Serious Mental Illness and Work Requirements

When Executive Function Meets Administrative Burden

Marcus Thompson, 28, had been stable for nine months. Bipolar disorder diagnosed at 22, medication adjusted over years of trial and error, now finally working. He managed a warehouse at a distribution center outside Columbus, Ohio, earning $18 an hour, 40 hours weekly. He attended therapy every other week, saw his psychiatrist monthly, took his lithium and quetiapine religiously. He had a system: pill organizer, phone alarms, calendar blocks. The system worked. He worked.

In August, the warehouse got a new contract requiring mandatory overtime. Sixty-hour weeks. His sleep schedule fractured. The lithium requires consistent sleep. His psychiatrist had told him this repeatedly. By late August, the mania was building. Racing thoughts. Grandiose plans. He recognized the signs but convinced himself he could manage through the contract period.

He couldn't. By month's end he was sleeping three hours nightly, convinced he could start his own logistics company, spending his savings on equipment for his future empire. His mother noticed when he called at 3am to explain his business plan in rapid, pressured speech. She drove down from Cleveland and took him to the emergency department.

Three weeks in the psychiatric unit. Medication adjustment. He stabilized. He remembered who he was before the mania took over. He felt the familiar shame of the aftermath.

He was discharged September 18th. The mail had accumulated. Three notices from Ohio Medicaid. The first reminded him verification was due September 1st. The second informed him coverage would terminate if not submitted within 15 days. The third informed him coverage had been terminated September 22nd for non-compliance.

He'd been in the hospital when the deadline passed. He'd been psychotic when the reminder arrived. The system didn't know this. The system knew only that verification hadn't been submitted.

His medications cost $1,247 monthly without insurance. His savings were gone, spent during the manic episode. He called the warehouse. They'd filled his position after three weeks of absence without FMLA paperwork.

No job. No insurance. No way to afford the medications keeping him stable. He rationed the quetiapine, taking half doses. His psychiatrist had warned against this specifically. Within two weeks, agitated depression set in. He couldn't sleep but couldn't get out of bed. He couldn't focus on appeal paperwork but couldn't stop ruminating about losing coverage.

His mother found him October 15th, having not answered calls for three days. Back to the hospital. Six weeks this time before discharge.

He emerged in late November to find his coverage still terminated, his apartment lost to unpaid rent, his belongings in his mother's garage. A community mental health center social worker helped him apply for emergency Medicaid, approved within a week. She understood work requirements. She had seen this pattern before. She helped him apply for medical exemption based on diagnosis and hospitalizations. The exemption was approved for six months.

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But Marcus was changed. Two hospitalizations in four months. Medications making him groggy and slow. Thirty pounds heavier. No job, no apartment, living in his mother's basement at 28. The stability he'd built over years had collapsed in weeks.

Three months later, he started working again through a supported employment program. Twenty hours weekly at a grocery store. The job coach checked in weekly. The employer understood he might need flexibility. He wasn't back to where he'd been. The warehouse job paid $18 with benefits and advancement potential. The grocery position paid $12 with no benefits. But he was working again, rebuilding again.

The work requirement didn't cause his bipolar disorder. But the system's inability to accommodate psychiatric crisis turned a manageable episode into catastrophic cascade. Coverage termination led to medication discontinuation led to rehospitalization led to job loss led to housing loss. Each domino fell because the verification deadline couldn't bend around acute psychiatric illness.

Demographics and Scope

Serious mental illness affects 1.5-2.2 million expansion adults, approximately 8-12% of the population subject to work requirements. This population is defined not by diagnosis alone but by substantial functional impairment: conditions that significantly interfere with major life activities including employment, self-care, and social functioning.

The diagnostic distribution within this population spans multiple conditions. Major depressive disorder in its severe, recurrent form accounts for 35-40% of the SMI population. Bipolar disorder, including both type I and type II, represents 25-30%. Schizophrenia spectrum disorders comprise 15-20%. Severe PTSD, particularly treatment-resistant cases, accounts for 10-15%. Other conditions reaching disabling severity, including severe OCD and panic disorder, make up the remaining 5-10%. Many individuals carry multiple diagnoses, and the boundaries between conditions blur in clinical reality.

