
Key Demographic and Mental Health Predictors of Receiving Disability Benefits with Mental Health Limitations

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Abstract

Purpose: This study examines demographic and mental health factors that predict Social Security Disability Insurance (SSDI) receipt among individuals with primary mental health limitations. We investigated whether age and other demographics directly predict SSDI receipt, if specific mental health symptoms are associated with benefit receipt.

Methods: Using data from the 2014 Social Security Administration public-use mental health disability dataset, we analyzed a sample of 4,781 individuals through logistic regression to identify predictors of SSDI receipt, with particular focus on those reporting mental health as their primary work limitation (n=381).

Results: Having a mental health condition as a primary work limitation nearly doubled the odds of receiving SSDI benefits (OR=1.96, 95% CI [1.50, 2.58]), even after controlling for demographics, health status, functional limitations, and specific symptoms. Age was strongly associated with SSDI receipt, with the 50-64 age group having four times higher odds (OR=4.08) compared to those 65 and older. Females had lower odds of receiving benefits than males (OR=0.70). Different mental health symptoms showed varying relationships: social difficulties increased odds of SSDI receipt (OR=1.22), while concentration difficulties (OR=0.76) and coping difficulties (OR=0.75) were associated with decreased odds.

Conclusions: This study demonstrates that having a mental health condition as a primary work limitation significantly increases SSDI receipt likelihood. The complex pattern of associations between specific symptoms and benefit receipt highlights the multifaceted nature of disability determination for individuals with mental health conditions.

Keywords: Social Security Disability Insurance; Mental health; Work disability; Functional limitations; Public health

1. Introduction

Mental health conditions represent a significant public health challenge in the United States, with the Surgeon General identifying them as a nationwide crisis [1,2]. While substantial research has examined the determinants and prevalence of mental health conditions [3], less attention has been given to understanding when these conditions become disabling enough to prevent sustained employment [4]. While physical ailments (e.g., back and neck problems) are the leading cause of work disability, mental health limitations are reportedly second, highlighting the importance of examining contributing factors to mental health disability [5, 14, 15]. This limited focus becomes increasingly problematic as the prevalence of mental health disorders continues to rise, yet the specific social burdens (e.g., unemployment, stigma) and financial costs (e.g., healthcare expenditures, lost income) of individuals who qualify for government assistance programs like Social Security Disability Insurance (SSDI) [6,7] remain poorly understood.

Existing literature often fails to identify the specific demographic and clinical predictors of SSDI eligibility among those with mental health conditions. Instead, most studies focus on commonly described factors that prevent people from returning to work [8], prognostic factors of long-term disability [9], or workplace conditions in other countries [10-13]. These studies do not examine what leads to actual benefit receipt or the prevalence of successful claims among individuals with mental health limitations. Nevertheless, SSDI functions as a governmental safeguard for individuals whose mental health limitations preclude sustained employment.

A particularly critical gap in the existing literature concerns the potential for structural barriers within the disability determination system itself. While research has documented barriers to employment among individuals with mental health conditions and examined predictors of SSDI application, few studies have interrogated why certain disabling symptoms might be inversely associated with benefit receipt. This gap is especially significant because the SSDI application process requires sustained cognitive effort, organizational capacity, and often advocacy from support networks—capacities that may be compromised by the very symptoms that qualify individuals for benefits. Individuals experiencing severe concentration impairment, for example,

may struggle to complete the complex, multi-stage application process, maintain consistent treatment documentation, or effectively communicate their limitations during assessments. Understanding which demographic and clinical factors predict SSDI receipt among those with mental health as their primary limitation can illuminate whether the current system systematically disadvantages applicants with specific symptom profiles, thereby informing both clinical practice (in terms of targeted application support) and policy reform (in terms of assessment process redesign). This approach aligns with contemporary disability frameworks that emphasize the dynamic interplay between individual health conditions and environmental factors that influence community participation and quality of life [19, 21].

In the present study, we examine demographic and mental health factors that predict Social Security Disability Insurance (SSDI) receipt among individuals with primary mental health limitations. Controlling for demographic factors (gender, race, education), we analyze a sample of 320 individuals to test whether (a) age and other demographics, (b) specific mental health symptoms (anxiety, social difficulties, concentration problems), and (c) functional limitations influence disability benefit status. We hypothesize that older age, more severe symptom profiles, and greater functional impairment will predict a higher likelihood of receiving SSDI. Through logistic regression analysis, we explore how these factors interrelate to identify potential barriers and facilitators in disability benefit access for those with mental health conditions.

