Child-Only CalWORKs Study

Report #3

SSI Parents with Children Receiving CalWORKs Cash Assistance in San Francisco: A Population on the Edge

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The CalWORKs Child-Only Project, of which this is the fourth study, aims to inform policy makers about the families who compose California's child-only CalWORKs (TANF) caseload. This report describes a study of children on child-only CalWORKs in San Francisco whose parents or guardians receive Supplemental Security Income (SSI). Study reports, policy briefs, and updates are posted at www.cfpic.org.

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Richard Speiglman and Jane Mauldon conceived the project and, with Christina Sogar, designed the recruitment effort and the survey instrument. Speiglman and Sogar conducted the interviews and reviewed completed surveys before data entry. Mauldon prepared the data file and conducted statistical analyses. Speiglman and Mauldon had primary responsibility for the writing effort. Logistical support was provided by the San Francisco Human Services Agency. Jonathan Gold provided data entry services.

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Abstract
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This study, based on telephone and in-person interviews with 60 San Francisco SSI parent, guardian, or caregiver heads of household with children with CalWORKs (TANF) aid, examines the situation of the heads of household in these cases as well as the well-being of their children. (Since almost all heads of household are the parents of the children on CalWORKs, henceforth we use the term "parents.") We present findings on parents' health and mental health limitations, availability of practical and social support to families, their experiences of hunger and other hardships, children's physical and behavioral health, and services for children. Noteworthy findings include:

- All respondents had serious health problems; two-thirds reported both significant mental and physical health problems.
- Almost all respondents experienced at least one physical or mental health limitation of activities of daily living, and one-half experienced six or more limitations.
- While most respondents had enough practical help, fewer had enough emotional support. Almost all of the people who needed a lot of help with everyday activities received it, often from paid In-Home Supportive Services (IHSS) staff.
- Material hardships were widespread among respondents: one-quarter had been hungry in the past year, and nearly three-quarters had faced other material hardships. Hunger was concentrated among the most vulnerable respondents, those who had both many limitations on daily activities and disabling mental health problems.
- Half of the most seriously disabled parents reported that they had children who were in poor health or had chronic health problems.
- Sixty percent of parents of children over age 5 reported that their school-age children demonstrated behavior problems such as school suspension, fighting, and drug or alcohol use.
- Behavior problems were 40% less likely to be reported for children whose families had Section 8 certificates than they were among youth living in unsubsidized housing or public housing. Further, subsidized housing was linked to less hunger and fewer hardships.

We recommend strategies to meet children's needs and strengthen families through SSI advocacy and family support, subsidized housing, mental health services for parents, early childhood education, and support for successful parenting. In terms of further research efforts, we suggest that comparative research be conducted both in poorer California counties, with weaker social safety nets, and in states that provide smaller TANF and SSI cash assistance grants. Longitudinal research should follow families as they move from CalWORKs to SSI. Additionally research should be undertaken (1) to understand how families acquire subsidized housing and learn what distinguishes them from families who remain in unsubsidized housing, (2) to determine how parents obtain child care assistance, and to what extent it meets their needs, and (3) to assess the extent to which children in these families secure needed health care, mental health services, and other types of assistance.

INTRODUCTION

Raising children, a challenge for virtually all parents, is made harder when a parent is disabled by poor physical health, mental illness, or learning barriers. In 2008-2009, about 31,000 California parents sufficiently disabled and poor to qualify for Supplemental Security Income (SSI) were raising between them some 55,000 children with cash assistance from CalWORKs, California's TANF program (Smilanick, 2010a, c),[1] and additional aid from the Food Stamp program.

Remarkably, given the considerable amount of research that exists on CalWORKs clients, virtually nothing is known about how well these especially vulnerable families are faring. Drawing on interviews with recipient SSI parent, guardian, and caregiver heads of household in San Francisco, this report aims to help policy makers assess how adequately the combination of SSI and CalWORKs meets these families' needs.[2]

Because SSI provides a much larger parent grant than does CalWORKs and is not time-limited, it seems that families with parents on SSI should be better off than families who are solely reliant on CalWORKs.[3] Under SSI, however, parents and their children are not automatically linked to social work or other services. They rarely qualify for auxiliary supports such as transportation, subsidized child care, or behavioral health resources beyond Medi-Cal-funded mental health or alcohol and drug services.

SSI. SSI is a federal cash assistance program for low-income people who have a disability, are blind, or are age 65 or older. The minor children of an SSI recipient are eligible to receive child-only CalWORKs (TANF) assistance.

The majority (73%) of parents in our sample received CalWORKs before moving to SSI. San Francisco, like some other California counties, actively supports programs that help disabled CalWORKs parent recipients qualify for SSI.

How Much Cash Aid? In an urban California county, a typical non-working SSI parent with one child receives an SSI grant of $845, a child-only CalWORKs grant of $345, and food stamps of $200, for a total of $1390. If this same parent were on CalWORKs instead of SSI the family would receive a two-person CalWORKs grant of $561 and $367 in food stamps, for a total of $928 (See Benchmark Institute 2010 and Legal Services of Northern California 2010).

[1] The children in these families are classified as constituting "child-only" cases under CalWORKs, a category that includes a variety of different circumstances under which children are eligible for TANF, but their parents or caregivers are not. SSI-parent cases constitute 6% of the Fiscal Year 2008-09 CalWORKs caseload (authors' calculations; Smilanick 2010a, b). Details on the SSI parent CalWORKs caseload appear in Appendix Table A-1.

[2] Since 54 of the 60 study respondents were in fact the parent of one or more of the CalWORKs recipient children in the household, henceforth we use the term "parent' to refer to all head of household study participants. For further details, see the description of the study sample below.

[3] Additionally, SSI assures a recipient of unconditional eligibility for Medi-Cal (California's Medicaid program).

In this report we consider non-financial strategies that could help support healthy child development and adult well-being among SSI-adult families who receive CalWORKs cash assistance on behalf of their children. Since counties differ in their welfare funding, in aspects of CalWORKs program design, and in the extent and variety of resources available, the range and potential impacts of such programs will differ from county to county.

We also intend this report to contribute to a national conversation about the growing SSI-TANF caseload (see Appendix D).

STUDY IMPLEMENTATION

Characteristics of the Research Site

California's welfare system, CalWORKs, is state-run and county-administered. Levels of benefits and eligibility rules are determined in Sacramento. SSI also operates independent of county influence, with benefits and eligibility determined federally and implemented at the state level. Thus, in many respects the findings of this study – although conducted in only one county – should be generalizable statewide.

However, distinctive features of the research site should be noted. At a purely practical level, our ability to conduct the study owes much to the commitment of San Francisco's Human Services Agency leaders to policy research, and the existence of the county's planning and policy infrastructures that support research and evaluation efforts.

Additionally, San Francisco is a leader in social welfare issues statewide and has a reputation for having both the resources and the commitment to provide quite extensive supports for low-income families, especially compared to other counties. Thus, it appeared that San Francisco offered a site in which SSI/CalWORKs recipients might find an array of social as well as other services.

Specifically, San Francisco has a CalWORKs-SSI referral and advocacy program, focused at two points in the careers of CalWORKs recipients.[4] When an intake worker detects that a recipient new to CalWORKs experiences challenges with the intake process, s/he may ask the Americans with Disabilities Act (ADA) Social Worker to determine whether the applicant has a disability that warrants additional assistance (San Francisco Human Services Agency n.d.). If so, the ADA Social Worker is to provide links with other HSA staff, including, if appropriate, referral to a social work unit that supports SSI advocacy. The second opportunity for a connection to SSI occurs after a CalWORKs participant has been exempt from welfare-to-work activities for 12 months, when s/he is called by the ADA Social

[4] CalWORKs clients composed one target population within a larger program of comprehensive, citywide SSI advocacy proposed to San Francisco's Mayor Newsom in 2004 to promote individuals' access to health services and "the financial means to stabilize their living situation and better their nutritional needs" while at the same time controlling costs and generating revenue for the City (Martinez 2008). See also Appendix C of this report for results of a survey of county CalWORKs agencies' SSI advocacy activities.

Worker to determine the appropriateness of and interest in applying for SSI. In both circumstances the CalWORKs Social Work Supervisor assigns the client to a CalWORKs social worker for assessment and support through the SSI process. The social worker makes service referrals to the client, keeps in touch with the client at least monthly, and provides a variety of supports, from transportation to doctor appointments to assistance in acquiring needed documentation.[5]

Study Design

This report is based primarily on interviews with a random sample of adults receiving SSI benefits who are raising children supported by CalWORKs child-only aid. Survey data are informed by interviews with selected staff members of the San Francisco Human Services Agency, the San Francisco Department of Public Health, and other organizations concerned about and/or working with the SSI parent population and/or CalWORKs children. We also benefited from conversations with members of the project Advisory Committee (some of whom also served as key informants), observations of a few Human Services Agency staff meetings, and review of relevant documents provided by Human Services Agency and Public Health Department staff.

