



**Improving Mental Health Service Delivery:**  
Focus on Coordinated Specialty Care for Youth with  
First Episode Psychosis Using Resources Available  
through the Workforce Development System  
and American Rescue Plan

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## Introduction

To assist communities grappling with mental health and substance use needs during the COVID-19 pandemic, in May 2021 Health and Human Services (HHS) Secretary Becerra announced that the Substance Abuse and Mental Health Services Administration (SAMHSA) would be dispersing \$1.5 billion in Community Mental Health Services Block Grant (MHBG) Program and Substance Abuse Prevention and Treatment Block Grant Program (SABG) funding. On the heels of the March 2021 announcement of supplemental funding of nearly \$2.5 billion for these non-competitive grant programs, this represents the largest aggregate funding to date for these programs. In addition, President Biden's proposed FY2022 Budget builds on mental health resources included in the American Rescue Plan (ARP) by calling for historic investments, including \$1.6 billion in additional funding for the MHBG; an amount more than double the 2021 enacted level.

The MHBG program enables states and territories to provide comprehensive community mental health services and address needs and gaps in existing treatment services for those with severe mental health conditions. The SABG program allows states and territories to plan, implement, and evaluate activities to prevent, treat and help more people recover from substance use disorder. This funding will also allow recipients to make investments in existing prevention, treatment, and recovery infrastructure, promote support for providers and address unique local needs to deliver substance use disorder services.

During the COVID-19 pandemic, the country has seen a significant increase in anxiety, depression, and other behavioral health conditions. Substance misuse has also increased significantly. The COVID-19 pandemic and the corresponding economic crisis have been especially devastating for Black, American Indian, Alaska Native, and Hispanic communities, who are experiencing a disproportionate number of COVID-19 infections and deaths along with higher than average unemployment rates. Asian American, Native Hawaiian, and Pacific Islander (AANHPI) populations have experienced increased stigma and hate due to COVID-19 anti-Asian rhetoric, which is impacting the behavioral health of AANHPI communities.

Emerging data also indicate that people with schizophrenia and other serious mental illnesses have also been hard hit by the pandemic. Individuals with schizophrenia, for instance, are nearly 10 times more likely to contract COVID-19 and are nearly three times more likely to die from it if they do fall ill, compared with individuals who do not have a mental illness (Nemani et al., 2021).

While the impact of COVID-19 has been challenging for people of all ages, it may have been particularly difficult for adolescents and young adults, who are at a stage developmentally where peer connections for emotional support and social development are extremely important (Rogers et al., 2021). Increased symptoms of depression, anxiety, and post-traumatic stress disorder have been shown among youth of various age groups (Ma et al., 2020). Private insurance [data](#) also shows that while all health care claims for adolescents ages 13-18 were down in 2020 compared to 2019, mental health-related claims for this age group increased sharply (Panchal et al., 2020). There is also some evidence to suggest that, based on the uptick in mental health-related emergency room visits during the pandemic, suicidal ideation and suicides may also have increased (Hill et al., 2021).

While vaccination efforts, reopening schools, and robust economic relief packages have begun to pave the way for Americans to start to live life in the so-called “new normal,” the mental health effects of the pandemic are not likely to dissipate quickly. Historically, pandemics such as COVID-19 have lasting impacts beyond the viral infection itself, in the form of long-term physical and mental health effects. In terms of mental health, studies have documented greater prevalence of symptoms such as anxiety, depression, post-traumatic stress, grief, substance abuse, anger, self-stigmatization, suicidality, and psychosis among survivors, caregivers, healthcare workers, and the general public during and after recent pandemics such as the 2003 severe acute respiratory syndrome (SARS) (Piltch-Loeb et al., 2021). And as was the case with the virus itself, the longer-term mental health impact also will not be borne equally. The same communities that were discussed previously as already more vulnerable to mental health conditions prior to COVID-19, and that were struck by the virus and impacted by its subsequent economic fallout the most, are likely to continue to see disproportionately higher rates of longer-term mental health issues also (Boden, Matt et al., 2021; Novacek et al., 2020). When the potential long term mental health effects of COVID-19 are considered along with the collective trauma of the racial unrest and related discourse that has gripped our nation since the summer of 2020, along with the level of unmet mental health needs that existed prior to the pandemic, researchers warn that our nation is on the cusp of facing a mental health crisis for which it is inadequately prepared (Silver et al., 2021).

This brief discusses the importance of early intervention in mental health service delivery for youth experiencing their first episode psychosis (FEP) through Coordinated Specialty Care (CSC). It also indicates how elements of CSC service delivery, including supported employment (SE) and education, can be funded using traditional (e.g., MHBG and Medicaid, state funds) and less traditional funding sources, including those available through the workforce development system. Finally, the brief discusses the significant investments in mental health and substance use service delivery and related infrastructure being made by the Biden-Harris Administration through the ARP as well as other funding sources that states could potentially leverage to provide services to youth experiencing FEP and other individuals whose mental health may have been impacted by the COVID-19 pandemic.

## First Episode Psychosis and the Importance of Early Intervention

It is important to keep in mind that the mental health impact of the pandemic is occurring against the backdrop of the high rates of mental illness and substance use that already existed before the current crisis. Even prior to the unprecedented stressors associated with living through a pandemic, each year an estimated 115,000 individuals experience their FEP and 70% of FEP occurs before the age of 25 years (Oluwoye et al., 2019). In the U.S., people diagnosed with psychotic disorders such as schizophrenia die an average of 11 years earlier than the general population, typically due to co-occurring medical conditions (Druss et al., 2011). Up to 10 percent of individuals with schizophrenia die by suicide, often in the early years of illness (Meltzer, 2001).

Stile, et. al. (2018) report that non-Hispanic Blacks are five times more likely to be diagnosed with schizophrenia and are at a higher risk of being misdiagnosed with schizophrenia compared to non-Hispanic whites. Moreover, they report that relative to non-Hispanic whites, non-Hispanic Blacks and other racial and ethnic minorities (i.e. Hispanics) with psychotic disorders have higher rates of involuntary hospitalizations, and are less likely to be enrolled in outpatient mental health services and adhere to treatments (Coid et al., 2008). In addition they further indicate that although the causes of these disparities are unclear, racial and ethnic minorities are more likely than non-Hispanic whites to have limited access to care, to lack insurance coverage, to experience implicit bias, to have negative opinions toward mental health care, and to mistrust providers (Alegría et al., 2002; Dixon et al., 2001; Kohn-Wood & Hooper, 2014; Whaley, 2001).