2. Methods

2.1. Sample and Statistical Analysis

We analyzed data from the 2014 Social Security Administration (SSA) public-use mental health disability dataset, derived from the U.S. Census Bureau's Survey of Income and Program Participation (SIPP). The SIPP provides nationally representative, cross-sectional data on income, program participation, and disability, including detailed measures of functional limitations, psychosocial factors, and employment sector. After data cleaning and recoding, the analytic

sample consisted of 4,781 complete cases out of 35,980 respondents, as a high proportion of missing data was observed in key variables (e.g., 86.7% missing for life interference).

While the 2014 SSA Supplement data are now a decade old, they represent the most recent and comprehensive nationally representative dataset available for examining the intersection of detailed mental health symptomatology, functional limitations, and SSDI receipt. Following SIPP's 2014 redesign, which eliminated topical modules to reduce respondent burden, the SSA commissioned this one-time supplement specifically to retain critical disability assessment data needed for policy analysis [16-18]. Subsequent SIPP panels (2018 onward) have incorporated only select SSA-sponsored disability questions that lack the depth and breadth of the 2014 supplement, particularly regarding specific mental health symptoms and their relationship to work limitations. Importantly, core SSDI eligibility criteria and disability determination processes have remained fundamentally stable since 2014, with the most recent revisions to mental disorder evaluation criteria occurring in 2016. Thus, while the prevalence of mental health conditions and labor market conditions have evolved, the underlying mechanisms through which mental health symptoms influence disability determination—the focus of this analysis—are likely to have remained consistent, making these data suitable for identifying predictors that remain policy-relevant today.

2.2. Two-Stage Analytical Approach

We employed a two-stage analytical approach to comprehensively examine SSDI predictors. First, we conducted a population-level analysis examining predictors of SSDI receipt across all individuals with work limitations (N=4,781) to establish the role of mental health conditions relative to other disability types. Second, recognizing the clinical and policy importance of mental health-related disabilities and their unique assessment challenges, we conducted a focused stratified analysis among individuals with mental health as their primary work limitation (N=320 with complete data from N=381 total) to identify specific demographic, symptom, and functional factors that predict benefit receipt within this vulnerable population.

Logistic regression analyses were conducted using SAS 9.4 (SAS Institute Inc., Cary, NC) for both stages. Model discrimination was assessed using the c-statistic. To address potential bias

from missing data, we conducted sensitivity analyses, including multiple imputation and alternative model specifications, which confirmed that our findings were robust to different assumptions about missing data patterns [20]. Descriptive statistics for all variables are presented in Table 1.

2.3. Dependent Variable

The primary outcome variable was receipt of Social Security Disability Insurance (SSDI), coded as a binary variable (1 = Yes, 0 = No) based on reported income sources.

2.4. Independent Variables

2.4.1. Demographics

Demographic variables included age group (18-34, 35-49, 50-64, 65+), gender (male, female), race/ethnicity (White, Black, Asian, Other), education level (less than high school, high school graduate, some college, associate degree, bachelor's degree, advanced degree), and marital status (married, previously married, never married).

2.4.2. Health Status, Mental Health Symptoms, Functional Limitations

Self-rated health status was assessed using a 5-point scale (excellent, very good, good, fair, poor). Five mental health symptoms were included as individual binary predictors: anxiety, social difficulties, concentration difficulties, coping difficulties, and life interference. Missing data were primarily attributable to the life interference measure (86.7% missing, e.g., difficulty engaging in social activities). Additionally, a functional limitation index was created by summing five functional limitation measures, with higher scores indicating greater functional capacity [22]. The functional limitation index is typically constructed from self-reported items assessing limitations in various domains of physical and/or mental functioning. Validation studies have demonstrated that such indices possess strong convergent and discriminant validity, correlating well with established measures of activities of daily living, overall health, and quality of life [23].

2.4.3. *Employment Factors*

Industry sectors were classified into nine categories: Primary Industries, Manufacturing & Construction, Trade, Transportation & Utilities, Business & Financial Services, Education & Health Services, Leisure & Other Services, Government, and Not Classified. Industry codes were mapped to 22 detailed industry groups and aggregated into eight major sectors using a SAS data step. Observations with missing, invalid, or out-of-range industry codes (TIND) were grouped into a 'Not Classified' category, which included respondents not in the labor force (e.g., retirees, homemakers) and unresolved data entries. This catch-all grouping thus captures respondents not in the labor force (e.g., students, retirees, homemakers), refusals, and unreadable or subverted records.