Sample frame. In February 2010 San Francisco had 379 English-speaking CalWORKs heads of household who were SSI recipients living with at least one CalWORKs child.[6] These SSI-CalWORKs cases, which made up approximately 9 percent of the San Francisco CalWORKs caseload, provided the sampling frame for the study. Cases in which the adult did not speak English were excluded from the study.[7]

[5] Not infrequently, service referrals include referral to Westside Community Services (2006). Westside provides integrated, family-focused mental health and substance abuse assessment and treatment program for CalWORKs recipients for mental health evaluation and treatment. In turn, Westside may refer clients on for legal assistance, making use of a county contract with a local community agency, the Positive Resource Center (PRC). SSI applications are monitored by the Human Services Agency and – unless the client is already being served by PRC – if the SSI application is not successful the client is re-referred to the social worker with whom she previously worked for assistance applying for reconsideration and, when appropriate, to PRC for legal advocacy services. The Social Work Supervisor reports that 180 clients were referred to CalWORKs social workers in the first half of 2010. Currently the Human Services Agency funds 120 PRC slots annually. See Appendix Table B-2 for data on San Francisco's SSI referral process.

[6] Two-parent cases in which one parent received SSI or SSDI while the other received CalWORKs along with the child(ren) are not child-only cases and were excluded from the study. However, cases in which two adult household members (not necessarily spouses or partners) received SSI while child(ren) had CalWORKs were eligible for inclusion in the study, and seven such households participated. We do not know the relationships among these adults except to say that none were married to or partners with each other.

[7] The next-largest group in the SSI-CalWORKs caseload, after English speakers, was Cantonese-speakers, who comprised 5% of the SSI–CalWORKs caseload. In total non-English-speaking SSI-CalWORKs cases are estimated to constitute 13% of the caseload.

Recruitment. A randomly selected sample of 127 SSI-recipient heads of household was mailed letters inviting them to participate in the survey. The letters, printed on Human Services Agency letterhead and signed by the Agency's Director of Planning, invited recipients to complete an interview to promote better understanding of the "needs and challenges of SSI-receiving parents and their children" and offered a $40 grocery store voucher for participating. Recipients were asked to return a postcard to or telephone the researchers if they were interested in participating. The research team and Human Services Agency staff made telephone and written follow-up efforts to boost participation.

Persons interested in study participation were offered three interview modalities:

- Phone interview during one call.
- Phone interview broken into two calls.
- In-person interview at a place convenient to the respondent.

Interviews took place between March 5 and May 28, 2010.

The survey covered a variety of topics about respondents' lives, including their housing and household composition; their reasons for being on SSI and their health and mental health barriers to employment; their and other household members' sources of income, including cash assistance, wages, housing subsidies, and food stamps; their use of food banks and hot meal programs; their work and education histories; their and their children's health status, health problems, and use of medical and other services; their use of alcohol and drugs and experiences with family violence; their use of In-Home Supportive Services (IHSS); their use of child care; their children's behavior problems; their experiences of hunger, homelessness and other material hardships; and their involvement over the preceding five years with Child Protective Services.

Responses were recorded on paper survey instruments and subsequently entered into an electronic database. Including the informed consent process, time to complete the survey ranged from one hour to almost two-and-one-half hours. Not including time for the consent, mean and median interview length were about one-and-one-quarter hours.

Recruitment and responses. Four respondents were, when contacted, found to be ineligible for the study.[8] Interviews were completed with 61 study-eligible individuals. Another three persons started the interview but did not finish. Hence the project *response* rate (consent granted and interview initiated/eligible for study) was 64/123 or 52.0%, and the interview *completion* rate was 61/123 or 49.6%. Excluded from analyses were data on one respondent who was about to exit SSI and who reported earnings sufficient to disqualify her child from CalWORKs. Hence findings are based on interviews with 60 respondents. Fifty of

[8] One no longer received SSI, one no longer lived with a child receiving CalWORKs, one did not speak English, and we learned that one was deceased.

the 60 respondents completed the interview in one sitting, 34 by phone and 16 in person. Ten persons made use of the two-session phone option.

Fourteen potential respondents (11.4%) declined to participate in the study. The remaining 45 potential participants (36.6%) could not be contacted, or, in one case, although contacted, did not complete the consent process. This information is summarized in Table 1.

The administrative data on the age, race/ethnicity and gender of the San Francisco SSI-parent caseload confirm that the 127 individuals randomly selected to receive invitation letters closely resembled those not randomly selected; those selected for study recruitment were slightly older and included slightly fewer men, Blacks and Latinos, but these differences were small and statistically insignificant (Table B-1).

Table 1. Sample recruitment

	Invited and Eligible	As percent of eligible
Completed survey	61	49.6
Began but did not complete survey	3	2.4
Declined to participate	14	11.4
No contact or minimal contact, presumed eligible for study	45	36.6
Total invited to participate and not excluded because ineligible	123	100.0
Contacted but identified as ineligible	4	
Total number of invitations sent out	127	

Among persons randomly selected for study recruitment, respondents and non-respondents differed significantly in ethnicity and gender. Compared to non-respondents, there were significantly fewer males and members of the "Other" race/ethnic group (mainly Asians and Southeast Asians), and significantly more Whites (Table B-1) among the interviewees. This ethnic disproportionality may be an artifact of language problems among the Other race/ethnic recipients (and perhaps among Hispanics as well). The project was designed to survey only English speakers; some of the Other and Hispanic cases administratively coded as English-speaking might have had a head of household who was not proficient enough in English for the study, and should have been omitted from the sample frame.[9]

The respondents' mean age of 40.9 was statistically indistinguishable from the 42.9 average age of non-respondents.

[9] One potential respondent with whom we spoke expressed her hesitance at participating in the study due to her limited English and our inability to speak her language. We suspect that similar problems may have explained our inability even to make contact with some potential study participants.

Protection of human subjects. The protocol for the protection of human subjects was reviewed and approved by the University of California, Berkeley, Institutional Review Board. Among other protections, individual responses to interviews were not shared with county welfare staff, and county staff members are unaware of which parents participated in the study.

Study limitations. Findings reflect the population represented in this study: English-speaking SSI recipients with children receiving cash assistance in San Francisco's CalWORKs program. Although the SSI and TANF programs are national in scope, the relative wealth of services and housing subsidies in San Francisco and the relative generosity of California's welfare program compared to TANF in other states both suggest that respondents in this study may be materially better off than SSI parents in other jurisdictions.

Except for the administrative data used to compare the sample with the study population, all information in this document is based on respondent self-report. Because of memory limitations or other reasons, respondents might not answer some questions accurately.

FINDINGS

Study sample. Most (58 out of 60) study respondents were women. A majority (58%) of respondents lived with only one child, one-third (35%) lived with two, and the remainder (7%) lived with three (see Figure 1). Most respondents were mothers, but three were grandmothers with no children of their own in the household, two others had an infant grandchild in the household in addition to their own teenage sons, and one respondent was raising an apparently unrelated 12-year-old boy as well as her own 14-year-old son. All adults, of course, were on SSI.

Two-thirds (63%) of respondents were African American, and 25% were white (Table 2).[10] Table 2 breaks race/ethnicity into further detail. Since respondents could use as many race/ethnic categories as they wanted to describe themselves, and seven mentioned more than one, percents sum to greater than 100%.

One in eight respondents (13%) spoke a language other than English at home. Most (63%) respondents were born in California (Figure 2). Another 15% moved to California before adulthood.

Because only three percent of respondents were male, feminine pronouns are used in this report. The Figures report results for the full sample of 60 respondents, unless otherwise noted.

[10] The survey data for race/ethnicity and for age differ slightly from these measures in the administrative data.

Figure 1. Number of children living with respondent

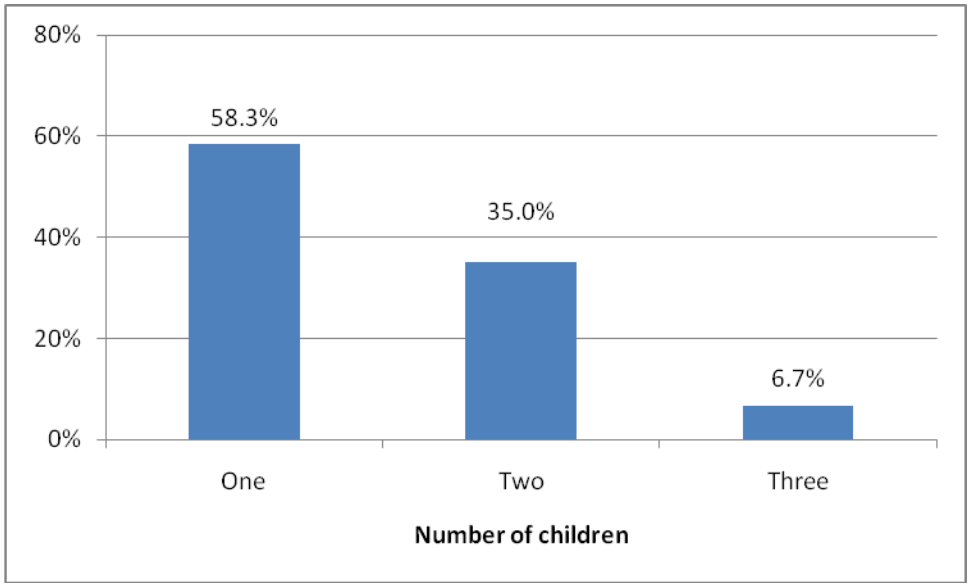
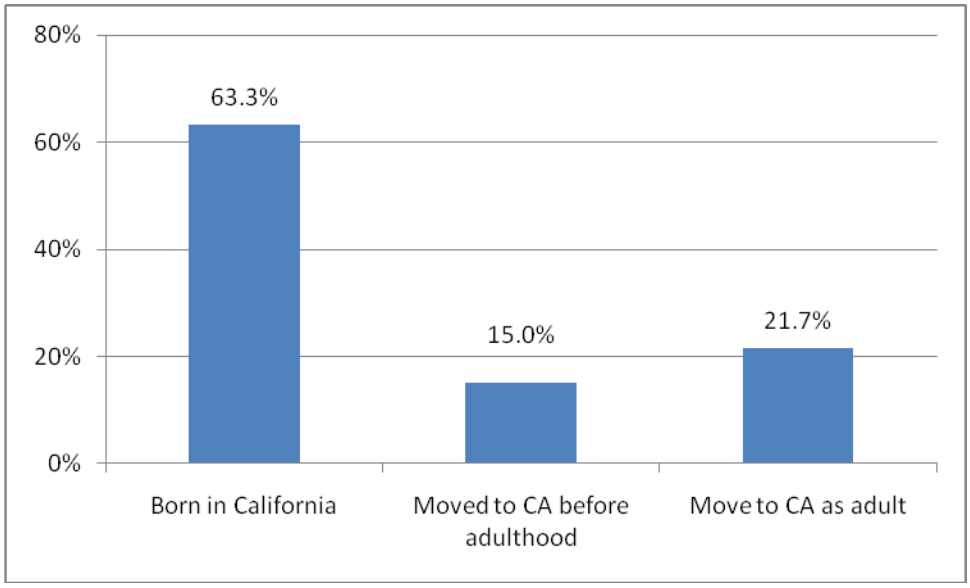