With a peak onset occurring between 15-25 years of age, psychotic disorders such as schizophrenia can derail a young person's social, academic, and vocational development and initiate a trajectory of accumulating disability (Goldstein & Azrin, 2014). On average, 50% of individuals who experience FEP do not complete secondary school (Boychuk & Stuart, 2018). Young adults with early onset (ages 14–24 years) are more negatively influenced by FEP than those with later onset (ages 25–35 years) because of psychosis-related experiences that result in protracted vocational and social development (Krupa et al., 2009; Woodside & Krupa, 2010). Substance abuse is also common among young adults with FEP (Wisdom et al., 2011). In addition to the high level of disability associated with untreated psychosis, it also costs our economy an estimated \$155.7 billion a year in direct health care costs, unemployment, and lost productivity for caregivers (NAMI, 2017).

Fortunately, however, person-centered, age-appropriate, culturally sensitive and trauma-informed treatment can help many young people with psychotic disorders lead healthy and productive lives. Early intervention during the FEP, however, is considered key to a favorable prognosis and to long-term success (Heinssen et al., 2014).

To focus attention on improving recovery trajectories and reducing the personal and economic toll associated with delayed treatment, in 2008 the National Institute of Mental Health (NIMH), implemented the Recovery After an Initial Schizophrenia Episode (RAISE) research initiative. RAISE involved two randomized control trials: the RAISE Early Treatment Program (RAISE-ETP)<sup>1</sup> and the RAISE

<sup>1</sup> The RAISE-ETP randomized control trial involved 404 young people with FEP in 34 community clinics. Community-based clinicians were trained to deliver a team-based approach to CSC that included four core interventions: resilience-focused individual therapy, family psychoeducation and support, supported education and employment, and personalized medication management.

Implementation and Evaluation Study (RAISE-IES).<sup>2</sup> RAISE was intended to develop, test, and implement CSC programs for FEP previously found to be effective in other studies internationally. CSC is a team-based, recovery oriented approach to treating FEP primarily in youth and young adults ages 15-25. It is premised on shared-decision-making and commonly includes psychotherapy, medication management, family education and support, supported employment, supported education, and case management. Outreach and engagement activities also are essential to hasten the identification of young people with FEP and reduce the duration of untreated psychosis. Peer support services, primary care coordination, and supportive housing services are increasingly being included in addition to the traditional core components of the model.

RAISE involved a large multisite randomized controlled trial that investigated the efficacy of a CSC intervention called NAVIGATE, which incorporates shared-decision-making, family psychoeducation, individual therapy, medication management, and supported employment and education. The programming was delivered in “real world” community clinics by clinicians who were already members of the behavioral health workforce, rather than specially trained research staff, and preexisting billing/reimbursement structures were used to pay for services whenever possible. Findings from the RAISE project demonstrated that, compared to patients who received usual care, participants in CSC experienced significantly greater improvements in total symptoms, social functioning, work or school involvement, and overall quality of life. Individuals with a shorter duration of untreated psychosis derived the most benefit (Heinssen et al., 2014). In addition, CSC was found to be cost-effective and feasible in U.S. community mental health settings (Rosenheck et al., 2016). Secondary analysis of the research data conducted subsequently produced new research-based knowledge on the capacity of its Supported Education and Employment (SEE) approach to improve work or school outcomes (Davis & Munson, 2018; Lynde et al., 2017; Rosenheck et al., 2016).

From 2006-2013, the NIMH supported the Specialized Treatment in Early Psychosis (STEP) randomized control trial, which compared the effectiveness of CSC conducted in a public sector mental health center for 120 youth and young adults experiencing FEP to usual care. After one year of treatment, the participants in CSC experienced significantly greater improvements in psychopathology, fewer hospitalization episodes, and better school and work participation compared to those in usual treatment (Wachino et al., 2015).

<sup>2</sup> RAISE-IES was conducted with 65 young adults in two publically funded CSC mental health clinics in Maryland and New York using a CSC model incorporating medication, supported employment and education, family support and education, skills training and support based on cognitive-behavioral methods, substance abuse treatment, and suicide prevention. Over two years, a range of positive outcomes was achieved, including total symptom reduction, better occupational functioning, and greater participation in school or work. In partnership with state mental health authorities in New York and Maryland, RAISE-IES established the feasibility of CSC teams in routine practice settings and the success of such teams in engaging and retaining youth and young adults in treatment.

## STATE EXAMPLE OF FEP TREATMENT: CONNECTICUT'S STEP

**The Specialized Treatment Early in Psychosis (STEP) is a joint program between Yale School of Medicine and Connecticut Department of Mental Health & Addiction Services and is based at the Connecticut Mental Health Center. STEP is an early intervention clinic with a vision to “build a clinic that could easily be replicated in ordinary community settings.” STEP utilizes a multi-disciplinary treatment team, including nurses, psychiatrists, primary clinicians, and social workers. If the patient expresses interest in working, STEP will provide occupational and vocational services. The clinicians at STEP look at the intersectionality of the patients and provide individualized treatment based on their assessment.**

Taken together, RAISE-ETP, RAISE-IES, and STEP demonstrated convincingly that first episode psychosis CSC programs are cost-effective, feasible in U.S. community mental health settings, and provide better clinical and functional outcomes than typical treatment (Wachino et al., 2015). In 2014, as the RAISE studies were nearing completion, the United States Congress recognized the value of CSC programs by directing SAMHSA to require state behavioral health authorities (SBHAs) to dedicate at least 5 percent of their MHBG funds (“Set Aside”) “to support programs that address the needs of individuals with early serious mental illness (SMI), including psychotic disorders” (Shern et al., 2018). This original directive suggested, but did not require, that states use the funds to support the treatment of FEP. When, however, Congress doubled the amount of the Set Aside to 10 percent of the MHBG in the 2016 Omnibus Bill, it also directed that funds be used “only for programs showing strong evidence of effectiveness” that exclusively support individuals experiencing an FEP (Shern et al., 2018).

