Estimated Payments to Employment Service Providers for Persons With Mental Illness in the Ticket to Work Program

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Objective: **The Ticket to Work and Work Incentives Improvement Act of 1999 removes work disincentives and promotes access to vocational services for people with disabilities. This study calculated the amount of payments that would have been made to employment service providers if study participants had been enrolled in the Ticket program.** ***Methods:*** **Data were from 450 Social Security Disability Insurance beneficiaries with psychiatric disabilities enrolled in a multisite study of supported employment. Earnings over two years were used to calculate provider payments under two reimbursement formulas used in the Ticket program.** ***Results:*** **Only a quarter of service recipients (26 percent) reached earnings levels that would have triggered provider payments under the first reimbursement formula. Only 4 percent would have completed their trial work period and left the rolls, generating payments under the second formula.** ***Conclusions:*** **The current provider payment systems of the Ticket to Work program do not reflect the reality of rehabilitation for individuals with severe mental illness. Reforms should take into account outcomes of return-to-work services for this population. (*Psychiatric Services* 57:465–471, 2006)**

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A large and growing segment of U.S. population—disproportionately comprising adults with severe mental illness—finds itself out of work and dependent on public benefits and entitlements for cash income and health care coverage. Formidable barriers to employment include a lack of vocational rehabilitation services (1), employment discrimination (2,3), the ineffective response of federal-state vocational rehabilitation (4,5), inadequate education (6), failure to provide best-practice clinical services (7–9), and the effects of poverty (10–12). Data from the National Health Interview Survey indicate that 60 percent of working-age adults with mental health disabilities are out of the labor force, compared with 18 percent of the general population (13).

This situation is perpetuated by a series of unintended consequences that arise from disability income support policies of the Social Security Administration (SSA) that create employment disincentives (14). The practice of continuing disability review, in which beneficiaries' disability status is reevaluated when their earnings increase substantially, discourages significant attempts to work (15). Another

disincentive is an "implicit tax" on disabled workers whose participation in the labor force causes them to lose benefits, such as health insurance, housing subsidies, utility supplements, transportation stipends, and food stamps (16). Recipients of Social Security Disability Insurance (SSDI)—but not of Supplementary Security Income (SSI)—encounter a "cash cliff," whereby cash payments cease entirely once their earned income exceeds a certain threshold, referred to as substantial gainful activity (SGA), for more than nine months plus a three-month grace period (17).

Persons with psychiatric disabilities are disproportionate users of both SSI and SSDI. In 2003, 35 percent of all working-age SSI beneficiaries had a psychiatric disability, and 28 percent of all adult SSDI recipients were disabled workers with a psychiatric disability (38 percent of those on SSDI under age 50) (18). In a study of individuals with schizophrenia who were followed for an average of five years after their first hospitalization (11), 72 percent relied on SSI, SSDI, or other welfare payments throughout much of the follow-up period. Research has shown that SSI beneficiaries with psychiatric disorders are significantly less likely to work than those with other types of disabilities (19) and that SSDI beneficiaries remain on the rolls significantly longer than those with other disabilities (20).

To address employment disincentives and encourage return to work, the 1999 Ticket to Work and Work Incentives Improvement Act (TWWIIA) Public Law 106-170 (21) was passed. This law was intended to give people with disabilities increased options for obtaining vocational services and to remove unintended employment disincentives caused by SSA policies (22). The latter was to be accomplished by providing counseling on benefits and entitlements, eliminating continuing disability reviews tied to employment, and encouraging state Medicaid buy-ins that would enable people to keep their health insurance after cash benefits cease. To give people with disabilities increased options for obtaining vocational services, SSA would send beneficiaries "tickets" or vouchers through the mail that could be redeemed for vocational services from local providers of their own choosing, creating a competitive market that would enhance the service quality (23). Because another purpose of the law was to reduce government spending on people with disabilities (24), it limited ticket eligibility to SSI and SSDI beneficiaries, because these groups were receiving cash and other forms of income.

Somewhat of a misnomer, Ticket to Work employment networks are typically individuals or organizations that qualify as providers of employment services under the Ticket to Work program. A large majority of providers are state vocational rehabilitation authorities, with a much smaller proportion comprising not-for-profit and for-profit employment programs, businesses and corporations, Workforce Investment Act One-Stop Career Centers, and peer provider organizations (25).