Table 2. Respondent race/ethnicity

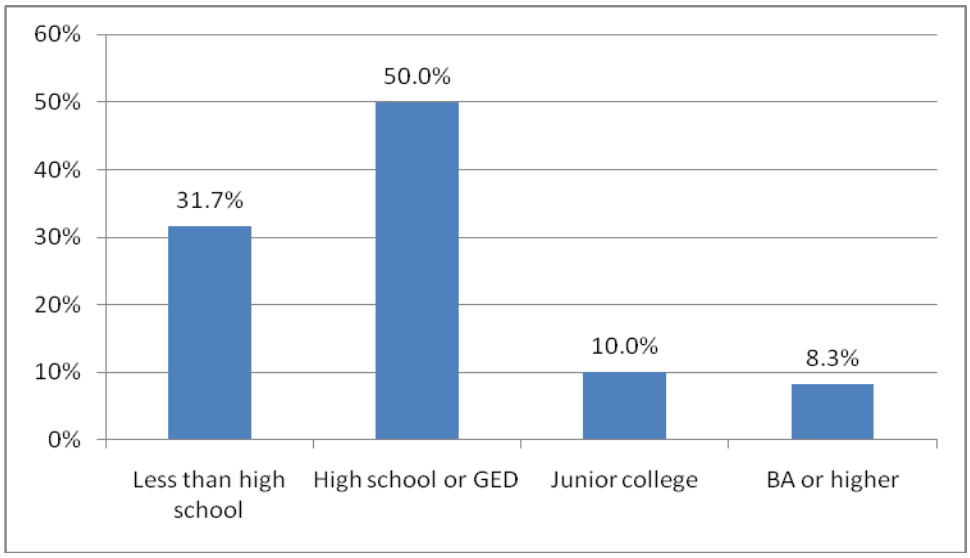
	n	Percent of 60
African American	38	63.3
White	15	25.0
Hispanic/Latino	7	11.7
Native American	4	6.7
Asian	1	1.7
Other or missing race/ethnicity	3	5.0

Figure 2. Respondent residence in California



Education. For 82 percent of study participants, their highest educational attainment was high school or less (Figure 3). Nearly one in three did not have a high school credential, and exactly half had a diploma or GED. Another 18% achieved either a 2-year or 4-year college degree. Thirty-eight percent of those without a 2- or 4-year degree had completed a certificate program after high school. At the time of the interview, 13 study participants were enrolled in an education or training program, and others said they had interest in doing so.

Figure 3. Respondent education completed



Age. Compared to typical parents on welfare, study respondents, as well as their children, were quite old. The average age of respondents was 40.4 years, and the

average age of the children in their care was 10.3 years. (Figure 4 displays the distribution of respondents by age; Figure 5, children by age.) More than half the children in these homes (52%) were aged 12 or above, and one-quarter (24%) were aged 5 or younger. Looking at it from the perspective of the parents, the majority had adolescents ages 12-18 at home (62%), and four-fifths (80%) had school-aged children.

Figure 4. Respondent age

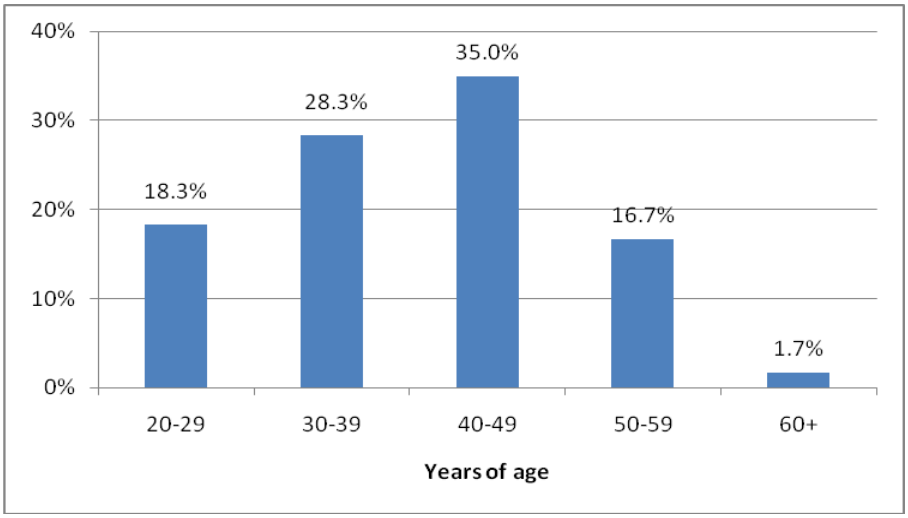
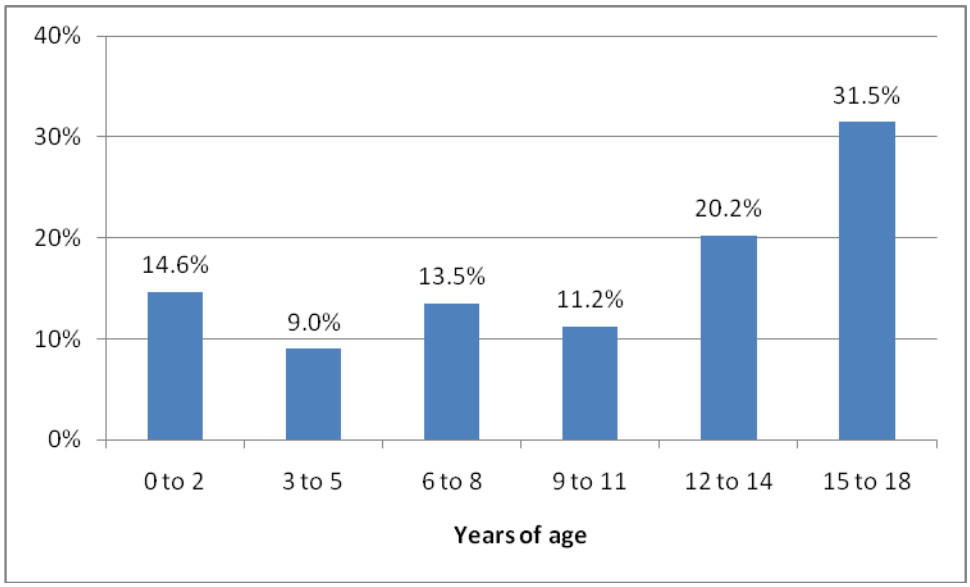


Figure 5. Children's age



Number of children = 89.

Note on confidence intervals. With a randomly-selected sample size of 60, the confidence (CI) surrounding any estimated value is (for most estimates) +/- 12 percentage points or less. For example, an estimate of 68% in a random sample of 60 has a 95% CI (or "margin of error") of 56% to 80%. The most likely measure for the proportion in the population remains 68%.

Children's status. Four respondents (7%) had a child living with them who was on SSI. Six respondents (10%) had, between them, 15 minor children not living with them, four of whom resided with the other parent, six with relatives or friends, two in juvenile hall, one each in a treatment facility, formal foster care or child welfare placement, and transitional housing.[11]

Study measures. Health and disability were assessed according to three measures:

1. To assess how much help clients needed with everyday activities, the survey included questions about two Activities of Daily Living (ADLs) – bathing and personal care – and ten Instrumental Activities of Daily Living (IADLs): (a) shopping for and (b) carrying groceries, doing (c) housework and (d) laundry, (e) preparing meals, (f) mobility within the home, (g) taking medications correctly, and successfully remembering or handling (h) appointments, (i) instructions and (j) money. All these activities are referred to as ADLs in this report.[12]

2. Respondents rated their health and the health of their children – relative to others of the same age – on a five-point scale: excellent, very good, good, fair, and poor.[13]

3. Respondents were asked if physical health problems, mental health problems, or learning disabilities limited their ability to work. Limitations due to mental health problems or learning disability problems were combined for analyses into "mental health limitations."[14]

[11] These data should be seen within the context that these mothers still have at least one child residing with them. A topic for future research is the extent to which parents on SSI, overall, lose or relinquish custody of their minor children.

