

Mental Health Conditions and Service Use Among Cash Assistance Recipients: A Comparison of TANF and SSI Recipients Enrolled in Fee-for-Service Medicaid

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Objective: During the last decade, TANF caseloads have declined dramatically, leaving on the rolls recipients with mental disorders or other challenges that may affect their ability to meet the program's work requirements. This study identifies TANF recipients who use mental health services, compares them to SSI recipients, and estimates the number of TANF recipients who may qualify them for SSI. **Methods:** Based on data from the 2003 Medicaid Analytic Extract files from four states, this analysis included Medicaid beneficiaries age 19 to 64 in fee-for-service payment systems who met the eligibility requirements for SSI and/or TANF for at least one month. **Results:** 13% of TANF and 29% of SSI beneficiaries used mental health services. Common disorders among TANF beneficiaries included neurotic and other depressive disorders, major depression and affective psychoses, and stress and adjustment reactions. SSI beneficiaries had similar disorders, but also had frequent diagnoses of schizophrenia and other psychoses. Fourteen percent of TANF recipients had levels of mental health service use comparable to SSI recipients. **Conclusion:** The number of TANF recipients identified as having mental disorders is lower than previous studies that gather data on symptoms associated with mental health disorders. Among those with mental disorders, some have patterns of service use indicate potential eligibility for SSI, but the majority appear to have more modest limitations that could be addressed through a combination of work accommodations and more intensive work support.

Introduction

High rates of mental disorders have been found among low-income women, particularly those who have been exposed to traumatic experiences in their lives, such as adult and childhood abuse, crime victimization, and rape (1-4). Studies indicate that when left undiagnosed or untreated, mental disorders may contribute to physical health conditions, poverty, homelessness, child welfare involvement, and intimate partner violence (5-7). Early detection and treatment is paramount to preventing potential negative consequences.

Individuals with mental disorders who have difficulty maintaining steady work may turn to two government programs for financial assistance. Parents with children younger than age 18 may apply for Temporary Assistance for Needy Families (TANF), a short-term cash assistance program. Individuals with limited or no work history and documented long-term disabilities may be eligible for Supplemental Security Income (SSI).

The TANF and SSI programs differ in three important ways: their degree of uniformity, the heterogeneity of the populations they serve, and their approach to work. SSI is a federal program that provides uniform benefits and eligibility requirements, regardless of where recipients live. In contrast, TANF is a block grant provided to states which have the authority to set payment levels and eligibility requirements. Although SSI recipients have a broad range of disabilities and functional limitations, they are similar in that they have physical or mental impairments that inhibit work. In contrast, a range of circumstances lead individuals to TANF, including job loss, caring for a disabled child, and mental or physical health conditions.

SSI recipients are not required to work or prepare for work, although they are increasingly encouraged and provided opportunities to do so. In contrast, work is a central component of TANF; most recipients must participate in work activities as a condition of eligibility. States must engage 50% of their TANF cases headed by an adult or teen parent in work activities, as

defined by the federal government, for at least 20 and often 30 hours per week, or face financial penalties. States may exempt recipients with mental disorders from the work requirement, but few do so. Mental health treatment may count as a work activity, but only for six weeks (of which no more than four may be consecutive) in 12 months and must be combined with other activities to meet the required hours. Feeling the urgency to meet the federal requirement, states typically design their programs to quickly engage recipients in labor market activities rather than assess or treat their potentially disabling conditions. Additionally, TANF staff often have limited skills, experience, or training to identify behaviors that might indicate a mental disorder or create a realistic work plan for those with documented disorders.

Previous studies indicate that mental disorders are prevalent among TANF recipients. One-fourth to one-third of current recipients have symptoms associated with a mental health condition (8-10). Estimates differ depending on how disorders are defined and measured, and by the data collection strategy and research methodology. One study found major depression to be the most common mental disorder (26.7%), followed by post-traumatic stress disorder (14.6%) and generalized anxiety (7.3%) (11). Several studies found that recipients with mental disorders are less likely to work than their counterparts without a mental disorder (12-13). One study of poor single mothers indicated that having a psychiatric disorder was associated with a 25% lower likelihood of working (14). Some TANF recipients may have mental disorders severe enough to qualify for SSI (15). While these studies give some indication of the prevalence of serious mental disorders among welfare recipients and their relationship to work, little is known about the frequency and intensity of services that TANF recipients use to address these disorders.