3. Results

3.1. Sample Characteristics

Table 1 presents the descriptive characteristics of the full sample and mental health recipient subgroup. The age distribution showed that most participants were between 50 and 64 years old (40.5%), followed by those aged 35 to 49 (20.6%), 65 and older (22.6%), and 18 to 34 (16.3%). Mental health symptoms included anxiety (26.1%), coping difficulties (23.1%), concentration difficulties (20.7%), life interference (18.8%), and social difficulties (10.9%). The average functional limitation index score was 9.01 (SD= 1.23). Among the 4,781 individuals included in the final analysis, 1,102 (23.0%) received SSDI benefits. Individuals with mental health as their primary work limitation comprised 8% (n=381) of the analytic sample. The SSDI receipt rate among this subgroup was 39.1% (n=149), nearly double the SSDI receipt rate (21.7%) observed in individuals without a primary mental health limitation.

Within the mental health subgroup (N=381), 60.9% did not receive SSDI while 39.1% did receive benefits. The largest age group was 50-64 (46.5%), and most participants (83.7%) were not currently working. Mental health symptoms were highly prevalent, with 74.3% reporting anxiety, 63.5% reporting coping difficulties, and 56.4% reporting concentration difficulties.

3.2. Population-Level Analysis: Mental Health Among All Disability Types

The population-level logistic regression model was statistically significant ($\chi^2(33) = 937.38, p < .001$) and demonstrated good discrimination ($c = .789$) (Table 2).

3.2.1. Mental Health as Primary Limitation

Having a mental health condition as a primary work limitation significantly predicted SSDI receipt (OR = 1.96, 95% CI [1.50, 2.58], $p < .001$), after controlling for demographic characteristics, health status, functional limitations, specific mental health symptoms, and industry sector. Individuals with mental health as their primary limitation had nearly twice the odds of receiving SSDI benefits compared to those without a mental health primary limitation.

3.2.2. Population-Level Demographic and Health Predictors

Age was strongly associated with SSDI receipt (Wald $\chi^2 = 232.26, p < .001$), with the 50-64 age group having significantly higher odds of receiving benefits (OR = 4.08, 95% CI [3.36, 4.94], $p < .001$) compared to those 65 and older. Females had lower odds of receiving SSDI than males (OR = 0.70, 95% CI [0.60, 0.81], $p < .001$). Education level significantly predicted SSDI receipt (Wald $\chi^2 = 17.70, p = .003$), with those having advanced degrees (OR = 0.54, 95% CI [0.34, 0.86], $p = .035$) or bachelor's degrees (OR = 0.61, 95% CI [0.44, 0.87], $p = .049$) showing lower odds of SSDI receipt compared to those with some college education.

Self-rated health status strongly predicted SSDI receipt (Wald $\chi^2 = 88.42, p < .001$), with poorer health linked to higher odds. Compared to those in very good health, individuals reporting fair health (OR = 3.41, 95% CI [2.40, 4.84], $p < .001$) or poor health (OR = 3.17, 95% CI [2.21, 4.56], $p < .001$) had substantially higher odds of receiving SSDI.

3.2.3. Mental Health Symptoms and Functional Limitations

Different mental health symptoms showed varying relationships with SSDI receipt. Social difficulties were associated with increased odds of SSDI receipt (OR = 1.22, 95% CI [1.01, 1.47],

$p = .043$), while concentration difficulties ($OR = 0.76$, 95% CI $[0.65, 0.91]$, $p = .002$) and coping difficulties ($OR = 0.75$, 95% CI $[0.63, 0.89]$, $p < .001$) were linked to reduced likelihoods of SSDI receipt. Anxiety and life interference were not significantly associated with SSDI receipt.

Interestingly, higher functional limitation index scores were associated with lower odds of SSDI receipt ($OR = 0.84$, 95% CI $[0.80, 0.89]$, $p < .001$), indicating that individuals with greater functional capacity were less likely to receive SSDI benefits.

3.2.4. Industry Sector

The industry sector significantly predicted SSDI receipt in the population-level analysis (Wald $\chi^2 = 90.30$, $p < .001$). However, examination of sector-specific effects revealed that only one category showed a statistically significant individual association: the "Not Classified" sector, which demonstrated substantially elevated odds of SSDI receipt ($OR = 16.01$, 95% CI $[2.15, 119.27]$) compared to the reference category of Transportation & Utilities. As described in the Methods section, the "Not Classified" category is a heterogeneous grouping that captures respondents not currently in the labor force (e.g., students, retirees, homemakers), those with missing or invalid industry codes, and unresolved data entries. This finding underscores that labor force detachment—rather than employment in any particular industry sector—represents the most salient predictor of SSDI receipt. All other industry sectors (Business & Financial Services, Education & Health Services, Government, Leisure & Other Services, Manufacturing & Construction, Trade, and Primary Industries) showed very wide confidence intervals crossing the null value, precluding meaningful interpretation of sector-specific effects. These findings demonstrate that having a mental health condition as a primary work limitation is a significant predictor of SSDI receipt, even after accounting for demographics, health status, functional capacity, specific mental health symptoms, and employment status.

