

Documenting Disability for Persons with Substance Use Disorders & Co-occurring Impairments: *A Guide for Clinicians*

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PREFACE

This guide was written to assure that individuals with substance use disorders and co-occurring impairments that meet Social Security disability criteria receive Federal disability assistance under the Supplemental Security Income (SSI) program or the Social Security Disability Insurance (SSDI) program.

The guide focuses on the complex issues involved in documenting impairments that co-occur with substance use disorders – particularly for homeless SSI/SSDI applicants, who are more likely than those with stable housing to be denied benefits for procedural rather than medical reasons.

The information contained in this document is primarily intended for licensed physicians, psychologists, and other medical professionals who are authorized by the Social Security Administration (SSA) to provide medical evidence of impairment and for other clinicians (including nurses, physician assistants, and licensed clinical social workers) who assist with the documentation of medical and functional impairments in support of SSI/SSDI applications.¹

For an explanation of SSI/SSDI eligibility criteria, how these programs differ, and the disability determination process, readers are referred to *Documenting Disability: Simple Strategies for Medical Providers* (O’Connell, Quick, and Zevin 2004). This document and other disability resources are available via the National Health Care for the Homeless Council’s website at <http://www.nhchc.org/disabilityresources.html>.

¹ Documentation of a medical impairment for the purpose of supporting a disability claim must come from “acceptable medical sources” as defined by SSA: licensed physicians, licensed or certified psychologists, licensed optometrists (for vision impairments only), licensed podiatrists (for foot and ankle impairments only), or qualified speech and language pathologists (20 CFR §§ 404.1513(a) and 416.913(a)). Medical practitioners who are not “acceptable medical sources” can prepare supporting letters and complete disability claims forms for their patients, but a licensed physician or other acceptable medical source must also provide medical evidence to establish the impairment (O’Connell et al. 2004).

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- Yvonne Perret, MA, MSW, LCSW-C – Executive Director, Advocacy and Training Center, Cumberland, Maryland; consultant and trainer for the Federal SSI/SSDI Outreach, Access & Recovery (SOAR) initiative and co-author of *Stepping Stones to Recovery: A Case Manager’s Manual for Assisting Adults Who Are Homeless with Social Security Disability and Supplemental Security Income Applications* (2005)
- Sarah Anderson, JD – Managing Attorney, Health Unit, Greater Boston Legal Services; and member of the Homeless Subcommittee of the Massachusetts Disability Determination Services Advisory Committee, which investigates barriers encountered by homeless claimants in applying for SSDI/SSI benefits
- Mark Dalton – Administrator of the Belltown Community Service Office, Washington State Department of Social and Health Services, which facilitates enrollment in the state General Assistance program and SSI/SSDI applications
- Barry Zevin, MD – Physician at the Tom Waddell Health Center, San Francisco Department of Public Health; Diplomate American Board of Internal Medicine, certified in Addiction Medicine; co-author of *Documenting Disability: Simple Strategies for Medical Providers* (2004)

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- Robert Taube, PhD, MPH – SSI Task Force Chair and Executive Director, Boston Health Care for the Homeless Program, Boston, Massachusetts
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- Dan F. Reardon, JD – Benefit Acquisition and Retention Team Coordinator, Colorado Coalition for the Homeless, Denver, Colorado, and Homeless Outreach Projects and Evaluation (HOPE) grant project coordinator
- Laurel Weir – Policy Director, National Law Center on Homelessness & Poverty, Washington, DC, an advocate for improved access to SSI/SSDI for people with disabilities who are homeless

EXECUTIVE SUMMARY

This guide was written to assure that individuals with substance use disorders and co-occurring impairments that meet Social Security disability criteria receive Federal disability benefits under the Supplemental Security Income (SSI) program or the Social Security Disability Insurance (SSDI) program. The guide provides practical tips that medical providers and others who assist with the documentation of disability can use to expedite SSI/SSDI benefits for individuals with co-occurring impairments. Special emphasis is placed on the importance of assisting homeless applicants, who are more likely than individuals with stable housing to be denied benefits for procedural rather than medical reasons.

This document is intended as a supplement to *Documenting Disability: Simple Strategies for Medical Providers* (O'Connell et al. 2004). Readers are referred to the 2004 manual for an explanation of SSA disability criteria, the 5-step disability determination process, and general guidance for medical providers regarding the documentation of medical and functional impairments. The 2007 supplement focuses in more detail on the complex issues involved in documenting impairments that co-occur with substance use disorders.

The 1996 statutory change that terminated SSI/SSDI eligibility for individuals whose drug addiction or alcoholism is material to their disability was not intended to disqualify persons who have disabling co-occurring impairments. Such denials have nevertheless been widely reported to occur at the initial stage of disability determination, frequently requiring later reversal at the appeals level. Individuals with substance use disorders who present sufficient medical evidence of impairment that meets SSA disability criteria are entitled to SSI/SSDI regardless of current alcohol or drug use. This guide is intended to educate clinicians on how best to document impairments independent of active substance use, so as to help these disability applicants and to assure broad understanding of current policy and its implementation.

The document is divided into four main sections, a bibliography, and three appendices:

1. The introductory section explains the importance of SSI/SSDI benefits to individuals with co-occurring mental impairments who are homeless and why they have been disproportionately affected by changes in Social Security's Drug Addiction & Alcoholism (DAA) policy in 1996.
2. Section II explains current DAA policy with regard to SSI/SSDI eligibility and identifies problems with the policy's implementation and impact on personal and public health from the perspective of scientists, clinicians, and advocates for homeless claimants. Problems identified include:
 - Inconsistent application of the policy across jurisdictions;
 - The difference between DAA policy and the scientific understanding of addiction (cf., clinical articles published by the HCH Clinicians' Network with support from HRSA (CN 2006, CN 1998); and

- The policy’s impact on preventing and ending homelessness, most notably specified in the DHHS/SAMHSA publication, *Expediting Access to SSA Disability Benefits: Promising Practices for People Who Are Homeless* (Dennis, Perret, and Seaman 2007).
3. Section III focuses on practical difficulties in determining the etiology of impairment in individuals with a history of substance use disorders, the use of psychoactive substances to manage trauma sequelae, and recommendations for clinicians regarding:
 - When to support a SSI/SSDI application by an individual with a substance use disorder;
 - The importance of discussing medical evidence of substance use disorders in letters to SSA supporting disability claims; and
 - Documenting impairments independent of active substance use for SSI/SSDI applicants.
 4. Section IV presents examples of appropriate documentation of impairment in letters written by clinicians in support of SSI/SSDI claims that have been allowed.
 5. The bibliography lists key references where more detailed information about substance use, disability, and homelessness is available.
 6. Appendix I provides a summary of Federal laws and court findings that form the statutory basis of the Social Security Administration’s DAA policy.

Appendix II provides a list of acronyms used in this document.

Appendix III provides links to important disability resources.

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INTRODUCTION

Disability precipitates and prolongs homelessness. Research suggests that physical and cognitive impairments are among the factors that increase the likelihood of becoming and remaining homeless if material and other assistance is lacking (CN 2002, CN March 2003). Homelessness itself can be an indicator of functional impairment and often a marker of disability. Indeed, people with disabilities constitute the “chronically homeless” population in America.² Any strategy to prevent and end homelessness must include adequate financial supports and an emphasis on recovery for those whose disabilities prevent them from earning sufficient income through employment to secure housing and other basic needs, including health care.

People who are homeless suffer disproportionately from mental impairments. Roughly half of all people with serious mental disorders have co-occurring substance use disorders and half of people with substance use disorders have co-existing mental illness, regardless of their housing status (NAMI, 2006). The prevalence of these disorders is considerably higher among people who are homeless (Bonin et al. 2004). According to conservative estimates, about 30 percent of homeless people have serious and persistent mental disorders, compared to about 3 percent of all adults (CN Oct 2006). Substance use disorders are also overrepresented among people without stable housing, who are estimated to be 2–5 times more likely to have these disorders than the general population (CN Oct 2006). Approximately two out of three homeless people in the United States (66 percent) have an alcohol or drug problem (Burt et al. 1999).

Disability assistance can mitigate health risks associated with homelessness. The most important sources of assistance for Americans with disabilities are two Federal programs – Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) – which provide cash assistance and eligibility for public health insurance (Medicaid/Medicare). Those who qualify for SSI/SSDI are also more likely than others to obtain available low-cost housing, including supportive housing (Dennis et al. 2007, Burt and Sharkey 2002, p. 38). By increasing access to healthcare and housing, these programs can mitigate the extraordinary health risks associated with homelessness, expedite recovery, improve quality of life, and help a number of beneficiaries achieve stability and participate in gainful employment (Dennis et al. 2007). Expediting SSI/SSDI benefits is therefore extremely important to protect and increase economic security, and to prevent and resolve homelessness.

Many homeless people considered likely to qualify for SSI/SSDI do not receive benefits.

Unfortunately, only a small proportion of the homeless population in America receives Federal disability assistance. In a national study of homeless assistance providers and their clients conducted in

² According to the Federal definition, a chronically homeless person is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years” (Collaborative Initiative to Help End Chronic Homelessness, notice of funding availability, 2000).