Given TANF's increasing emphasis on work, understanding the mental disorders among its recipients may create realistic expectations about work and which system—TANF, SSI, or something in between—would provide them with the most appropriate services and supports. To

this end, this study addresses the following questions: How many TANF recipients are using mental health services and have diagnosed mental disorders? How do the characteristics and types mental disorders of TANF recipients compare with those of SSI recipients? How many TANF recipients have levels of service use comparable to the SSI population?

Methods

The tables in this article are based on data from the 2003 Medicaid Analytic eXtract (MAX) files in four states: X, X, X and X. The MAX data contains information on beneficiaries, service use, prescription drugs, and expenditures in state Medicaid programs. Researchers can use administrative and claims data from the files to construct a comprehensive picture of service use for each beneficiary. All claims, except those for prescription drugs, contain a primary diagnosis using *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) codes; the amount of the combined state and federal Medicaid reimbursement; and the type of service (TOS) that generated the claim. The TOS codes can be used to identify treatment settings (such as emergency rooms) and distinguish psychiatric from general hospitals.

Data from beneficiaries in fee-for-service (FFS) care for at least one month in the year are included in the tables. We used FFS Medicaid claims because they yield more complete information on service use than data from Medicaid managed care organizations. For beneficiaries enrolled for part of the year in Medicaid managed care and part of the year in a FFS system, we excluded data for the months of managed care enrollment.

The four states were selected based on two criteria: (1) the ability to identify whether a Medicaid claimant was a TANF recipient and (2) data quality. We excluded states where the number of 1931 Medicaid beneficiaries was substantially larger than the TANF population in the state, where more than 33% of the state's Medicaid beneficiaries were enrolled in Medicaid managed care plans and states that did not meet data quality standards related to mental health

and substance abuse services (16). Common problems included missing diagnosis codes, uneven reporting of enrollment, missing eligibility data, duplicate records, and missing claims.

The study population includes beneficiaries with a primary diagnosis of a mental disorder on at least one FFS Medicaid claim during the year, and those who received treatment in a psychiatric facility during the year. The diagnoses used to identify beneficiaries with mental disorders, identified primarily by the first three digits of ICD-9-CM codes, are those considered by most payers to be mental disorders (16); these can be found in Table 1.

TANF and SSI receipt were defined based upon the MAX uniform eligibility codes. Beneficiaries were coded as TANF recipients if they were categorically needy as specified in Section 1931 of the Social Security Act for at least one month. In 1996, TANF and Medicaid eligibility were delinked, however, nearly all TANF recipients receive Medicaid through Section 1931. Beneficiaries were coded as SSI recipients if their eligibility code indicated they were receiving cash assistance and were aged, blind, or disabled for at least one month. The tables in this article are restricted to adults ages 19 to 64 because they represent the majority of TANF recipients subject to work requirements.

To determine which beneficiaries had a costly physical health condition, we applied the Chronic Illness and Disability Payment System (CDPS). The CDPS categorizes diagnoses into one of 13 body systems; within these categories, diagnoses are sorted into low, medium, high, or very high cost diagnoses. Beneficiaries with costly physical health conditions were defined as beneficiaries with physical co-morbidities or medium to very high cost diagnoses such as congestive heart failure, multiple sclerosis, and breast cancer (17). Cases where a beneficiary had at least one claim with a primary mental disorder diagnosis and at least one claim with a substance use diagnosis (alcohol and/or drug dependence) were classified as having a co-occurring mental and substance use disorder.

Results

Across the 13 states, 13% (N=115,960) of TANF and 29% (N=266,567) of SSI beneficiaries were identified as having mental disorders on the basis of their service use. Compared with the SSI beneficiaries, TANF beneficiaries with these disorders were younger and more often white and female (Table 1). The age and gender composition of the TANF population with a mental disorder was comparable to the overall TANF population, but the racial composition was strikingly different (results not shown): 70% of TANF recipients with a mental disorder were white compared with 47% of all TANF recipients. We do not observe this same pattern for SSI recipients; the age, gender and racial distribution are comparable for SSI recipients with and without a mental disorder.