## Funding CSC the Traditional Way

Since 2014, when Congress allocated the set aside funding in the MHBG, SAMHSA, NIH, and CMS have worked together closely to develop guidance for states about the use of evidence-based practices for FEP and mechanisms for funding it, and have strongly encouraged the implementation of CSC models using Set Aside funds through guidance, training, and technical assistance. For example, on November 13, 2018 CMS released [\*\*Opportunities to Design Innovative Service Delivery System for Adults with Serious Mental Illness \(SMI\) and Children with Serious Emotional Disturbance \(SED\)\*\*](#), and SAMHSA also encouraged integrating CSC services into their Systems of Care (SOC) (Sale et al., 2018). As a result, there has been an exponential growth in CSC; today there are more than 200 CSC programs (Meyer-Kalos et al., 2020). To illustrate the range of possible programming, several model programs are highlighted throughout this document.

Despite this growth in programs, however, and the strong research and business case that exists, the need for CSC for youth experiencing FEP continues to far exceed the number of programs available. Difficulties in expanding CSC services have been attributed to a variety of issues — chief among which is funding (Karakus et al., 2017).

Financing CSC services through Medicaid and commercial insurance poses a unique challenge due to the types of services that compose CSC, their intensity in terms of time and frequency, and in some instances the location and type of service provider used to provide the service (Jackson et al., 2020). Before a service can be billed to Medicaid, the individual requiring services has to establish their eligibility to participate (Shern et al., 2018). Although individuals may qualify for Medicaid on the basis of a disability, CSC programs are early intervention services intended to avoid the development of a disability, and youth experiencing FEP are generally not considered disabled (Shern et al., 2018). However, the ACA provided extensive federal support to the largest expansions of mental health and substance use disorder coverage in a generation by requiring Medicaid coverage for children without regard to disability status for individuals whose income fell below 138 percent of the federal poverty level (FPL) (Gonzalez et al., 2016), and most states cover children to higher income levels. The ACA also created the opportunity for states to extend Medicaid eligibility to adults with incomes at or below 138 percent of the FPL. As a result, thirty eight states (including the District of Columbia) now use Medicaid to cover low-income adults, including young adults with FEP who are not likely to meet traditional disability criteria (Dixon et al., 2018).

The ACA also increased options for states to provide home and community-based services through Medicaid, including for people with mental illnesses, by expanding the state plan option established under Section 1915(i) of the Social Security Act, to include individuals at higher incomes and to allow states to include early intervention services, such as case management, assertive community treatment, and psychosocial rehabilitation under the state plan option (Shern et al., 2018).

In addition, the ACA also expanded coverage for mental health by requiring that most individual and small employer health insurance plans, including all plans offered through the Health Insurance Marketplace, cover mental health and substance use disorder services, and expanded parity protections to this coverage (Siegwarth & Blyler, 2014). Moreover, rehabilitative and facilitative services that can help support people with behavioral health conditions are also covered under the ACA, and young adults who can remain on their parent's private insurance plan until age 26 may also

be eligible for third-party liability coverage for denied services under Medicaid (Shern et al., 2018). Even though many more young individuals with FEP are now potentially eligible to receive Medicaid services under the ACA, Medicaid's conventional package of services does not cover all CSC service program elements (Shern et al., 2018; Shern, 2020). Supported employment, supported education, family support services, public education, outreach to potential enrollees, and engagement activities prior to program enrollment are cited as examples of the types of services that generally are not covered by Medicaid. Although such services are currently covered by either state general funds or through MHBGs, the 2018 Issue brief on Use of Medicaid to Finance Coordinated Specialty Care Services by Shern et al., (2018) and the Joint Center for Medicaid & CHIP Services and SAMHSA Informational Bulletin on Coverage of Behavioral Health Services for Youth with Substance Use Disorders (2015), excerpts of which are set forth below, describe how it is possible to devise comprehensive approaches for serving individuals with FEP by utilizing a variety of Medicaid financing options, including the following:

### **Targeted Case Management Services**

Targeted case management services (defined at 42 CFR 440.169) include services that assist eligible individuals to gain access to needed medical, social, educational, and other services. Targeted case management services are comprehensive and must include all of the following: assessment of an eligible individual, development of a specific care plan, referral to services, and monitoring activities.

### **Preventive Services**

Preventive services must involve direct patient care and be for the express purpose of diagnosing, treating, or preventing (or minimizing the adverse effects of) illness, injury, or other impairments to an individual's physical or mental health. As of January 1, 2014, preventive services may be furnished by non-licensed practitioners who meet qualifications set by the state.

### **Rehabilitative Services**

The optional Medicaid rehabilitative services state plan benefit ("rehab option") is the primary vehicle states use to finance their mental health services. Rehab services are medical or remedial services "recommended by a physician or other licensed practitioner ... for maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." Under the rehab option, states have the flexibility to determine service eligibility and service array, and can impose limitations on services and determine which providers can deliver which services. Services can be provided in community settings, including a person's home or work environment, and by a broader range of professionals including community paraprofessionals and peer specialists. Moreover, services can be covered beyond clinical treatment of a condition, including pharmacotherapy, crisis management, peer support, and family therapy as well as services that assist individuals in re-acquiring skills essential for everyday functioning. Supported employment and education, however, are not covered, but may be provided through the 1915(c) waiver and Section 1915(i) State Plan option, as discussed below. Costs associated with the outreach and public education components of CSC also are not covered, but could be reimbursable under funds available for the administration of the Medicaid program.

### **Medicaid Managed Care**

States may include CSC service costs in the Medicaid managed care capitation rates if all of the regulatory requirements specified in 42 C.F.R. § 438.3(e)(2) for “in lieu of services” are met, including that the state has determined that CSC services are a medically appropriate and cost effective substitute for covered services under the Medicaid State plan. This may require a state to negotiate a comprehensive reimbursement rate with managed care plans that includes all of the components of the evidence-based CSC service. States must also authorize and identify any in lieu of services in the managed care plan contracts to be offered at the option of both Medicaid managed care enrollees and managed care plans. CSC services for outreach and public education as well as training and fidelity assessment, however, would not be reimbursable under Medicaid managed care and would have to be funded through a separate contract, for which Medicaid administrative match may be available, subject to federal approval.

### **Home and Community-Based Services**

The 1915(c) Waiver Authority and 1915(i) State Plan Authority can also be used to fund CSC services. 1915(c) waivers allow a state to design a comprehensive package of community-based long-term care services and supports for individuals who would otherwise need institutional care so long as there is cost-neutrality. States can propose “other” types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. CSC services that have been provided under the 1915(c) program for older adolescents and young adults include respite and supported employment. Under this waiver, states may limit the services to subgroups of Medicaid beneficiaries, and limit participation to a specific number of beneficiaries or area within the state.