[12] Being unable to perform ADLs or IADLs, or needing help with them, is considered a measure of "severe disability" in disability research (Public Policy Institutes of the American Association of Retired Persons 2004; Steinmetz 2002).

[13] This simple measure is highly correlated with specific illnesses and with overall longevity, and so is routinely used in surveys (Idler and Kasl 1995).

[14] Most of the respondents with learning disabilities (all except four) also reported a work-limiting mental health problem.

Parents' Physical and Mental Health

Disability onset, SSI cash assistance and CalWORKs cash aid. The large majority of respondents – 75% – reported that they were adults before they became limited in their ability to work (or realized they were limited). The average age at which they became limited in their ability to work was 28 (see Table 3).[15] Only one-quarter (25%) said they were limited in their ability to work at or before age 18.

Respondents typically (73%) transitioned into SSI from CalWORKs, starting on SSI at an average age of 32. One-third (37%) of the respondents who came to SSI from CalWORKs said that a CalWORKs worker suggested they apply for SSI.

Table 3.
Age of onset of limitation to work and receipt of SSI

	n	Percent
Work Limitation began at or before age 18	15	25.0
Work Limitation began at ages 19-29	16	26.7
Work Limitation began at or after age 30	29	48.3
SSI began at or before age 18	5	8.3
SSI began at ages 19-29	19	31.7
SSI began at or after age 30	34	56.7
Missing data for age that SSI began	2	3.3

Key Finding. All respondents had serious health problems, and two-thirds (63%) reported both significant mental and physical health problems.

Key Finding. Almost all respondents (92%) experienced at least one physical or mental health limitation of activities of daily living, and 48% experienced six or more limitations.

[15] Four people reported that their ability to work became limited after they enrolled in SSI, and two did not record an age of work limitation. The age of limitation for these cases was recoded to the age of SSI enrollment.

Basis of SSI qualification. Just over half the respondents (53%) mentioned a physical health problem as (or among) the problem(s) that provided the basis for SSI qualification, and virtually all of these respondents also said that a physical health problem limited their work currently. The diverse physical health problems they mentioned as the basis for SSI included asthma, arthritis, cancer, carpal tunnel syndrome, cerebral palsy, diabetes, heart disease, HIV, kidney problems, lupus, migraines, seizures, and others. An additional quarter (22%) of respondents noted that physical health problems currently limit work. Overall, three-fourths of the sample (75%) either had a physical health problem that limited work currently or listed a physical health problem among the diagnoses for SSI.

Even more frequently, respondents identified mental health problems as their reason for SSI. Two-thirds (69%) named a mental health diagnosis among the conditions that qualified them for SSI, most often mentioning depression (22), post-traumatic stress disorder (PTSD) (13), and bipolar disorder (8). Mental health problems continued to limit work among almost all the respondents who qualified for SSI for mental health reasons; overall, four in five respondents (83%) reported either a mental health diagnosis for SSI or a work-limiting mental health problem or learning disability.

Limitations on activities Almost all respondents (88%) were limited in at least one ADL, and half (48%) were limited in six or more. As Table 4 shows, more than half of respondents needed help in each of the practical aspects of daily life – lifting things, getting to appointments, and doing housework, shopping and laundry. The top panel of the table focuses on the nine ADLs that are primarily physical, while the lower panel shows the distribution of the three ADLs that require only cognitive skills.

Table 5 reports on the concentration of ADLs. Respondents varied widely in the number of ADLs for which they needed help. One-third (33%) needed help with three or fewer ADLs – indeed, 12% did not need any help with ADLs – while another one-third needed help with eight or more ADLs. Half the sample (48%) needed help with six or more.

Table 4.
Areas in which Activities of Daily Living help is needed

Physical ADLs	**n**	**Percent**
Lifting	43	71.7
Getting to or managing appointments	41	67.8
Doing housework	40	66.7
Shopping	34	55.9
Doing laundry	32	53.3
Bathing or personal care	26	43.3
Preparing meals	24	40.0
Going up or down stairs	19	31.7
Any of the physical ADLs	53	88.3
Four or more of the physical ADLs	37	61.7
Cognitive ADLs		
Understanding instructions	25	41.7
Handling money	21	35.0
Taking medications correctly	20	33.3
Any of the cognitive ADLs	37	61.7
Any of the ADLs	53	88.3

Note: Because needing help with bathing and with personal care often overlap, these two are listed as one ADL.

Table 5.
Number of Activities of Daily Living for which help is needed

Number of ADL limitations	n	%	Cumulative %
10 – 11	10	16.7	16.7
8 or 9	9	15.0	31.7
6 or 7	10	16.7	48.3
4 or 5	11	18.3	66.7
1 – 3	13	21.7	88.3
No help needed with ADLs	7	11.7	100.0
Average number of ADL limitations	60	5.13	

Note: Because needing help with bathing and with personal care often overlap, these two are considered one ADL. Eleven is the maximum possible number of ADLs.

ADL challenges; limitations on work. Poor physical health and limited mobility combined with serious mental health difficulties for nearly two-thirds (63%) of respondents. More than one-third (37%) needed help with six or more ADLs and also had mental health problems limiting work (Figure 6). A further 27% needed help with fewer ADLs but had both physical and mental health problems that limited work. The remaining one-third of respondents reported mental health problems limiting work while needing help with fewer than six ADLs (20%), or reported multiple ADLs but did not report mental health problems (17%).

Figure 6.
Distribution of physical and mental health problems within study sample

	Has work-limiting mental health problems	No work-limiting mental health problems
Many physical health problems: 6+ ADLs or needs help with bathing and personal care	22 (36.7%)	10 (16.7%)
Some physical health problems: Has one or more physical health problems that limit work	16 (26.7%)	
Fewer physical health problems: < 6 ADLs and no work-limiting physical health problems	12 (20%)	0 (0%)

Ratings of overall health. Half (50%) of respondents rated their own health as only "fair" or "poor" (Table 6). This figure stands in contrast to the national rate of 9.7% of all U.S. adults in fair or poor health (National Center for Health Statistics 2010). Perhaps surprisingly, however, 17% of respondents reported being in

"Excellent" or "Very Good" health. Two of these ten individuals required help with a very large number of ADLs but regarded themselves in good health otherwise; the remaining eight all reported suffering from mental health conditions and may have considered the question as relating chiefly to their physical health.

Table 6.
Health relative to health of other people respondent's age

Health status	n	Percent
Excellent (=1)	6	10.0
Very Good (=2)	4	6.7
Good (=3)	20	33.3
Fair (=4)	15	25.0
Poor (=5)	15	25.0

Medical care utilization. Health problems take respondents to the hospital or to doctors frequently. Nearly half of the survey respondents (46%) had visited a hospital emergency room within the preceding three months, and 8% had spent one or more nights in a hospital.

Practical and Social Support

Key Finding. While most respondents had enough practical help (74%), fewer had enough emotional support (63%). Almost all of the people who needed a lot of help with everyday activities received it, often from paid IHSS staff (54%).

One-third (33%) of respondents had help from IHSS with tasks such as housecleaning, laundry and personal care, receiving an average of 73 hours of help per month.[16] The overwhelming majority (86%) of respondents said they had either an IHSS worker or someone else they could turn to for practical help, and when asked whether they received all the help they needed, three-quarters (74%) said they did. Emotional support was less available, with 37% of respondents saying they could not think of anyone to whom they could routinely turn for support.

IHSS services were targeted to the most physically disabled respondents, the 62% who needed help with four or more of the physical ADLs. About half (54%) of these respondents had IHSS. Informal support is also important: when all sources of help including friends and family are counted, 92% of the more physically disabled

[16] IHSS is partially funded with federal Medicaid dollars in order to help seriously disabled people live independently in their homes. Applicants' limited abilities in ADLs and IADLs are indicators of need for IHSS services.

respondents said they had IHSS, or had an important person in their lives who helped them, or that they received the practical help they needed.

About two-fifths (38%) of the sample did not need as much (or any) help with physical ADLs. These respondents were disabled by cognitive problems, mental health problems, or illnesses that were chronic and disabling but not necessarily physically limiting. They had less access to both informal and formal support. None of them received IHSS, and while two-thirds (65%) did have sources of practical help or emotional support, one-third (35%) reported that they did not have any such help.

Table 7 categorizes respondents by the types of barriers to work that they report, whether related to physical health, to mental health, or to both. Study participants who reported only physical health limitations were 5 years older than the study sample generally and 10 years older than participants reporting only mental health limitations; they also had somewhat older children. Respondents with only mental health limitations were less likely to report that their health was only "fair" or "poor".