The Ticket to Work program was established to give people with disabilities increased options for obtaining vocational services and to remove unintended disincentives to work caused by Social Security Administration policies.

The Ticket to Work program has now been implemented in all 50 states and U.S. territories; however, individuals with disabilities have been slow to participate in the program. Since the program's start in 2002, less than .8 percent of all tickets issued have been assigned to a provider (26). Most tickets are used by individuals who are already receiving services from state vocational rehabilitation agencies (25). In its latest report to the President and Congress (27) the Ticket to Work and Work Incentives advisory panel found that TWWIIA program is foundering because of implementation problems, including slow and inefficient methods of provider reimbursement; unequal payments for serving SSI and SSDI beneficiaries; inadequate levels of provider reimbursement, especially during the first 12 months of service delivery; and the inability to reward providers for benefit reduction to amounts other than zero.

The slow uptake of the Ticket to Work program was not entirely unexpected, because economists had forecasted that the program's provider payment system would offer too little financial incentive to serve certain clients, including those with mental illnesses and mental retardation (28). Providers receive payments only for months in which ticket holders' earnings achieve SGA, currently $830 per month. Even then, providers are eligible only for $295 to $347 per month, for a maximum of $20,820 per client. Therefore, the incentive is to accept tickets solely from SSA beneficiaries who can work full-time without interruption (29), which raises the question of whether providers will be adequately reimbursed for serving ticket holders with significant preemployment needs or ongoing service requirements or those who do not have the goal of full-time, continuous work. Individuals with severe mental illness are usually unemployed at program intake, take longer to obtain employment, require extensive postemployment support, and may not desire full-time employment with earnings above SGA, which threatens cash benefits and health insurance coverage (30,31).

This study used data from 450 participants in the Employment Intervention Demonstration Program (EIDP), a large, multisite, randomized trial of employment services for persons with psychiatric disabilities (32) to deter-

mine how service providers for a large group of these individuals would have fared in terms of reimbursements if the sample had been enrolled in the Ticket to Work program. Only one previous study (33) has attempted to model provider payments in the Ticket to Work program by using data on actual wage earnings that came from SSA's project NetWork, a multisite demonstration that expanded return-to-work services for SSI and SSDI beneficiaries in the mid-1990s. However, in this earlier study, only yearly earnings data from project NetWork were available for analysis, limiting the ability to examine participants' achievement of above-SGA earnings on a month-by-month basis, which is critical to accurately simulating payment mechanisms in the Ticket to Work program.

Methods

Multisite study background

The EIDP involved eight study sites located in Maryland, Connecticut, South Carolina, Pennsylvania, Arizona, Massachusetts, Maine, and Texas (32). All participants met criteria for severe and persistent mental illness on the basis of diagnosis, duration of illness, and severity of disability as established by the federal Center for Mental Health Services (34). To be eligible, participants had to be aged 18 years or older, able to provide informed consent, and unemployed at study entry. For this analysis, the population was restricted to SSDI beneficiaries who were enrolled in a vocational rehabilitation program.

All sites recruited participants from existing clinical populations by referrals from case managers, self-referral, and word of mouth. Sites received approval of human subjects' protections and confidentiality safeguards from their organizations' institutional review boards. Participants were recruited between February 1996 and June 1998 and were monetarily compensated for participation in each interview with amounts that varied by site and over time from $10 to $20.

Intervention

For the analysis presented here, a vocational rehabilitation program was defined as a program providing services that included placement into community-based jobs that paid at least the minimum wage and that were in socially integrated settings, with ongoing supports available without time limits. Several of the sites implemented models specifically tailored for people with mental illness, such as individual placement and support (35), the Program of Assertive Community Treatment (36) and the Clubhouse model certified by the International Center for Clubhouse Development (37). Other programs delivered generic supported employment services (38) with novel enhancements developed for the study. Further information about the models tested is available at the EIDP Web site (39).