1996, only 11 percent of homeless service users received SSI and 8 percent had qualified for SSDI (Burt et al. 1999). Local studies conducted since then suggest that homeless disability claimants are denied benefits at significantly higher rates than other claimants, often for failure to negotiate the arduous application process, rather than for lack of severe medical impairments that meet SSA disability criteria.³ Case managers working in Health Care for the Homeless have reported that as many as 80 percent of their uninsured clients should have qualified for SSI or other disability assistance but had not done so (Post 2001, 72–73). People experiencing homelessness often fail to qualify for Federal disability assistance despite the high likelihood that they would meet eligibility requirements due to a variety of systems barriers – lack of access to health services, insufficient documentation of functional impairment, remote application offices, lack of transportation, and complex application processes. These obstacles are exacerbated by mental impairments and the lack of stability necessary to see a complex application process through to completion.

People whose substance use is deemed material to their disability are ineligible for SSI/SSDI. The 1996 termination of SSI and SSDI eligibility for individuals whose drug addiction or alcoholism is material to their disability was not intended to disqualify persons disabled by co-occurring impairments. Such denials have nevertheless been widely reported to occur at the initial stage of disability determination, many of which are reversed to allowances at the appeals level. Lack of sufficient medical evidence of impairment attributable to other disorders can delay access to essential services for some people and deter others from pursuing disability claims further.

People with impairments that would remain severe if they discontinued substance use may qualify for SSI/SSDI. Individuals with substance use disorders who present sufficient medical evidence of impairment that meets SSA disability criteria are entitled to SSI/SSDI, regardless of their current alcohol or drug use. This guide is intended to help these disability applicants by educating clinicians how best to document impairments independent of active substance use.

For a brief explanation of current DAA policy and exactly what kinds of evidence are required for persons with DAA disorders to qualify for SSI/SSDI benefits, read on. Information about the statutory basis of this policy, which clinicians may also find helpful, is available in Appendix I, beginning on page 31.

³ A review of disability claims submitted to the Disability Determination Services in Boston from July 2002 to September 2004 revealed that SSI/SSDI denials were 2.3 times more common than approvals for homeless individuals, while denials for housed claimants were only 1.5 times more common than approvals (O’Connell et al. 2004, p.7). An earlier study by the Homeless Subcommittee of the Massachusetts DDS Advisory Committee had found that over one-third of unsuccessful disability claims submitted by homeless persons (over a nine month period in 1998–99) were denied for lack of sufficient medical evidence or failure to keep appointments for a consultative examination (Post 2001, 61).

SOCIAL SECURITY POLICY ON DRUG ADDICTION & ALCOHOLISM (DAA)

Persons determined disabled by Social Security are not eligible for SSI/SSDI benefits if there is evidence that substance use is “a contributing factor material to the determination of their disability.” In other words, if there is medical evidence that an applicant’s impairments would not be severe enough to prevent substantial gainful activity (employment) if s/he stopped using alcohol or drugs, disability benefits would be denied. Only *after* SSA finds a claimant disabled, however, is the materiality of substance use considered.

SSA POLICY ON DRUG ADDICTION & ALCOHOLISM

- **DAA is considered ‘material’** only when the medical evidence establishes that the individual would not be disabled if he or she stopped using drugs or alcohol.
- **“Medical evidence of DAA”** means that the evidence is from an “acceptable medical source” (see [DI 22505.003B.1](#)) and is sufficient and appropriate to establish that the individual has a ‘medically determinable substance use disorder.’
- **Medically determinable substance use disorders** are medical conditions described as “substance dependence” and “substance abuse” disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (the DSM-IV)* — conditions in which the individual’s maladaptive pattern of substance use leads to clinically significant impairment or distress—not including medical conditions that arise from a mother’s use of alcohol or drugs during pregnancy (e.g., fetal alcohol syndrome or “crack baby” cases).
- **An individual’s own statement about his/her condition**, e.g., “I am an alcoholic” or “I am a drug addict,” is considered “evidence,” but [is] never sufficient and appropriate to establish the existence of DAA, even if that statement is reported by an acceptable medical source.
- **If there is no medical evidence of DAA**, no material determination is needed.
- **If DAA is material**, the individual cannot be considered to be disabled.
- **If DAA is not material**, the individual *can* be considered to be disabled.

SOURCE: *Social Security Administration’s Program Operations Manual System (POMS)*
Section DI 90070.050 DAA Material Determinations.
<https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0490070050!opendocument>

The Social Security Administration explicates its DAA policy as follows:

- (a) *General* If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.
- (b) *Process* we will follow when we have medical evidence of your drug addiction or alcoholism.
 - (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the determination of disability is whether we would still find you disabled if you stopped using drugs or alcohol.
 - (2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

- (i) If we determine that your remaining limitations would not be disabling, we will find that your drug addiction or alcoholism is a contributing factor material to the determination of disability.
- (ii) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of disability.

SOURCE: 20 CFR §404.1535[60 FR 8147, Feb. 10, 1995]; §416.935 [60 FR 8151, Feb. 10, 1995]

How SSA determines whether a DAA disorder is “material” to the disability or not:

CONSIDERATIONS IN MAKING A MATERIAL DETERMINATION

Adjudicators [are instructed by SSA to] take the following considerations into account when DAA is involved:

1. DAA Is Material Only When

SSA will make a finding that DAA is material only when the evidence establishes that the individual would not be disabled if he/she stopped using drugs or alcohol.

2. Key Factor to Consider

The key factor to consider when making a material determination is whether you would still find the individual disabled if he/she stopped using drugs or alcohol. In doing this, decide:

- Which of the current physical and mental limitations, upon which you based the current disability determination, would remain if the individual stopped using drugs or alcohol; and
- Whether any or all of these remaining limitations would still be disabling.

3. Examples of When DAA Is Material

The following are some examples of when DAA is material.

- a. The only impairment is a substance use disorder.
- b. The individual's other impairment(s) is by itself not disabling; e.g., a hearing impairment that is “not severe.”
- c. The individual's other impairment(s) is exacerbated by DAA and the evidence documents that, after a drug-free period of 1 month, the other impairment(s) is by itself not disabling.

*SOURCE: SSA POMS DI 90070.050 DAA Material Determinations.
D. Process - Considerations in Making a Material Determination.
<https://s044a90.ssa.gov/apps10/poms.nsf/lrx/0490070050!opendocument>*

These considerations also apply to “impairments caused by substance abuse, e.g., organic brain damage, liver problems, neuropathy. If the functional limitations caused by these impairments would remain if the substance abuse were to stop and are disabling alone or in combination with other impairments, the claimant is disabled independent of DAA and eligible for benefits” (Landry 2006).

Policy Implementation and Impact

1. Inconsistent application

- Application of the concept of “materiality” varies from state to state, from Disability Determination Service (DDS) to DDS. Interpretation of this standard is extraordinarily difficult.
- Court rulings on appeals vary from state to state.
- Stigma about drug and alcohol use may influence some disability determinations.

Disability determinations and court rulings vary as adjudicators’ interpretations of the complex notion of materiality differ and rely upon subjective determinations (Perret 2006). Providers of Health Care for the Homeless and other advocates report widely varying application of DAA policy in various jurisdictions nationwide. Stigmatization of persons with substance dependence often results in the presumption of voluntary drug misuse and willful resistance to behavioral change. Federal legislation passed in 1996 (Public Law 104-121) resulted in new limitations on access to health care and material support for persons with behavioral health disorders (see Appendix I, p. 31). All of these factors create an unfavorable environment for SSI/SSDI claimants with substance use disorders, regardless of their co-occurring impairments.

2. The difference between DAA policy and scientific understanding of addiction

During the last 25 years, scientific research has begun to reveal the biochemical mechanisms by which mood-altering drugs – including caffeine, nicotine, alcohol, opiates, stimulants, and sedatives – change brain structure and function, thereby triggering addiction and dependence (compulsive drug seeking and use) in persons with particular neurological vulnerabilities. There is evidence that the biological changes persist long after drug use has ceased. From these findings has evolved the current theory of addiction as a chronic brain disorder with intrinsic behavioral and social-context components, similar to other forms of mental illness. (WHO 2004, CN 2006, CN 1998) Indeed, substance use has for decades been categorized as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV), the standard psychiatric reference used by mental health professionals worldwide.

The etiology of substance dependence, like many other health conditions, is a complicated blend of genetic, psychosocial, and environmental factors. Biologically, addiction is currently understood as a disorder of neurotransmission associated with the effects of certain drugs on particular parts of the brain. Significant scientific advances have been made in understanding the biology of addiction and the neurological effects of addictive drugs. The view of substance dependence as a moral and legal issue may mean that treatment approaches and programs operated according to explicit public policy are not grounded in evidence-based research. This attitude is especially detrimental to people without homes (see CN 2006, NLCHP 1999, CN 1998). In addition, it is inconsistent with the traditional understanding of drug addiction or alcoholism as a public health problem.