Co-occurring conditions create multiplicative complexity. Substance use disorders co-occur in 40-50% of the SMI population, creating overlapping barriers and treatment needs. Physical health conditions affect 60-70%, with diabetes, heart disease, and obesity occurring at rates far exceeding the general population. Housing instability or homelessness affects 15-25%. Justice system involvement touches 20-30%. This population is multiply-burdened, facing simultaneous challenges across health, housing, and social domains.

Functional capacity varies dramatically within the SMI population and fluctuates over time within individuals. Approximately 30-40% remain stable on medication with minimal functional impairment between episodes. Another 40-50% experience recurring episodes requiring accommodation but maintain substantial work capacity during stable periods. The remaining 20-30% have persistent severe symptoms limiting work capacity even with optimal treatment. The critical insight is that capacity changes across illness phases. Someone highly functional today may be incapacitated next month, and vice versa.

Treatment engagement patterns reveal both coverage importance and system fragmentation. Approximately 60-70% of the SMI expansion population receives some form of treatment, whether medication, therapy, or case management. The remaining 30-40% remain untreated despite meeting SMI criteria, due to access barriers, lack of insight into illness, or distrust of mental health

systems often rooted in prior coercive treatment experiences. For those in treatment, psychiatric appointments average 2-3 monthly. Intensive outpatient programs require 9-12 hours weekly. Partial hospitalization programs demand 20-25 hours weekly. Each treatment modality consumes time that competes with work hour requirements, creating the fundamental tension between recovery activities and compliance activities.

The treatment-to-work timeline matters for policy design. Evidence-based practices like Individual Placement and Support show that people with SMI can achieve competitive employment, but the pathway isn't linear. Someone experiencing first-episode psychosis may need 12-24 months of treatment stabilization before employment becomes realistic. Someone with treatment-resistant depression may cycle through multiple medication trials over years before finding an effective combination. The assumption that people should be working within months of Medicaid enrollment ignores the clinical reality of SMI recovery timelines.

Medication effects on work capacity create challenges beyond the illness itself. Side effects are common: sedation, weight gain, tremors, cognitive dulling. Morning sedation from nighttime medications affects capacity for early shift work. Dosage adjustments, which may take 2-6 months to optimize, create fluctuating side effects that undermine consistent functioning. Medication non-adherence, often driven by intolerable side effects, triggers relapse. Some medications contraindicate certain work, including operating heavy machinery or commercial driving.

Hospitalization patterns reveal both illness severity and system interaction. Between 25-35% of the SMI expansion population has been hospitalized for psychiatric reasons within the past two years. Average psychiatric hospitalization lasts 7-14 days, though complicated cases extend longer. Crisis service utilization, including mobile crisis teams and emergency psychiatric screening, affects 15-20% annually. The 30-90 day period following hospitalization carries highest relapse risk, requiring intensive support precisely when administrative demands for exemption documentation also peak.

Economic characteristics reflect both cause and consequence of mental illness. Between 40-50% have some employment history in the past year, though often unstable or part-time. Approximately 15-25% receive SSI or SSDI, which automatically exempts them from work requirements but leaves the majority without that protection. The 55-65% relying entirely on Medicaid expansion for coverage have no backup if coverage terminates. Poverty rates run 2-3 times the general population. Social isolation is common, with 30-40% reporting minimal social support, limiting the informal help networks that might assist with administrative navigation.

The intersection with other vulnerable populations creates compounded challenges. Veterans with service-related PTSD and other mental health conditions navigate both VA and Medicaid systems with different rules and documentation requirements. Transition-age youth between 18 and 25 face emerging serious mental illness during the developmental period when work history and administrative skills are least established. Older adults with SMI approaching the age-60 exemption threshold may have decades of illness but face 2-3 years of work requirements before aging out. Parents with SMI must navigate both their own exemption needs and caregiving responsibilities for children who may themselves have behavioral health needs.

Geographic variation in mental health infrastructure affects access to both treatment and exemption support. Urban areas have more community mental health centers, crisis services, peer

support programs, and specialized providers. Rural areas face severe behavioral health workforce shortages, forcing people to travel hours for psychiatric care or rely on primary care providers less familiar with SMI management. Some states have invested in behavioral health infrastructure, while others have fragmented systems leaving SMI populations without adequate treatment or navigation support. The availability of crisis stabilization alternatives to hospitalization varies dramatically, affecting whether acute episodes result in brief interventions or extended inpatient stays.