Table 7.
Characteristics of study participants, by type of work barrier

Reasons for work limitations	Average age	Number of children	Average age of children	Percent In Fair/Poor health
ALL cases (60)	40.4	1.5	10.3	50.0 (30)
Only physical health problems limit work (15)	45.3	1.3	11.1	47.7 (7)
Only mental health problems limit work (17)	35.5	1.5	8.9	23.5 (4)
Both types of problems limit work (28)	40.7	1.6	10.8	67.9 (19)

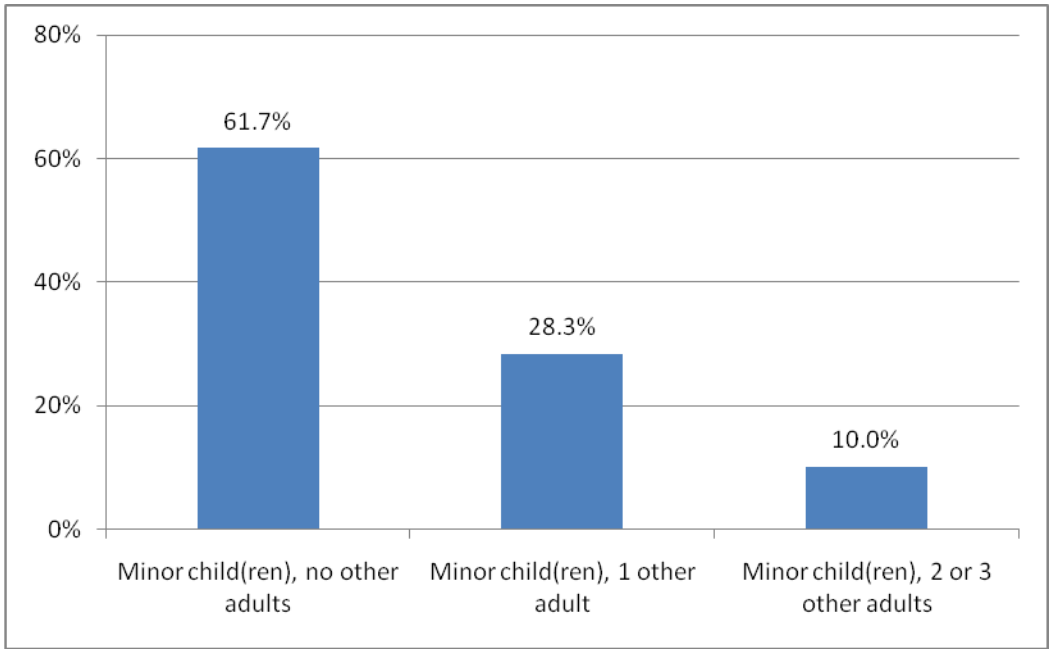
Living Arrangements, Work, Income and Rent

Living arrangements. Interviewees were all single parents, and most (62%) lived with their minor children and no other adults (Figure 7).[17] Even among parents with multiple activity limitations, the same fraction, 62%, lived alone with their children. Indeed, two-person families – one adult and one child – comprised nearly two-fifths (38%) of the entire sample. Figure 1 above displays the distribution of number of respondents' children, including, in a small number of

[17] There were no two-parent families in the study, because families with one non-disabled parent and one parent on SSI would not have children on *child-only* CalWORKs, while CalWORKs families with two parents on SSI (who were eligible for the study) are rare.

cases, 18-year-old children who remained on CalWORKs because still enrolled in school.[18]

Figure 7. Household composition



Two-fifths (38%) of respondents lived with one or, occasionally, two other adults (sometimes an adult child or other family member, rarely a boyfriend or partner). These multiple-adult households averaged nearly four (3.8) people in them. Nine of those adults living with study participants received SSI and/or SSDI. Four of them needed help with personal care.

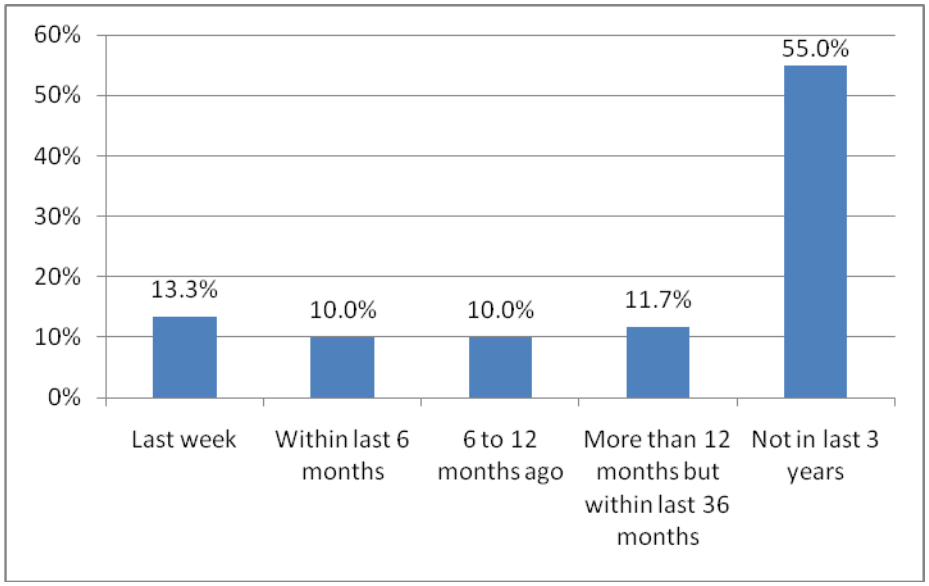
Work. About half of study participants (45%) reported some work experience in the previous three years, and among the 54 respondents who enrolled in SSI after age 18, five out of six (85%) had worked at least a little before going on SSI. Eight respondents (13%) had worked for pay in the previous week, for an average of 8 hours per week, and another two worked but were not paid (Figure 8). For example, one respondent worked 3-4 hours per month helping an elderly neighbor with minor household repairs. Another respondent was paid minimum wage for working 4-6 hours per month on an effort to promote community health.

Of the respondents not currently working, many (60%) wanted to work, typically part-time. Several respondents expressed deep feelings of concern about the meaning of their lives if they could not re-engage in work. However, most noted that they did not have the support – including, in some cases, the child care – they

[18] The children in the survey are the 83 children reported by respondents as their own or their step-children and 6 grand- or great-grandchildren. Respondents also reported having 15 minor children not living with them who are not included in analyses. Four of the 15 had lived with the respondent at least part-time at some point in the past month.

would need to find, obtain, and keep employment, and worried that their health limitations might prevent them from successfully caring for their children and managing their households while also working. Many also acknowledged that they might need accommodations and assistance that would not be feasible for most employers.

Figure 8. Most recent paid work experience



Income, rent subsidies, and food stamps. Half (52%) of the parents relied exclusively on public assistance income. However, half did have other income sources themselves or shared resources with other adults who had their own incomes. These included earnings, pensions, disability payments other than the respondent's own SSI, and child support (usually only the $50 routinely passed through to the family under CalWORKs). Average monthly income from all sources, including food stamps, amounted to $1,615, with SSI providing nearly half ($731), CalWORKs another quarter ($414), and food stamps just over $200 (Figure 9).

Ten respondents received Social Security Disability Insurance (SSDI) benefits in addition to SSI. The SSI grants that these respondents received were smaller than typical because the value of their SSDI payment was subtracted from the SSI grant for which otherwise they would be eligible. Their total incomes were not higher than the incomes of respondents whose only disability payments were from SSI.

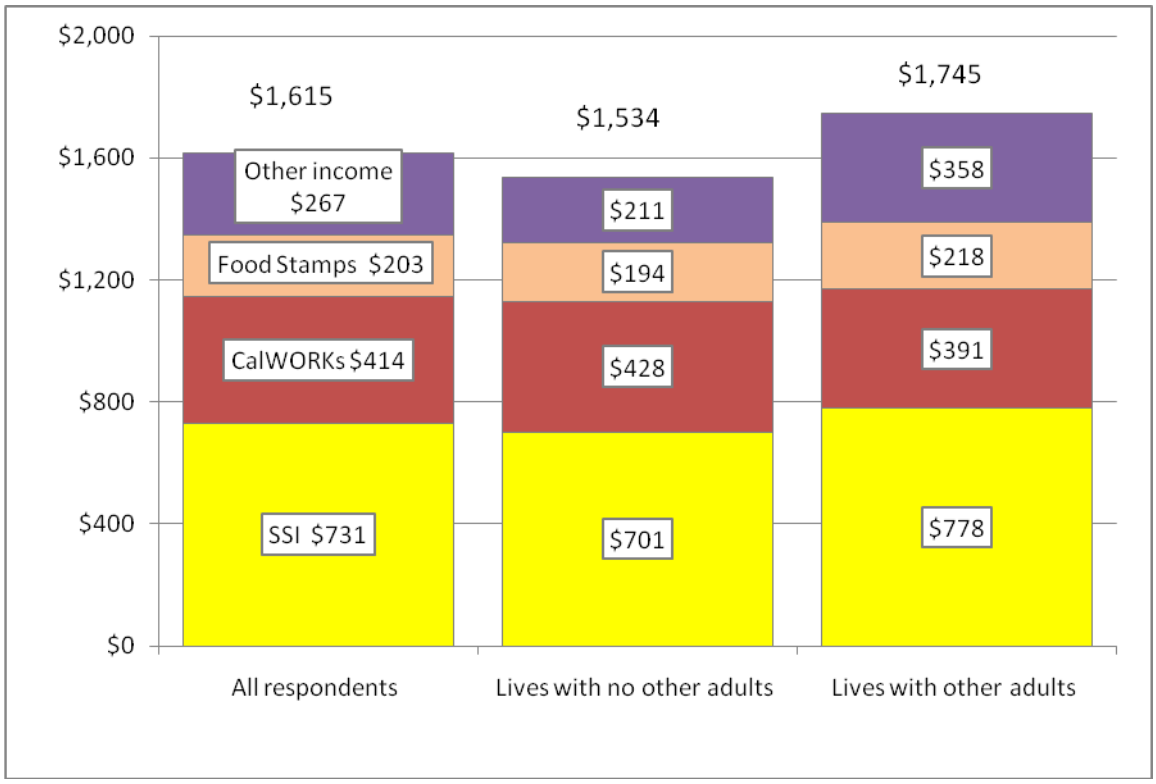
Incomes in multiple-adult households were only slightly higher than in single-adult homes ($1,745 versus $1,534), because the adult housemates of study respondents typically contributed little or no income to the household. Rent and utilities were on average the same in single adult and multiple adult homes ($486 per month). The larger number of mouths to feed in multiple-adult households, without a corresponding increase in household income, increases the risk of hunger: the chances that a respondent was hungry in the past year were twice as high if they lived with other adults (35%) as if they lived alone with their children

(16%). Neither were respondents living with other adults assured of practical or emotional support; only 64% of them said they got the help they needed, compared to 80% of respondents who lived alone.