Measures

The study's dependent variable was the dollar value of provider payments from either of the Ticket to Work program's two reimbursement systems. Providers themselves choose between the two systems when they apply to the program. In the milestone-outcome system, providers are paid for the first month that clients' earnings are above the SGA level and subsequently for the third, seventh, and 12th "milestone" months of above-SGA earnings. Then, for months in which the client achieves an "outcome" (cessation of cash benefits), providers receive only 85 percent of the amount they would have received without the milestone payments, further reduced by the amount paid for the milestones spread across 60 possible payments. Thus, in return for "front-loaded" payments, total reimbursement is limited to 85 percent of potential payout under the second payment system, called the outcome payment system. In the outcome payment system, providers receive 40 percent of the national average monthly SSI or SSDI cash benefit for each month a worker does not receive SSA payments because of employment. Thus, although no payments are received earlier in the process, more generous amounts are provided once cash benefits cease. In the study reported here, researchers and vocational staff tracked clients' earnings weekly, including number of hours worked, wages earned, and benefits received.

Table 1

Characteristics of 450 Social Security Disability Insurance beneficiaries with psychiatric disabilities who were receiving vocational rehabilitation services

Characteristic	N[a]	%
Male	265	59
Race or ethnicity		
African American	88	20
Hispanic or Latino	61	14
Caucasian	279	62
American Indian or Alaska Native	12	3
Asian or Pacific Islander	1	<1
Other race or ethnicity	8	2
Diagnosis[b]		
Schizophrenia spectrum disorder	247	55
Mood disorder	188	42
Personality disorder	102	23
Substance use disorder	161	36
Married or cohabiting	45	10
Employed in the 5 years before study entry	273	61
Education		
High school graduate	328	73
Some college	185	41
Mean±SD age (years)[c]	39±9.3	

[a] Numbers vary because of missing data.
[b] Primary or secondary diagnosis on axis I. Some participants had more than one diagnosis.
[c] Median, 38 years; range, 19–71 years

Analyses

The actual 1999 SGA level of $500 was used to calculate potential earnings in the Ticket to Work program, because that year was the study's midpoint. To estimate provider payments during the Ticket to Work era, the 2003 national average monthly SSDI payment of $819 was used to arrive at monthly payments of $327.60, or 40 percent of the national average benefit. The simulated provider payments were averaged across all clients for an estimate of reimbursement per client served. Finally, savings that would have been returned to SSA—calculated by using $1 for every $2 offset on participants' earnings—were estimated and applied to actual cash payments made to the 450 SSDI beneficiaries with psychiatric disabilities in calendar year 2003.

Results

Participants

Table 1 presents the demographic and clinical characteristics of the 450 SSDI beneficiaries who were receiving vocational services.

Table 2

Employment characteristics of 450 Social Security Disability Insurance beneficiaries with psychiatric disabilities who were receiving vocational rehabilitation services over 24 months

Variable	N	%	Median
Number of days before first job (mean±SD)[a]	206±176.8		15
Number of days before achieving above-SGA earnings (mean±SD)[b]	283±188.4		243
Provider involvement in securing job[c]			
Job developed for client[d]	241	34	
Job found with provider's assistance[c]	276	38	
Job found by client	201	28	
Full- and part-time jobs (one or more hours per week)			
Number of full- and part-time jobs	718	100	
Hourly salary (mean±SD)	$5.84±$1.56		$5.35
Hours worked per week (mean±SD)[c]	17±11.7		15
Job benefits[c]			
Medical benefits	29	4	
Sick leave	23	3	
Vacation	28	4	
Full-time jobs (35 or more hours per week)			
Number of full-time jobs[c]	84	12	
Hourly salary (mean±SD)[e]	$6.39±$2.27		$6.00
Job benefits			
Medical benefits[e]	20	24	
Sick leave[e]	15	18	
Vacation[e]	19	23	
Total earnings per person over 24 months (mean±SD)[a]	$3,670±$5,483		$1,819
Total Supplementary Security Income and SSDI cash benefits per person over 24 months (mean±SD)[d]	$12,570±$5,253	$12,288	

[a] For all participants employed (N=310)
[b] For all participants with earnings above the threshold of substantial gainful activity (SGA) (N=116)
[c] Out of all jobs held (N=718)
[d] For all participants (N=450)
[e] Out of all full-time jobs held (N=84)

Employment outcomes

As shown in Table 2, for the clients who worked, the average number of days before obtaining a job was 206, or around seven months. A third of all jobs (34 percent) were developed by providers or obtained with their assistance (38 percent). For those whose earnings exceeded the SGA level, the average number of days before that earning level was achieved was 283, or more than nine months. The mean salary was $5.84 per hour, and the mean number of hours worked per week was 17. Few jobs offered benefits: 4 percent provided medical insurance coverage, 4 percent provided vacation, and 3 percent provided sick leave.