3.3. Stratified Analysis: Predictors Within the Mental Health Subgroup

The stratified analysis focusing exclusively on individuals with mental health as their primary work limitation ($N=320$) revealed distinct patterns of association. This model was

statistically significant ($\chi^2(22) = 50.18, p < .001$) with moderate discrimination ($c = .719$). See Table 2 for complete stratified analysis results.

3.3.1. Age Effects in Mental Health Subgroup

Within the mental health subgroup, age remained a strong predictor (Wald $\chi^2 = 11.49, p = .009$), but with different patterns than the population-level analysis. Compared to the youngest group (18-34), all older age groups had significantly higher odds of receiving SSDI: ages 35-49 (OR = 3.78, 95% CI [1.50, 9.51], $p = .005$), ages 50-64 (OR = 4.88, 95% CI [1.94, 12.28], $p = .001$), and ages 65+ (OR = 4.11, 95% CI [1.35, 12.54], $p = .013$).

3.3.2. Mental Health Symptom Profiles

Among individuals with mental health as their primary limitation, specific symptoms showed varying associations with SSDI receipt. Anxiety significantly increased the odds of SSDI receipt (OR = 2.88, 95% CI [1.29, 6.41], $p = .010$), as did social difficulties (OR = 1.70, 95% CI [1.02, 2.83], $p = .044$). Counterintuitively, concentration difficulties were associated with lower odds of SSDI receipt (OR = 0.47, 95% CI [0.26, 0.87], $p = .015$). Coping difficulties and life interference were not significantly associated with SSDI receipt in this subgroup.

3.3.3. Functional Limitations in Mental Health Context

Within the mental health subgroup, higher scores on the functional limitation index were associated with lower odds of SSDI receipt (OR = 0.79, 95% CI [0.65, 0.96], $p = .018$), indicating that individuals with fewer functional limitations (higher capacity) were less likely to receive benefits.

3.3.4. Demographic Factors in Mental Health Subgroup

Unlike the population-level analysis, gender, race/ethnicity, education, marital status, and self-rated health status were not significantly associated with SSDI receipt within the mental health subgroup, suggesting these factors may operate differently for individuals with mental health

versus other types of work limitations. See Figure 1 for full visual of predictors for population and subgroups (Figure 1).

4. Discussion

In this nationally representative sample of adults with work-limiting disabilities, we found that having a mental health condition as the primary limitation nearly doubled the odds of receiving Social Security Disability Insurance (SSDI) benefits (OR = 1.96, 95% CI [1.50, 2.58]), even after adjustment for demographic characteristics, health status, functional limitations, specific mental health symptoms, and industry sector. Our stratified analysis of individuals with mental health as their primary limitation (N=320) revealed distinct patterns that differ from the broader disability population, highlighting three critical findings with important policy implications.

4.1 Age and Systemic Barriers Drive SSDI Receipt

Age emerged as one of the strongest predictors of SSDI receipt across both analyses, though with notably different patterns. In the population-level analysis, the 50-64 age group had significantly higher odds of receiving benefits (OR = 4.08, 95% CI [3.36, 4.94]) compared to those 65 and older, reflecting the transition to retirement benefits at full retirement age. Within the mental health subgroup, however, all older age groups had substantially higher odds compared to those 18-34: ages 35-49 (OR = 3.78, 95% CI [1.50, 9.51]), ages 50-64 (OR = 4.88, 95% CI [1.94, 12.28]), and ages 65+ (OR = 4.11, 95% CI [1.35, 12.54]). This pattern suggests that young adults with mental health limitations face particular barriers in accessing disability benefits, potentially due to shorter work histories, less developed advocacy skills, age-related biases in symptom evaluation [28], or the intersection of these factors with the systemic challenges described below.

The gender disparity observed in the population analysis—with females having lower odds than males (OR = 0.70, 95% CI [0.60, 0.81])—was not significant within the mental health subgroup, suggesting that traditional demographic advantages may be attenuated when mental health is the primary limitation. This could reflect either more equitable assessment practices for mental health conditions or unique barriers that affect all demographic groups similarly [29].

Similarly, education level was significantly associated with SSDI receipt in the population analysis, with those having advanced degrees (OR = 0.54, 95% CI [0.34, 0.86]) or bachelor's degrees (OR = 0.61, 95% CI [0.44, 0.87]) showing lower odds compared to those with some college education. However, education was not significantly associated with SSDI receipt within the mental health subgroup, indicating that educational protective effects may be diminished when mental health is the primary work limitation.

