercise, and poor diet.

**Medical conditions often fluctuate or worsen but most improve or stabilize with treatment and time.** People with similar medical conditions have heterogeneous courses and outcomes. While some health conditions follow a predictable course, others do not. While some people have a deteriorating course, other people have a fluctuating or improving course. This variation is true for people with schizophrenia, ulcerative colitis, autism, diabetes, spinal cord injury, pain syndromes, and many other conditions.

**Psychological and social factors can impact function and recovery.** Anxiety, fear of the unknown, isolation, and frustration often produce inactivity, low

expectations, and lack of opportunity, which, in turn, can result in hopelessness, long-term disability (including unemployment), and deterioration. On the other hand, high expectations, psychosocial support, and opportunity can overcome these barriers and facilitate improvement and recovery. Employment exemplifies this process. People who lose jobs often develop family, social, behavioral, and economic problems, whereas moving from unemployment to employment typically improves all of these dimensions.

**Medical interventions for social risks are expensive, misdirected, and ineffective at returning individuals to work.** Medical treatments often improve symptoms without meaningfully improving function. More effective interventions aim specifically at functional outcomes. For example, treating the symptoms of mental disorders aggressively has little impact on homelessness, while

integrating evidence-based treatments with supported housing has a strong impact (National Academies of Sciences, Engineering, and Medicine, 2018; Krotofil, McPherson, & Killaspy, 2018).

Relative to the United States, countries with higher per-capita income and better health outcomes typically spend much less on medical interventions and much more on social services to address social risks (Papanicolas, Woskie, & Jha, 2018). In fact, medical treatments are often used inappropriately and in isolation, and may worsen function and prevent recovery. Examples abound. Multiple back surgeries often worsen pain and mobility (Mafi, McCarthy, Davis, & Landon, 2013). Polypharmacy for psychiatric conditions often creates debilitating side effects that prevent recovery (Iverson et al., 2018). Areas with high hospital use do not have better outcomes but do have greater hospital-based harms (Wennberg, 2010).

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**Integrated services are almost always more effective than fragmented services.** Close integration of medical and social services is generally more effective than parallel interventions: for example, combining housing and treatment, mental health care and employment services, and mental health and substance abuse treatments. The U.S. health care system is, however, famously fragmented. Services exist in separate silos, with communication, collaboration, and integration typically honored in the breach.

## INTERVENTION STRUCTURE

We believe that the foundation of a time-limited disability support model should be a multidisciplinary team of service providers who can address the multiple factors associated with disablement. Team-based care offers the most efficient way to integrate different interventions and approaches aimed toward

the common functional goal of employment. Team members from multiple disciplines meet regularly, learn from each other through discussions with and about specific clients, and develop common treatment strategies to improve functional outcomes, not just medical outcomes. The team operates with a set of principles



that place employment as the primary functional outcome, even though medical recovery may be a key first step. These principles include the following:

- Intervention is multipronged, addressing medical, behavioral, social, and emotional risks. Without these supports, people may recover from their medical conditions but struggle to avoid the downward spiral that creates disability.
- A team-based approach offers the greatest opportunity to create a focus on employment first.
- While the decision to work is the individual's, the multidisciplinary team can help with motivation and assist the individual in achieving his or her employment goal.
- Sensible integration of medical care, social services, and vocational services creates a culture of recovery (rather than despair).
- Effective multidisciplinary teams are mobile and flexible enough to join caregivers in different settings (such as primary care, specialty care, Federally Qualified Health Centers, and community health and mental health centers).

## MULTIDISCIPLINARY TEAM

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The multidisciplinary team includes professionals from several disciplines, works collaboratively, has regular meetings (at least weekly) and daily interactions, provides outreach and community-based interventions, and builds on people's personal, familial, social, and community strengths.

The team should include a team lead, employment specialist, psychologist/therapist, nurse, and care manager. Experience suggests that successful teams also access (as needed) additional providers, including, for example, medical specialists, a benefits counselor, housing specialists, and legal assistance. Some teams, depending on caseloads, may combine positions for efficiency. For example, the psychologist or nurse may also serve as team lead. Nevertheless, the basic multidisciplinary team includes the functional positions described here.

The **team lead** is a master's-level clinical professional, nurse, or employment specialist with experience working on "employment-focused" teams. The team lead organizes and runs team meetings, ensures training and fidelity, tracks client progress, and ensures team integration.