A small proportion of jobs (12 percent) were held full-time (defined by the U.S. Department of Labor as 35 or more hours per week). Full-time jobs paid more, averaging $6.39 per hour. Full-time jobs were also more likely to offer benefits: 24 percent provided medical insurance coverage, 23 percent provided vacation, and 18 percent provided sick leave.

Over 24 months, employed participants' earnings averaged $3,670 per person. The average SSA cash payment during this same period, for working and nonworking individuals combined, was $12,570 per person.

Overall, study participants' employment was characterized by low-paying, part-time jobs without benefits. On average, those who worked did not begin to work until their seventh month of program participation, and their earnings did not exceed the SGA level until the ninth month of participation.

Simulated provider payments

Participants' actual monthly earnings were then used to simulate provider payments under the Ticket to Work program. On average, providers operating under the milestone-outcome payment system would have received a total of $184±$472 per person served over the two-year period. Among the 116 clients whose earnings would have generated payments, amounts would have ranged from $151 to $2,899: 70 percent of these payments would have been less than $500, and 30 percent would have exceeded $500. Under the outcome payment system, $31 per person would have been returned to service providers for two years of service provision. Only 16 clients would have generated payments under this system: 62 percent of these would have totaled less than $1,000, and 38 percent would have exceeded $1,000. Because actual annual costs for direct services in these programs ranged from $2,000 to $6,000 per client, neither payment mechanism would have covered program costs.

Why would these programs have done so poorly as providers in the Ticket to Work program? First, almost

a third of participants (140 participants, or 31 percent) did not achieve any paid employment. Another 43 percent (N=194) had earnings below the SGA level throughout the study, leaving only 26 percent (N=116) with above-SGA earnings. Under the milestone-outcome system, 26 percent (N=116) would have reached the first milestone, 18 percent (N=82) the second milestone, 8 percent (N=35) the third, and 4 percent (N=16) the fourth. Under the outcome payment system, only this last group of 4 percent would have completed their trial work period and left the rolls, thereby generating income for their providers

At the same time, study participants could have generated substantial savings for SSA under a less stringent earnings threshold than the "cash cliff" currently in place. Savings could have occurred, for example, if more individuals worked and achieved higher monthly incomes as a result of being able to retain some of their beneficiary income instead of losing all of it abruptly. Currently, workers stop receiving SSDI cash income after they earn above SGA for ten months. If instead, beneficiaries were allowed to retain $1 in cash benefits for every $2 above SGA they earned, SSA would be able to reduce its payments (rather than continuing them indefinitely as happens now), and beneficiaries would add to their monthly income by retaining some cash benefits plus earned income (up to half the amount of their maximum cash benefit). This $1 for $2 offset formula is used for SSI beneficiaries who earn above SGA but not for SSDI beneficiaries.

In this scenario, given average earnings of $3,670 per employed worker in the EIDP, if half that amount (that is, $1,835 per worker) had been returned to SSA over a two-year period, the savings generated for SSA would have totaled $568,850 over all workers. During the same two-year period, EIDP study participants received actual SSA cash payments of $12,570 per participant, totaling $5.66 million. Thus savings of $568,850 would have constituted 10 percent of total cash payments that could have been recouped by SSA.

Nationwide, in 2003 SSA reported payments to disabled workers with mental illness that averaged $792.70 per month; more than 1.66 million disabled workers with mental illnesses were enrolled, and they received cash benefits totaling $15.8 billion (18). When the 10 percent savings figure (derived from EIDP participants' earnings and their SSA cash payments as described above) is applied to this $15.8 billion, an estimated $1.6 billion could have been saved by using a $1 for $2 offset formula. This significant amount might have been even higher without income restraints caused by the cash cliff. That is, with reassurance that their benefits would not cease altogether, which was not the case for EIDP participants, under a $1 for $2 formula, beneficiaries might have generated even higher earnings with concomitant higher savings for SSA.