Racial and ethnic disparities in SMI diagnosis, treatment access, and outcomes create differential exposure to work requirement failures. Black Americans are more likely to be diagnosed with schizophrenia and less likely to be diagnosed with mood disorders compared to white Americans with similar symptoms, affecting which diagnostic pathways and treatment approaches they access. Hispanic Americans face language barriers in both treatment settings and administrative systems. Cultural stigma around mental illness varies across communities, affecting willingness to seek treatment and disclose diagnoses for exemption purposes. These disparities mean that work requirement systems failing to accommodate SMI will disproportionately affect communities already experiencing mental health inequities.

Failure Modes: When Mental Illness Meets Administrative Demands

The interaction between serious mental illness symptoms and work requirement administrative processes creates systematic compliance impossibility for substantial portions of this population. These failures aren't personal inadequacies. They're structural mismatches between what the illness impairs and what the system demands.

The executive function paradox creates the foundational failure. Serious mental illness typically impairs executive function: the capacity to organize tasks into sequences, initiate complex processes, maintain focus across weeks, remember deadlines without external prompts, and prioritize competing demands. These are precisely the capacities required to navigate work requirement verification. The system demands that people use the cognitive skills their illness specifically damages.

Consider what verification requires: receive notice in mail, understand what's required, contact employer for documentation or gather exemption materials, complete forms accurately, submit by deadline, follow up if problems arise, navigate appeals if denied. Each step requires intact executive function. Someone experiencing depression may lack energy to open mail. Someone with schizophrenia may not process what the notice requires. Someone manic may intend to handle it but become distracted by racing thoughts. The system punishes disability by requiring people to demonstrate the capacity their disability impairs.

The acute episode timing failure manifests because psychiatric crises arrive unpredictably and destroy documentation capacity exactly when exemptions are most needed. Someone stable for months experiences a psychotic break, is hospitalized for three weeks, and emerges to find coverage terminated for missing the deadline during hospitalization. The hospitalization itself demonstrates incapacity to work, yet the system terminated coverage for failing to document that incapacity while incapacitated.

States schedule verification deadlines based on coverage periods, not illness patterns. Manic episodes don't wait for post-deadline grace periods. Depression doesn't lift conveniently before windows close. Psychotic symptoms don't pause for administrative convenience. The system's temporal rigidity collides with illness's temporal chaos.

The capacity fluctuation problem emerges because serious mental illness rarely presents as binary capable or incapable states. Someone with bipolar disorder may be highly capable during euthymic periods, incapable during mania or depression, and variably capable during mixed states. Someone with major depression may function well seven months yearly and be unable to function five months during episodes.

Traditional exemption frameworks ask whether someone can work and expect yes or no answers. But episodic conditions don't fit binary categories. The person doesn't qualify for permanent exemption because they can work sometimes, but they can't maintain continuous verification because they can't work predictably. Monthly verification requirements particularly disadvantage episodic conditions, treating each month independently rather than recognizing that illness patterns span multiple months.

The documentation burden creates cascading failures because gathering exemption documentation requires the same capacities the illness impairs. To prove you're too psychiatrically impaired to work, you must successfully navigate a complex process requiring executive function, sustained attention, and task initiation. Getting exemption documentation typically involves scheduling provider appointments, attending them, communicating symptoms clearly, ensuring providers complete correct forms, following up if they delay, and submitting before deadlines. Each step challenges people whose illness impairs exactly these capacities.

Provider availability compounds the problem. Many people with SMI see psychiatrists monthly for 15-minute medication checks, insufficient for comprehensive functional capacity assessment. Therapists may see patients weekly but lack prescribing authority, creating questions about whether their attestations suffice. Crisis clinicians interact during emergencies but don't provide ongoing care enabling detailed attestations. The fragmented behavioral health system means no single provider sees the complete clinical picture that exemption documentation requires.

The stigma and disclosure barrier creates failures unique to psychiatric conditions. Someone with diabetes can disclose their condition without fear. Someone with schizophrenia faces employment discrimination if disclosed, social stigma if known, and potential custody consequences if documented in official records. Work requirement systems demanding disclosure force impossible choices.

An employer may accommodate a vaguely described "health issue" but fire someone disclosed as having bipolar disorder. A person may work successfully by managing symptoms privately but lose that job if required to document their diagnosis for exemption purposes. Family members may not know about diagnoses. Cultural communities may view mental illness as shameful. The verification system's transparency requirements conflict with the practical self-protection that stigma necessitates.

