Published in final edited form as:

J Dev Behav Pediatr. 2016 May ; 37(4): 267–268. doi:10.1097/DBP.0000000000000283.

Poverty and Supplemental Security Income: Can DBPs Take a More Active Role

Kelly J. Kelleher, MD, MPH,

Professor of Pediatrics and Public Health, Colleges of Medicine and Public Health, The Ohio State University

Thomas F. Boat, MD,

Professor, University of Cincinnati Department of Pediatrics

Amy J. Houtrow, MD, MPH, PhD, and

Associate Professor of Physical Medicine and Rehabilitation and Pediatrics, University of Pittsburgh School of Medicine

Kimberly Hoagwood, PhD

Vice Chair for Research in the Department of Child and Adolescent Psychiatry at the New York University School of Medicine

In their work caring for children who present with health problems that adversely impact development and behavior—from failure to thrive, speech and language disorders, abusive head trauma, and fetal alcohol/drug exposures to disabling behavioral health conditions—developmental and behavioral pediatricians can feel like disaster relief workers: putting bandages on victims in the warzone. These conditions frequently emerge from impoverished neighborhoods and worsen poverty among those living on the edge while our treatments rarely seem to change the underlying problems.

In a society where 40% of its citizens live below 200% of the federal poverty line, poverty takes a toll on children's health and well-being by limiting opportunities for stable housing, nutritional security and education. Children's health is directly proportional to poverty status. A gradient exists such that those living in poverty experience worse health outcomes.^{1,2} Poverty is associated with other disadvantages such as discrimination, single parenthood and poor parental education. It is an unfortunate fact of life that a disproportionate share of patients in DBP clinics and their families are impoverished. For example, more than 60% of patients seen at DBP clinics at Nationwide Children's Hospital are enrolled in Medicaid.

Social disadvantages like poverty have a marked cumulative effect on child health and disability.^{3,4} While it has been long known that children in poverty have increased rates of many chronic health conditions or enhanced morbidity from those conditions, including

Corresponding Author: Kelly J. Kelleher, MD, MPH, Center for Innovation in Pediatric Practice, The Research Institute at Nationwide Children's Hospital, 700 Children's Drive, JW4985, Columbus, OH 43205 (Kelly.Kelleher@nationwidechildrens.org).

Conflict of Interest:

All authors listed above were on the originating IOM Committee that prepared the report. There are no other conflicts of interest to disclose for the authors.

cystic fibrosis, spina bifida, congenital heart disease, obesity and asthma,⁵ the multiplicity of poverty's deleterious effects on children are felt nowhere more clearly than in the young child's emotional, behavioral and cognitive development. Poverty is a major risk factor for mental disorders in children, including ADHD and depression, and for the severity of their impairments. ⁶ Furthermore, a child with disability often reduces family income, creating a disadvantageous economic cycle for the family.

One important program designed to ameliorate the effects of poverty on families supporting children and others with disabilities is the Supplemental Security Income (SSI) program of the Social Security Administration. SSI provides cash assistance on a sliding scale to low income families caring for a child with disabilities, including mental, behavioral, and emotional disorders, and qualifies them for other assistance such as Medicaid through a federally-mandated, state-administered entitlement and automatic enrollment in Title V. Eligibility for SSI depends upon three factors: a medically-diagnosable condition or its equivalent (eg, a mental disorder diagnosis); significant functional impairment that limits activities; and family income generally less than 200% of the federal poverty level (FPL). Like other entitlement programs, SSI has come under fire in some circles because of the growth of payments for children with mental health related disabilities. As a result, in 2014 the Social Security Administration asked the National Academy of Sciences to create a committee to review trends in the prevalence of mental disorders in children who receive SSI disability benefits. The report was issued in September 2015.⁷

To conduct their work, the NAS Committee examined trends in each aspect of the SSI criteria: mental disorder diagnoses, functional impairment related to the disorders and poverty. The results were striking. First, the Committee compared population-based trends of childhood mental disorders from the literature and from analyses of Medicaid data from more than twenty states. SSI trends in diagnoses generally mirrored those found in comparison sources for mental disorders globally and for the most common individual disorders. Secondly, although the definition of what constitutes a disability has changed in the past two decades, national data on childhood disability underscore the steady increase in the proportion of children with disabilities irrespective of the definition used. In 1980, 3.8% of US children had parent-reported, health-related limitations of activity. In 2014, 7.9% of children had a similar activity limitation and the health conditions associated with disability had also shifted. Between 2001 and 2011 there was a 21% increase in disability related to mental health and a 12% decline in disability owing to physical conditions.⁶ Newer data suggest that the increase in disability linked to mental health may have stabilized.⁷

Possibly the most striking findings were how closely SSI enrollment tracked childhood poverty rates. Eligibility criteria for SSI select for families that have incomes of less than 200% of the federal poverty level (FPL) with few exceptions. Numbers of low-income families change as economic conditions change. For instance, after the 2008–09 great recession, more families met eligibility criteria and thus more children with disability owing to mental disorders would have met the poverty criterion for SSI benefits. Consequently the report emphasized that an increase in the percentage of children with mental health disorders on SSI reflects an increase in the percentage of children with these disorders meeting the poverty threshold for SSI eligibility and the higher rates of disability among children in

poverty with mental disorders, as much or more so than the increasing prevalence of diagnosed behavioral disorders.