The payment mechanisms established by the Ticket to Work program do not reflect the reality of the vocational rehabilitation process for people with psychiatric disabilities.

Discussion

Our original question was whether the Ticket to Work program would adequately compensate providers who serve people with psychiatric disabilities. The answer appears to be no, given that actual earnings seldom reached levels that would have triggered payments to providers under that program. The earnings of 74 percent of all participants remained below the SGA level throughout the study. Moreover, the "back-loaded" outcome payment system would not have generated financial rewards until after clients had spent a considerable amount of time in vocation rehabilitation programs. Even then, payments would not have reached levels commensurate with providers' costs. Thus payment mechanisms established by TWWIIA do not reflect the reality of the vocational rehabilitation process for people with psychiatric disabilities, with its need for heavy up-front investment of resources, its relatively slow pace, and the low earnings of participants.

A number of caveats qualify our study findings. The most important is that the study's calculations represent a simulation of the Ticket to Work payment systems rather than an analysis of actual performance of ticket holders and providers. In actual situations, when ticket holders assign their tickets to registered providers, both parties may behave quite differently. Providers might be more selective, accepting tickets only from clients who are likely to have above-SGA earnings and to maintain those earnings. Actual ticket users might be more likely than those in this study to seek full-time work that provides above-SGA earnings.

Second, we were unable to take into account the number of months before the study in which participants' earnings exceeded the SGA level. Because we counted only the months after study enrollment, we may have underestimated the number of clients who would have completed their trial work period and left the rolls, thereby generating provider payments under the outcome payment system. We also used only a two-year work history rather than the unlimited number of months over which the maximum 60 monthly payouts per client are allowed, thereby underestimating the total amount of possible reimbursement per client in the Ticket to Work program. On the other hand, use of the 1999 SGA of $500 per month may have inflated our estimates of payments, because clients today might find it more difficult to earn above the 2005 SGA of $830.

Also, given the randomized controlled study design, the participants were not a nationally representative sample of SSDI beneficiaries with psychiatric disabilities, which suggests that the results may not be generalizable to this population and calls for caution in extrapolation of our findings. Finally, the EIDP study took place during the second half of the 1990s and early 2000, a time of labor market expansion, in sharp contrast to the current period of economic downturn. For example, throughout much of the study, local unemployment rates at the study sites declined steadily (40). Current participation in the labor force would most likely be influenced by today's poorer job economy, with lower earnings and longer periods of unemployment.

The final report of the President's New Freedom Commission on Mental Health (41) identified the low employment rate of individuals with severe mental illness as a major barrier to recovery and community integration. Several of the report's recommendations are germane to future directions in the development of the Ticket to Work program, particularly to any reforms that are considered. First, the report recommended that "return-to-work should be consumer-driven," and, in order to make this a reality, the report called for a dramatic increase in the quality and availability of employment services. Such an increase in service capacity appears unlikely without changes to the program's reimbursement structure. The report also noted that "return-to-work should involve a multi-systemic approach" and that "States will have the flexibility to combine federal, state, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between health care, employment supports, housing, and the criminal justice system." What would such a multisystemic approach look like? It would comprise federal, state, and local systems responsible for employment, income support, rehabilitation, mental health, health care, housing, education, legal aid, asset accumulation, and other social services.

It remains for SSA and other federal agencies to partner with states and local organizations and advocacy groups to explore such multisystemic models. The Ticket to Work program's narrow emphasis on reducing SSA cash payments targets only one important stakeholder in the return-to-work process and offers insufficient benefits for people with disabilities and service providers. Failure to take account of the complexity of the return-to-work process may be taxing the Ticket to Work program, contributing to its poor performance. The policy of incremental reform underlying this legislation is not likely to succeed in the face of such complexity. Moreover, the program is not appropriate for all individuals. It remains for us to develop new solutions that go beyond the Ticket to Work program and encompass larger-scale policy reforms as well as rigorous outcome assessment of their effectiveness.