The treatment burden timing conflict occurs when treatment engagement prevents meeting work hour requirements while failing to qualify as exemption. Intensive outpatient programs provide 9-12

hours weekly of structured treatment. Someone attending IOP while working enough to meet 80 monthly hours faces 100-110 hour monthly commitment during psychiatric crisis. Partial hospitalization programs requiring 20-25 weekly hours create even sharper conflicts.

The paradox is cruel: engaging in treatment that might enable future work creates present barriers to meeting requirements. If states don't count treatment hours as qualifying activity, people must choose between treatment and coverage. Skipping treatment to work more hours triggers relapse making work impossible. The system punishes therapeutic engagement.

The medication stabilization gap creates failures during the 2-6 month period after acute episodes when people aren't well enough for employment but aren't acutely symptomatic enough to easily demonstrate incapacity. Post-hospitalization recovery involves medication adjustments, side effect management, gradual return of functioning. The person isn't hospitalized, so no automatic exemption triggers. They're not in intensive treatment, so no program documents their limitations. They simply feel terrible and can't function well and need time for medications to work.

Documenting this liminal state requires provider attestation of something ambiguous. The person is recovering but not recovered. They're improving but not improved. They're better than they were but not well enough to work. The standard categories of "disabled" and "capable" don't capture the extended transition between acute illness and stable functioning.

The communication accessibility failure manifests when notices use complex language, assume consistent mail access, and require written responses. Someone with thought disorder struggles to parse bureaucratic language. Someone with poor concentration can't track dense paragraphs. Someone experiencing homelessness doesn't receive mail consistently. Someone hospitalized doesn't check mail at all. The notices presume cognitive capacity that symptomatic illness impairs.

Phone-based alternatives don't solve the problem for people who can't afford phone service, changed numbers during crisis, don't answer calls from unknown numbers due to paranoia, or can't process verbal information during symptomatic periods. Digital portals assume internet access, device availability, and digital literacy that many SMI individuals lack. Every communication channel assumes capacities that psychiatric symptoms may impair.

The provider burden problem emerges when states require detailed functional capacity assessments rather than accepting simple diagnostic attestations. A psychiatrist seeing someone for 15-minute medication checks can easily attest to diagnosis but providing detailed narrative about how symptoms affect work capacity requires time the appointment doesn't allow. Therapists may have deeper understanding of functional limitations but lack the medical authority some states require for exemption documentation. The behavioral health system's fragmentation means no single provider sees the complete picture, yet exemption systems demand comprehensive documentation.

The anosognosia challenge affects the subset of SMI individuals who lack insight into their illness. Someone with schizophrenia who doesn't believe they're ill won't seek exemption for a condition they don't acknowledge having. Someone manic may feel more capable than ever and reject suggestions they need accommodation. This lack of insight is itself a symptom of the illness, yet administrative systems assume people will self-identify as needing exemption. The population least able to advocate for themselves receives the least protection.

The relapse-after-stability pattern creates particular cruelty. Someone demonstrates work capacity during stable periods, maintains employment, meets verification requirements. Then relapse occurs. The prior successful compliance may actually work against them: if they could work before, why can't they work now? The system struggles to recognize that the same person can be highly capable during euthymic periods and completely incapacitated during episodes. Prior success becomes evidence against current incapacity.

State Policy Choices: Accommodation or Exclusion

The policy architecture states construct around serious mental illness reveals fundamental choices about disability, administrative efficiency, and whether systems should accommodate psychiatric conditions or expect psychiatric conditions to accommodate administrative demands.

The first choice involves exemption triggers. Should serious mental illness diagnosis alone qualify for exemption, or should states require functional impairment documentation beyond diagnosis? Diagnosis-based exemption is simpler: someone with schizophrenia or bipolar disorder receives automatic exemption. Functional assessment is more targeted: exemption requires documentation that specific symptoms currently impair work capacity. The first approach may over-exempt people functioning well despite diagnosis. The second creates documentation burdens during periods when documentation capacity is impaired.

The second choice involves episode accommodation. Should states recognize that episodic conditions create variable capacity requiring flexible verification? Quarterly averaging, allowing 240 hours across three months rather than 80 each month, permits good months to compensate for bad months. Automatic exemption triggers when crisis indicators appear, such as hospitalization or emergency department visits, protect coverage during acute episodes without requiring documentation while acutely ill. States rejecting episodic accommodation force people with fluctuating conditions into frameworks designed for stable conditions.

