Brief Reports

The Health and Mental Health of Disabled Substance Abusers

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Abstract

In 1996 Congress terminated Supplemental Security Income (SSI) benefits to individuals disabled by substance abuse. Although most were expected to continue benefits under another disability category, 64% were not reclassified. This article examines data from a longitudinal study of individuals in Los Angeles County affected by the legislation. While poor physical health predicted both continued SSI benefits and receipt of public income assistance, many individuals reporting significant mental and physical health problems were not reclassified and did not receive public income assistance, raising concern for their welfare. Local safety nets may become increasingly important for this population.

Introduction

The Contract with America Amendment Act, passed in 1996, eliminated substance abuse as a basis for establishing eligibility for disability under the Supplemental Security Income (SSI) program as of January 1, 1997. Under prior law, individuals who demonstrated a drug addiction and alcoholism (DA&A) disability received monthly SSI cash benefits and Medicaid health insurance. Unlike other SSI recipients, those disabled by substance abuse were required to participate in substance abuse treatment and to have a representative payee manage their funds as a condition for receiving benefits. Although the 1996 law provided that individuals with multiple impairments could apply for reclassification under another disability category, those denied reclassification and those who did not reapply lost SSI cash and health insurance benefits. In addition, individuals who were reclassified were no longer required to attend substance abuse treatment or to appoint a representative payee.

An earlier study indicated that many DA&A recipients reported high levels of both medical and psychiatric problems, even among those who reported no alcohol or drug use in the previous month.[1] Over 30% reported attempting suicide at some time, and, as a group, they reported significantly

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more current and chronic medical and psychiatric problems than a comparison group of clients entering substance abuse treatment, or a group of homeless substance abusers. At the time of the legislation it was widely expected that approximately 75% of the group would qualify for continued benefits, primarily under a mental illness disability.[2,3] However, nationally 36% were reclassified, leaving 64% without federal income support or health insurance.[3] Prior work using administrative records suggested that many individuals who reported psychiatric and medical problems were not reclassified, either because they did not request reclassification or because their request was rejected.[4] However, because this work relied on administrative data, it is unclear how valid and reliable the reports of health status were. In addition, since individuals who were not reclassified could request reclassification at a later date or could have their benefits reinstated through an appeal process, it is possible that some individuals were reclassified subsequently.

The low reclassification rate raises the question of whether persons with comorbid mental and physical illness were able to negotiate the reclassification process successfully and continue to receive benefits, and, if not, whether they were able to turn to some other form of public income assistance such as General Relief. This article examines data from a longitudinal study of individuals in Los Angeles County affected by the legislation to examine the health and mental health of the group at the time the legislation took effect. It analyzes the relationship between health status at the time of the legislation and income source after the legislation. The focus is on Los Angeles County because 25% of those affected by the legislation lived in California, and, within California, Los Angeles County had the greatest number of affected individuals.

Methods

Study design and sample selection

Data were drawn from a longitudinal study of a sample of SSI recipients in Los Angeles County. The initial sample consisted of 400 SSI recipients randomly selected from the Social Security Administration October 1996 rolls. Of these, 308 were interviewed at baseline (79% response rate), adjusting for 10 persons who were confirmed dead. A total of 253 recipients (82% of baseline) completed the baseline, 12-month, 18-month, and 24-month interviews and had sufficient data to be categorized according to income source. A comparison between the 55 persons who did not complete all four interviews and the 253 persons that did indicates that there were no statistically significant differences between the two groups with respect to demographics, substance abuse, or length of time on SSI. Males comprised 65% of the sample; the mean age was 44 (range, 21–59, standard deviation [SD] 7.9). Relative to ethnicity, 24% were white, 55% were black, and 22% were of other backgrounds.

Interviews occurred either at the University of California, Los Angeles (UCLA) or in the community. Interviewers were part of the fieldwork staff at the UCLA Drug Abuse Research Center and received 3 days of training including specific training in the administration of the Addiction Severity Index (ASI) prior to entering the field. Supervisors evaluated interviewers before beginning fieldwork and periodically during the follow-up period.