Under Section 1915(i), states can amend their state Medicaid plans to offer intensive home and community-based behavioral health services that were previously provided primarily through 1915(c) but without regard to whether the individuals would otherwise need an institutional level of care. Intensive care coordination, respite, and supported employment can be offered under 1915(i) and serve youth and young adults with significant mental health conditions. Under 1915(i), states may not waive the requirement to provide services statewide or limit the number of participants, but to target the initiative and limit costs, states may identify a specific population based on age, disability, diagnosis, and/or Medicaid eligibility group and establish additional needs-based criteria.

## **STATE EXAMPLE OF BRAIDED FUNDING**

**OnTrackNY is an innovative state-wide CSC treatment program for adolescents and young adults. It is an initiative of the Center for Practice Innovations at Columbia Psychiatry and the New York State Psychiatric Institute. The New York State Office of Mental Health using the Mental Health Block Grant set-aside funds the Center. Faculty at the Columbia University College of Physicians and Surgeons and the Columbia University Medical Center play a role in program oversight and supervision. Staff at the Center for Practice Innovations at the New York State Psychiatric Institute provide training, consultation, technical assistance, and evaluation services. The Center for Practice Innovations supports OnTrackUSA, which provides manuals, a learning community, and other web-based resources as well as consultation and training to programs and State agencies that would like to implement CSC.**

### **1115 Authority**

Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children’s Health Insurance Program (CHIP). These demonstrations give states additional flexibility to design and improve their programs; to demonstrate and evaluate policy approaches, such as providing services not typically covered by Medicaid; and using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

Although not discussed in the CMS, NIMH, and SAMSHA joint guidance and related issue briefs regarding funding for CSC programming discussed previously, SAMSHA also provides funding for supported employment through the Transforming Lives Through Supported Employment Program. This program is designed to support state and community efforts to refine, implement, and sustain evidence-based supported employment programs and mutually compatible and supportive evidence-based practices (e.g., supported education) for transition-aged youth/ young adults (ages 16-25) with serious emotional disturbance (SED), and adults with serious mental illness (SMI) or co-occurring mental and substance use disorders (COD). Grant funds may also be used to:

1. Link to and collaborate with the Social Security Administration’s Supported Employment Demonstration Program.
2. Link to and collaborate with the Department of Labor’s Employment First State Leadership Mentoring Program Provider Visionary Opportunities to Increase Competitive Employment; and
3. Integrate compatible and mutually supportive programs/ services (e.g., supported housing, supported education) to facilitate the goal of individuals securing competitive employment.

The Department of Health and Human Services published a FOA on [\*\*\*The Supported Employment Program\*\*\*](#) on March 3, 2019. 7 grants were awarded for a five-year period of performance from September 30, 2019 through September 29, 2024.

## **CSC CASE STUDY: EPIC-NOLA**

**New Orleans’ Early Psychosis Intervention Center, New Orleans (EPIC-NOLA) is a CSC model based on the RAISE research and adapted for the New Orleans community. EPIC-NOLA focuses on six treatment components when working with the youth:**

- 1. Medication management with add-on therapy;**
- 2. Individual psychoeducation and psychotherapy;**
- 3. Education and employment support;**
- 4. Family psychoeducation and psychotherapy;**
- 5. Group interventions; and**
- 6. Socialization.**

**In 2015, EPIC-NOLA started with only an academic partnership and a community based service partnership. In 2016, Louisiana Department of Health allocated some of SAMHSA block grants to EPIC-NOLA, and in 2019, EPIC-NOLA became part of the Tulane Department of Psychiatry and Behavioral Sciences. EPIC-NOLA is still in operation and has expanded its efforts to try to help its community better understand early psychosis.**

## Significant New Sources of Funding Through the American Rescue Plan

In addition to the \$3 billion in funding being provided for the SABG and MHBG (\$1.5 billion each) discussed previously, the Biden Administration is also making additional significant mental health and substance abuse investments through the ARP that states may be able to leverage to support CSC programming and other mental health services, including services to individuals experiencing a mental health impact due to the pandemic. The ARP allocates approximately \$4 billion in mental health and substance abuse funding over the supplement funding previously provided through the Consolidated Appropriations Act of 2021, and regular fiscal year 2021 appropriations. The ARP funding being allocated is described below:

### **Specific Provisions:**

#### Subtitle H - Mental Health and Substance Use Disorder

- Sec. 2701. \$1.5 billion for the **Community Mental Health Services block grant**.
- Sec. 2702. \$1.5 billion for the **Substance Abuse Prevention and Treatment block grant**.
- Sec. 2703. \$80 million **to provide training for mental health and substance use healthcare professionals, paraprofessionals, and public safety officers** in rural and underserved communities. Training focuses on evidence-informed strategies for reducing and addressing suicide, burnout, mental health conditions, and substance use disorders among healthcare professionals through HHS/Health Resources Services Administration (HRSA) for mental health and substance use disorder training for health care professionals, paraprofessionals, and public safety officers.
- Sec. 2704. \$20 million through the Center for Disease Control (CDC) for an evidence-based **national education and awareness campaign** encouraging healthy work conditions and use of mental health and substance use disorder services by health care professionals.
- Sec. 2705. \$40 million to HRSA for grants or contracts with healthcare entities, including provider trade associations and Federally Qualified Health Centers (FQHCs), to establish or expand protocols **to promote mental health among healthcare providers, particularly in rural and underserved communities**.
- Sec. 2706. \$30 million in funding to SAMHSA for grants to **support community-based services** including overdose prevention programs, syringe services programs, and other harm reduction services while also preventing and controlling the spread of infectious diseases.
- Sec. 2707. \$50 million in grant funding to SAMHSA for **community-based funding for local behavioral health needs** to support care coordination among local entities; train the mental and behavioral health workforce, relevant stakeholders, and community members; expand evidence-based integrated models of care; address surge capacity for mental and behavioral health needs; and otherwise provide mental and behavioral health services to individuals with mental health needs.
- Sec. 2708. \$10 million to SAMHSA for the **National Child Traumatic Stress Network**.