Rental assistance, received by 68% of respondents in the form of Section 8 housing (47%) or subsidized public housing (21%), is a vital resource.[19] The sliding-scale subsidies keep rents at one-third or less of income among most (82%) of the subsidized families. In contrast, two-fifths (43%) of unsubsidized respondents paid more than one-third of their incomes in rent, and almost as many (39%) paid more than half of their income in rent.

Subsidized families paid 27% of their incomes (including food stamps) in rent and utilities and had $1,186 left for other expenses; unsubsidized families paid a much larger share of their incomes – 42% – for shelter, with only $917 remaining for everything else.

Figure 9.
Household incomes in one adult and multiple adult homes



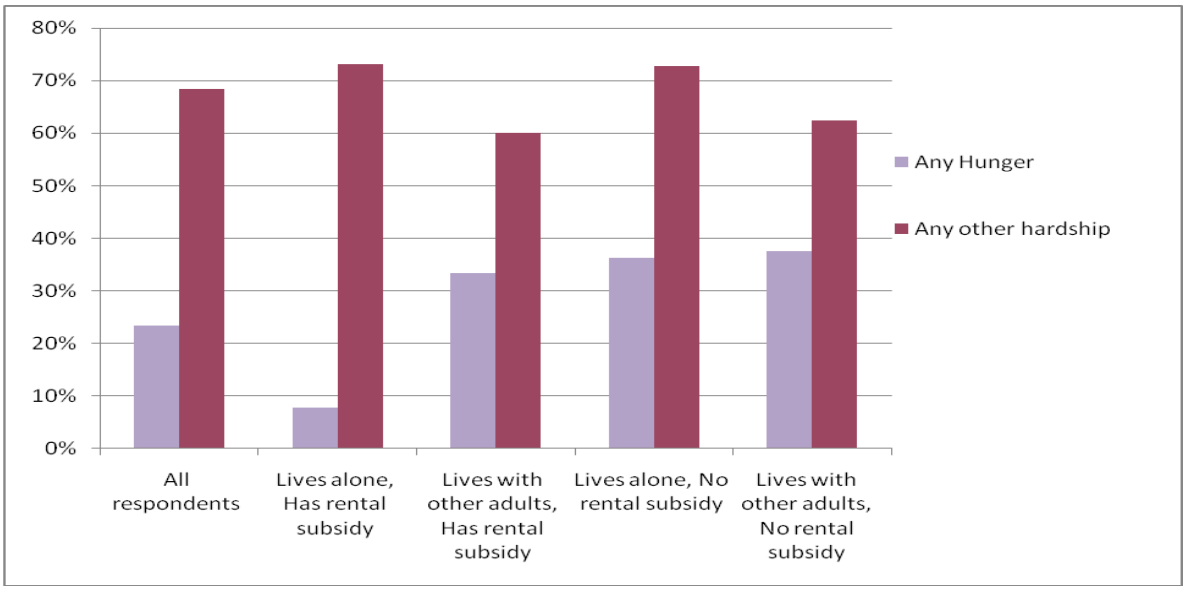
[19] Section 8 participants receive a voucher for a substantial rental subsidy on any qualifying unit, in any neighborhood. The percentage of families in this study who had Section 8 is unexpectedly high, given the difficulty of acquiring these vouchers; many municipalities have closed their waiting lists to new applicants.

Key Finding. Material hardships were widespread among respondents: one-quarter had been hungry in the past year, and nearly three-quarters had faced other material hardships. Hunger was concentrated among the most vulnerable respondents, those who had both many limitations on daily activities *and* disabling mental health problems.

Hunger and other hardships. One in four respondents (23%) had gone hungry in the preceding year because they could not afford enough food, and 7% of their children had also gone hungry. Families who had experienced hunger had rents nearly 40% higher than the average for the entire group, while having a rent subsidy seemed to ward off hunger. Only one in 12 (8%) of subsidized parents living alone with their children reported having gone hungry (Figure 10), a sharp contrast to the one-third of unsubsidized solo households who had gone hungry. One-third of respondents who were living with other adults had also gone hungry, irrespective of rental subsidies.[20] Having multiple disabilities also increases the chances of hunger. Among particularly vulnerable respondents, the 37% who had six or more ADLs in combination with work-limiting mental health problems, more than one-third (36%) reported having gone hungry.

Hardships other than hunger, such as not having enough money to pay rent or utilities on time or having, by the end of the month, run out of money for necessities, had been experienced by 60% to 75% of respondents. The more disabled families, in addition to being most at risk of hunger, were also the most likely to have other types of hardships, as well.

Figure 10. Proportion of respondents reporting hunger or other material hardship in past year



[20]IHSS support does not appear to protect against hunger: 30% of respondents receiving IHSS also reported having gone hungry.

Children's Physical and Mental Health

National studies have shown that low-income children have worse health than more affluent children (Case and Paxson, 2000), but even when compared to their low-income peers the children in this study suffer from atypically poor health, at least according to their parents' reports.

One in five parents (18%) reported that they had a child in fair or poor health, and an additional 12% had a child with a chronic, activity-limiting health problem.

These relatively high rates of health problems among children reflect the assessments provided by the one-third of parents who themselves are in poor mental health and have multiple limitations (more than six ADLs). More than one-third (36%) of these parents reported that they had a child in fair or poor health and nearly half (45%) said that their child(ren) had a chronic activity-limiting condition. The remaining 63% of parents – those with fewer than six limitations in their own activities, or no mental health problems – were far less likely to report fair/poor health or activity limitations among their children (Table 8).

Table 8. Parents' reports of children's health, by parents' health

	All parents n = 60	Parent has <6 ADLs n = 28	Parent has >=6 ADLs and **no** disabling mental health conditions n = 10	Parent has >=6 ADLs and disabling mental health condition n = 21
Has at least one child in fair or poor health	18.3%	7.1%	10.0%	36.4%
Has a child with a chronic, activity limiting condition	24.1%	14.3%	10.0%	45.0%
Has a child in fair/poor health ***or*** with a chronic, activity limiting condition	30.0%	17.9%	20.0%	50.0%
Average number of children per respondent, whose health status is reported	1.4	1.3	1.3	1.4

It is plausible that the same environmental or genetic factors that harm parents' own health—for example, environmental pollutants or a heritable propensity that triggers asthma—also affect their children. Equally, parents' beliefs may have been shaped by their awareness of their own health problems and the extent of their contact with the health care system. However, even if some parental concerns about children's health are exaggerated, these beliefs can have problematic

consequences: children may stay home from school, become unnecessarily anxious about their health, or over-use health care services and medication.

Key Finding. Half of the most seriously disabled parents reported they had children who were in poor health or had chronic health problems.

Key Finding. Sixty percent of parents of children over age 5 reported that their school-age children demonstrated behavior problems such as school suspension, fighting, or drug or alcohol use.

Behavior problems are common among the children in these families. Three-fifths (60%) of parents of children over age 5 reported a school-age child displaying significant behavior problems such as school suspension, fighting, and drug or alcohol use (Table 9).[21]

Table 9. Behavior problems

	Respondent has a child age 12-17 who ever:	Respondent has a child age 6-11 who ever:	Respondent has a child age 6-17 who ever:
Was suspended, excluded, or expelled from school	41.7% (n=15)	23.8% (n=5)	42.6% (n=20)
Was in trouble with the police	30.1% (n=11)	Not Asked	--
Used drugs or alcohol	13.9% (n=5)	0%	10.6% (n=5)
Was in trouble for fighting	27.8% (n=10)	33.3% (n=7)	31.9% (n=15)
Was involved with a gang	5.6% (n=2)	Not Asked	--
Any of above	61.1% (n=22)	40.0% (n=8)	59.6% (n=28)
n	36	20	47

Rates of reported behavior problems are quite similar across parents with different types of health problems. Substantially different rates are reported, however, for children living in Section 8 housing compared to other types of housing. Parents living in Section 8 housing reported significantly fewer behavior problems among their children and teens (48%) than did parents in families living in unsubsidized or public housing (85% and 67% respectively) (Table 10).

Section 8 subsidies give access to higher-value housing: the 47% of interviewees with these vouchers reported that their units carried monthly market rents of

[21] Table 9 reports behavior problems among youth living with the respondent. Some respondents mentioned behavior problems among youth not living with them: the one who had a child in a treatment program and the two with a child in juvenile detention reported many behavior problems.

$1,792 on average, although they were paying only $381. In contrast, unsubsidized respondents lived in lower-value units with average market rents of $597 (with respondents' share, on average, of $574).[22] These lower rents presumably implied more dangerous or impoverished neighborhoods. Families in public housing paid little rent ($404, on average) but, typically, got low quality housing in bad or isolated neighborhoods.