Among TANF beneficiaries, the most prevalent diagnoses included neurotic and other depressive disorders (45%, N=52,313), major depression and affective psychoses (30%, N=34,969), and stress and adjustment reactions (11%, N=13,125) (Table 1). Few TANF beneficiaries were diagnosed with schizophrenia and other psychoses (2%, N=2,288). In contrast, 32% (N=84,422) of SSI beneficiaries were diagnosed with these disorders. About one-fifth (22%, N=59,222) of SSI recipients were diagnosed with neurotic and other depressive disorders and 32% (N=86,207) with major depression and affective psychoses.

Beneficiaries with mental disorders had other challenges as well. Almost one in 10 TANF beneficiaries (N=10,266) had a physical co-morbidity which is a costly physical health condition (Table 1). The percentage of those with diagnosed physical co-morbidities among SSI beneficiaries was substantially higher at 26% (N=69,058). About 4% (N=4,824) of TANF and 5% (13,535) of SSI beneficiaries were diagnosed with a substance use disorder. The percentage of TANF recipients with a mental disorder caring for a newborn (9%, N=10,541) was higher

than the percentage of SSI recipients with a mental disorder caring for a newborn (1%, N=1,788).

The extent to which TANF and SSI beneficiaries diagnosed with a mental disorder utilized mental health treatment services differed considerably. For TANF beneficiaries, treatment was mostly short-term (Table 2). Almost three-quarters (N=83,980) received treatment for three or fewer months. Compared with TANF beneficiaries, on average, SSI beneficiaries participated in treatment for twice as long and fewer than half (N=113,924) received treatment for three or fewer months. Among the beneficiaries, 6% (N=6,806) of TANF recipients and 10% (N=27,750) of SSI recipients used inpatient treatment to address their disorders; 13% (N=14,950) of TANF recipients and 16% (N=41,869) of SSI recipients had one or more emergency room visits for mental health treatment.

TANF and SSI recipients differed somewhat in the type and number of psychotropic drugs they used. Among TANF beneficiaries, 69% (N=79,512) used antidepressants and 35% (N=40,124) used antianxiety agents; only 17% (N=19,402) used antipsychotic drugs. Among SSI beneficiaries, 64% (N=169,796) used antidepressants, 54% (N=143,648) used antipsychotics and 34% (N=91,533) used antianxiety agents. TANF beneficiaries were also less likely than SSI beneficiaries to rely on more than one psychotropic drug, 37% (N=42,943), compared with 53% (N=140,416).

The use of the emergency room or an inpatient facility for mental health treatment, use of one or more psychotropic drugs, and the co-occurrence of a substance abuse disorder or physical co-morbidity can be used to gauge the extent to which recipients' mental disorders that may limit work or require additional support to promote successful labor market outcomes. In Table 3, we use these indicators to classify TANF and SSI beneficiaries into three groups representing low, moderate and high levels of mental health service use. TANF recipients are concentrated in the

low category while SSI recipients are distributed more evenly across all three categories. Among TANF recipients, 54% (N=62,183) are in the low use category, 33% (N=37,693) are in the moderate use category, and 14% (N=16,084) are in the high use category. Among SSI recipients, 39% (N=104,760) are in the low use category, 32% (N=86,621) are in the moderate category, and 28% (N=75,186) are in the high category. The median expenditures for the high use TANF group are comparable to the median expenditures for all SSI recipients with a mental disorder, suggesting that this high use TANF group may be comparable to SSI recipients with respect to their potential for employment (Table 3).

Discussion

This study found that 13% of TANF beneficiaries have diagnosed mental disorders for which they are receiving treatment. Common disorders include neurotic and other depressive disorders, major depression and affective psychoses, and stress and adjustment reactions. Schizophrenia and other psychoses that are relatively common among the SSI population with diagnosed mental disorders are rare among the TANF population. While this study confirms existing research documenting the types of mental disorders among TANF recipients, the proportion of TANF recipients with mental disorders is substantially lower. This suggests some recipients who display symptoms of a mental disorder may not be diagnosed or may have been diagnosed, but are not receiving treatment. This finding is consistent with the perceptions of TANF staff who note that many TANF recipients with mental disorders have never been diagnosed or treated (18).