- At least half of severely mentally ill homeless people are estimated to have a co-occurring substance use disorder.
- Substance use often exacerbates cognitive impairment over the long term, making recovery and response to traditional addictions treatment more difficult.
- Substance use disorders wreak havoc with personal finances and significantly increase other health risks – exposure to infectious diseases and violence, social isolation, and other hardships associated with extreme poverty.
- Co-occurring mental illness and substance use increase the likelihood of chronic homelessness. (CN 2000)

3. Impact of DAA Policy on personal and public health

1996 DAA policy changes resulted in:

- Limited or non-existent access to Medicaid in many states for persons who lost SSI benefits;
- Restricted access to treatment for substance abuse and co-occurring disorders;
- Increases in the incarceration of homeless people;
- High numbers of people in jail or prison with co-occurring disorders;
- Increased difficulty accessing employment for those with criminal drug convictions, even for possession;
- Limited or non-existent access to housing; and
- Increases in the incidence and duration of homelessness. (Hunt and Baumohl 2003, NLCHP 1999)

4. Access to SSI/SSDI plays a role in preventing and ending homelessness

Lack of income, health insurance, and social support makes recovery from substance dependence virtually impossible for impoverished people. Access to appropriate housing and comprehensive, well-integrated, client-centered services provided by qualified staff is key to preventing and ending chronic homelessness for individuals with co-occurring impairments. Programs recognized for providing effective treatment to homeless people with substance use disorders consistently emphasize that a continuum of comprehensive services is needed to address their safety, health, social and material needs – including help obtaining food, clothing, stable housing, identification papers, financial assistance and entitlements, legal aid, medical and dental care, psychiatric care, counseling, job training, and employment services. (Kraybill and Zerger 2003)

Assisting individuals with SSI/SSDI and Medicaid applications prior to discharge from hospitals and jails can help to prevent homelessness. Programs that facilitate access to housing, income, and supportive services have demonstrated reductions in shelter and emergency department use, hospitalization and incarceration, as well as improved treatment engagement (Culhane et al. 2002; Zerger 2002). To the extent that DAA policy or its inappropriate implementation delays or impedes access to such services for people with substance use disorders and co-occurring impairments, it is contrary to best practices in preventing and ending homelessness (Dennis et al. 2007, CN 2005).

CO-OCCURRING DISORDERS & SSI/SSDI: CLINICAL CONSIDERATIONS

Practical Difficulties in Determining the Etiology of Impairment

Clinically, it's extraordinarily difficult to determine which health conditions contribute to particular impairments. Multiple co-morbidities that are characteristic of homeless individuals complicate diagnosis of the underlying cause(s) of disability. For example, cognitive impairment in a homeless patient with HIV may be indicative of AIDS-related dementia, depression, opportunistic infection, or a side effect of medication, including chronic "self-medication" with psychoactive substances. Symptoms of some diseases mimic organic brain disorders – e.g., confusion, incoherence, and distorted speech caused by very low blood sugar levels in patients with uncontrolled diabetes (CN March 2003). People with co-occurring disorders experience them simultaneously, interactively, and synergistically.

SSA acknowledges that it is often difficult or impossible to separate functional limitations resulting from drug or alcohol use from those resulting from other mental impairments and recognizes that *an individual should be found disabled when it is not possible to separate limitations* (DAA Q&A Teletype: <http://tinyurl.com/3nn4y>)

Use of Psychoactive Substances to Manage Trauma Sequelae

Trauma – physical, sexual, and emotional – is both a cause and a consequence of homelessness, regardless of age or gender. Among the most serious cognitive disabilities seen in homeless people are those resulting from traumatic brain injury, commonly caused by vehicular accidents (being hit by cars), falls, assaults, gunshot wounds, and violent shaking. There is evidence that homeless individuals bear a disproportionate risk for severe head injury, which increases with prolonged homelessness (CN March 2003). Other cognitive impairments commonly seen in individuals who are homeless are associated with acquired brain injury secondary to mental illness, chronic substance abuse, infection, strokes, tumors, poisoning, or near drowning. In addition, a history of trauma, including sexual abuse as children and as adults, often leads to significant ongoing problems that interfere with functioning.

More than 90 percent of women seen by Health Care for the Homeless providers have experienced severe physical, sexual or emotional abuse by intimate partners or spouses, and 43 percent were sexually molested as children (CN May 2003). Physical abuse during childhood is a powerful risk factor for adult homelessness, and violence experienced by children and adolescents often continues after they become homeless. Those who are mentally ill or under the influence of drugs or alcohol are even more vulnerable to attack and less likely or able to seek help afterwards.

There is a strong correlation between physical/sexual abuse and substance dependence among people who experience homelessness (CN 1999). Many of these individuals suffer from posttraumatic stress

disorder (PTSD). Victims of trauma may use psychoactive substances to manage the overwhelming negative feelings that result from such abusive experiences. Experts in the care of trauma victims speak to the difficulty these clients have feeling safe, and homelessness exacerbates their feelings of insecurity. Addictive substances quell some of these feelings, even if temporarily.

These are some of the reasons why co-occurring mental health and substance use disorders are more common among homeless than housed populations (Perret 2006).

Beginning at age 8, Mr. M. used medications and liquor found in his home to cope with the severe physical, emotional, and sexual abuse he experienced as a young child. “I took whatever was around to get me into my dream world — that’s what helped me to survive what happened to me as a child.” His addiction masked not only psychological trauma but also undiagnosed mental health issues he only learned about when he stopped using [addictive substances], two decades later. Mr. M. describes how his trauma affected his recovery: “[When I stopped using drugs,] those feelings would start coming up again. I started feeling like my perpetrator was in the room.”

– HCH Clinicians’ Network. *Addiction on the Streets; October 2006 Healing Hands*

Recommendations for Clinicians

1. When to support/encourage a SSI/SSDI application by an individual with a DAA disorder:

- *Support disability claims submitted by persons with substance use disorders if there is evidence that their impairments meet or medically equal the criteria of a medical listing⁴ or prevent them from engaging in substantial gainful activity (or, in a child, result in comparable functional limitations), and the impairment is likely to remain if the patient were to stop using alcohol or other drugs* (O’Connell et al. 2004).
- *Advise such persons to apply for SSI/SSDI if they have not already done so.* Some clinicians wrongly believe that people who are actively using psychoactive substances cannot or should not receive Social Security benefits, despite any other disabilities they may have, and erroneously discourage them from applying (Rosen and Perret 2005). Individuals with impairments that meet SSA disability criteria independent of active substance use are eligible for SSI/SSDI benefits. Empirical research suggests that “few, if any, adverse effects result from providing federal disability benefits to persons with addictive disorders” (Frisman and Rosenheck 2002). Several research studies conducted over the past decade have demonstrated that people with addictive disorders who receive Federal disability payments are *not* more likely than those engaged in gainful employment to purchase alcohol or drugs or to increase their substance use, and that SSI/SSDI benefits can significantly improve their quality of life (Frisman and Rosenheck 2002, Rosen et al. 2006).

⁴ as specified in SSA’s Medical Listing of Impairments: <http://www.socialsecurity.gov/disability/professionals/bluebook/>

2. Providing medical evidence of impairment:

- ***Make sure that medical records submitted to SSA specify one or more diagnoses made by a medical professional.*** An applicant without evidence of an independent diagnosis from an acceptable medical source will be denied benefits (Rosen and Perret 2005). (See O’Connell et al. 2004, p. 16, for the definition of an “acceptable medical source.”)

“‘Disability’ is an administrative/legal determination made by an agency (such as SSA or an insurer), not a medical diagnosis. It is the conclusion of an administrative process conducted by a disability determination service. Statutes and regulations make it clear that SSA decides if a person is disabled, not medical providers. The role of clinicians and others is to provide documentation, or evidence of disability. In other words, medical professionals are asked to provide the facts — diagnoses and functional limitations — that are necessary to determine disability. That’s why a simple statement such as ‘my patient is disabled’ is not sufficient.”
(O’Connell et al. 2004)

- ***Ensure that functional impairments and medical diagnoses are thoroughly described in the material submitted to SSA/DDS.*** Typically, medical records do not provide sufficient evidence of functional impairment to support a disability claim based on mental impairment. Clinical staff should work collaboratively to describe such functional impairment, its linkage to the claimant’s medical disorders, and how the impairment affects the person’s ability to engage in substantial gainful activity (i.e., employment).

