PEDIATRICS PERSPECTIVES

Supplemental Security Income for Children With Mental Disabilities

Kelly J. Kelleher, MD, MPH,[a] Ruth E.K. Stein, MD,[b] Kimberly Eaton Hoagwood, PhD[c]

Supplemental Security Income (SSI) is the state-administered, federal benefit program that provides income support for low income families of children with disabilities in the United States. To qualify for benefits, children must have chronic impairments and their families must meet income requirements. More than 75% of children qualifying for SSI come from families below 150% of the federal poverty level. SSI provides critical income support to the impoverished families of these children, many of whom have had to curtail work hours to care for their children, and it provides access to other programs, such as Medicaid. Although there is considerable state-to-state variation among recipients, SSI provides support for slightly <2% of all US children (1.3 million) of whom half are eligible because of disability due to mental disorders. The number of child SSI recipients increased significantly over the past decade, as did the number of recipients eligible because of disability due to mental disorders (Fig 1).

In a time of political debate over entitlement programs, both of these last facts raised concern in the lay press[1] and in Congress.[2] In response, the Supplemental Security Administration (SSA) commissioned the Institute of Medicine of the National Academies of Sciences, Engineering, and Medicineto evaluate the scientific literature, data from SSA, and other data sets to identify whether the growth of mental disorders among SSI children was consistent with changes in rates of mental disorders in the general population and among low-income children.

That report was released in September, 2015.[3] Because of its length and depth, it may go unnoticed or unexplored. However, several important findings deserve serious discussion as pediatricians and child advocates seek ways to cope with the increasingly evident burden of poverty and disabilities on child growth and development.

First and most relevant for the original question, the percent of new child allowances (finding that a child is sufficiently disabled to qualify for SSI) among applicants overall and those due to mental disorders is flat or falling, even when corrected for growth in childhood poverty. In fact, growth of the SSI program has trailed growth in the rates of child poverty and both mental disorder diagnoses and treatment in the child Medicaid population. Nevertheless, few children leave the SSI rolls once they qualify

[a]Center for Innovation in Pediatric Practice, Nationwide Children's Hospital, Columbus, Ohio; [b]Albert Einstein College of Medicine/ Children's Hospital at Montefiore, Bronx, New York; [c]New York University, New York, New York

All three authors conceptualized, designed, revised, and approved the manuscript as submitted and agree to be accountable for all aspects of the work.

DOI: 10.1542/peds.2015-3342

Accepted for publication Nov 30, 2015

Address correspondence to Kelly J. Kelleher, MD, MPH, Center for Innovation in Pediatric Practice, The Research Institute at Nationwide Children's Hospital, 700 Children's Dr, JW4985, Columbus, OH 43205. E-mail: kelly.kelleher@nationwidechildrens.org

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

FINANCIAL DISCLOSURE: The authors have indicated they no financial relationships relevant to this article to disclose.

FUNDING: The study on which this article is based was supported by the National Academies of Sciences, Engineering, and Medicine.

POTENTIAL CONFLICT OF INTEREST: Drs Kelleher and Hoagwood were unpaid members of the originating Academies Committee that prepared the report. Dr Stein was an unpaid liaison and consultant to the Committee, but did not sign off on the final report. The authors have no other conflicts of interest to disclose.

To cite: Kelleher KJ, Stein RE, Hoagwood KE. Supplemental Security Income for Children With Mental Disabilities. *Pediatrics.* 2016;137(3):e20153342

(unless their family incomes increase above the income threshold) because re-assessments for termination are underfunded and infrequently performed. Also, fewer children age out than are coming into SSI. With so many more children eligible because of the growth both in the number of US children and of child poverty, the total number of recipients continues to climb. In short, the numbers of suspensions, terminations, and aging-out continue to be fewer than the total number of new allowances for children with disabilities due to mental disorders in SSI.

For those concerned about the increasing cost of federal entitlement programs like SSI, the message is clear. Poverty is a risk factor for some mental disorders and for the severity of disorders and impairment.[4] The growth in the proportion of children living in poverty, especially during the recession, increased the pool of those financially eligible for SSI. Although the percent of those receiving allowances has not increased, the overall numbers of recipients certainly have because of the growth in the number of children eligible,and those numbers track the high rate of US children living in poverty, which is currently the second highest rate among developed nations of the world, after Romania.[5]

Therefore, the question may not be why so many children with mental disorders are receiving SSI, but why so few are. The Academiesreport summarizes prevalence estimates for the 10 most common mental disorders for which children receive SSI and includes estimates of disability/severity for each of them. The conditions include the following: attention-deficit hyperactivity, autism spectrum, conduct, mood, oppositional defiant, organic mental, anxiety, learning, and intellectual disability and borderline intellectual function, each of which is discussed in detail in the Academiesreport. SSI recipient trends among these various conditions differ, but allowance rates for almost all of them are stable or declining. Although the data sources are not consistent, nor are there standardized diagnostic or impairment data in SSA data sets, a small proportion of the US children living in poverty with moderate to severe disability due to mental disorders currently receive SSI. For example, the report estimates that only 3% of all children living in poverty with moderate to severe mood disorders are recipients: 15% of those with moderate to severe attention-deficit hyperactivity and 4% of those with moderate to severe oppositional defiant disorder/conduct disorder. This means that large numbers of children may be eligible for benefits, but are not receiving them.