For TANF beneficiaries with a diagnosed mental disorder, mental health treatment was primarily short-term. From these data, we cannot tell whether this is reflective of the nature of their disorder or because TANF recipients had difficulty participating in treatment for longer periods of time. Other studies have documented that many TANF recipients have personal and

family challenges that interfere with work (e.g., lack of transportation or child care, children with behavioral problems, or recipients' physical health conditions or cognitive impairments) (19-22). These same conditions may create obstacles to participation in regularly scheduled treatment or appropriate medication management. Other beneficiaries may experience difficulty in finding a treatment provider that will accept Medicaid, particularly in rural areas.

Based on the levels of service use data, we found that 14% (N=16,084) of TANF beneficiaries who were diagnosed with a mental disorder face serious obstacles to work and may meet the eligibility criteria for SSI. Based on their levels of service use, the majority of TANF beneficiaries appear to face fewer obstacles. About half of TANF recipients have low levels of service use, suggesting that with additional support to help them manage their mental health disorder, they may be able to meet their work requirements and eventually find and sustain paid employment. Recipients with modest use of mental health services may need more intensive support and may benefit from modified work requirements until their conditions are stabilized. This latter group, accounting for about a third of TANF recipients diagnosed with a mental disorder, may pose the greatest challenge for TANF agencies because they do not appear to have limitations serious enough to meet SSI eligibility criteria but they may be unable to work for 20 or 30 hours per week, especially during times when they require emergency room or inpatient treatment.

Our study has a couple of limitations. First, because we include Medicaid claims data from only 13 states, our results may not be generalizable to other states or to the country as a whole. And, owing to considerable state policy and program variation, this problem may be more acute for TANF than for SSI beneficiaries.

Second, we may underestimate the number of TANF and SSI recipients who have a diagnosed mental disorder. Because we select only those who have a mental disorder as a

primary diagnosis, recipients who have been treated for these conditions but have other primary diagnoses are not included in these data.

Conclusion

This study provides evidence to suggest that a nontrivial portion of the TANF caseload has a diagnosed mental health disorder for which they are receiving treatment. When compared with results from other studies, it appears that an equal number of recipients display symptoms of a mental health disorder but are not receiving treatment. Because few recipients appear to have service patterns comparable to SSI recipients, most TANF recipients will continue to be subject to the program's work requirements. Thus, the key challenge facing mental health providers and TANF agencies is how to implement work programs that recognize the special needs that TANF recipients with mental disorders may face. A key characteristic that distinguishes TANF from SSI recipients, and many others who have successfully participated in employment programs for individual with mental disorders, is that TANF recipients are raising children, often as single parents, and face all the challenges that come with parenting in addition to the challenges that arise from their mental disorder. Many TANF recipients report difficulties in finding child care or having access to adequate transportation to work. Additional challenges may include domestic violence, low levels of education, poor housing and homelessness. A mental disorder in combination with any of these challenges may result in far greater treatment and employment challenges than programs for childless individuals are used to addressing.

In recent years, some also have questioned whether the TANF system is capable of addressing the needs of families with mental disorders and proposed creating a new work-based service system designed to meet the needs of parents who experience personal and family challenges, including mental disorders, that limit their ability to work, but do not create limitations serious enough to qualify for SSI (23). These proposals acknowledge that some

parents need more assistance and more time than others to make the transition to paid employment, and, for some, steady full-time employment may not be a realistic goal.

In a few states, TANF agencies have cultivated partnerships with mental health systems where co-located mental health providers train TANF staff to identify the signs of a potential mental disorder or provide clinical assessments and referrals. Such systems have not been rigorously studied, but may offer opportunities for implementing evidence-based practices for TANF recipients with mental disorders. As another alternative, a new work-based service system might promote joint case planning where a mental health practitioner and TANF case manager create an individualized employment plan based on the strengths and functional limitations of the participant. Such a system could provide necessary work-based and personal supports to TANF eligible families and divert some from the SSI caseload.