3. Discussing substance use in letters to SSA supporting disability claims:

- ***Address any medical evidence of a substance use disorder explicitly in your letter to SSA.*** Substance use is commonly documented in homeless patients’ medical records. References to substance use are often found in emergency room and specialist notes even for nonusers, due to the strong prevailing stereotype that all homeless people have drug and alcohol problems (O’Connell et al. 2004). Failure to mention a known history of substance use may undermine the credibility of the medical source. When substance use is involved, determination of disability is confounding for both DDS adjudicators and administrative law judges, especially when the clinical analysis of the claimant’s substance use and co-occurring impairments is unclear. This lack of clarity often leads to incorrect eligibility denials. It is critical, therefore, to address explicitly how impairments that are unrelated to active substance use affect the claimant’s ability to work.
- ***Advise SSI/SSDI applicants to be candid about past or current drug/alcohol use.*** Many applicants fear their claim will be denied if they admit drug or alcohol use. However, any inconsistency between oral accounts and medical records could undermine the applicant’s credibility. This can result in a finding of “not disabled.” Assure the applicant that it is possible for SSA to make a correct disability determination when given thorough, accurate, and complete medical and functional information. (Rosen and Perret 2005)

- **Recommend a Representative Payee and assure that one is available.** If the applicant is considered incapable of managing his or her own SSI/SSDI benefits or is at risk of spending cash payments on alcohol or drugs, recommend in a letter to the Social Security Administration that s/he be required to receive cash benefits through a Representative Payee. Well-run charitable or public agencies may be preferable as payees for such individuals, who are easily victimized (O'Connell et al. 2004). (For more information about the Representative Payee Program, see <http://www.ssa.gov/payee/>; Rosen and Perret 2005, 75–81.) Besides asserting the need for a payee, it is critical to assure the availability of programs that provide such a service. Recommending a payee without ensuring access to one is futile.

4. Documenting impairment independent of active substance use:

When a person is determined disabled, considering all impairments, and there is evidence of alcoholism or drug addiction, SSA must decide whether that person would still be disabled if drug or alcohol use stopped.

Chronic and irreversible medical illnesses and fixed functional deficits that result from the use of alcohol and other substances may qualify as eligible impairments. Examples include cirrhosis, cardiovascular disease, organic brain syndrome secondary to alcohol use, and loss of limb function from infections related to intravenous drug use (O'Connell et al. 2004). Medical providers can effectively support such disability claims by providing evidence of co-occurring impairments that would not disappear even if the individual were sober and abstinent from alcohol and drug use.

For claimants who are actively using psychoactive substances:

- **Take a comprehensive longitudinal history.** Ask the patient about issues such as trauma, abuse, education and learning problems, employment history and problems, legal history, emotional and physical health (Rosen and Perret 2005). (For guidance in asking these questions, see Bonin et al. 2004.) Comprehensive histories are essential to understand the context of an individual's substance use and factors that may influence such use. Elicit this information sensitively, with open-ended questions that allow for elaboration.

Avoid words that label, such as “sexual or physical abuse,” since victims of abuse may not understand such experiences in this way. Questions such as “What happened when you did something growing up that was considered naughty?” can help elicit information about abuse without having to name it as such. Ask if the individual was ever in foster care, which is a significant predictor of risk for post-traumatic stress disorder (see Pecora et al. 2005). Explore learning problems, not just years of education completed. To understand the extent to which substance use may or may not contribute to the individual's impairments, learn more about his or her personal history.

- *State whether or not there is reason to conclude that the individual's impairment(s) would resolve if substance use ended*, and report all irreversible adverse effects of this problem. If it is impossible to determine whether a patient's impairment(s) would be reversible with abstinence, state this explicitly (O'Connell et al. 2004).

For individuals with chronic pain or mental health disorders:

- *It is helpful to state that alcohol and drug use may represent attempts at managing symptoms of the underlying illnesses*, particularly if the medical provider making this statement has observed the patient over an extended period of time (Ibid.). Roles that substance use can play in "self-medicating" underlying mental illness include: energizing persons with major depression, reducing manic and depressive symptoms of bipolar disorder, suppressing voices and other psychotic symptoms associated with schizophrenia, and repressing and anesthetizing overwhelming feelings caused by trauma or PTSD. Describing the sequelae of trauma that many homeless people have experienced and continue to experience can provide a context for substance use that is important for DDS to understand. It is important that your reports to DDS include such details. (Perret 2006)
- *Ask the claimant whether reported problems occur when s/he is sober or only when using alcohol or drugs*. For example, if a person states that s/he takes substances to dull the fear and discomfort created by hallucinations, the clinician could conclude that the mental disorder is the problem and that the symptoms are likely to remain, even in the context of abstinence from drugs. Conversely, if an individual reports that s/he manages activities of daily living fairly well while sober but avoids these tasks when using or withdrawing from substances, this person might be found not disabled (i.e., ineligible for SSI/SSDI). (Rosen and Perret, 2005)
- Since addiction is a brain disease marked by recurrent relapses, it is helpful to *document the claimant's physical and mental status during periods of abstinence*. Such periods may occur during recovery, with or without treatment. Periods of abstinence may also occur during incarceration or hospitalization.
- If the claimant has relapsed at the time of assessment, it is also helpful to *comment on any additional damage sustained during the current relapse* (Ibid.).

Clinicians and others who work with homeless people are well aware of the extent of substance use in this population. A comprehensive understanding of substance use and its relationship to other disorders and impairments is critical to the appropriate documentation of disability in support of SSI/SSDI claims.

Readers are invited to consult the bibliography for more comprehensive information about the diagnosis and treatment of individuals with co-occurring substance use disorders and mental impairments (see especially Zerger 2002, Kraybill and Zerger 2003, CSAT 2006). In addition, the National Health Care for the Homeless Council encourages primary care practitioners to seek further training in the care of individuals with substance use disorders (see the American Society of Addiction Medicine for more information: <http://www.asam.org/>).

“No matter how strong one’s belief in the importance of abstinence or sobriety, remember that SSI is an entitlement program that should be available to all persons meeting SSA disability criteria, and that SSDI is an insurance program that presupposes a history of work to which beneficiaries have already contributed in some measure through payroll taxes. Too many homeless people with disabilities do not get the assistance they urgently need. “

— *Documenting Disability: Simple Strategies for Medical Providers*, p.25
(O’Connell, Quick and Zevin 2004)

EXAMPLES OF APPROPRIATE DOCUMENTATION

The following letters and excerpts of letters, written by clinicians in support of disability claims filed by individuals with substance use disorders and co-occurring impairments, resulted in allowances (approval of SSI or SSDI disability benefits). These examples focus on the documentation of functional impairments independent of substance use.

- A. This letter establishes the treating source's long-term relationship with the claimant, adding credibility to his observations regarding the relationship between the claimant's substance use and his psychiatric impairments. The physician recommends use of a Representative Payee if disability benefits are awarded. (p. 14)

- B. This letter is a good example of the differentiation of effects of the patient's alcohol use from his other presenting issues. Although the impact of alcohol use on the applicant's physical and mental conditions is certainly powerful, the physician clearly outlines the other causes of disability; he is also careful to state explicitly that that his patient would be disabled (and has, in fact, remained disabled) during periods of sobriety. (p. 16)

- C. This letter addresses the issue of separating the effects of the claimant's substance dependence from his co-occurring impairments, in the absence of known periods of sobriety. The fact that the author is a certified specialist in Addiction Medicine adds weight to his opinion that the client's "health seeking behavior...is atypical for patients primarily with stimulant dependence as their diagnosis," supporting the conclusion that the patient's Bipolar disorder and personality disorder, in addition to his chronic back pain secondary to an untreated spinal condition of long standing, are primarily responsible for his disability.⁵ (p. 18)

- D. This letter details evidence to support the conclusion that a medical listing of impairment is met. Presenting such evidence is critical; merely stating that the claimant meets a listing is insufficient in many jurisdictions. (p. 21)

- E. & F. These letters have been abbreviated to emphasize the documentation of functional impairment independent of substance use. They offer an especially good illustration of documented activities of daily living. Because DDS adjudicators rarely interview or even see applicants, it is important that supporting documentation offer as clear a picture as possible of the impact of the claimant's impairments on day-to-day functioning. (pp. 24, 26)

⁵ The disability claims described in examples A–C were sent to an administrative law judge known to be very strict in his rulings on claims involving DAA issues. The treating physician provided information at the appeals hearings as an expert in addiction medicine, reiterating information contained in his letters to DDS. Disability benefits were ultimately awarded.

CITY AND COUNTY OF SAN FRANCISCO



Department of Public Health

Homeless Programs

Tom Waddell Health Center

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EXAMPLE A

Medical Summary [10/04]

S.L.

I have followed S. L. as his primary care treating physician since 8/15/03. I have seen him approx. every 6 weeks since that time and at times more frequently. Mr. L. is a 54 year old man who initially presented with a history of mental health problems, alcohol abuse, and a history of back problems and hospitalization for “pneumonia and congestive heart failure.” On presentation he was homeless and sleeping on the steps of a church. He was unable to access services due to severe anxiety and shame. He reported a career as a ballet dancer and choreographer both in the United States and Europe. He is currently abstinent from alcohol and seeking psychiatric treatment. His problems and course in summary:

Bipolar disorder: the patient was diagnosed with bipolar disorder in New York City several years ago. He reports greater than 20 years of episodic severe depression, alternating with periods of feeling invincible and starting big projects. Symptoms of his disorder include anxiety with severe panic attacks, many losses including failed relationships, lost friendships, homelessness, and severe interference with his career. He reports bulimia and anorexia as symptoms he has struggled with for many years. He reports episodes of using alcohol to blunt his feelings of irritability, depression, and anxiety. Previous treatment had included Valium and ativan. He reports being told that he might need medications to stabilize his mood but never took these nor believed he needed them. Initial attempts at prescribing Valproate (Depakote) to him were unsuccessful due to his perception of side effects. He was referred to a psychiatrist (Dr. Hammond) and psychotherapist at Mission Mental Health Center. He was prescribed anti-psychotic medication but did not adhere well to this. Most recently he has been restarted on Valproate which he has tolerated since he has been abstaining from alcohol. His poor insight and the presence of a co-occurring narcissistic personality style or disorder have complicated his psychiatric care.