- Sec. 2709. \$30 million to SAMHSA for **Project Advancing Wellness and Resiliency in Education (AWARE)** to award grants to state educational agencies to support school-based mental health for children.
- Sec. 2710. \$20 million in grant funding to SAMSHA for **youth suicide prevention**.
- Sec. 2711. \$100 million in grant funding to HRSA to support **behavioral health workforce recruitment and education and training**, including peer support specialists.
- Sec. 2712. \$80 million to HRSA for **grants to promote behavioral health integration in pediatric primary care**.
- Sec. 2713. \$420 million to SAMSHA for **expansion grants for Certified Community Behavioral Health Clinics**.

#### Subtitle J—Medicaid

- Sec. 9813 establishes **community-based mobile crisis intervention services** as a Medicaid state option, beginning April 1, 2022 through March 31, 2027. Qualifying community-based mobile crisis intervention services are eligible for 85% federal matching funds for the first 12 fiscal quarters occurring during the period of April 1, 2022 through March 31, 2027 in which a state meets the requirements in the statute. The statute also provides \$15 million for planning grants to states to develop state plan amendments or waivers which will ultimately help increase the amount of mental health and substance use disorder services and related supports states can offer to those impacted by the pandemic (American Rescue Plan Act of 2021, page 210, 2021).
- Sec. 9814 **incentivizes Medicaid expansion** for the 13 states that have not yet expanded the program, by providing a temporary (eight-quarter) 5 percentage point increase in the regular matching rate for many medical services for states that newly expand Medicaid. As discussed previously, expanding Medicaid coverage without regard to disability status for individual whose income falls below 138 percent of the federal poverty level (FPL) opens the door to many more young adults with FEP being able to participate in CSC programming.
- Section 9817 of the bill also provides qualifying states with a **temporary ten percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS)** during the period from April 1, 2021 through March 31, 2022 (American Rescue Plan, page 213, 2021). On May 13th, 2021, in a [letter to State Medicaid Directors](#), the Centers for Medicare & Medicaid Services (CMS) noted that states could use these funds for all rehabilitative services, “including mental health and substance use disorder services...” Further, CMS clarified that states can use these additional funds to “assist eligible individuals *in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services* to regain skills lost during the pandemic” (Costello, 2021).

### ***Elementary and Secondary School Emergency Relief (ESSER) Funding***

School-based mental health services also play an extremely important part in youth mental health service delivery. In 2018, nearly 3.5 million adolescents received mental health services in education settings (Hertz & Barrios, 2021; SAMHSA, 2019). Adolescents with public insurance, from low-income households, and from racial/ethnic minority groups, were more likely to only access services in an educational setting, compared with services in both educational and other settings or in other settings only (private specialty or general medical settings) (Ali, 2019; Hertz & Barrios, 2021).

Funding being allocated under the Elementary and Secondary School Emergency Relief (ESSER) Fund, which has been funded through the Coronavirus Aid, Relief, and Economic Security Act (CARES), the Coronavirus Response and Relief Supplemental Appropriations (CRRSA), and ARP, can be used for any activity authorized under the Individuals with Disabilities Education Act (IDEA), the Adult Education and Family Literacy Act, or the Perkins Career Technical Education Act of 2006 (Perkins V). This includes, but is not limited to, implementing transition programs, including coordination of services with agencies involved in supporting the transition of children with disabilities, English learners, and those experiencing homelessness, to postsecondary activities. For students who graduated high school in the class of 2020 and 2021 (i.e., during the pandemic) but have not yet successfully transitioned to college or careers, GEER-ESSER funds may be used for college or career counseling, assistance with college applications, entry into job training programs, mental health services, and financial literacy (Hertz & Barrios, 2021). Funding is available through September 30, 2023. Additional information can be found at [U.S. Department of Education](#).

### ***Other Funding Streams Available to Support Supported Employment and Education (SEE) and Other Aspects of CSC Programming***

After the initial EP, young people are usually anxious to focus on resuming a “normal” life, and often specifically on returning to work or school or both with 53% identifying employment and 38% identifying education as goals (Ramsay et al., 2011; Nuechterlein et al., 2020). Accordingly, having access to supported employment and education services (SEE) plays a particularly important role in supporting them in their recovery.

As described in the [RAISE-NAVIGATE Supported Employment and Education Manual](#), the SEE components of CSC have their roots in the Individual Placement and Support (IPS) model of supported employment, the most extensively and rigorously researched of all supported employment models and the only evidence-based model for people with serious mental illness (Bond et al., 2020). In a SEE program, the SEE specialist works with the client to identify his or her personal preferences regarding work and school goals, including career interests, and then provides the necessary supports to help the person achieve them. In contrast to traditional approaches to vocational rehabilitation for psychiatric disorders that emphasize extensive assessments and prevocational training, in SEE the focus is on a briefer Education and Career Inventory, followed by rapid job search or enrollment in an educational program, and then the provision of follow-along supports to ensure success. Although initially proven effective in adults with severe mental illness, IPS principles have more recently been adapted to provide supported employment for young people who have just experienced a FEP (Bond et al., 2020). Supported education builds upon this by incorporating the added goal of supporting clients in their education.

Supported education involves individualized, practical assistance for people with psychiatric disabilities to pursue educational goals, and encompasses many forms of assistance aimed at clarifying educational goals, finding academic programs consistent with these goals, navigating the application process, securing appropriate financial support, and using educational supports and accommodations to help assure success in meeting academic requirements (Becker et al., 2015). Supported education programs can be housed in a variety of academic, mental health, home, and other settings, and can help people who have dropped out of academic programs to return to school, and those who are currently enrolled but are at risk of dropping out.

The 8 principles of SEE are described on page 14 of the [RAISE-NAVIGATE Supported Employment and Education Manual](#) and include:

1. All clients can participate in the SEE Program
2. SEE and clinical services are integrated on the NAVIGATE team
3. SEE focuses on competitive work when work is the goal, and integrated education when school is the goal
4. Comprehensive assessment
5. Respect for clients' personal preferences
6. Benefits counseling
7. Rapid job or school search begins after enrollment in SEE Program
8. Follow-along supports are provided after attaining a job or enrolling in school.