Income source status

Longitudinal data were used to classify respondents into those continued on SSI, those who regularly depended on other forms of public income assistance (primarily General Assistance), and those who primarily relied on non-public sources of income such as employment, friends, family, and illegal activity for the 2 years following the legislation. Subjects' income source was first classified at each wave. Subjects who reported receiving income from SSI for either the last 30 days or for 3 months out of the last 6 were classified as receiving SSI for that wave. Of the remaining subjects,

those who reported receiving income from other public sources (primarily General Assistance) for either the last 30 days or for 3 out of the last 6 months were classified as receiving public income assistance; the remainder were classified as relying on non-public sources of income for that wave. After classifying subjects' income source at each wave, overall income source status was classified. Subjects were assigned to an income source status based on their reported income source for the majority of the waves. When there was no majority, classification was based on the subject's income source at the 24-month follow-up. Forty-two percent of the sample continued to receive SSI based on another disability, 27% replaced lost SSI benefits through other forms of public assistance, and 31% relied on non-public sources.

Health and mental health measures

Both health and mental health were characterized using baseline data in order to assess the relationship between health status at the time the legislation took effect and income source after the legislation. Particularly for SSI reclassification, there can be a significant delay between the time of health assessment and the time the reclassification occurs.

Health was characterized on three dimensions. Subjects were asked to give an overall assessment of their health in the past 6 months; general health status was assessed by the percentage reporting excellent, good, fair, or poor health. Medical problem severity for the past 30 days was measured using the medical composite score from the ASI,[5] and disability or functioning was assessed by the number of bed or restricted activity days in the past month due to a medical problem. Perceived health status is highly predictive of subsequent mortality, and bed or restricted activity days are frequently considered a measure of disability and impaired functioning.[6,7] The composite scores from the ASI, calculated from self-report during a semistructured interview, are reliable and valid measures of problem severity.[8] Composite scores range from 0 to 1, with higher scores indicating greater severity. The scores are not standardized and cannot be compared across domains.

Mental health was characterized on four dimensions: emotional health status, self-reported diagnosis, symptoms and problem severity, and disability or functioning. Emotional health status was assessed by the percentage reporting excellent, good, fair, or poor emotional health. Diagnosis was based on self-reported diagnosis together with lifetime psychotropic medication use. Because many of the subjects were not in treatment, and cost constraints precluded a clinical interview, the diagnostic categorization could not be confirmed with professionally determined diagnoses. Symptoms and problem severity for the past 30 days were measured using the psychiatric composite score from the ASI.[5] This score is a weighted combination of 11 questions (seven measure psychiatric symptoms in the past 30 days, one measures use of prescribed psychotropic medication, and three assess the frequency of symptoms and perceived need for treatment). The number of bed or restricted activity days in the past month due to an emotional problem indicated disability or functioning status. There was substantial agreement between measures of emotional health with Pearson's correlation coefficients greater than .48 for continuous variables, and χ^2 significant at $p < .001$ for categorical variables.

Analyses

Results regarding the baseline health and mental health of the sample of 253 individuals with complete data are reported. First the health and mental health of the sample is described. Then it is compared with those who were reclassified and continued to receive SSI, those who regularly depended on other forms of public income assistance, and those who were reliant on non-public sources of support. Logistic regression examined whether health or mental health characteristics were associated with either reclassification or, among those not reclassified, with receipt of public income assistance, adjusting for demographics.

Results

Physical and mental health

Eight percent of the sample reported being in excellent or very good health at baseline, 17% reported being in good health, and 74% reported being in fair or poor health. The mean ASI medical composite score was 0.64 (SD, .37), as compared with 0.24 among inpatient substance abusers and 0.15 among outpatient substance abusers in treatment.[5] Fifty percent of the sample reported at least one bed day in the past month, with a mean of 4.3 (SD, 7.0) bed days.

At baseline 12% of the sample reported being in excellent or very good emotional health, 13% reported being in good emotional health, and 75% reported being in fair or poor emotional health. Twenty-five percent had no current psychiatric diagnosis, 28% reported current distress but no diagnosis, 28% had a probable affective or anxiety disorder, and 19% had a probable psychotic or bipolar disorder. The mean ASI psychiatric composite score was 0.53 (SD, .23). By comparison, the average score for inpatient substance abusers was 0.22 and for outpatient substance abusers it was 0.11.[5] Fifty-six percent reported experiencing bed days or restricted activity days in the past month, and the sample reported a mean number of 5 (SD, 6.9) bed days due to an emotional problem in the past month.