Musculoskeletal complaints: the patient reports a history of problems with his back, extremities, and “diaphragm” which result from his years as a dancer. He has received various therapies in the past for these and reports he can no longer dance professionally due to his pain but otherwise copes with his chronic pain. He has not requested further work up or treatment of his pain.

CHF/pneumonia/: these were apparently acute and resolved problems. There are currently no signs of heart or lung problems.

Alcoholism: The patient has a history of drinking in an excessive and uncontrollable manner. He has required several episodes of medically supported detoxification while under my care. He participated in a residential rehab program at Baker Places and was abstinent for 3 months but continued to have severe psychiatric symptoms and relapsed soon after completing the program. He required hospitalization in July 2004 after being assaulted when intoxicated. He had severe alcohol withdrawal at that time and required medical detox. He had a seizure which we have assessed as alcohol related at that time. He has abstained from alcohol since that time and reports he has had 13 years of sobriety between 1989 and 2002 and feels he has the tools to do this again especially if his underlying psychiatric issues are stabilized.

Multiple somatic complaints: The patient has had frequent complaints of respiratory, GI, and GU complaints. These do not seem to be caused by any underlying severe disorder but reflect somatization of his underlying psychiatric disorders.

In Summary: S. L. has a long history of untreated Bipolar disorder and alcoholism. Observation of him during periods of abstinence strongly suggests that his psychiatric disorder is the primary diagnosis. He has been unable to engage in any Substantial Gainful Activity during the period of time I have been treating him. At times he has embarked on volunteer work or started planning for large projects but has been unable to follow through with these commitments. His insight into the nature of his problems is low. With continued treatment he has a guarded chance of recovery and improvement but I would expect this to require several years of adherence with medications, psychotherapy, and abstinence from alcohol. If Mr. L. were to be awarded benefits I would recommend that he have a payee for money management as his illness has a severe effect on his judgment.

Barry Zevin MD
Diplomate American Board of Internal Medicine

CITY AND COUNTY OF SAN FRANCISCO


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EXAMPLE B**Medical Summary Update 2/9/06**

S.L.

This is a follow up to a letter written in 10/04. I have continued to follow this patient as his primary care treating physician. I have seen him at intervals of about monthly and at times weekly. Unfortunately the patient's condition has deteriorated since that time. He has attempted paid or volunteer work a few times in the past year but these have ended quickly due to his inability to maintain psychiatric stability. This will update the patient's problems as outlined in the previous letter:

Bipolar disorder / narcissistic personality disorder: The patient has now been taking Divalproex sodium (Depakote) on a regular basis. He has had good adherence and reports the medication helps avoid what he describes as his manic episodes. He still has episodes of severe depression which have triggered relapses to drinking alcohol several times over the past 4 months. He has had less episodes of panic attacks in the past year but continues with occasional (about once a month) very debilitating panic and daily anxiety effecting his ability to function. He has had several referrals and episodes of treatment in the mental health system since the last report. Each of these has ended with patient dissatisfaction and exacerbations of the patient's condition. He has also had conflict and increased stress related to his attempts to return to working as a ballet instructor. He was apparently accused of some type of inappropriate behavior toward a young student. These conflicts and difficulties are consistent with his diagnosis of narcissistic personality disorder. Unfortunately no psychotherapy has been effective as of yet in helping the patient cope with this problem. In the past 6 weeks the patient has had at least 6 emergency room visits due to feelings of severe depression, anxiety, and suicidal behavior or ideations. The patient is socially very isolated at this time and is markedly impaired in this area. He is having a very difficult time keeping up with basic self care. He has markedly impaired concentration, persistence, and pace.

Musculoskeletal complaints: The patient continues with complaints of back and joint pain. These seem to be degenerative in nature. They limit him from exercising as he would like to and would likely limit his ability to do exertional work. He has not requested treatment or further diagnostic studies for these problems.

Alcoholism: The patient maintained sobriety for greater than 1 year during 2004-2005. He reported no or low amounts of craving except during periods of increased anxiety and depression. In the past 3-4 months he has had several drinking episodes (binges). These have resulted in his depression and anxiety getting worse. We treated his alcoholism with extensive counseling and also tried naltrexone. He does not seem to tolerate the medication well and as of yet he does not seem to be having much benefit. He had one episode in residential medically supported detox. He left before completing the full course of treatment (3 weeks) again related to his narcissistic personality disorder. The relationship of his mental illness to his alcoholism continues to be very strong. His

mental health symptoms do not abate during periods of sobriety. These symptoms do become more dangerous when he is drinking as he becomes more impulsive and potentially acts on his suicidal ideations.

In summary: The patient's condition has somewhat deteriorated over the past year. The patient meets listings in section 12.04 and 12.08 in the Disability Evaluation Under Social Security. The patient does have a diagnosis of alcoholism and this is of serious concern as outlined above. Observation of the patient during extended periods of sobriety and based on past history indicate that the patient's impairments exist independent of the patient's alcoholism and alcoholism is not material to the patient's disability. Please feel free to contact me if I can be of any further assistance.

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EXAMPLE C

Medical Summary
V. H.

2/9/06

I have followed V. H. as his primary care treating physician since 8/6/04. I have seen him at intervals of 1 month or more frequently. The patient presented for care with complaints of back pain, pain from inguinal hernia, history of bipolar disorder, and homelessness. The patient perceived himself as quite ill but also expressed the expectation that he would soon be able to return to work. The patient has been an extremely high user of medical services due to physical illness and mental illness. Since 7/04 the patient has had 166 encounters in our health network alone (San Francisco General Hospital and Tom Waddell Health Center). He has had numerous visits at other hospitals and crisis centers which I do not have records of but have been reported by the patient. He has had conflict with staff and has appeared to be threatening and possibly violent at times. Education and redirection toward more appropriate and healthier uses of the healthcare system have not been effective. This likely reflects the seriousness of his mental health disorders. The patient's medical problems include:

Chronic Back Pain: The patient complains of severe and intractable pain in his lower back. He reports onset of this pain after an injury in 2000 in which he reports "disc rupture of L4 and L5." Medical records from that time are not available to me. Lumbar spine X-Ray shows rotatory levoscoliosis, osteophytes at the level of L4 through L5, narrowed disc space with vacuum phenomenon seen at the level L5-S1. This is consistent with the patient's history and subjective complaints. He has been treated with NSAIDS which have not been effective. The patient is treated with MS Contin (extended release oral morphine) which has been partially effective for the patient's pain. He has had constipation and some sedation as a side effect. With use of the morphine he is able to sleep more comfortably and ambulate. He still has severe pain with bending or lifting any weight. He is not interested in considering surgical options and has been too unstable to follow up for physical therapy.

Inguinal hernia recurrent: The patient has had R and L inguinal hernias and has had at least 3 surgeries in the past year. His post-operative self care has been poor due to his homeless status and poor judgment. He does have pain in both inguinal areas. His ability to stand long periods or walk for expended periods is effected by this pain.

Asthma/COPD/bronchospasm: the patient has an extensive smoking history. He is short of breath at times and this is so severe that he must go to the hospital emergency department several times each year. CXR shows increased lung volumes suggestive of COPD. Office spirometry was within predicted range with small improvement after inhaled bronchodilator. The patient uses albuterol and atrovent and steroid inhalers regularly. He may have periodic exacerbations of asthma. His pulmonary symptoms may also be exaggerated by his mental health disorders. Smoking cessation counseling is underway and full PFT's would be beneficial.

Bipolar Disorder: The patient reports bipolar disorder initially diagnosed in 1990. He also reports he was “hyper” as a child but it is unclear if this was ever diagnosed or treated. The patient reports a family history that his mother had manic depression and committed suicide in 1988. The patient reports his symptoms as episodes of severe depression and episodes of acting impulsively and with very poor judgment. He reports he did well when prescribed Lithium between 1990 and 1999. He reports stopping because he thought he was better. He has had many losses and problems since that time including loss of his home and jobs. The patient has received treatment at Westside Crisis Clinic and South of Market Mental Health Clinic. He was initially prescribed several medications and reports adherence to them. He has been non-adherent with appointments and follow up and has not been on medications regularly for approximately the past year. At times he has acted in an impulsive manner here in the clinic and staff have felt threatened and that he was capable of being violent. He has not been physically violent in the clinic but has been asked to leave at times.

At times the patient has appeared quite depressed in the clinic. He is often quite irritable and describes episodes that he can not name as irritability but are quite typical of bipolar disorder. He has exhibited grandiosity at times. He has kept most of his appointments and been late at times. His hygiene and self care has ranged from adequate to poor. He has not been able to obtain or maintain housing and usually uses homeless shelters. He expresses high levels of guilt and shame about his condition at times and minimizes and denies his problems at other times. He appears to have few or no friends and no social support system. The patient has marked impairments in his concentration, persistence and pace. In the time I have been seeing him his condition has somewhat worsened. We continue to redirect him and move him toward obtaining mental health care. He seems overall hopeless that he will be able to benefit at this point from such care.