SSI is a critical and under-used program in the fight against the adverse effects of child poverty among the growing number of US children with disabilities, and the income supplementation alone in 2010 kept more than 315 000 families above the poverty line.[6] Many improvements in the implementation of the SSI program have been recommended over the past few years,[7] and their implementation would improve the efficiency, effectiveness, and consistency of SSI for children. In addition, research on the short- and long-term health and income effects of the SSI program for children and their families is critically needed to better understand how to improve the program and make it consistent across states.

Politically, child advocates should be aware that the increased costs of the SSI program largely stem from the rapid growth in child poverty rates since the recession of 2008, not from liberalization of criteria for allowances for children with mental disorders. Many children who are likely to be eligible for SSI are not receiving benefits. Pediatricians and others who regularly care for children with severe impairments can help poor families through engaging more of them in the application process.

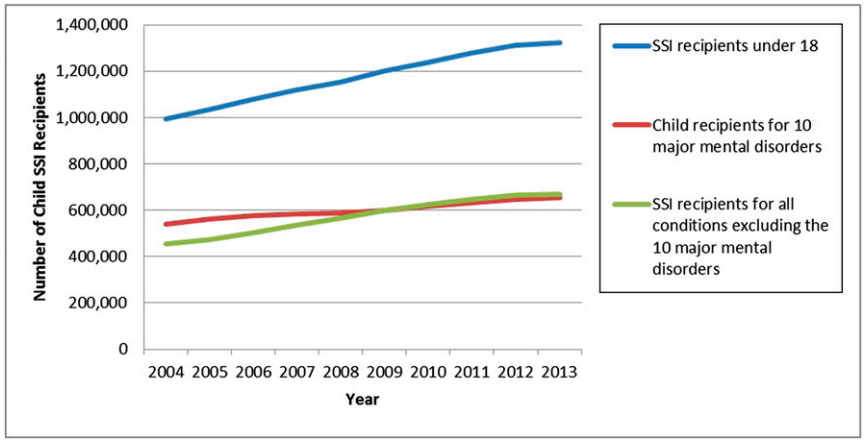

FIGURE 1
Trend in number of child recipients (2004–2013). Reprinted with permission from Institute of Medicine. Mental Disorders and Disability Among Children. 2015:3-3.

ABBREVIATIONS

SSA: Supplemental Security Administration
SSI: Supplemental Security Income

REFERENCES

1. Wen P. A legacy of unintended side effects. The Boston Globe. Dec. 12, 2010

2. Koyanagi C, Schulzinger R. *In the Line of Fire: Children With Serious Emotional Disturbance and the 104th Congress*. Washington, DC: Bazelon Center for Mental Health Law; 1996

3. National Academies of Sciences, Engineering; and Medicine. *Mental Disorders and Disability Among Children*. Washington, DC: National Academies Press; 2015

4. Costello EJ, Compton SN, Keeler G, Angold A. Relationships between poverty and psychopathology: a natural experiment. *JAMA*. 2003;290(15):2023–2029

5. UNICEF Innocenti Research Centre. Measuring child poverty: New league tables of child poverty in the world's rich countries. In: *Innocenti Report Card 10*. Florence, Italy: UNICEF Innocenti Research Centre; 2012

6. Stegman Bailey M, Hemmeter J. Characteristics of Noninstitutionalized DI and SSI Program Participants, 2010 Update. Research and Statistics Note No. 2014-02. Washington, DC: US Social Security Administration; 2014

7. Supplemental Security Income: Better Management Oversight Needed for Children's Benefits. GAO-12-497. Washington, DC: US Government Accountability Office; 2012

Supplemental Security Income for Children With Mental Disabilities

Kelly J. Kelleher, Ruth E.K. Stein and Kimberly Eaton Hoagwood

Pediatrics 2016;137;
DOI: 10.1542/peds.2015-3342 originally published online February 8, 2016;

PEDIATRICS®
OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

Supplemental Security Income for Children With Mental Disabilities

Kelly J. Kelleher, Ruth E.K. Stein and Kimberly Eaton Hoagwood

Pediatrics 2016;137;
DOI: 10.1542/peds.2015-3342 originally published online February 8, 2016;