The [RAISE-NAVIGATE Supported Employment and Education Manual](#), indicates that broadly speaking, SEE can be divided into three phases: 1) assessment (Education and Career Inventory), 2) job search or enrollment in school, and 3) follow-along supports, and describes the types of services provided in each phase. The **assessment phase** is described as generally limited and not focused on a formal evaluation of the client's skills or aptitude, but rather on gathering important information to develop a shared understanding of the individual, their employment or school history, and their preferences with respect to school, types of work, and career. The **job search or school enrollment phase** is described as action-oriented and focused on providing practical assistance to the client in finding the type of job or school program in which he or she would like to participate. Examples of common activities in this phase include completing job applications, practicing job interview skills, going on job interviews with the client, applying for school programs, and meeting with a school counselor or administrator (McGurk & Mueser, 2014). The final SEE phase, which the manual also describes as action-oriented and not time-limited, involves providing **follow-along supports** aimed at giving clients practical assistance to facilitate good performance, prevent crises from arising, and promote success at work or school. This may include helping the client move on to another job or school program, as well as activities such as on-the-job training or coaching, teaching study skills, meeting with teachers or employers (with client permission) to discuss issues related to improving the client's performance, and assistance with locating or using transportation and managing money (McGurk & Mueser, 2014).

Given the broad range of educational and employment services SEE encompasses, Title I and Title IV of the Workforce Innovation and Opportunity Act would appear to be possible, albeit largely undiscussed, sources that also could be used to help support CSC programming, including SEE, through collaborative activities and the blending and braiding of resources. WIOA Title I outlines a broad youth vision that supports an integrated service delivery system and provides a framework through which states and local areas can leverage other federal, state, local, and philanthropic partnerships, including with the Mental Health System to support in-school youth (ISY) and out-of-school youth (OSY). Through Title I of WIOA, youth program funding is provided to states and outlying areas that provide local workforce development areas with resources to deliver comprehensive youth services focused on assisting ISY and OSY with one or more barriers to employment prepare for employment and postsecondary education opportunities; attain educational and/or skills training credentials; and secure employment with career/promotional opportunities. Populations eligible for services include youth who are dropouts, low income, offenders, homeless, or run away, youth in or aging out of foster care, pregnant or parenting youth, individuals with disabilities, and individuals who are basic skills deficient or English language learners.<sup>3</sup> The WIOA Youth program elements include: tutoring; alternative secondary school services; paid and unpaid work experiences, including: summer and year round employment opportunities, pre-apprenticeship programs, internships and job shadowing, and on-the-job training; occupational skills training; education offered concurrently with workforce preparation and training; leadership development opportunities; supportive services; mentoring; follow-up services; comprehensive guidance and counseling; financial literacy education; entrepreneurial skills training; services that provide labor market and employment information; and postsecondary education and training preparation activities. Workforce systems are required to spend at least 75% of their youth funding for services for OSY.

Individuals with FEP over the age of 18 may also be eligible to receive individualized career and training services from WIOA's Adult program through one of the six core programs authorized by the Workforce Innovation and Opportunity Act (WIOA).<sup>4</sup> These services are designed to meet local needs and may vary from state to state, and priority of service is given to recipients of public assistance, other low-income individuals, and individuals who are basic skills deficient. For more detailed information about the WIOA Adult Program see [WIOA Adult Program | U.S. Department of Labor \(dol.gov\)](#)

<sup>3</sup> Under Section 129(a)(1) of WIOA and 20 CFR Section 681.210(a), an OSY is defined as an individual who is: (a) Not attending any school (as defined under State law); (b) Not younger than age 16 or older than age 24 at time of enrollment; and (c) One or more of the following: (1) A school dropout; (2) A youth who is within the age of compulsory school attendance, but has not attended school for at least the most recent complete school year calendar quarter; (3) A recipient of a secondary school diploma or its recognized equivalent who is a low-income individual and is either basic skills deficient or an English language learner; (4) An offender; (5) A homeless individual, a homeless child or youth, or a runaway; (6) An individual in foster care or who has aged out of the foster care system or who has attained 16 years of age and left foster care for kinship guardianship or adoption, a child eligible for assistance under sec. 477 of the Social Security Act (42 U.S.C. 677), or in an out-of-home placement; (7) An individual who is pregnant or parenting; (8) An individual with a disability; or (9) A low-income individual who requires additional assistance to enter or complete an educational program or to secure or hold employment.

An In School Youth (ISY) is defined at 20 CFR § 681.220 as an individual who is: (a) Attending school (as defined by State law), including secondary and postsecondary school; (b) Not younger than age 14 or (unless an individual with a disability who is attending school under State law) older than age 21 at time of enrollment; (c) A low-income individual; and (d) One or more of the following: (1) Basic skills deficient; (2) An English language learner; May 2021 Workforce Innovation and Opportunity Act (3) An offender; (4) A homeless individual, a homeless child or youth, or a runaway; (5) An individual in foster care or who has aged out of the foster care system or who has attained 16 years of age and left foster care for kinship guardianship or adoption, a child eligible for assistance under sec. 477 of the Social Security Act (42 U.S.C. 677), or in an out-of-home placement; (6) An individual who is pregnant or parenting; (7) An individual with a disability; or (8) An individual who requires additional assistance to complete an educational program or to secure or hold employment. See [WIOA Youth Fact Sheet long updated 05 2021 \(2\).pdf](#)

<sup>4</sup> The six core programs are the WIOA Title I Adult, Dislocated Worker, and Youth programs; WIOA Title II Adult Education and Family Literacy Act program; WIOA Title III Wagner-Peyser Employment Service program; and WIOA Title IV Vocational Rehabilitation program.

Because research shows that the at-risk youth populations targeted under WIOA experience high incidence of mental health issues as a result of poverty and trauma associated with their lived experiences (Baglivio et al., 2017; Dansby, 2021; Treskon, 2016), WIOA Youth programs can play an important outreach and referral function for CSC program services. Similarly, given the large overlap that exists between the WIOA program elements and the types of services provided through CSC/SEE (e.g., tutoring, alternative secondary school services, on the job training, comprehensive guidance and counseling, and financial literacy education), CSC programs should consider how WIOA funding could be leveraged to provide access to CSC/SEE for eligible youth. In addition, because young people with FEP should have the ability to exercise informed choice in setting their educational and employment goals, SEE Specialists should consider visiting a variety of WIOA funded education and workforce training programs to learn about alternative secondary school services, and the wide variety of the degree, apprenticeship, and certificate programs available. Collaboration between the Workforce and Mental Health Systems to comprehensively address the educational and employment needs of eligible youth with FEP will maximize available resources, and through expansion of evidence-based practices such as SEE ultimately result in better program outcomes for both systems.