Physical and mental health by income source

Table 1 presents differences among the three income source groups (continued on SSI, received public income assistance, and no public income assistance) on health and mental health status. To clarify which differences were significant some additional analyses were rerun comparing individuals continued on SSI with those receiving public income assistance and, in separate analyses, with those receiving no public income assistance. Individuals continued on SSI were more likely to report fair or poor health than those on no public income assistance ($p < .001$). On none of the other measures (diagnosis, current symptoms/problem severity or bed days) was there an increased likelihood of being in a particular income source group by level of impairment. Fifty-four percent of those reporting a psychotic or bipolar illness were not reclassified, and 31% described no regular public source of income assistance. Fifty-five percent of those receiving ASI medical composite scores greater than .7, and 59% of those receiving ASI psychiatric composite scores greater than .7 were not reclassified. Twenty-five percent of those with medical composite scores greater than .7 and 26% of those with psychiatric composite scores greater than .7 did not receive any form of public income assistance. By comparison with average scores for inpatient and outpatient substance abusers and homeless individuals with substance abuse problems, scores greater than .7 are high.[1,5]

Logistic regression was used to predict continuation on SSI, and, among those who were not reclassified, receipt of public income assistance, by physical and mental health status. Models also included age, ethnicity, and gender. Those who reported fair or poor health were more likely to receive either SSI (odds ratio [OR], 2.04; confidence interval [CI], 1.02–4.07; $p < .04$) or public income assistance (OR, 3.25; CI, 1.35–7.85; $p < .008$). When tested together, the group of mental health variables (emotional health status, psychiatric problems, diagnosis, and bed days), predicted receipt of SSI ($\chi^2 = 21.13$, $p < .005$, likelihood ratio chi-squared test with 6 degrees of freedom) and income assistance ($\chi^2 = 13.21$, $p < .5$, likelihood ratio chi-squared test with 6 degrees of freedom), although the odds ratios for individual predictors were generally not large and not significant. Neither the measure of psychiatric symptoms nor functioning predicted either reclassification or receipt of public income assistance, although reporting a current depressive or anxiety disorder increased the odds of reclassification (OR, 2.44; CI, 1.02–5.83; $p < .04$). Individuals with a probable bipolar or psychotic disorder also were more likely to be continued on SSI, but the odds ratio failed to reach significance ($p < .09$). Neither type of mental disorder predicted receiving public income assistance.

Table 1

Comparison of the physical and mental health status of subjects continued on Supplemental Security Income (SSI), receiving public income assistance or receiving no public income assistance at the time of the termination of SSI benefits, Los Angeles County

	Continued on SSI ($n = 106$)		Public income assistance ($n = 68$)		No public income assistance ($n = 71$)		Significance	
	n	%	*n*	%	*n*	%	χ^2	*p*
Physical health							22.20	.001
Excellent/very good	6	29	3	14	12	57		
Good	14	33	7	16	22	51		
Fair	34	41	24	29	25	30		
Poor	52	50	33	31	20	19		
Mental health							9.06	.170
Excellent/very good	12	41	5	17	12	41		
Good	10	29	8	23	17	49		
Fair	42	44	28	29	25	26		
Poor	42	45	27	29	25	27		
Diagnosis							6.24	.400
None	22	35	16	26	24	39		
Situational problems	25	36	21	30	23	33		
Affective or anxiety	36	51	18	26	16	23		
Psychotic or bipolar	22	46	11	23	15	31		
	Mean	**SD**	**Mean**	**SD**	**Mean**	**SD**	***F***	***p***
Medical problem severity*	0.68	0.34	0.69	0.35	0.52	0.39	5.52	.005
Physical bed days, past month	4.9	7.8	4.5	6.3	3.3	6.5	1.14	.320
Psychiatric problem severity	0.54	0.23	0.55	0.22	0.51	0.26	0.47	.630
Emotional bed days, past month	4.9	6.9	5.6	7.4	4.7	6.6	0.31	.730

SD, standard deviation

*Problem severity measured using the composite score of the medical or psychiatric subscale of the Addiction Severity Index, range 0–1.