Substance Abuse: The patient initially reported occasional alcohol use and later noted “recreational” cocaine use. He reported that he felt these were not a problem for him. Further evaluation over time indicates the patient does have a substantial problem with stimulant abuse of crack cocaine. He does not appear to drink alcohol regularly and does not appear to abuse opiates or other sedatives. He has never reported to the clinic in an intoxicated state. He has received very extensive counseling from myself and our staff and been offered assistance. The patient appears to have some insight and acceptance of this as a problem which represents progress from his initial presentation. He has not moved toward obtaining treatment and we continue to use motivational enhancement techniques. The patient’s cocaine use clearly exacerbates his underlying medical and psychiatric conditions.

Somatization and extensive use of medical system: The patient has had numerous complaints of pain and numerous other symptoms for which he has presented to emergency rooms and urgent care centers. He does not appear to have severe physical problems causing these symptoms but they appear to represent a high degree of anxiety and somatization. Review of these records demonstrates that the patient has not been making these visits as “drug seeking behavior.” He reports to the medical staff that he is receiving opiate medication from his primary care physician and does not ask for additional medicine. The visits appear to be impulsive behavior and help seeking. Efforts to redirect this help seeking to more productive ends have failed thus far but will continue.

Summary

Mr. H. is an unfortunate 48 year old man with physical and mental health problems. He has severe back pain requiring opiate analgesic treatment. It is likely that the extent of this back pain would prevent him from doing any activities that required more than minimal exertion. He has bipolar disorder which manifests as depression at times and irritability and impulsiveness. He has exhibited very poor judgment. He has had multiple losses and been unable to function adequately to obtain his own housing. He uses crack cocaine which exacerbates his condition. I do not believe the patient has had any extended period clean from drugs during my care of him to evaluate the severity of his impairments without drugs. His health seeking behavior is disordered in a way atypical for patients primarily with stimulant dependence as their diagnosis. His symptoms and behavior are more typical of Bipolar disorder and probably a personality disorder than stimulant abuse alone.

As a physician with extensive experience in addiction medicine it is my best judgment that this patient would have severe impairments even if he were abstinent. The patient's prognosis for improvement is guarded. His back pain is likely to continue or worsen as he ages. His mental health disorders while treatable are not curable. Poor judgment about the need for adherence to medication is particularly common in bipolar disorder. This patient's impairments taken together meet or equal listings in Disability Evaluation Under Social Security. I believe this is the case independent of the patient's substance abuse. If this patient were awarded benefits I would recommend that he have a mandated payee due to his poor judgment and likely inability to provide minimal food, clothing, and housing for himself.

Please feel free to contact me if I can provide any further information.

Barry Zevin MD

Diplomate American Board of Internal Medicine

Certified in Addiction Medicine
American Society of Addiction Medicine

EXAMPLE D

February 22, 2006

To Whom It May Concern:

I am writing this letter in regards to Mr. J. S., Case # 1111111 and SS# 111-11-1111. This letter is intended to give the Social Security Administration information regarding Mr. S's current status as it relates to his application for SSI. I am currently Mr. S's Treating Source. We have had an ongoing treatment relationship since February 2005. I have also consulted on this case with Mr. S's former therapist George Gilman, LCSW and his Case Manager, Jennifer Alfredson, APSW. Mr. Smith was admitted into the Health Care for the Homeless Case Management Program in August 2005.

Mr. S. is not currently engaging in any Substantial Gainful Activity.

Mr. S. was diagnosed with Bipolar Disorder Type 1 by myself, Dr. Steven Ortell, in February 2005. Prior to February 2005, Mr. S's mental impairments were undocumented. Mr. S. had been living in the woods, outdoors, since 2002 and was not seeking any treatment for what he described as problems with his thinking. He was engaged by the Health Care for the Homeless – Street Outreach. He agreed to begin seeing a psychiatrist at Health Care for the Homeless' Recovery Behavioral Health Clinic. He also agreed to begin working with the Red Cross Outreach Nurse and was referred to a Safe Haven Shelter.

Mr. S's impairments became clearer once he was staying at Safe Haven, where they have only 8 residents and staff present 24 hours a day. Ms. Alfredson was able to inform this writer about the occurrences at Safe Haven. Mr. S. did not respond appropriately to the supervision at Safe Haven. He did not get along with other residents or the staff and mostly stayed to himself. He had trouble understanding that his situation differed from the other residents. He would become very irritable when comparing his situation to others and would ask why he can't get a bus pass or other things that residents with income had access to. He expressed paranoia about the other residents and the staff. He demonstrated an irritable and labile mood that inhibited his ability meet the expectations of staff in the area of household chores and/or keeping his room in order. Mr. S. demonstrated poor judgment when he had trouble following the rules and was eventually asked to move out due to his chronic non-compliance with the curfew of 10 PM. When Mr. S. left the Safe Haven in September 2005, he went back to living in the woods, outdoors. He was quite upset about the consequence of his poor judgment. I think that Mr. S. does demonstrate a severe impairment.

I think that Mr. S. does meet the criteria listed in the Social Security Blue Book, section 12.04 for Affective Disorders. Mr. S. does have a disturbance of mood, accompanied by partial manic and depressive symptoms. Mr. S. meets the criteria of 12.04 (A) in the following way: Mr. S. has depressive symptoms that were first assessed and documented in February 2005. Mr. S. reported a loss of interest in all activities, a sleep disturbance, feelings of guilt and worthlessness, difficulty concentrating and feeling very paranoid. Mr. S. avoids public transportation due to paranoia and is extremely guarded with Outreach Workers and most other staff that he has come into contact with since being engaged by the Outreach Worker. Mr. S. has also experienced symptoms of mania. Mr. S. has been observed to have pressured speech, flight of ideas, and he is easily distracted. He also gets involved in activities that have negative consequences, such as fighting with people on the streets have led to both injury and incarceration. Again, Mr. S. reports feeling very paranoid. As a

result of the previously described impairments, Mr. S. was diagnosed with Bipolar Disorder and has had periods manifested by the full symptomatic picture and currently is characterized by both depressive and manic symptoms.

And, Mr. S. meets the criteria of 12.04 (B) in the following way: Mr. S. evidences a marked restriction of activities of daily living. Most notably, Mr. S. has been unable to maintain a residence since 2002. Since that time, he has been living outdoors in a wooded area on the East side of Milwaukee. Mr. S. does not appropriately care for his personal grooming and hygiene. His appearance is usually odorous, his clothing dirty, and his hair appears dirty and unruly. Mr. S. has not had the opportunity to demonstrate the ability to pay bills, cook, or shop due to his having no income and living outdoors. When Mr. S. was living at Safe Haven from July until September 2005, his grooming and hygiene did improve somewhat. At the Safe Haven, he still did not have the opportunity to cook or shop. Mr. S. also avoids public transportation due to his paranoia, which then causes anxiety.

Mr. S. has marked difficulties in maintaining social functioning. Mr. S. has demonstrated that he is unable to interact appropriately with other individuals. Mr. S. does not have any relationships with any of his family, which includes his father and six living siblings. Mr. S. has referred to working for temp agencies where he would only work for a short time and he asked to not return. Mr. S. often refers to arguing with others and specifically, he is not welcome to visit his girlfriend because the people she stays with will not allow him to come to their home. When Mr. S. has staying at Safe Haven, he did not get along with the other residents and complained constantly about their behaviors. It was explained to him that all residents have mental health issues, but Mr. S. continued to not get along with and often argue with the other residents. Mr. S. did attend a Health Care for the Homeless sponsored picnic. He sat by himself and when others went and sat by him, he did not talk with them at all. Mr. S. is often uncooperative with this writer, the Therapist, and the Case Manager. He will attend appointments and then yell at the staff. Mr. S.'s strength is that although he discontinued therapy, he does continue to meet with Case Management staff and the Psychiatrist.

Mr. S. has marked difficulties in maintaining concentration. This writer does not have any observance of Mr. S. in a work setting. Ms. Alfredson was able to report that in the setting of case management, they had great difficulty completing the assessment and initial care plan. Mr. S. cannot concentrate on the task at hand and when asked a question, he begins to answer it, but then gets lost on a long tangent. He is difficult to re-direct. The therapist, Mr. Gilman, noted that he could not assess tasks of short-term memory due to tangents and paranoid thinking that the therapist was actually playing a trick on him. I think that Mr. S.'s inability to complete a basic mental status exam is indication that when under the stress of employment, he would not be able to maintain concentration, persistence, or pace.

Mr. S. has also had repeated episodes of decompensation. He was in a decompensated state when first engaged by the Outreach Worker in February 2005. He agreed to treatment by a psychiatrist and after beginning medications, he did demonstrate some improvement. In April 2005, Mr. S. had a Lithium level tested at the lab and the result was slightly below therapeutic level. By May 2005, the Lithium level was within therapeutic level and Mr. S. was reporting to be feeling better. In August 2005, Mr. S. reported to the psychiatrist that he did not take medications for one week and was feeling the effects of mood instability.