Title IV of WIOA also provides a mechanism to fund supported employment for a subset of individuals eligible for vocational rehabilitation services. Section 7(38) of the Rehabilitation Act, and its implementing regulations 34 CFR §§361.5(c)(53) and 363.1(b), define “supported employment” as competitive integrated employment, including customized employment (CE), or employment in an integrated work setting in which an individual with a most significant disability, including a youth with a most significant disability, is working on a short-term basis toward competitive integrated employment; and that is individualized and customized, consistent with the individual’s unique strengths, abilities, interests, and informed choice, including with ongoing support services for individuals with the most significant disabilities.

Customized employment is defined by 34 CFR §361.5 (c) (11), as competitive integrated employment, for an individual with a significant disability, that is:

- i. Based on an individualized determination of the unique strengths, needs, and interests of the individual with a significant disability;
- ii. Designed to meet the specific abilities of the individual with a significant disability and the business needs of the employer; and
- iii. Carried out through flexible strategies, such as:
  - A. Job exploration by the individual; and
  - B. Working with an employer to facilitate placement, including:
    1. Customizing a job description based on current employer needs or on previously unidentified and unmet employer needs;
    2. Developing a set of job duties, a work schedule and job arrangement, and specifics of supervision (including performance evaluation and review), and determining a job location;
    3. Using a professional representative chosen by the individual, or if elected self-representation, to work with an employer to facilitate placement; and
    4. Providing services and supports at the job location.

Extensive information regarding customized employment is available through the [LEAD Policy Development Center](#), funded by the Office of Disability Employment Policy at the United States Department of Labor.

One aspect of CE, the Discovery Model, aligns particularly well with SE because rather than using a protracted formal assessment process to determine the individual's employment-related goals, information gathered from the job seeker and network of support (e.g., teachers, family, peers, coaches, co-workers, case managers) is used to determine the job seeker's interests, skills, and preferences related to potential employment, and that information is then used to guide the development of a customized job. See the Lead Center's [Frequently Asked Questions: Using Customized Employment's Discovery and Group Discovery Models to Promote Job Seeker Success in American Job Centers](#).

The Supported Employment program serves individuals with the most significant disabilities, including youth, for whom competitive integrated employment has not historically occurred or has been interrupted or intermittent as a result of a significant disability, and who, because of the nature and severity of their disabilities, need intensive supported employment services and extended services after the transition from support provided by the VR agency in order to perform the work involved. Supported employment services are based on a determination of the needs of an eligible individual as specified in their individualized plan for employment (IPE), and are provided for a period of not more than 24 months, unless under special circumstances the eligible individual and the rehabilitation counselor jointly agree to extend the time to achieve the employment outcome identified in the IPE.

Extended services, as defined in 34 CFR §361.5(c)(19), are ongoing support services and other appropriate services that are needed to support and maintain an individual with a most significant disability, including a youth with a most significant disability in supported employment. Pursuant to sections 603(d) and 604(b)(2) of the Rehabilitation Act, as amended by WIOA and 34 CFR §§361.5(c)(19)(v) and 363.4(a)(2) of the regulations, extended services may be provided to youth for up to four years or until the youth turns 25 years of age, whichever occurs first.

In addition to the changes WIOA made to the Rehabilitation Act with regard to supported employment, significant changes were also made with regard to services provided to transition-aged youth. Although prior to WIOA, students typically were not seen by VR until they were close to graduating or aging out of high school, the passage of WIOA focused VR on serving students earlier. Under Section 113 of the Rehabilitation Act as amended by WIOA, and 34 CFR §361.48(a) vocational rehabilitation (VR) agencies are required to set aside at least 15% of their federal funds to provide "pre-employment transition services" (Pre-ETS) to "students with disabilities," generally ages 14 to 21 who are eligible or potentially eligible for VR services.<sup>5</sup> This would likely cover almost any student with a serious mental health condition (Marrone, 2016).

<sup>5</sup> 34 CFR §361.5 (51) defines a student with a disability as an individual with a disability in a secondary, postsecondary, or other recognized education program who is not younger than the earliest age to receive transition services under IDEA; or not younger than the earliest age, if determined by the State as being different, to receive pre-employment transition services; not older than 21 years old; or the highest age determined by the State to receive services under IDEA, if older than 21 years of age; and eligible for, and receiving, special education or related services under Part B of the Individuals with Disabilities Education Act (20 U.S.C. 1411 et seq.); or is an individual with a disability, for purposes of section 504. (Workforce Innovation Technical Assistance Center. (2016). CRP Pre-ETS Guidebook.; <http://www.wintac.org/topic-areas/pre-employment-transition-services/resources/crp-guidebook>).

Pre-ETS are designed to be an early start at job exploration for students with disabilities necessary for movement from school to post-school activities that will maximize their potential to enter competitive integrated employment (WINTAC, 2016). The five Pre-ET Services required under WIOA include: (1) Job Exploration Counseling; (2) Work Based Learning (WBL); (3) Counseling on Opportunities for Enrollment in Comprehensive Transition or Post-Secondary Education Programs at institutions of higher education; (4) Workplace Readiness Training to Develop Social Skills and Independent Living; and (5) Instruction in Self-Advocacy (WINTAC, 2016).

Because the Pre-ETS required align closely with several elements of SEE service delivery, CSC programs should also consider how they may be able to leverage and/or blend VR funding for Pre-ETS with other funding available to support CSC program delivery to address the needs of students with FEP, both eligible and potentially eligible for VR services. It is important to keep in mind that although Pre-ETS are only available to students with disabilities, the VR program also provides other types of services to OSY. For example, transition services provided for the benefit of a group of individuals under section 103(b)(7) of the Act and 34 CFR §361.49(a)(7) may be provided to both students and youth with disabilities. Moreover, youth with disabilities who are not students may also receive transition-related services identified in an individualized plan for employment (IPE) under Section 103(a) of the Act. In addition, as was the case with WIOA Title I Youth services, to support informed choice and enhance SEE service delivery, SEE specialists may also want to speak with vocational rehabilitation counselors to get referrals, learn about local education and training programs, and determine the extent to which VR may be able to assist them in providing Pre-ETS, supported employment, and other vocational rehabilitation and related services.