Industry sector significantly predicted SSDI receipt in the population analysis (Wald $\chi^2 = 90.30$, $p < .001$), with individuals coded as "Not Classified"—predominantly those not currently employed—having over 16-fold higher odds compared to the reference group. This underscores the critical role of labor-market detachment in the disability-insurance pathway, aligning with recent findings that mental health conditions reduce employment entry by 31% and increase employment exit by 42% among young adults [30]. The chronic and disabling nature of mental health disorders contributes to sustained workforce disengagement, as evidenced by persistently high SSDI utilization rates—averaging 47.2% over 24 years among individuals with borderline personality disorder [24]. These findings suggest that, beyond individual factors, systemic challenges greatly hinder workplace retention for individuals with mental health conditions, often exacerbated by fluctuating symptoms and functional impairments [25].

4.2 Anxiety and Social Limitations Strongly Predict Benefit Receipt

Our findings reveal that specific mental health symptoms have differential relationships with disability determination. Within the mental health subgroup, anxiety emerged as a strong predictor of SSDI receipt (OR = 2.88, 95% CI [1.29, 6.41], $p = .010$), and social difficulties remained significant (OR = 1.70, 95% CI [1.02, 2.83], $p = .044$). In the broader population analysis, social difficulties were also associated with increased odds of SSDI receipt (OR = 1.22, 95% CI [1.01, 1.47]). These findings align with SSA's emphasis on "marked social limitations" in disability evaluations [28] and suggest that symptoms manifesting in observable interpersonal difficulties may be more readily recognized and documented in the disability determination process.

The stronger association of anxiety with SSDI receipt in the mental health subgroup compared to the population analysis (where anxiety showed no significant relationship) highlights the importance of condition-specific assessment. Anxiety disorders, particularly when severe enough to cause marked social limitations and warrant a primary work limitation designation, appear to substantially increase the likelihood of benefit approval. This finding reinforces growing evidence that the chronic and disabling nature of mental health disorders—particularly those affecting social functioning—contributes to sustained workforce disengagement and withdrawal.

4.3 Concentration Difficulties Show Unexpected Patterns: Implications for SSA Screening

The most striking and policy-relevant finding concerns the consistent inverse relationship between concentration difficulties and SSDI receipt observed across both analyses. In the population-level analysis, concentration difficulties were associated with decreased odds of SSDI receipt (OR = 0.76, 95% CI [0.65, 0.91], $p = .002$), with this relationship even more pronounced in the mental health subgroup (OR = 0.47, 95% CI [0.26, 0.87], $p = .015$). Similarly, coping difficulties were associated with reduced likelihoods of SSDI receipt in the population analysis (OR = 0.75, 95% CI [0.63, 0.89], $p < .001$), though this relationship was not significant within the mental health subgroup.

This paradoxical finding warrants careful interpretation and has critical implications for disability policy. According to the SSA, eligibility for SSDI benefits requires an inability to perform substantial gainful activity (SGA) due to a medically determinable impairment that has lasted or is expected to last at least 12 months [27]. Several mechanisms may explain why severely disabling cognitive symptoms predict lower benefit receipt. First, individuals with severe concentration problems may struggle to complete the complex, multi-stage SSDI application process itself, which requires sustained cognitive effort, organizational capacity, comprehensive documentation gathering, and often multiple appeals [26]. Second, concentration difficulties may be inadequately captured by standardized assessments that fail to account for episodic impairments characteristic of many mental health conditions. Third, while concentration difficulties can be

profoundly impairing in real-world settings, they may not always prevent an individual from engaging in work during brief assessment periods, potentially leading evaluators to underestimate their functional impact.

The counterintuitive finding that higher functional capacity was associated with lower odds of SSDI receipt appeared in both analyses (population: OR = 0.84, 95% CI [0.80, 0.89]; mental health subgroup: OR = 0.79, 95% CI [0.65, 0.96]), providing important validation of the disability determination process. This demonstrates that functional ability is appropriately weighted heavily in benefit decisions regardless of the nature of the primary limitation, underscoring the importance of functional assessment. However, it also highlights the challenge of capturing fluctuating functional capacity in individuals with mental health conditions whose abilities may vary significantly across time and context.

5. Policy Implications and Calls to Action

For the Social Security Administration: The SSA should refine disability determination criteria to better capture episodic cognitive impairments that characterize many mental health conditions. Current assessment procedures may systematically disadvantage applicants whose concentration difficulties make it harder for them to complete the application process. We recommend developing streamlined application pathways with enhanced support for individuals reporting cognitive symptoms, implementing functional assessments that capture day-to-day variability rather than single-point-in-time evaluations, and training adjudicators to recognize that applicants' difficulty navigating the application process may itself constitute evidence of disabling impairment.