The third choice involves treatment as qualifying activity. Should participation in intensive outpatient programs, partial hospitalization, or regular therapy count toward the 80-hour monthly requirement? Counting treatment hours removes the conflict between therapeutic engagement and coverage maintenance. Someone attending 40 hours of IOP monthly plus working 40 hours meets requirements through combined activity. States refusing to count treatment hours force choices between treatment and compliance, often triggering the relapses that treatment prevents.

The fourth choice involves medication stabilization protection. Should pharmacy claims showing new medications or significant dosage changes trigger automatic grace periods? The 2-6 months required for medication optimization create variable functioning and side effects limiting work. Automatic protection during adjustment periods accommodates medical reality. Manual exemption applications during adjustment periods demand documentation capacity that medication side effects may impair.

The fifth choice involves crisis documentation. Should hospitalization, emergency department visits for psychiatric reasons, or crisis service contacts create automatic exemption without additional documentation? The crisis itself demonstrates incapacity. Requiring documentation beyond the crisis record demands that people prove what the crisis already proved. Automatic exemption from crisis indicators protects the most vulnerable during their most vulnerable periods.

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The fundamental tension is between administrative controllability and clinical reality. Systems designed for stable populations with predictable capacity assume conditions that serious mental illness violates. Illness fluctuates. Episodes arrive unpredictably. Recovery takes variable time. Medication adjustment requires patience. Administrative systems that can't accommodate this variability will systematically fail people whose conditions don't match administrative assumptions.

The permanence question poses another choice. Should states offer permanent exemption status for individuals with persistent, treatment-resistant illness, or require periodic renewal even for conditions unlikely to improve? Someone with treatment-resistant schizophrenia who has been hospitalized repeatedly despite medication adherence shouldn't need to re-prove their incapacity every six months. Permanent status for clearly chronic conditions reduces administrative burden on both members and systems while maintaining dignity for people whose illness isn't going away.

The supported employment question affects how states view work capacity among SMI populations. Supported employment programs like Individual Placement and Support have strong evidence for helping people with SMI obtain and maintain competitive employment. But supported employment requires ongoing job coaching, workplace accommodation, and flexibility that standard verification processes don't capture. Someone working 30 hours weekly in a supported employment position is achieving remarkable success given their illness, yet may not meet 80-hour requirements. States must decide whether to accommodate supported employment as meaningful activity deserving recognition.

The confidentiality tension requires navigating between documentation needs and privacy protections. Mental health records carry special confidentiality protections under federal and state law. Exemption systems requiring detailed psychiatric documentation may conflict with these protections. Someone may want exemption but not want their diagnosis entered into state databases accessible to multiple agencies. States must design systems that protect coverage while respecting the legitimate privacy interests that mental health confidentiality laws recognize.

Stakeholder Roles in Supporting SMI Populations

The structural failures in exemption systems for SMI populations require multiple stakeholders to adapt their operations. Each occupies different positions in the ecosystem and can address different failure modes.

Managed Care Organizations bear responsibility for identifying SMI members and providing intensive support through exemption processes. MCOs should use diagnosis codes, pharmacy claims for psychiatric medications, and behavioral health utilization to identify members likely needing exemption support. Care coordinators specializing in behavioral health should manage SMI member panels with caseloads of 50-75, lower than general populations given the complexity of needs. When hospitalization claims appear, coordinators should proactively contact members post-discharge about exemption status rather than waiting for members to navigate systems while recovering. MCOs preventing coverage losses during psychiatric crises avoid the downstream costs of rehospitalization, emergency services, and chronic instability.

Behavioral Health Providers serve as primary documentation sources yet often don't understand work requirement policy. Psychiatrists completing 15-minute medication checks can easily attest

to diagnosis but may need simplified forms for functional capacity documentation. Community mental health centers should integrate exemption support into standard intake and ongoing care, training case managers in verification requirements and exemption options. Crisis services should automatically generate exemption documentation when providing emergency intervention, recognizing that crisis contact itself demonstrates exemption need. Providers should understand that completing exemption paperwork is clinical care, not administrative burden separate from treatment.