Another largely undiscussed possible stream for SEE funding is the Ticket to Work Program. Under the Ticket to Work Program, Employment Networks (ENs), and State Vocational Rehabilitation (VR) agencies operate as service providers to provide a large variety of employment-related services and supports to Social Security beneficiaries known as Ticket Holders, including supported employment and benefits counseling. ENs can be individuals, a partnership/alliance (public or private) or a consortium of organizations collaborating to combine resources to serve eligible individuals. While State VR agencies, as discussed above, can operate separately from the Ticket Program under Title IV of WIOA, they can also choose to function as an EN and receive compensation under the Ticket Program or partner with ENs to provide Ticket Holders with a seamless transition from receiving VR services to receiving ongoing employment supports from an EN. Because the Ticket Program can provide a large variety of employment-related services and supports, including SE, CSC programs may want to consider becoming ENs or partnering with them to provide CSC including SEE to those individuals within their programs who are Social Security beneficiaries. Individual assistance with benefits planning and work incentives, one of the core components in SEE, is also available to individuals receiving Social Security Disability benefits through Certified Work Incentive Counselors (CWICs) funded through the Ticket to Work Program.

## Conclusion

This brief discussed the continuing effect that COVID is likely to have on our nation's mental health, as well as the importance of early intervention through CSC for youth experiencing their FEP, with a particular focus on SEE because of the importance of employment and education to recovery. It also discussed a variety of funding strategies, both traditional (e.g., state funds, MHBG, and Medicaid) and less traditional, including leveraging and blending and braiding resources available through the workforce development system. Finally, the significant investments in mental health and substance use service delivery and related infrastructure being made by the Biden-Harris Administration through the ARP were discussed as funding sources that states could potentially leverage to provide CSC services to youth experiencing FEP and other individuals with mental health needs, including those who may have been impacted by the pandemic. To be able to better address the needs of youth with FEP, those experiencing a mental health impact from COVID, and the generally high level of our nation's unmet mental health needs, it is imperative that state and local agencies coordinate their efforts and collaborate to maximize available resources to effectively provide the holistic customer-centered care needed to improve outcomes for this population.

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## Appendix — Additional Resources

### **First Episode of Psychosis/Coordinated Specialty Care**

Early Serious Mental Illness Treatment Locator

<https://www.samhsa.gov/esmi-treatment-locator>

National Association of State Mental Health Program Directors (NASMHPD); An Inventory & Environmental Scan of Evidence-Based Practices for Treating Persons in Early Stages of Serious Mental Disorders, (2015)

[http://www.nasmhpd.org/sites/default/files/Environmental%20Scan%20%202.10.2015\\_1%285%29.pdf](http://www.nasmhpd.org/sites/default/files/Environmental%20Scan%20%202.10.2015_1%285%29.pdf)

Goldstein, A. B., & Azrin, S. T. (2014). [Evidence-Based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care](#), provides several examples of staffing models implemented successfully in the RAISE-ETP and IES projects

[Evidence-based Treatments for First Episode Psychosis: Components of Coordinated Specialty Care](#) summarizes the evidence base for coordinated specialty care for FEP, and addresses core components of care, staffing needs, training and supervision requirements, quality assurance, and financing information.

### **RAISE Implementation and Evaluation Study (RAISE-IES) Manuals**

[Manual I: Outreach and Recruitment](#)

[Manual II: Implementation](#)

### **NAVIGATE RAISE Early Treatment Program Manuals and Program Resources**

NAVIGATE, a CSC treatment model developed by the RAISE [Early Treatment Program](#) (RAISE-ETP), was one of two CSC models tested as part of the RAISE research study, and has been implemented in over 60 sites throughout the U.S. as well as in China, Canada, and Israel. A wide variety of resources to support the program are available on the NAVIGATE consultants [site](#) including:

- Program Director Manual
- Family Education Manual
- Individual Resiliency Trainer (IRT) Manual
- IRT Training Videos
- Psychopharmacology (Prescribers) Manual
- Supported Employment and Education (SEE) Manual, and
- Team Members Guide.

## ***OnTrackNY Manuals and Program Resources***

The OnTrackNY manuals [available for download](#) include:

- Team Manual
- Medical Manual
- Primary Clinician’s Manual
- Supported Employment and Supported Education Manual
- Recovery Coach Manual, and
- Outreach and Recruitment Manual
- Family Involvement Resources Manual.
- Relevant tools and other free resources are also available.

## ***WIOA Youth***

[WorkforceGPS](#) Youth Eligibility

[WIOA Youth OWI Fact-Sheet long.pdf](#)

[CareerOneStop](#), is the flagship career, training, and job search website for the U.S. Department of Labor. The website, which incorporates a local service locator, serves job seekers, businesses, students, and career advisors with a variety of free online tools, information, and resources.

## ***Vocational Rehabilitation Supported Employment and Pre-Ets***

[Frequently-Asked Questions: State Supported Employment Services Program under WIOA](#)

[RSA Frequently-Asked Questions: Pre-Employment Transition Services](#)

[A Transition Guide to Postsecondary Education and Employment for Students and Youth with Disabilities](#)

[What to Know About Transition Services for Students and Youth with Disabilities](#)

[Workforce Innovation Technical Assistance Center\(WINTAC\)](#). The WINTAC project officially ended on September 30, 2020 but the website, which is currently being maintained through the Center for Innovative Training in Vocational Rehabilitation grant through the George Washington University contains a wealth of information on WIOA, supported employment and Pre-ETS

## ***Resources from the Office of Disability Employment Policy***

The [\*\*Center for Advancing Policy on Employment for Youth\*\*](#) (CAPE-Youth), a policy development center funded by ODEP, improves employment outcomes for youth and young adults with disabilities by helping states build capacity in their youth service delivery and workforce systems. CAPE includes a variety of resources related to mental health.

The [\*\*National Center on Leadership for the Employment and Economic Advancement of People with Disabilities \(LEAD Center\)\*\*](#) promotes employment of people with disabilities by ensuring they receive effective services under WIOA. Areas of focus include nondiscrimination and equal opportunity, financial literacy, health care, and apprenticeship, and there are a wealth of resources related to customized employment, use of home and community-based waivers, and mental health.

## ***Ticket to Work Resources***

### **[Types of ENs](#)**

### **[Becoming an EN Frequently Asked Questions \(FAQs\)](#)**

### **[Qualifications to become an Employment Network \(EN\)](#)**

Visit [\*\*www.ServiceLocator.org/ENs\*\*](http://www.ServiceLocator.org/ENs) to search for Employment Networks in any area across the United States by entering a ZIP code or city and state.

### **[Benefits Counseling and the Path to Employment - Ticket to Work - Social Security](#)**

[dol.gov/odep](https://dol.gov/odep)



**ODEP**  
Office of Disability  
Employment Policy