For public health systems and policymakers: To mitigate reliance on SSDI, policymakers should prioritize expanding access to evidence-based interventions like Individual Placement and Support (IPS), which has been shown to improve job retention by 40% among adults with severe mental illness [31]. The strong association between mental health as primary limitation and SSDI receipt underscores the need for robust mental health treatment and workplace accommodation as

prevention strategies. Our results support the integration of mental health screening and vocational supports within disability assessment and rehabilitation programs. The influence of psychosocial factors suggests that bolstering social participation and adaptive coping strategies may mitigate functional decline and potentially delay or reduce SSDI dependence [19].

For researchers: The differential associations between specific mental health symptoms and SSDI receipt highlight the necessity for continued research examining how disability determination processes can better address the complex and often less visible aspects of mental health limitations. Future research should examine longitudinal patterns of mental health limitations and SSDI receipt to better understand causal pathways, with particular attention to how predictors may operate differently within mental health versus other disability populations. More detailed investigation of specific mental health diagnoses and their relationship to SSDI receipt would enhance understanding. Qualitative research exploring experiences of individuals with mental health limitations in the disability application process could provide valuable context for these quantitative findings.

6. Limitations

This study has several important limitations affecting both analyses. The cross-sectional design precludes causal inference between mental health symptoms, functional limitations, and SSDI receipt. All key variables were self-reported, introducing potential recall and social desirability bias. For the stratified analysis, we excluded 61 participants (16%) due to missing data, potentially introducing selection bias and limiting generalizability. Mental health symptoms were assessed using single-item questions rather than validated clinical scales. Respondents were not directly asked whether SSDI awards were specifically for mental health-related disabilities, limiting our ability to definitively attribute benefit receipt to mental health conditions. Unmeasured confounders including treatment history, symptom duration and severity, and workplace accommodations were unavailable and may influence both functional status and benefit receipt likelihood.

7. Conclusion

This study demonstrates that having a mental health condition as a primary work limitation significantly increases the likelihood of receiving SSDI benefits, with age and systemic barriers, anxiety and social limitations, and a paradoxical association with concentration difficulties serving as key predictors. The complex associations between specific mental health symptoms and benefit receipt highlight the multifaceted nature of disability determination for individuals with mental health conditions. Most critically, the inverse relationship between concentration difficulties and SSDI receipt suggests that the current disability determination system may systematically disadvantage applicants with cognitive symptoms who struggle to navigate the application process itself. These findings call for immediate policy action: the SSA must refine assessment procedures to capture episodic cognitive impairments, public health systems must expand evidence-based employment supports like IPS, and clinicians must provide targeted application assistance to vulnerable populations. Only through these coordinated efforts can we ensure equitable access to disability benefits while promoting workforce participation and recovery among individuals with mental health conditions [32,33].

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Appendix

Table 1: Sample Characteristics by Analysis Level

Variable	Full Sample (N = 4,781)	Mental Health Subgroup (N = 381)
SSDI Receipt		
Yes	1,102 (23.0%)	149 (39.1%)
No	3,679 (77.0%)	232 (60.9%)
Age Group		
18–34	780 (16.3%)	66 (17.3%)
35–49	985 (20.6%)	88 (23.1%)
50–64	1,935 (40.5%)	177 (46.5%)
65+	1,081 (22.6%)	50 (13.1%)
Gender		
Female	2,480 (51.9%)	193 (50.7%)
Male	2,301 (48.1%)	188 (49.3%)
Self-Rated Health		
Excellent	350 (7.3%)	16 (4.2%)
Very Good	920 (19.2%)	39 (10.2%)
Good	1,350 (28.2%)	89 (23.4%)
Fair	1,310 (27.4%)	144 (37.8%)

Poor	851 (17.8%)	93 (24.4%)
Mental Health Symptoms		
Anxiety	1,250 (26.1%)	283 (74.3%)
Social Difficulties	520 (10.9%)	167 (43.8%)
Concentration Difficulties	990 (20.7%)	215 (56.4%)
Functional Limitation Index (M ± SD)	9.01 (1.23)	8.52 (1.48)

Note. SSDI = Social Security Disability Insurance. Life interference n = 320 for mental health subgroup due to missing data. Bolded variables (age, self-rated health, mental health symptoms, and functional limitations) indicate key predictors highlighted for policy relevance.