Acknowledgments

This study is part of the Employment Intervention Demonstration Program (EIDP), a multisite collaboration between eight research demonstration sites, a Coordinating Center, and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (cooperative agreement SM51820). Preparation of the manuscript was funded by the National Institute on Disability and Rehabilitation Research of the U.S. Department of Education and the Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration (cooperative agreement H133 B050003). The views expressed herein are those of the authors and do not necessarily reflect the policy or position of any federal agency.

References

1. Lehman A, Steinwachs DM, Dixon LB, et al: Patterns of usual care for schizophrenia: initial results from the Schizophrenia Patient Outcomes Research Team (PORT) client survey. Schizophrenia Bulletin 24:11–20, 1998
2. Baldwin MI, Johnson WG: Dispelling the myths about work disability, in New Approaches to Disability in the Workplace. Edited by Thomason T, Burton JF. Madison, Wis, Industrial Relations Research Association, 1998
3. Stefan S: Unequal Rights: Discrimination Against People With Mental Disabilities and the Americans With Disabilities Act. Washington, DC, American Psychological Association, 2001
4. Andrews H, Barker J, Pittman J, et al: National trends in vocational rehabilitation: a comparison of individuals with physical disabilities and individuals with psychiatric disabilities. Journal of Rehabilitation 58:7–16, 1992
5. Noble JH: Policy reform dilemmas in promoting employment of persons with severe mental illnesses. Psychiatric Services 49: 775–781, 1998
6. Cook JA, Solomon ML: The community scholar program: an outcome study of supported education for students with severe mental illness. Psychosocial Rehabilitation Journal 17:84–97, 1993
7. Manderscheid RW, Henderson M, Witkin MJ, et al: Contemporary mental health systems and managed care. International Journal of Mental Health 27:5–25, 1998
8. Wang PS, Berglund P, Kessler RC: Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. Journal of General Internal Medicine 15: 284–292, 2000
9. Cook JA, Lehman A, Drake R, et al: Integration of psychiatric and vocational services: a multisite randomized, controlled trial of supported employment. American Journal of Psychiatry 162:1948–1956, 2005
10. Cohen CI: Poverty and the course of schizophrenia: implications for research and policy. Hospital and Community Psychiatry 44: 951–959, 1993
11. Ho B, Andreasen N, Flaum M: Dependence on public financial support early in the course of schizophrenia. Psychiatric Services 48:948–950, 1997
12. Ware NC, Goldfinger SM: Poverty and rehabilitation in severe psychiatric disorders. Psychiatric Rehabilitation Journal 21(1):3–9, 1997
13. Kaye HS: Employment and social participation among people with mental health disabilities. Presented at the Ninth National Disability Statistics and Policy Forum, Washington, DC, Oct 2002
14. Burkhauser RV, Wittenburg D: How current disability transfer policies discourage work: analysis from the 1990 SIPP. Journal of Vocational Rehabilitation 7:9–27, 1996
15. Newcomb C, Payne S, Waid MD: What do we know about disability beneficiaries' work and use of work incentives prior to Ticket? Background information and baseline data, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work? Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003
16. Polak P, Warner R: The economic life of seriously mentally ill people in the community. Psychiatric Services 47:270–274, 1996
17. White JS, Black WE, Ireys HT: Explaining enrollment trends and participant characteristics of the Medicaid Buy-In Program, 2002–2003. Mathematica Policy Research Inc, 2005
18. Annual Statistical Report on the Social Security Disability Insurance Program. Baltimore, Social Security Administration, 2003
19. Muller LS, Scott CG, Bye BV: Labor-force participation and earnings of SSI disability recipients: a pooled cross-sectional time se-

ries approach to the behavior of individuals. Social Security Bulletin, spring 1996, pp 22–42

20. Hennessey JC, Dykacz JM: Projected outcomes and length of time in disability insurance program. Social Security Bulletin, Sept 1989. pp 2–41

21. Ticket to Work and Work Incentives Improvement Act of 1999. Pub L No 106-170, 113 Stat 1860 (Dec 17, 1999)

22. Cook JA, Burke J: Public policy and employment of people with disabilities: exploring new paradigms. Behavioral Science and the Law 20:541–557, 2002