Peer Support Specialists provide uniquely effective navigation for SMI populations because they understand psychiatric illness from lived experience. Peer navigators recognize symptom patterns, understand medication side effects, anticipate documentation barriers, and provide hope through example that navigation is possible. Clubhouses, peer-run organizations, and community mental health centers employing peer specialists should add work requirement navigation to their scope. Peer navigators can accompany members to appointments, help complete paperwork, follow up on pending applications, and advocate when denials occur.

Employers shape whether people with SMI can maintain employment compatible with psychiatric treatment. Employers offering flexible scheduling accommodate therapy appointments and medication side effects. Employers providing employee assistance programs can connect workers to treatment before crises develop. Employers trained in reasonable accommodation under the ADA understand that modified duties or temporary reduced hours during episodes may retain valuable employees who would otherwise lose both job and coverage. The warehouse that required Marcus to work 60-hour weeks during peak season could have accommodated his need for consistent sleep, retaining an experienced employee rather than losing him to hospitalization.

Educational Institutions provide qualifying activities that may be more sustainable than employment during psychiatric instability. Online courses permit completion during variable-capacity periods. Flexible deadlines accommodate episodes. Educational activities during treatment-intensive periods position people for better employment when stability returns. Community colleges should understand that students with SMI may need accommodations including incomplete grades during hospitalizations and extended timelines for degree completion.

Community-Based Organizations provide navigation support that prevents documentation failures. Organizations serving SMI populations, including clubhouses, drop-in centers, and supportive housing providers, can identify members facing verification deadlines and assist with documentation before crises occur. These organizations often maintain ongoing relationships with SMI individuals, enabling proactive outreach that clinical settings providing episodic care cannot match.

Clubhouse programs deserve particular attention. The clubhouse model creates structured environments where people with SMI participate in meaningful work-ordered days alongside staff members. Clubhouses already understand work capacity variation, supported employment principles, and documentation for disability benefits. Adding work requirement navigation to clubhouse services leverages existing infrastructure and relationships. Members trust clubhouse staff because the relationships are non-hierarchical and recovery-oriented.

Supportive housing providers interact with SMI tenants regularly and can identify when someone is decompensating before full crisis develops. Housing case managers noticing that a tenant isn't

answering doors, isn't taking medications, or isn't attending appointments can intervene early, potentially preventing the hospitalization that would trigger coverage loss under rigid verification systems. The housing-health intersection makes supportive housing providers natural partners in work requirement navigation.

Family members and informal caregivers often provide the actual support that maintains SMI individuals in the community, yet formal systems rarely incorporate them. States could establish processes for family members to request exemption review when they observe decompensation, creating early warning systems that don't depend on the affected individual's capacity to self-advocate. Family psychoeducation programs that already exist in many community mental health centers could add work requirement information to curricula.

The common thread across stakeholders is proactive intervention before crises compound. Marcus's cascade, from missed deadline to terminated coverage to medication discontinuation to rehospitalization to job loss to housing loss, could have been interrupted at multiple points. An MCO coordinator checking on members during psychiatric hospitalizations. A provider completing exemption paperwork before discharge. A peer specialist helping navigate the appeal. The absence of any stakeholder stepping into that support role left Marcus alone with administrative demands he couldn't meet while acutely ill.

Marcus's Situation as Structural Pattern

Marcus Thompson's experience follows predictable trajectories when administrative systems can't accommodate psychiatric crisis. His stability on medication, his productive employment, his August decompensation, his hospitalization during the verification deadline, his coverage termination while unable to respond, his medication discontinuation, his second hospitalization, his job and housing loss all reflect structural patterns affecting over 1.5 million expansion adults with serious mental illness.

The financial calculus exposes the policy's self-defeating nature. His nine months of coverage cost approximately $4,500. His first hospitalization cost $18,000. His second cost $31,000. The coverage termination designed to encourage work generated healthcare costs ten times higher than continued coverage. The human cost exceeds financial accounting: he lost the stability built over years, the confidence that he could function despite bipolar disorder, the independence of his own apartment, the identity of productive worker rather than psychiatric patient.

The policy question is whether requirements should apply uniform administrative processes to populations whose defining characteristic is impaired capacity for administrative processes, or accommodate psychiatric reality through automatic crisis exemptions and proactive support. December 2026 will reveal which approach states choose. Marcus's situation, multiplied across the SMI population, will demonstrate whether work requirements can coexist with serious mental illness or whether administrative demands will systematically exclude people whose illnesses make those demands impossible to meet.

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