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Table 1
Characteristics of TANF and SSI Beneficiaries with Mental Disorders

	TANF Recipients		SSI Recipients	
	N	%	N	%
Age				
19–21	10,379	9%	12,609	5%
22–44	95,559	82%	130,005	49%
45–64	10,022	9%	123,953	46%
Gender				
Female	102,699	89%	162,310	61%
Male	13,258	11%	104,253	39%
Unknown	3	0%	4	0%
Race				
White	81,143	70%	155,175	58%
Black	23,771	20%	73,556	28%
Hispanic	7,659	7%	20,978	8%
American Indian/Alaska Native	1,852	2%	2,203	1%
Asian/Hawaiian/Pacific Islander	262	0%	2,388	1%
Other/unknown	1,273	1%	12,267	5%
Diagnosis among beneficiaries with mental disorders*				
Hyperkinetic syndrome	1,535	1%	3,037	1%
Other childhood disorders**	859	1%	6,390	2%
Major depression and affective psychoses	34,969	30%	86,207	32%
Neurotic and other depressive disorders	52,313	45%	59,222	22%
Schizophrenia and other psychoses***	2,288	2%	84,422	32%
Stress and adjustment reactions	13,125	11%	14,902	6%
Other mental disorders	10,871	9%	12,387	5%
Other challenges				
Co-occurring substance use disorder	4,824	4%	13,535	5%
Physical co-morbidity (Costly physical health conditions)	10,266	9%	69,058	26%
Caring for a newborn****	10,541	9%	1,788	1%
Total	115,960	100%	266,567	100%

* The diagnostic category for each beneficiary is the one that occurred most frequently among primary diagnoses on claims during the year.

** Primarily conduct disorders and emotional disturbances.

*** Includes childhood psychoses.

**** Individuals are identified as caring for a newborn if they have a record of a maternal delivery diagnosis code. A small number of these may not have resulted in a live birth.

Table 2

Mental Health Service Utilization and Psychotropic Drug Use Among TANF and SSI Beneficiaries with Mental Disorders

	TANF Recipients		SSI Recipients	
	N	%	N	%
Average number of months with mental health (MH) treatment services	3	n/a	6	n/a
1–3 months	83,980	72%	113,924	43%
4–6 months	15,995	14%	51,312	19%
7–12 months	11,420	10%	99,624	37%
With inpatient MH treatment	6,806	6%	27,750	10%
With more than one ER visit for MH treatment	14,950	13%	41,869	16%
Use of psychotropic drugs	89,971	78%	231,739	87%
Antidepressants	79,512	69%	169,796	64%
Antipsychotics	19,402	17%	143,648	54%
Antianxiety agents	40,124	35%	91,533	34%
Stimulants	3,574	3%	7,965	3%
Use of more than one psychotropic drug	42,943	37%	140,416	53%
Total	115,960	100%	266,567	100%

Table 3

Levels of Mental Health Service Use and Median Mental Health Expenditures Among TANF and SSI Beneficiaries with Mental Disorders

Levels of Service Use	TANF Recipients		SSI Recipients	
	N	%	N	%
Low*	62,183	54%	104,760	39%
Moderate **	37,693	33%	86,621	32%
High ***	16,084	14%	75,186	28%
Total	115,960	100%	266,567	100%

Median Expenditures	TANF Recipients		SSI Recipients	
	US Dollars			
Low	\$1,848		\$5,159	
Moderate	\$3,248		\$6,773	
High	\$7,774		\$16,370	
Total	\$2,802		\$8,121	

* None of the following: inpatient or emergency room mental health treatment, multiple psychotropic drugs, co-occurring substance abuse disorder

** One of the following: inpatient or emergency room mental health treatment, multiple psychotropic drugs, co-occurring substance abuse disorder

*** At least two of the following: inpatient or emergency room mental health treatment, multiple psychotropic drugs, co-occurring substance abuse disorder, co-occurring moderate- or high-cost physical health condition