Discussion

At the time of the legislation there was widespread concern among the advocacy and treatment community that many individuals who received benefits for a substance abuse disability also suffered from co-occurring physical and mental illnesses.[9] Many felt that, in particular, co-occurring mental illnesses might make it difficult for beneficiaries to comply with the reapplication procedures in a timely fashion, leading to either a cessation or a break in benefits and health insurance and causing increased suffering and disability. These results suggest that many beneficiaries did report high levels of health problems and disability at the time of the legislation, and that many of these individuals were not reclassified under another disability category. Although in California public income assistance is available to the indigent, a substantial number of those individuals who were not reclassified did

not turn to other forms of income assistance as a regular source of income. Over half of those who reported high levels of medical or psychiatric problems were not reclassified, and half of those did not receive any public income assistance on a regular basis.

Being in poor overall health positively predicted both reclassification and receipt of income assistance. At the individual variable level, poor mental health status did not predict either reclassification or receipt of income assistance with one exception. However, when tested as a group of variables poor mental health did predict both reclassification and, among those not reclassified, receipt of public income assistance. This suggests that while the relationship is not strong, some of those with impaired mental health status were able to obtain financial assistance. Of concern because of the high costs of their care,[10] the dually diagnosed are frequently at risk for homelessness and indigence.[11,12] The weakness of the relationship between mental health status and reclassification is somewhat surprising since both the Social Security Administration and policy analysts expected that most individuals would be reclassified on the basis of a mental health disabilty.[2,3]

This study has several limitations. Baseline interviews were conducted at a time when many respondents were attempting to become reclassified. Respondents may have overreported their physical and mental health problems, believing that it would aid them in the reclassification process. A study by McKay et al[1] looked at ASI composite scores among a large sample of DA&A recipients at the time of drug treatment entry. They reported mean medical and psychiatric composite scores of 0.47 (SD, .38) and 0.33 (SD, .25), substantially lower than the means reported here, although higher than the norms reported for other populations at the time of entry into drug treatment.[5] Notably, the current study relied on self-report measures, administered by trained interviewers as opposed to a clinical interview. In particular self-reported diagnosis may not map to a clinical diagnosis. It is possible that given a larger sample, associations between health status and reclassification or income source might have been found. In addition, while the study started with a random sample of beneficiaries, complete data existed for only two thirds of the sample. However, the 55 individuals who did not complete all waves of data collection were no more likely to advise of a probable mental disorder, report emotional bed days, or have higher ASI psychiatric scores than those who did complete all waves of data collection.

Implications for Behavioral Health Services

Several policy and public health implications arise from these results. First, while some individuals who reported impaired health and mental health were reclassified, many were not and reported no other forms of income assistance. While not equating these measures of impaired health with the federal definition of disability, the results suggest that at least some of these people have significant medical and psychiatric problems, raising concern for their welfare. Several researchers have questioned whether the Social Security Administration's determinations for mental disorders are reliable, particularly for those with a history of drug abuse.[13] This study's finding that mental health status was only weakly predictive of recertification and receipt of public income assistance provides independent corroboration of this concern.

Second, some of the individuals who lost benefits may require health services in the future. Whereas formerly the health care costs of beneficiaries were covered by Medi-Cal and funded in part by the federal government, most individuals who lost income benefits also lost health insurance and became reliant on health care provided at state and local community expense. This changing source of support represents a shift in costs away from the federal government and to the state and local community. In addition, some forms of medical care may be less accessible to individuals without insurance. Among medically needy and indigent adults, loss of health insurance has been shown to be associated with a significant decrease in access to care and health status.[14]

Clinicians and policy makers can address the consequences of the legislation in several ways. First, while the opportunity to request an expedited reclassification under the conditions of the 1996 law

has passed, former recipients are eligible to request a new assessment following the usual procedures. Clinicians can assess disability among former recipients and aid them in applying for either federal or local benefits. Program administrators can encourage clinicians to assist former recipients to apply for either federal or local income assistance. Second, policy makers can make the availability of local income assistance programs more widely known and accessible. Although less remunerative than federal programs, local income assistance programs provide a safety net for many indigent individuals. Last, monitoring health and social outcomes provides a way of assessing the long-term consequences of the legislation on the welfare of this population.

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