Table 2: Predictors of SSDI Receipt: Logistic Regression Models

Panel A. Population-Level Model (N = 4,781)

Variable	OR [95% CI]	p
Mental Health Primary Limitation (Yes vs. No)	1.96 [1.50, 2.58]	< .001
Age 50–64 (vs. 65+)	4.08 [3.36, 4.94]	< .001
Fair Health (vs. Very Good)	3.41 [2.40, 4.84]	< .001
Poor Health (vs. Very Good)	3.17 [2.21, 4.56]	< .001
Female (vs. Male)	0.70 [0.60, 0.81]	< .001
Bachelor’s Degree (vs. Some College)	0.61 [0.44, 0.87]	.049
Social Difficulties	1.22 [1.01, 1.47]	.043
Concentration Difficulties	0.76 [0.65, 0.91]	.002
Coping Difficulties	0.75 [0.63, 0.89]	< .001
Functional Limitation Index	0.84 [0.80, 0.89]	< .001

Model $\chi^2(33) = 937.38$, $p < .001$, $c = .789$

Panel B. Mental Health Subgroup Model (N = 320)

Variable	OR [95% CI]	p
Age 35–49 (vs. 18–34)	3.78 [1.50, 9.51]	.005

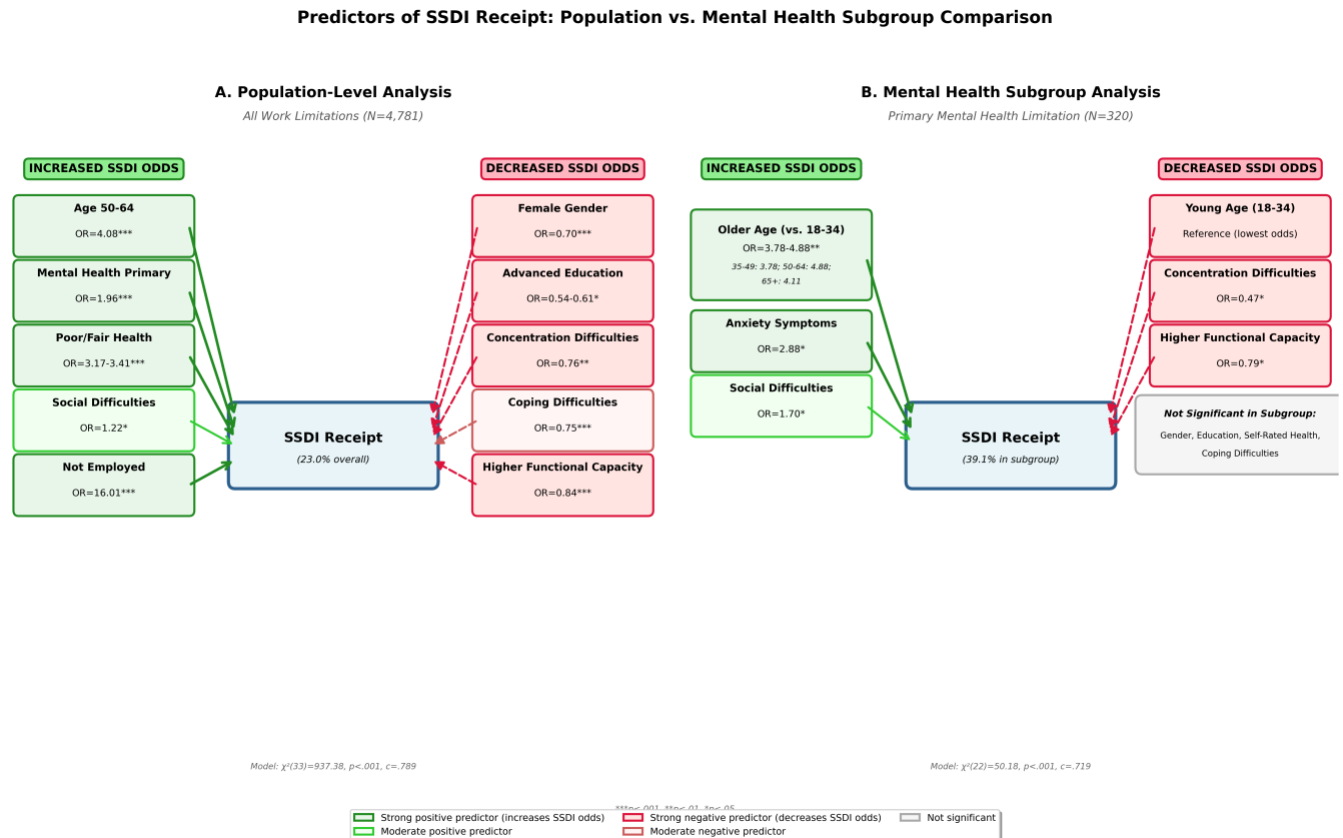
Age 50–64 (vs. 18–34)	4.88 [1.94, 12.28]	.001
Age 65+ (vs. 18–34)	4.11 [1.35, 12.54]	.013
Anxiety	2.88 [1.29, 6.41]	.010
Social Difficulties	1.70 [1.02, 2.83]	.044
Concentration Difficulties	0.47 [0.26, 0.87]	.015
Functional Limitation Index	0.79 [0.65, 0.96]	.018

Model $\chi^2(22) = 50.18, p < .001, c = .719$

Note. SSDI = Social Security Disability Insurance; OR = odds ratio; CI = confidence interval; ref = reference category. Only statistically significant and policy-relevant predictors are retained; full models with all covariates available in Supplementary Table S2.