In September 2005, Mr. S. again reported to the psychiatrist that he was not taking his medications and his mood was quite irritable. He had also suffered the consequence of getting discharged from the Safe Haven shelter due to non-compliance with rules in September 2005. He continued to report not taking meds and struggling with his moods in October 2005. In November 2005, the consumer reported to be taking his medications again and Case Management was monitoring his medications by only giving him one week at a time. Again, his mood improved, he became more cooperative, and he was granted re-admission to Safe Haven. Also at this time, his psychotropic medication was changed. Mr. S. reported feeling to “up” and agitated from the new medication. By January 2006 he was again asked to leave Safe Haven due to non-compliance with rules. Since that time, he has again been observed to be in a decompensated state. His activities of daily living have diminished, his social functioning markedly impaired, and his concentration again observed to be very low.

In conclusion, it is my opinion that Mr. S. has a severe impairment and meets the criteria listed in section 12.04 of the Social Security Blue Book for Affective Disorder.

Steven Ortell, MD Date

George Gilman, LCSW Date

Jennifer G. Alfredson, APSW Date

Health Care for the Homeless of Milwaukee, Inc.

EXAMPLE E

Ms. Jane Jones or Ms. Francine Smith
Disability Determination Services
P. O. Box 6338
Timonium MD 21094-6338

Re:
DOB:
SSN:

Dear Ms. Jones or Ms. Smith:

Ms. A. P. is a 25-year-old, married, Caucasian female who was first hospitalized psychiatrically in August, 1997 and who has had several hospitalizations and day hospital stays since that time. Ms. P. is a soft-spoken, anxious, tall woman of average build. She wears glasses. She is struggling enormously with her illness of schizoaffective disorder and desperately wants, as she states, to be “normal.” She is cooperative with treatment but is easily stressed and, when this happens, she often becomes symptomatic. She needs a great deal of support to maintain herself in the community.

...

Functional Information

According to Ms. P., a typical day is one in which she gets up at about 8 a.m. and showers. She sometimes eats breakfast. She said that her family assists with cleaning the house. She does clean the cats’ litter boxes and feeds the animals (4 cats and one dog). When she was attending the ADH, her mother-in-law would transport her. She generally watches television during the day. Her husband generally arrives home from work between 4:30-5:00. Her family supplies dinner for Ms. P. and her husband. She goes to bed between 10-10:30 p.m.

Ms. P. experiences significant impairment in her activities of daily living, in her social functioning, and in her ability to complete tasks. She has been unable to work since her release from the Army in 9/97.

Regarding her activities of daily living, in her interview with the SSI Project Director, Ms. P. said that her mother-in-law or her grandmother cooks for her; she said that she doesn’t know how to cook. Earlier in her illness, she had great difficulty talking on the phone and would experience “bad anxiety attacks. I couldn’t sit still enough to use the phone.” She does better with this now. To obtain a phone number, she said that she would call another friend who might have it or would use the yellow pages. Her family, especially her mother-in-law, takes care of her food shopping. She said that she went with her mother-in-law once but became very anxious. At the end of May, Ms. P. still spoke of her struggle with completing housework. She said that her mother-in-law and her husband do most of the household chores. Ms. P.’s grooming and hygiene are usually good except when she is symptomatic. She is able to handle her own finances. She has never been to the post office. Generally, her family or friends provide transportation for her to her appointments or on other outings.

Socially, Ms. P. is much more inhibited than she used to be. She generally stays inside watching television and said she “prefer[s] it.” She said that she becomes “a little uneasy” around “big crowds” and feels as though “people around me can tell I have an illness.” She becomes anxious if there are several people in her house. She said that her heart races and she takes “big gulps of air.” She said that she feels that she handles anger well, by expressing it verbally. Prior to her illness, she said, she was “outgoing.” This is no longer true. She participated in groups at the ADH but prefers individual time with others and in treatment.

Ms. P. often has difficulty persisting and pacing herself in the completion of tasks. She said that she finds it “really hard” to concentrate, but this has improved somewhat since her illness began. She finds that she “lose[s] her train of thought” easily, and this bothers her. She also finds that she has difficulty remembering “things that happened before I got ill.” When giving her history to the SSI Project Director, she had difficulty remembering dates. She said that she used to have a “drawing hobby,” but that she cannot do this anymore. She also enjoyed reading but finds this difficult because of problems with concentration and focus.

Ms. P. has not been employed since she was discharged from the Army in 9/97. Recently, she has been talking about working part-time but has not done so or attempted to do so.

Summary

Ms. P. is a 25-year-old, married woman who was first hospitalized approximately a week after she entered the Army, in August, 1997. Between August and December, 1997, she was hospitalized six times and had three episodes of treatment in a day hospital. Currently, she is involved with an intensive outpatient mental health team that provides treatment and case management services. She meets with her therapist twice a week. With this intensive support, Ms. P. has been able to remain out of the hospital. She is easily stressed, becomes anxious and, less often, experiences a recurrence of psychotic symptoms. She worries a great deal about managing her illness and getting back to “normal.” In addition, she feels stressed in her marital relationship and worries about the finances. Currently, Ms. P. is waiting for placement in a psychiatric rehabilitation day program. This would assist her in providing some structure to her day as, right now, she spends most of the day alone, watching television.

Ms. P.’s illness has been severe and disabling, and she is unable to work.

If you have any questions, please contact Ms. Perret at 410-328-1406 or Dr. Billingsley at 410-555-5555.

Sincerely,

Yvonne M. Perret, LCSW-C
Project Director

John Billingsley, M.D.
Psychiatrist

May 1, 2001

EXAMPLE F

Ms. Freida Johnson
Disability Determination Services
P.O.Box 7373
Fair Chance, MD 21643-7373

Re: L. W.
SSN: 333-33-3333
DOB: 9/2/73

Dear Ms. Johnson:

Mr. L. W. is a 26-year-old, single, African-American male who has a history of psychiatric hospitalization dating back to 1992. Mr. W. is a tall (6'1") man of slim build. He has cognitive limitations; for example, he could not find his way back to the SSI Project office even though he had been there twice before. He has difficulty keeping appointments and needed a great deal of outreach to maintain contact and to stay in treatment. He is a poor historian and is quite vague. He appears to be attempting to provide information, but his recall is poor.

When first interviewed by the SSI Project Director, Mr. W. presented with a strong body odor. He was ill-kempt. His speech was rambling and frequently non-responsive to the question. When asked about his mother, he began to cry. He spoke over and over about "not being able to go on" this way. He could not guarantee that he would be able to keep himself safe. Therefore, the Project Director walked him over to Babylon Psychiatric Crisis Center for evaluation. From there, he was admitted psychiatrically.

...

Functional Information

In general, Mr. W. said, most of the time he is up and walking around. He sometimes stays at a mission, sometimes at relatives, and sometimes on the street. For a short period of time, he was living at the Safe Haven, a transitional housing program. Typically, he usually misses breakfast and sometimes eats lunch at the soup kitchens, mostly at Our Daily Bread. He is out most of the day. Mr. W. tends to present his functional ability as more capable than observations note.

Functionally, Mr. W. exhibits significant impairment in most areas. He states that he can cook and names rice and frozen patties as things that he can cook. He is able to use the telephone and could look up a phone number in the yellow pages. He said that he doesn't eat much and would likely need help shopping for food and other items. He believes that he can keep things clean. However, he has never had his own place to live and his appearance is not clean. Although he states that he makes sure he's clean, he had a strong body odor on several occasions when seen by the SSI Project staff, and his clothes are often quite dirty. He is unkempt as well. He said that he obtains clothing from the shelters. He describes his psychiatric symptoms in terms of "stress," which affects his ability to take care of his personal needs. He needs a representative payee to handle his presumptive SSI benefits and does not manage money well at all independently. Although he states that he can ride the bus, he does so only on routes that he knows and has difficulty finding new places. As was mentioned, he has been homeless for some time and has never maintained his own independent housing but rather has relied on family and shelters to house him.

Socially, Mr. W. has troubled relationships and has no friends. His relationship with his mother is conflicted as is his relationship with his sister. He notes himself that he has no “long-term” friends. When angered, he claims that he will face the problem and tell others what he didn’t like. However, as recently as last year, he faced an assault charge for hitting his brother in anger. He frequently experiences psychotic symptoms that contribute to very difficult interactions with others. His representation of managing his behavior is not accurate.

Frequently, Mr. W. does not answer the question asked of him, i.e., his response is not appropriate for the question. For example, when asked about his concentration, he said it was “very good” and used as an example the following: “I was up on Pennsylvania Ave. A guy came upon me. I said please don’t do anything to me. I was real scared. I begged him so he left. I believe in honesty.” His memory is grossly intact but he has difficulty reporting dates and is vague about his history. He said that he likes “conversating” with others, but his conversation is frequently difficult to follow.

Mr. W. has been unable to sustain any employment for a significant period of time. His primary work history consists of temporary agency placements, and these were generally brief.