The **employment specialist** plans, coordinates, and delivers vocational services, and coordinates with the rest of the team in supporting vocational success. The employment specialist requires training and experience with an evidence-based model of employment support, such as the Individual Placement and Support (IPS) model. The employment specialist coordinates with local vocational resources, such as the state's department of vocational rehabilitation.

The **nurse** assesses, plans, and monitors medical care. In many settings, the nurse will coordinate

with the client's primary care physician. In other settings, the nurse will manage care coordination, including care for physical health, mental health, and substance use. The nurse should ensure that clients receive necessary medical and pharmacological interventions for both primary and comorbid medical conditions, and that these interventions are consistent with or support an employment goal. At





a minimum, medical interventions should not undermine employment goals. Given the requirements for this nurse position, he or she should be a registered nurse or nurse practitioner with at least 3 to 5 years of experience.

The **psychologist/therapist** assesses, plans, and addresses motivation, cognitive issues, family issues, and behavioral risks. The psychologist/therapist should have clinical training or experience in motivational interviewing, cognitive-behavioral therapy,

rehabilitation, and family psycho-education.

The **care manager** coordinates the team response to social and environmental risks, including issues related to finances, housing, transportation, legal aid, food security, and work clothing. The care manager should be familiar with the available community resources to help resolve basic client needs, such as housing, food, transportation, and legal assistance, which may be barriers to functional success. Given the number and complexity of issues a

care manager may have to address, he or she should have education and experience equivalent to an undergraduate or master's degree in mental health or social services.

Ancillary support can come in many forms. Some successful teams request the services (as needed) of a work incentive/benefits counselor, peer support counselor, or specialist in high-risk medical or behavioral issues.

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## IMPLEMENTATION

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The multidisciplinary team should be able to function in many possible health or vocational environments. Teams likely function best when provision of health care services (physical or mental) is on site. Thus, depending on the type of clients, team-based care could occur in a rehabilitation hospital (or outpatient setting), comprehensive care center, community mental health center, community health center, or vocational rehabilitation center.

The implementation of this team-based, interdisciplinary model of care requires the usual components of high-quality programs: leadership, funding, an operational manual, specific training, fidelity measures, technical assistance, and specialized assistance for

particularly challenging clients. Training provides a common understanding of the philosophy, goals, and best practices associated with the team-based model of employment support and how an “employment first” philosophy should drive return-to-work efforts. Evidence-based principles of employment support include honoring client preferences for timing, type of job, job search procedures, disclosure, and type of job support. All team members should receive training on these principles.

Ongoing assessments of fidelity to the model of team-based care can provide teams with feedback on their strengths, challenges, and strategies for improvement. Independent fidelity assessments can identify areas of need for

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technical assistance and help clinic or center directors to recalibrate their employment program structure and processes. Fidelity assessments help administrators and employment teams compare their program efforts to the expected model and determine if changes are necessary. Fidelity assessments provide external funders (e.g., state agencies, SSA,

other Federal agencies) with the documentation needed to justify continued support.

Finally, technical assistance provides teams with a valuable resource when particular evidence-based interventions or practices are unclear. Supporting clients who present with unusually complex situations or express

interest in questionable treatments may require external advice. Thus, a plan for providing teams with expert consultation when needed will improve the potential for positive employment outcomes.

## CONCLUSIONS

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This paper discusses the application of pairing evidence-based services with transitional benefits for newly awarded SSDI beneficiaries whose impairments are expected to improve. A comprehensive, team-based model, incorporating evidence-based principles and best practices, should accompany these time-limited benefits, including the provision of IPS services. This

model assumes that many SSDI beneficiaries can return to work with appropriate supports and, thereby, avoid the harms of long-term disability if given the means necessary to succeed.

While the comprehensive, team-based model described in this paper is currently being tested in the Supported Employment Demonstration (SSA, n.d.), similar

versions of this model have been successfully implemented, with robust findings of increased employment (e.g., in the MHTS [Drake et al., 2013]). Findings from the Supported Employment Demonstration will be available in 2022 (Frey, work in progress).



## SUGGESTED CITATION

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Frey, W., Drake, R., Bond, G., Goldman, H., Riley, J., & Bennici, F. (2019, August). A model for supported employment services for individuals receiving time-limited disability benefits. (Issue Paper, Employment and Disability Research Series). Rockville, MD: Westat.

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