The report found that the percent of children in poverty increased after 2006, peaked in 2010, and declined slightly thereafter. However in 2013, it was still above the 2006 level. Currently, one in five children in the country are living below 100% of the FPL. The report also found that in 2010, 315,440 families were brought above the FPL by SSI payments, an increase from 175,394 in 2002. The percentage of SSI recipient families brought above the FPL also increased from 36.9% in 2002 to 45.5% in 2010. It is highly likely that this change in economic status from SSI supplementation reduced their economic stress and reduced the risk of worsening child disability.

This finding leads to a related question: Can income supplements make a difference in mitigating childhood disabilities? There is evidence that the answer is yes.^{8,9} In a natural experiment in an economically depressed region, adolescent behavioral symptoms decreased significantly among families who received income supplements but not among families who did not. Furthermore, the lowered prevalence of psychopathology persisted into adulthood for adolescents whose families received supplements.

When understood in the context of long-term benefits on children's mental health, the importance of the SSI program becomes clear. Its effects are not only in reducing poverty but also potentially ameliorating the effects of childhood disability. Given the very small percentage of all SSA disability benefits that are allocated to children (5–6%), expanding even modestly the reach of this program could have a large effect on the future health of children.

The report also documented substantial state-to-state variations in administration of this federal entitlement program. For example, there was a 7.6-fold difference between states in the percentage of children living in poverty who were recipients of the SSI program. Furthermore, the initial allowance rate for child SSI claims varied from a low of 16% in one state to a high of 78% in another state. Given these significant and inexplicable variations, many children are likely to be eligible for the program but are not enrolled. There is an important role for DBP programs and personnel in providing medical documentation to support eligibility and application guidance when it is warranted.

DB pediatricians provide important care for children with disabilities and their families; because of that care, they are often affiliated with family groups, disorder-related foundations, advocacy communities and others. There is ample evidence of the benefits of lifting children out of poverty, providing them with continuous insurance and enrolling them in services designed to advance their health and well-being.⁸ Therefore, DB pediatricians can take a more active role and see their advocacy for expansion and enrollment in poverty reducing programs as an important part of their health care delivery armamentarium. Anti-poverty advocacy generally and SSI advocacy specifically can help many children and their families confronted with the double-edged sword of poverty and disability.

REFERENCES CITED

1. Brooks-Gunn J, Duncan GJ. The effects of poverty on children. The Future of children / Center for the Future of Children, the David and Lucile Packard Foundation. Summer-Fall;1997 7(2):55–71.
2. Starfield B, Robertson J, Riley AW. Social class gradients and health in childhood. Ambulatory pediatrics : the official journal of the Ambulatory Pediatric Association. Jul-Aug;2002 2(4):238–246. [PubMed: 12135396]
3. Bauman LJ, Silver EJ, Stein RE. Cumulative social disadvantage and child health. Pediatrics. Apr; 2006 117(4):1321–1328. [PubMed: 16585330]
4. Spencer N, Strazdins L. Socioeconomic disadvantage and onset of childhood chronic disabling conditions: a cohort study. Archives of disease in childhood. Apr; 2015 100(4):317–322. [PubMed: 25239950]
5. Silver EJ, Stein RE. Access to care, unmet health needs, and poverty status among children with and without chronic conditions. Ambulatory pediatrics : the official journal of the Ambulatory Pediatric Association. Nov-Dec;2001 1(6):314–320. [PubMed: 11888421]
6. Houtrow AJ, Larson K, Olson LM, et al. Changing trends of childhood disability, 2001–2011. Pediatrics. Sep; 2014 134(3):530–538. [PubMed: 25136051]
7. National Academies of Sciences, Engineering, and Medicine. Mental Disorders and Disabilities Among Low-Income Children. Washington, DC: The National Academies Press; 2015.
8. Costello EJ, Erkanli A, Copeland W, et al. Association of family income supplements in adolescence with development of psychiatric and substance use disorders in adulthood among an American Indian population. Jama. May 19; 2010 303(19):1954–1960. [PubMed: 20483972]
9. Milligan KSM. Do Child Tax Benefits Affect the Well-Being of Children? Evidence from Canadian Child Benefit Expansions. American Economic Journal: Economic Policy. 2011; 3(3):175–205.