Figure 1.

Predictors of SSDI Receipt: Population vs. Mental Health Subgroup Comparison



Supplemental Materials

Supplementary Table S1

Industry Sector as a Predictor of SSDI Receipt (N = 4,781)

Industry Sector	Distribution	B	SE	Wald χ^2	p	OR	95% CI
Industry Sector				90.30	<.001		
Business & Financial Services	1,178 (3.3%)	1.28	28.52	0.002	.964	4.92	[0.56, 43.56]
Education & Health Services	3,551 (9.9%)	1.06	28.52	0.001	.970	3.96	[0.50, 31.48]
Government	814 (2.3%)	1.04	28.52	0.001	.971	3.88	[0.41, 37.07]
Leisure & Other Services	2,085 (5.8%)	1.47	28.52	0.003	.959	5.99	[0.76, 46.98]
Manufacturing & Construction	1,887 (5.2%)	0.50	28.52	<0.001	.986	2.27	[0.27, 19.16]
Not Classified	23,664 (65.8%)	2.46	28.52	0.007	.931	16.01	[2.15, 119.27]
Primary Industries	112 (0.3%)	-9.06	228.10	0.002	.968	<0.001	[<0.001, >999.99]
Trade	1,900 (5.3%)	1.57	28.52	0.003	.956	6.63	[0.83, 52.79]
Transportation & Utilities (ref)	789 (2.2%)	---	---	---	---	---	---

Note. SSDI = Social Security Disability Insurance; OR = odds ratio; CI = confidence interval.

Reference category for industry sector: Transportation & Utilities.

Supplementary Table S2

Full Logistic Regression Results Including Non-Significant Predictors

Variable	Population OR [95% CI]	MH Subgroup OR [95% CI]	p
Age 18–34 (vs. 65+)	1.30 [0.92, 1.86]	—	.035
Age 35–49 (vs. 65+)	2.22 [1.72, 2.85]	—	.026
Gender (Female vs. Male)	0.70 [0.60, 0.81]	1.42 [0.83, 2.42]	.197
Race/Ethnicity (Asian vs. White)	0.47 [0.24, 0.93]	—	.029
Race/Ethnicity (Black vs. White)	1.06 [0.86, 1.30]	—	.051
Race/Ethnicity (Other vs. White)	0.98 [0.67, 1.44]	—	.353
Education (< High School vs. Some College)	0.83 [0.66, 1.05]	0.97 [0.45, 2.11]	.946
Education (High School Graduate vs. Some College)	1.01 [0.82, 1.24]	1.09 [0.54, 2.20]	.808
Education (Associate Degree vs. Some College)	0.95 [0.68, 1.33]	1.04 [0.41, 2.65]	.937

Education (Advanced Degree vs. Some College)	0.54 [0.34, 0.86]	0.57 [0.15, 2.12]	.398
Marital Status (Never Married vs. Married)	—	1.99 [0.96, 4.10]	.063
Marital Status (Previously Married vs. Married)	—	1.48 [0.81, 2.71]	.199
Self-Rated Health (Excellent vs. Very Good)	0.85 [0.46, 1.58]	0.45 [0.08, 2.67]	.381
Self-Rated Health (Good vs. Very Good)	1.65 [1.13, 2.40]	—	.653
Self-Rated Health (Fair vs. Very Good)	3.41 [2.40, 4.84]	1.38 [0.69, 2.76]	.364
Self-Rated Health (Poor vs. Very Good)	3.17 [2.21, 4.56]	0.80 [0.37, 1.76]	.581
Anxiety	1.01 [0.84, 1.22]	2.88 [1.29, 6.41]	.010
Coping Difficulties	0.75 [0.63, 0.89]	1.47 [0.78, 2.78]	.235
Life Interference	1.14 [0.96, 1.36]	0.94 [0.49, 1.80]	.855

Functional Limitation Index	0.84 [0.80, 0.89]	0.79 [0.65, 0.96]	.018
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Note. SSDI = Social Security Disability Insurance; OR = odds ratio; CI = confidence interval; ref = reference category; MH Subgroup = Mental Health Subgroup. Em dashes (—) indicate variable not included in that model. This table provides complete model results including statistically non-significant findings.