The substantially higher market value of the Section 8 housing compared to public or unsubsidized housing may be the key to understanding the lower rates of behavior problems among children. Section 8 lets families choose their neighborhoods, so they can live outside pockets of concentrated poverty and, perhaps, closer to better schools, or near their support networks. Plausibly, differences in the social resources in the neighborhood, the opportunities youth have for getting into trouble, and the peers they meet in the neighborhood and in school make the homes that parents can choose through Section 8 better environments for children than public housing or very-low-rent, unsubsidized apartments.[23]

Clients with no rental subsidies faced greater difficulties overall (Table 10) than did families in Section 8 or public housing. They had less income left after paying rent than the other groups ($972 compared to the average remaining income for families in either type of subsidized housing of $1,249), were more likely than the subsidized clients to have experienced hunger (33% compared to 18%), and were very likely to have children with behavior problems (85% compared to 53%).

Key Finding. Behavior problems were 38% less likely to be reported about children whose families had Section 8 certificates than they were among youth living in unsubsidized housing or public housing. Section 8 provides vouchers for access to a wider choice of higher-quality housing or housing located in areas with lower poverty concentrations.

Key Finding. Subsidized housing helped respondents ward off hunger and hardships. After paying for housing, unsubsidized respondents had only 78 cents for each dollar that respondents with housing subsidies had for food and other purchases each month.

[22] Some respondents were splitting rent with housemates or renting rooms in houses.

[23] The higher rent on Section 8 units was not because they were larger than public housing or unsubsidized housing; in fact, public housing was the most spacious type of housing.

Table 10. Distribution of child health status, hunger, housing characteristics, and disposable income, by housing type

	Section 8 n = 27	Public Housing n = 12	No subsidy n = 18
Actual (market) rent for housing	$1,792	$404	$597
Rent paid by respondent	$381	$404	$574
Disposable income (net of rent)	$1,269	$1,203	$972
% with hunger in past year	18.5%	16.7%	33.3%
% with child behavior problems	47.8%	66.7%	84.6%

Note: Data on housing type were missing for three cases.

Services for Children

Child care. Many parents on CalWORKs receive subsidized child care as an entitlement, but this service is far less available to SSI parents.[24] Among the 19 respondents with a baby or preschooler, one-third (37%) used substantial amounts (more than five hours per week) of child care, averaging 33 hours weekly. Among the two-thirds not using child care or preschool or using very little, half said they had tried, unsuccessfully, to enroll their child, and most of them referenced insufficient subsidies or ineligibility for aid as key barriers.

Child protective services. The survey asked respondents whether they or their children had experienced any contact with Child Protective Services (CPS) in the previous five years. Indeed, many had: nineteen (32%) reported at least one CPS contact, and nine (47%) of these parents indicated that there was subsequent follow-up by CPS. In five cases, a child was placed out-of-home; one person with a CPS contact reported a child staying currently with "family or friends." Three parents reported ongoing CPS monitoring but no out-of-home placement.[25]

Although in virtually all cases parents reported being told why CPS was contacting them, it is hard to interpret the reasons that they provided in the interview in terms of the standard CPS categories of physical abuse, sexual abuse or neglect. The

[24] CalWORKs clients engaged in welfare-to-work activities are eligible for child care for the hours of those activities. A CalWORKs child in subsidized child care prior to the parent's transfer to SSI retains eligibility for child care if there is no break in service. Once the parent has transferred to SSI her child is not eligible to use a CalWORKs subsidy to *start* child care.

[25] To put these rates of allegations of maltreatment (if those are what the "contacts" were) into perspective, in one year –2009 – in California allegations of child maltreatment were recorded for fewer than 5% of children. Entries into the child welfare system took place for 7% of allegations (Needell et al. 2010).

reasons provided by the twelve people with verbatim responses recorded in the survey mentioned reports of domestic violence, concerns about children's school attendance, behavior problems or neglected appearance, and mental health or drug use concerns.

Rates of CPS contact were similar across levels of child behavior problems, types of parental disability, and living arrangements. The one strong predictor of CPS contact was having a child in fair or poor health. Parents with any contact with CPS were five times as likely to report that their child was in fair/poor health than were parents with no contact – 40%, compared to 8% for children with no CPS contact. In San Francisco, a CPS contact can lead to service referrals and support for families, which is one possible explanation for the strong association between a child's poor health and CPS contact. CPS staff could have connected a family to needed health care, which in turn could have led to new diagnoses of health problems.

Equally, neighbors or teachers might have been concerned enough about the well-being of children who appeared to have many health problems to have reported the family to CPS. In some respects, the apparent targeting of CPS towards children with health problems (if, indeed, that is what is occurring) seems appropriate. Assertive early CPS intervention with resources not otherwise available to CalWORKs or SSI families may minimize the risk of subsequent foster care placement.

DISCUSSION

Summary of findings. It seems from these survey data that SSI is, as intended, serving parents with severe health problems. Most of the respondents were dealing with multiple limitations in everyday activities due to physical health problems, mental health problems, or both. Evidently, the SSI application process successfully excludes applicants who are not very disabled.

One consequence of imposing a high bar for SSI qualification is that successful SSI applicants often have gone through multiple applications or appeals before they qualify. This lengthy and arduous application process may be one reason that potentially eligible, disabled CalWORKs recipient parents do not make the transition from CalWORKs to SSI. Specifically, they may not have access to needed medical testing and a "treating physician" (whose reports are by Social Security law given great weight). Additionally, CalWORKs clients disabled by mental health problems, in particular, might be deterred from applying for SSI by a lack of insight about their limitations and insufficient information about qualifications for SSI.

Once on SSI, parents have substantially more income than if they were on a standard CalWORKs family grant. Nevertheless, many SSI-parent survey respondents had difficulty in making ends meet, reporting hunger and other hardships. One in four respondents had been hungry and unable to buy needed food in the past year, and a large majority reported other types of material hard-

ships. It is likely that poor mental and physical health limited these parents' flexibility and resourcefulness.

Families receiving Section 8 subsidies, who comprised nearly half of the sample, had the greatest disposable income after paying for rent. The higher quality of their housing or neighborhoods may explain why their children were far less likely than children in public or unsubsidized housing to have behavior problems.

One-third (30%) of the children were reported by their parents to be in poor health or had chronic health limitations.

Child Protective Services workers had been in contact with one-third of all families in the study, including with more than half of the families with children in fair or poor health or with chronic health limitations as well as with one-quarter of the families with children in good or excellent health.

Although parents on SSI have substantially more income than families solely reliant on CalWORKs, by definition they are also more disabled and unable to earn income to supplement their benefits. The picture painted by this research is of parents facing very considerable challenges with their own health, their children's health, their children's behavior, and their household's material well being.

RECOMMENDATIONS. Strategies to Meet Children's Needs and Strengthen Families

- **SSI advocacy and family support.** The increased income that SSI provides and the prospect of continued support beyond time-limited CalWORKs, combined with ongoing Medi-Cal coverage, make a move from CalWORKs to SSI financially advantageous for eligible recipients. The financial impacts for the state and the county are less clear, but appear on balance to be positive. Shifting an adult's support from CalWORKs to SSI seems on its face to be approximately cost-neutral for the state, at least in the short run, in that the state's contribution to the SSP portion of the SSI/SSP grant is roughly equal to a parent's portion of a CalWORKs grant. By removing non-working disabled parents from the denominator of the CalWORKs Work Participation Rate (WPR), counties may be better able to meet federal targets for the WPR. Failure to raise this rate sufficiently may trigger fiscal penalties for the state and county.[26]

[26] The parent's portion of a CalWORKs grant ($216 monthly in one-child families, $133 in two-child families, with $174 the average of the two) is comparable to the state's share of the SSI/SSP benefit ($169), so state (General Fund) spending on public assistance changes little when a parent transfers from CalWORKs to SSI. On WPR penalties, letters from the U.S. Department of Health and Human Services, Office of Family Assistance, and the California Department of Social Services describe the $47.7 million penalty amount levied against California for FY 2008 and the state's planned appeal. http://www.dss.cahwnet.gov/lettersnotices/entres/getinfo/acin/2010/I-45_10.pdf

Given the substantial financial gains to individual recipients and their families, and the likely benefits to counties and the state, of moving eligible cases from CalWORKs to SSI, agencies should sustain and if possible expand strategies to help eligible parents apply for SSI.

Once parents are on SSI, other services can also help support healthy child development.

- **Subsidized housing.** Without a subsidy, most disabled parents find that rent consumes a very large part of their income, often leaving them with too little for other necessities. Families with unsubsidized rents report more hunger and other material hardships as well as more behavior problems among their children. Public housing, while costing less and giving families higher disposable incomes, all too often presents a poor environment for children.

  In San Francisco neither public housing nor Section 8 certificates are prioritized to accommodate disabled persons. Augmenting the supply of certificates by establishing a category of Section 8 vouchers exclusively for very poor disabled *parents* might have multi-generational benefits while not greatly reducing the supply of vouchers for other groups who also need housing assistance. Strategies to improve the quality of public housing are hard to identify, but might include creating more mixed public housing that accommodates seniors, disabled persons, and others.

- **Mental health services for parents.** Counties can use CalWORKs allocations to fund therapy and other behavioral health services for CalWORKs clients, including some clients transitioning to SSI. Many study respondents qualified for SSI on the basis (in part, at least) of their mental illness, and many had been able to take advantage of CalWORKs-funded mental health therapy, which helped establish the medical record that substantiated their need for SSI.

