

—Sheldon Danziger, Richard Frank *and* Ellen Meara

MENTAL ILLNESS, WORK, AND INCOME SUPPORT PROGRAMS

Improved treatment makes it easier and more practical for individuals with mental illness to participate in mainstream society, including the labor force. However, a diagnosis of a severe and persistent mental illness or a substance use disorder is still often accompanied by a drop in employment and lower earnings.

The Social Security Disability Insurance program (DI) and the Supplemental Security Income (SSI) program provide income support for increasing numbers of individuals with mental illness. More than 30 percent of the current caseload receives benefits based on a diagnosed mental disorder. A growing share of a third program, Temporary Assistance for Needy Families (TANF), which offers cash support to low-income single mothers, is composed of individuals with mental illness, as new work requirements result in faster exits of those without mental health conditions.

These programs have come under increasing scrutiny as the shares of recipients with mental illness increase. Like most illnesses, there are many variations and gradations of mental illness. Some may completely prevent individuals from working, while others may be less debilitating. Many, in fact, question whether these programs serve only the “truly needy” and not also those who are capable of working and surviving on their own. Are these programs enticing individuals to choose them over work, even when they are capable of working?

Sheldon Danziger, Richard Frank, and Ellen Meara examine the research on this issue in their paper “Mental Illness, Work, and Income Support Programs” for the *Fundamental Policy – Spotlight on Mental Health Conference*.

Number of Recipients with
Mental Illness Grows Steadily

To limit the risk of enrolling those who are capable of working, both SSI and DI require ample documentation of a disability. Only one-third of initial applications are accepted, and even after appeals, most applicants, according to the Social Security Administration (SSA), are not awarded benefits. If the individuals show improvement, benefits are often terminated.

For many years, the SSI and DI programs served only those with physical disabilities or the most disabling mental disorders. However, beginning in the late 1980s the eligibility criteria were restructured to address conditions such as mental disorders and chronic pain. Between 1987 and 2005, according to SSA data, the share of the SSI (aged 18 to 64) disabled due to a mental disorder rose from 24 percent to 36 percent. Likewise, DI awards for mental illness were fewer than 2 percent of new awards in 1978. In 2005, individuals with a mental illness represented nearly 30 percent of all beneficiaries and 39 percent of those under age 50.

Mixed Evidence for Perverse Incentives

Some argue that the reason for this rise in SSI caseloads in the 1990s was the loosening eligibility criteria. However, as Danziger and coauthors argue, the question remains: were more “undeserving” applicants flooding the rolls or were the prior eligibility rules in the 1980s simply too exclusionary?

Others argue that the screening process is broken, and point to the parallel rise and fall of disability applications and unemployment rates during the 1990s. In other words, if individuals can work, they

do, but when employment tightens, they apply for disability benefits.

Although DI applications do follow the unemployment rates in the 1990s, Danziger, Frank, and Meara find that the award rate, or the share of applications approved for benefits, is counter-cyclical over the entire 1970–2006 period. They also find a continuous rise in SSI rates after 1997 for those with mental conditions while the trend for those with disorders other than mental disorders closely mirrors the unemployment rate.

Within the TANF program, the authors find little evidence of misplaced incentives among a large group of Michigan recipients between 1997 and 2003. Slightly more than one-third of this group met the diagnostic screening criteria for major depression, posttraumatic stress disorder, and generalized anxiety disorders. Yet only 12 percent received SSI. Another 26 percent applied for but did not receive benefits. Further evidence that eligibility criteria may exclude those in need is the continued vulnerability of those rejected for the program. Greater proportions of those rejected for SSI had unstable housing and homelessness than those who applied for and received SSI. Also, those who were rejected were much less likely to be working (or to have worked in the past) than those who had never applied for SSI.

Areas for Future Research

As SSI and DI caseloads rise, policymakers are increasingly concerned that the eligibility criteria are too lax. The evidence that SSI and DI are serving more than the “truly needy,” however, is mixed. It is therefore imperative that policymakers more

completely understand the dynamics of the mental health population when designing policies for the DI and SSI programs.

The authors raise three questions for policy research and practice and suggest that the policy response to addressing income support for those with mental illness will differ dramatically depending on answers to each.

First, are the criteria for eligibility into SSI and DI too stringent, too lax, or both? Barriers should be removed or reconfigured accordingly.

Second, are current rules and regulations to prevent the able-bodied from using limited resources appropriate? Given the unique nature of mental disorders, program design features to reduce this risk should differ as well.

Finally, what are the mechanisms driving the rising caseload for mental disorders in each program over time? The current focus on eligibility criteria is misplaced if, for example, the mental disorder caseload in fact reflects shifting labor markets from manufacturing toward services. People with mental illness might have been able to work on a factory line but may be less able to interact with the public in a service job, which could in turn affect employment rates of those with mental disorders.

Addressing these questions will allow policymakers to improve the efficiency and effectiveness of public support systems by ensuring the appropriateness of enrollees and maintaining a manageable flow of enrollees.

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