23. Berkowitz M: The Ticket to Work Program: the complicated evolution of a simple idea, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work? Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003

24. Stapleton DC, Livermore GA: A conceptual model and evaluation strategy for the empirical study of the adequacy of incentives in the Ticket to Work Program, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work? Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003

25. Huynh M, O'Leary P: Issues affecting alternatives to the Ticket to Work incentive structure, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work? Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003

26. Social Security Administration: Social Security Online: The Work Site. Available at www.ssa.gov/work/ticket/ticketinfo.html#ticketkettracker, Accessed Mar 9, 2005

27. Social Security Administration: Ticket to Work and Work Incentives Advisory Panel Annual Report, 2004. Available at www.socialsecurity.gov/work/panel/paneldocuments/reports.html

28. Wehman P, Revell G: Lessons learned from the provision and funding of employment services for the MR/DD population: implications for assessing the adequacy of the SSA Ticket to Work, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work? Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003

29. Salkever D: Tickets without takers: potential economic barriers to the supply of rehabilitation services to beneficiaries with mental disorders, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work. Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003

30. MacDonald-Wilson KL, Rogers ES, Ellison ML, et al: A study of Social Security work incentives and their relation to perceived barriers to work among persons with psychiatric disability. Rehabilitation Psychology 48:301–309, 2003

31. Cook JA, Leff HS, Blyler C, et al: Results of a multi-site randomized trial of supported employment interventions for individuals with severe mental illness. Archives of General Psychiatry 62:505–512, 2005

32. Cook JA, Carey MA, Razzano LA, et al: The Pioneer: the employment intervention demonstration program: a multisite study of vocational rehabilitation interventions, in New Directions in Evaluation: Conducting Multiple Site Evaluations in Real-World Settings. Edited by Herrell JM, Straw RB. San Francisco, Jossey-Bass and the American Evaluation Association, 2002

33. Rupp K, Bell SH: Provider incentives and access in the Ticket to Work program: implications of simulations based on the Project NetWork field experiment, in Paying for Results in Vocational Rehabilitation: Will Provider Incentives Work for Ticket to Work? Edited by Rupp K, Bell SH. Washington, DC, Urban Institute, 2003

34. Manderscheid RW: Mental Health, United States. Washington, DC, US Government Printing Office, 1992

35. Drake RE, McHugo GJ, Bebout DR, et al: A randomized controlled trial of supported employment for inner city patients with mental illness. Archives of General Psychiatry 56: 627–633, 1999

36. Russert MG, Frey JL: The PACT vocational model: a step into the future. Psychosocial Rehabilitation Journal 14:7–18, 1991

37. Anderson SB: We Are Not Alone: Fountain House and the Development of Clubhouse Culture. New York, Fountain House, Inc, 1998

38. Wehman P, Kregel J: A supported work approach to competitive employment for individuals with moderate and severe handicaps. Journal of the Association for Persons With Severe Handicaps 10:3–11, 1985

39. Employment Intervention Demonstration Program. Chicago, University of Illinois at Chicago, Center on Mental Health Services Research and Policy. Available at www.psych.uic.edu/eidp

40. Cook JA, Grey DD, Burke J, et al: Effects of unemployment rate on vocational outcomes in a randomized trial of supported employment for individuals with severe mental illness. Journal of Rehabilitation, in press

41. New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS pub no SMA-03-3832. Rockville, Md, Center for Mental Health Services, 2003

Submissions for Datapoints Invited

Submissions to the journal's Datapoints column are invited. Areas of interest include diagnosis and practice patterns, treatment modalities, treatment sites, patient characteristics, and payment sources. National data are preferred. The text ranges from 350 to 500 words, depending on the size and number of figures used. The text should include a short description of the research question, the database and methods, and any limitations of the study.

Inquiries or submissions should be directed to Harold Alan Pincus, M.D., Terri L. Tanielian, M.S., or Amy M. Kilbourne, Ph.D., M.P.H., who are editors of the column. Contact Ms. Tanielian at RAND, 1200 South Hayes Street, Arlington, Virginia 22202 (territ@rand.org).