  Once on SSI and no longer eligible for CalWORKs-linked behavioral health services, some clients were cut off from the therapy and other mental health supports they needed to care for their children and manage their lives. A strategy to enable these clients to continue with the same therapists after transferring to SSI would be very useful.

- **Early childhood education, child care, and educational support**. The high rates of behavioral problems among school-aged children of SSI parents may stem in part from impoverished early childhood environments. The young children of SSI recipients need priority access to high-quality child care and preschool settings, including Head Start and Early Head Start. With the respite that child care offers, disabled parents may have more energy to engage with and supervise their children when they are at home. Children in these settings would also be provided with free meals (if they were in a child care center participating in the Free and Reduced Price Meals program).

  Some of the children in these families would benefit from mental health services, whether provided directly or in the context of child care that is

informed by a mental health perspective. For example, San Francisco's comprehensive Early Childhood Mental Health Consultation program advises staff in some child care centers and child care homes serving low-income populations. If possible, children of SSI parents who have been identified as needing extra support should be placed in these settings.

Finally, policy makers should not disregard the potential contribution of child care to support employment and training for some members of this population. Two-thirds of respondents said they wanted to work, and a handful of these were working, typically a few hours a week.

- **Support for successful parenting.** Our respondents' frequent reports of behavioral and other health difficulties among their children, and the fact that one-third had been in contact with CPS, suggest that many of them have difficulties in parenting. Since these families are still connected to CalWORKs through their children's participation, program staff with responsibility for their cases might explore ways to foster community and mutual aid among the disabled parents. For example, they could inform disabled parents of targeted programs and support groups through which parents could meet others with similar disabilities.[27] Advocates, clinicians and parents could collaborate to design a parenting curriculum or a resource handbook for disabled parents to be shared through peer-based mentoring.

  Child Protective Services resources can be used to support families and prevent foster placement. This type of assistance is important especially when parents have physical or mental health disabilities; these parents might even benefit from services along the lines of IHSS, but targeted to parenting support. Collaboration between IHSS, CalWORKs and CPS might lead to an enriched program of in-home support for clients already receiving IHSS

We conclude this report with a vision for a broader system of support for all families, in which parents on SSI could find resources, health services, therapy, child care, and peer support. Other countries have systems of family resource centers to support families in communities: Britain, for example, has created the system of Sure Start Children's Centres.[28] Were California to adapt its own system from this and other models, all vulnerable families could gain access to the social support, mental health, and referral services discussed in this report.

[27] Examples include Through the Looking Glass, a national support and advocacy group for disabled parents, and disability support groups such as those sponsored by the Depression and Bipolar Support Alliance. <http://www.lookingglass.org> and <http://www.dbsalliance.org>

[28] Sure Start Children's Centres are service hubs where children under five years old and their families can receive seamless integrated services and information. By 2010, every British community will be served by a Sure Start Children's Centre, offering permanent universal provision across the country. http://www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/surestartchildrenscentres/childrenscentres/

Additional Recommendation. Explore the implications of cashing-out the child-only CalWORKs benefits and putting the subsidy directly into the SSI check. Since CalWORKs has no programmatic content for children in SSI parent cases, with a federal waiver California could presumably provide the CalWORKs child-only grant to SSI parents as a supplement to the SSI grant. (California is already doing this with the Food Stamps benefit for SSI recipients.) That will eliminate one bureaucracy with which SSI parents need to be involved, and would assure support to all eligible children of SSI parents.

FUTURE RESEARCH

This project answered a number of questions about SSI parent CalWORKs families, but it raised questions as well. For example:

- How are SSI parent TANF families faring in California counties with fewer social services, and in other states that provide fewer dollars for both SSI and TANF?
- How do families experience the move from CalWORKs (or TANF, if outside California) to SSI? Are there disadvantages to families in making this transition?
- Many functionally limited SSI parents appear to have no IHSS support. Is that because they do not know of the program's existence, do not know how to apply for IHSS services, have their applications denied, or for some other reason?
- How do families acquire subsidized housing, and what distinguishes those who attain that objective from those who do not?
- How do parents obtain child care assistance, and how well do available child care services meet their needs?
- Do children in these families secure the assistance they need from their public schools?
- How can children in these families who have behavior or physical health issues receive the assessments and the support they need?

Some of these questions may best be addressed through follow-up survey research. Others may benefit from ethnographic or other methods. We look forward to seeing the products of such studies.

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APPENDIX A.

Between 1998 (the start of the CalWORKs program) and 2003-2004 the number of SSI parent cases in California trended up and leveled off at around 40,000 cases monthly in FY 2003-04 (Table A-1). The caseload has fluctuated since then, peaking in FY 2007-2008 at 41,663.

During that period the CalWORKs caseload dropped, initially precipitously and then at a more gradual pace until 2007-8, when the number of cases started to increase as the recession took hold. The SSI parent cases increased from an estimated 3.8% of the CalWORKs caseload in 1998-1999 to a high of 8.9% of the total caseload in FFY 2007-08.

Table A-1.
CalWORKs child-only cases, FFY 1997-98 to 2008-09

	Average Monthly CalWORKs Cases	Average Monthly SSI Parent Cases	Percent SSI Parent Cases
1997-1998	731,445	unknown	unknown
1998-1999	640,989	24,579*	3.8*
1999-2000	575,086	27,073	4.7
2000-2001	516,591	32,505	6.3
2001-2002	501,351	32,784	6.5
2002-2003	482,736	32,113	6.7
2003-2004	480,732	40,447	8.4
2004-2005	490,113	34,900	7.1
2005-2006	475,984	34,409	7.2
2006-2007	459,781	39,339	8.6
2007-2008	465,951	41,663	8.9
2008-2009**	504,994	30,932	5.8

* Estimate.

** New coding introduced to identify child-only cases with SSI parents; not strictly comparable with earlier data.

Source: Smilanick (2010a) summarizing findings from California Department of Social Services Q-5 and RADEP data and California Department of Social Services, Monthly Caseload and Unemployment Rates http://www.dss.cahwnet.gov/research/res/pdf/caltrends/CWCaseloadUnemp.pdf

APPENDIX B.

Table B-1. Respondent versus study population characteristics

	CalWORKs child-only cases with English-speaking SSI parents		Not selected into sample		Invited into study, but not interviewed at all, or interview not completed		Completed Interview	
	n	%	n	%	n	%	n	%
Ineligible					4		0	
Black	244	64.4	164	65.1	39	62.9	38	62.3
White	54	14.2	33	13.1	5	8.1	16	26.2
Hispanic	39	10.3	28	11.1	7	11.3	4	6.6
Other	42	11.1	27	10.7	11	17.7	3	4.9
Total	379	100.0	252	100.0	62	100.0	61	100.0
Ineligible					4		0	
Female	345	91.0	227	90.1	56	89.6	59	96.7
Male	34	9.0	25	9.9	6	10.4	2	3.3
Total eligible	379	100.0	252	100.0	62	100.0	61	100.0
Mean age (years)	41.5		41.3		42.9		40.9	

Table B-2. SSI advocacy activity, 2006 – 2010

Fiscal Year	Referrals from Westside Community Services to Positive Resource Center (PRC)	SSI Awards reported by PRC	Number of unduplicated PRC clients funded by Human Services Agency
2006-2007	41	38	60
2007-2008	49	44	60
2008-2009	32	61	100
2009-2010*	21	31	120

* Partial year data on referrals and awards

APPENDIX C.

Variation in SSI Advocacy Activity among County CalWORKs Agencies

Thirteen of the 25 largest California counties responded to a brief August 2010 survey that inquired whether – and how – CalWORKs agencies conduct SSI advocacy on behalf of CalWORKs clients. Together these counties account for 57% of the 567,417 April 2010 CalWORKs cases (California Department of Social Services 2010).

Five of the thirteen counties (38%) have no SSI advocacy program.

The eight counties with programs provided information concerning the number of CalWORKs recipients involved in an advocacy process in the course of a year but it was apparent that they did not use similar methods in answering the question so responses across counties are not directly comparable. Understanding that limitation, it nevertheless seems noteworthy that the percent of the CalWORKs caseload that annually is involved in SSI advocacy varies widely, ranging from .02% of active CalWORKs cases in one county to 7.6% of active CalWORKs cases in another. San Francisco anchors the high end of that range.

APPENDIX D.

Situating SSI TANF Cases in the National Conversation

Describing a substantial increase in SSI applications said to be "straining SSA resources and delaying benefits" and echoing concerns voiced by Congress, GAO, its Advisory Board, and other experts and stakeholders, the Office of Retirement and Disability Policy at the Social Security Administration expressed interest in the trend of increasing numbers of SSI parent TANF cases in order to anticipate its obligations and work requirements, promote efficient staffing and decision-making, limit possibly inappropriate referrals, and develop and promote work for appropriate candidates (Tambornino 2010).[29]

Tambornino reports that 3.3 million SSI applications are anticipated in the current year, a 700,000 increase since 2008. He attributes this development primarily to the economic downturn and baby boomers entering disability-prone years, not to TANF-SSI conversions. Nevertheless, interest in or concern with these conversions is evident. The Social Security Administration, along with the Administration for Children and Families of the U.S. Department of Health and Human Services, provides funding to MDRC for the TANF/SSI Disability Transition Project (MDRC 2010, US DHSS n.d.).

[29] For a similar conversation about the dramatic growth in the SSDI program see Fletcher (2010).