

Mental Disorders and Disabilities Among Low-Income Children

Since 1975, the Social Security Administration (SSA) has paid benefits to children with disabilities in low-income households through the Supplemental Security Income (SSI) program. In 2013, approximately 1.3 million children received SSI disability benefits, roughly half of whom qualified primarily due to a mental disorder.

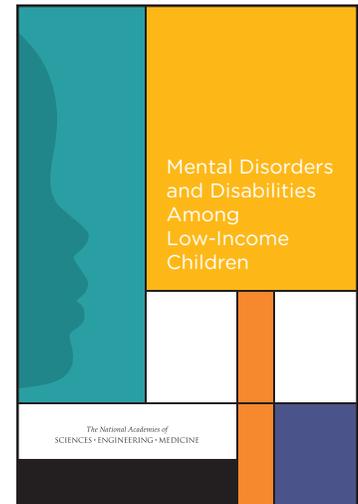
In response to considerable and recurring interest in the growth and sustainability of the SSI program for children, SSA commissioned the National Academies of Sciences, Engineering, and Medicine to identify trends in the prevalence of mental disorders among U.S. children and to compare those trends to changes observed in the SSI childhood disability population.

The resulting report, *Mental Disorders and Disabilities Among Low-Income Children*, provides evidence-based findings and conclusions concerning trends in the prevalence of mental disorders in children and also the diagnosis and treatment of these children. This report includes a novel review of previously unreleased data on the rates of mental disorders and disabilities among low-income children from the SSI program and from Medicaid.

NATIONAL TRENDS IN THE SSI PROGRAM

The committee reviewed data from 2004 to 2013 on trends in SSI benefits for disability attributed to 10 major mental disorders, including attention deficit hyperactivity disorder (ADHD); autism spectrum disorder (ASD); intellectual disability; and mood disorders, such as depression and bipolar disorder. The committee reviewed trends in the number and percentage of American children who were recipients of benefits and who were allowed benefits—meaning those who were determined to meet the medical definition of disability for the first time—for mental disorders.

The committee found that over the 10-year period studied, there has been a decrease in the percentage of children allowed SSI benefits for a mental disorder. Yet overall, the percentage of children from low-income households receiving SSI benefits has



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grown: from 1.88 percent in 2004 to 2.09 percent in 2013. Generally, it appears that each year, the number of allowances exceeded the number of children exiting the SSI program, leading to increased overall participation.

The committee found that after taking poverty into account, the growth in program participation is in keeping with trends in the prevalence of mental disorder diagnoses among children in the general population.

CHILD POVERTY AND THE SSI PROGRAM FOR CHILDREN

SSI program eligibility criteria requires that a child must have a severe disability and come from a low-income household. Comparisons between the general population and the SSI population of children are difficult, because not all children in the general population are disabled, and not all children in the general population are from low-income households. To control for some of the differences due to child poverty, the committee concluded that trends observed in the SSI program should take into account trends in child poverty.

Although the total number of U.S. children changed very little during the decade studied, both the number and percentage of all children who lived in impoverished households increased, particularly during the period of economic recession from 2008 to 2010.

This trend in child poverty was a major factor affecting trends observed in the SSI program for children with mental disorders during the study period: In times of economic hardship in the United States, more children with mental disorder–related disabilities will qualify

for benefits because they meet the income eligibility threshold.

PREVALENCE OF MENTAL DISORDERS IN CHILDREN

The committee completed focused reviews of prevalence for six major mental disorders—ADHD, oppositional defiant disorder/conduct disorder, ASD, intellectual disability, learning disorder, and mood disorders—using data from SSI, from population-based national surveys, and from Medicaid claims data. Although the availability and quality of data varied among individual disorders, overall, the trends observed in the SSI program were consistent with trends observed in the rates of the diagnosis and identification of mental disorders reported in national surveys and among children who received health care services through Medicaid. The committee concluded that the trends observed in the SSI program were consistent and proportionate to trends observed in the general population or in Medicaid. Notably, the increases observed in the rates of recipients are not unexpected in light of the committee’s finding that there is potentially a large reservoir of children with disabling mental disorders in impoverished families, and that the number of children in this reservoir consistently exceeded the number of children who were recipients of SSI benefits in the same year.

For instance, the committee estimated that between 20 and 50 percent of eligible children with ASD, and only 3 percent of eligible children with mood disorders, actually received SSI benefits for these disorders.

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ANALYSIS OF MEDICAID DATA

Since the data available on the prevalence and treatment of mental disorders among SSI children is very limited, the committee commissioned an analysis of the Medicaid data, which may be the most efficient source of continuously collected data that simultaneously include information on a child's SSI status, mental disorder diagnoses, and use of health services. Because the Medicaid program serves low-income families, looking at Medicaid data also provided an opportunity to test whether prevalence trends in the SSI data deviated substantially from a second comparison population.

The percentage of all Medicaid enrollees with a mental disorder diagnosis increased from 7.9 percent in 2001 to 11.1 percent in 2010. In the same time period, the percentage of SSI Medicaid enrollees with a mental disorder diagnosis also increased, from 29.2 percent in 2001 to 38.6 percent in 2010.

During the decade of inquiry, the number of ADHD diagnoses among all Medicaid enrollees in the study nearly tripled. Increases in SSI benefits paid for ADHD-related disability during this decade are therefore expected in view of this growth rate.

The number of children enrolled in Medicaid also increased from 2001 to 2010. The growing numbers of all Medicaid enrollees during the study period likely reflect increases in childhood poverty as well as policies that encouraged the enrollment of eligible children in Medicaid.

CONCLUSION

After taking into account changes in child poverty and the detrimental effects of poverty on disability and mental health in children, the trends observed in the SSI program for children with mental disorders between 2004 and 2013 are consistent with trends observed in prevalence of mental disorders among the general population of U.S. children. ♦♦

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