Summary

Mr. L. W. is a 26-year-old single male who has a history of psychiatric hospitalization dating back to 1992. Early on in his psychiatric treatment history, he was diagnosed with neuroleptic malignancy syndrome, thus making subsequent treatment difficult. In addition, in the last few years, he has begun abusing marijuana and cocaine, stating that the cocaine helps take the “stress off my mind.” Mr. W. has been intermittently homeless for a long period of time. His homelessness, poor interpersonal skills, use of cocaine and marijuana to treat his symptoms, and his dependence on his family have made any semblance of effective independent functioning impossible. He has maintained no steady relationships nor stable living. He has had a lengthy history of psychotic symptoms, violent acting out, lack of compliance with consistent outpatient treatment, and poor management of his life. Mr. W. clearly has schizophrenia. His family has tried to assist him, but they have found him to be very difficult to have in their homes given his assaultive and psychotic behavior. At the present time, Mr. W. is receiving services from the UMMS PACT team, an intensive, mobile outreach team for adults with serious and persistent mental illness. This team is reserved for individuals who have been non-responsive to conventional treatment.

Mr. W. has very limited employment history. He is clearly disabled and unable to work.

If you have any questions, please call Ms. Rothschild at 410-328-1406 or Dr. Brown at 410-328-2564.

Sincerely,

Maria M. Rothschild, LCSW-C
Program Director

Francis Brown, M.D.
Psychiatrist, PACT

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APPENDIX I

STATUTORY BASIS OF DAA POLICY

Legislative history:

Congress has played an active role in defining eligibility for Federal disability assistance of persons with impairments related to substance use. Three statutes passed by Congress and signed into law during the last 30 years are of particular interest to clinicians and advocates working with homeless SSI/SSDI claimants:

- 1972: Public Law 92-603** – defined Drug Addiction and Alcoholism as “potentially disabling” disorders, established the DAA program for SSI recipients, and required treatment and a representative payee for those with substance use disorders.
- 1994: Public Law 103-296** – mandated treatment referral and monitoring services for SSI beneficiaries with a DAA condition material to the finding of disability, to be administered by Referral and Monitoring Agencies (RMA) in every state. RMAs were responsible for placing these beneficiaries into treatment, arranging for payees, and monitoring their participation. Noncompliance with treatment requirements resulted in progressively longer payment suspensions, with termination of payments after 12 consecutive months of noncompliance.
- 1996: Public Law 104-121** – The Contract with America Advancement Act (“Welfare Act”) of 1996 – prohibited entitlement to SSDI/SSI benefits for any individual whose drug addiction or alcoholism is “a contributing factor material to a determination of disability.” This law did not change the definition of ‘material’, but resulted in a finding of not disabled if DAA is ‘material’, and applied DAA representative payee requirements to “disabled SSI recipients who have a DA&A condition and are incapable of managing their benefits.” These recipients were referred to “the appropriate state agency administering the state plan for substance abuse treatment.”

SOURCE: Social Security Bulletin, Annual Statistical Supplement, 2000.
SSI: History of Provisions, 19–20.

Key provisions of Public Law 104-121:

- a. **Materiality** The 1996 law eliminates disability eligibility for cases in which DAA is a contributing factor “material” to the disability determination. 20 CFR 404.1535(b), 416.935(b). DAA is “material” only when the evidence establishes that the individual would not be disabled if s/he stopped using drugs or alcohol. POMS DI 90070.050D.3.
- b. **Representative Payees** Prior to enactment of this law, individuals whose drug addiction or alcoholism was material to the disability determination were required to receive their benefits through a payee. The 1996 Welfare Act eliminated eligibility for DAA beneficiaries and created a new class of beneficiaries – those with “DAA conditions.” A DAA condition exists

when a beneficiary has a medically determined substance use disorder that is not material to the disability determination. There is no mandatory payee requirement for DAA condition beneficiaries. Instead, SSA must determine, on a case-by-case basis, the capability of these beneficiaries. POMS GN 00502.010A.2., GN 00502.020A.4; HALLEX I-2-314A.

SOURCE: Landry, Linda; Disability Law Center, Boston, MA. DAA Issues Update (June 2006); Disability Benefits Project SSI Coalition Newsletter; XXV(3), May -July, 2006, 92-100

A firestorm of publicity around DAA benefits nationwide in the 1990s led to Congressional withdrawal of SSI/SSDI eligibility for persons whose DAA disorders were factors material to their disability. Two years after welfare reform laws brought an end to SSI for many poor people with substance use-related disabilities, research demonstrated continued high levels of alcohol and other drug use and significant material deprivation among those who lost Social Security benefits (See Baumohl et al. 2003). Since then, a number of research studies have demonstrated that homeless people with substance use disorders who receive SSI/SSDI disability payments are no more likely to purchase alcohol or drugs than are those who do not receive public support payments and have increased access to housing (Frisman and Rosenheck 2002, Rosen et al. 2006).

Case Law: Selected DAA Decisions (Landry 2006):

- **Determination of materiality with multiple impairments:**

Social Security Appeals Council decision, 12/3/98

Appeals Council states it is SSA's policy that materiality will not be found when there are multiple impairments and it is impossible to project what limitations would remain if the claimant stopped using drugs and/or alcohol, citing EM-96-94 (August 30, 1996).

- **Burden of proof:**

Brown v. Apfel, 192 F.3d 492 (5th Cir. 1999)

Court holds that the claimant bears the burden of proof that drug or alcohol addiction is not a contributing factor material to her disability. ...The court also cited DAA Q&A #29 from EM-96-94 (August 30, 1996) for the proposition that if the ALJ is unable to determine whether substance use disorders are a contributing factor material to the claimant's otherwise acknowledged disability, the claimant's burden has been met and an award of benefits must follow. In other words, the court asserted that "on the issue of the materiality of alcoholism, a tie goes to [the claimant]."

- **Correct DAA analysis:**

Brueggemann v. Barnhart, 348 F.3d 649 (8th Cir. 2003)

1. The ALJ must **make an initial determination of disability**, using the 5 step sequential analysis and taking into account all of claimant’s limitations regardless of whether they are related to substance abuse. ...
2. The ALJ must **determine whether substance use is a concern** – i.e., whether there is material evidence of substance abuse.
3. If the claimant’s limitations, including the effects of substance use, show disability, then the ALJ must next **consider which limitations would remain when the effects of the substance use disorders are absent**. This is the materiality determination. The court notes that “when the claimant is actively abusing alcohol or drugs, this determination will necessarily be hypothetical and therefore more difficult than the same task when the claimant has stopped.” Despite this difficulty, the court continues, “the ALJ must develop a full and fair record and support his conclusion with substantial evidence on this point just as he would on any other.” In other words, **active substance use does not preclude an award of benefits**.

- **Medical evidence standard:**

McGoffin v. Barnhart, 288 F.3d 1248 (10th Cir. 2002)

Court finds ALJ may reject treating physician’s opinion outright only on the basis of contradictory medical evidence and not due to ALJ’s own credibility judgments, speculation, or lay opinion. ... Court holds that non-treating physicians’ assessments are not substantial evidence to refute evidence of treating physician when non-treating physician saw claimant only once a year prior to hearing, and expressed no opinion on claimant’s cognitive abilities in a work environment. Court also affirms that **when mental restrictions due to DAA cannot be separated from other evidenced mental disorders, a finding of not material is appropriate**.

Alderete v. Barnhart, No. 03-2256, 101 Soc.Sec.Rep.Serv. 321, 2004 WL 1926221(10th Cir. August 31, 2004)

Court finds that treating physician’s report should be given controlling weight only when “supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with other substantial evidence in the record.”

APPENDIX II

ACRONYMS

| | |
|--------|---|
| ALJ | Administrative Law Judge |
| CN | HCH Clinicians' Network of the National Health Care for the Homeless Council |
| DAA | Drug Addiction & Alcoholism |
| DDS | Disability Determination Services |
| HCH | Health Care for the Homeless |
| NAMI | National Alliance on Mental Illness |
| POMS | Program Operation Manual System |
| PTSD | Posttraumatic Stress Disorder |
| SAMHSA | Substance Abuse and Mental Health Services Administration |
| SOAR | SSI/SSDI Outreach, Access & Recovery (a Federal initiative sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA)) |
| SSA | Social Security Administration |
| SSDI | Social Security Disability Insurance |
| SSI | Supplemental Security Income |

APPENDIX III

DISABILITY RESOURCES

Advocating on Behalf of SSI Claimants: A Guide to Rights & Resources – Information for advocates supporting disability claims for Supplemental Security Income (SSI) benefits, prepared by the National Law Center on Homelessness & Poverty (July 2002).

http://www.nlchp.org/content/pubs/Inc_SSI_booklet.pdf

Consultative Examinations: A Guide for Health Professionals (the Green Book) – contains basic information about the Consultative Examination (CE) process for physicians and other health professionals. <http://www.ssa.gov/disability/professionals/greenbook/>

Disability Evaluation under Social Security (the Blue Book) – an online reference on the Social Security Administration’s website that contains medical criteria (Listing of Impairments) that SSA uses to determine disability (June 2006). <http://www.socialsecurity.gov/disability/professionals/bluebook/>

FirstStep on the path to benefits for people who are homeless (Income Assistance) – an interactive tool for case managers, outreach workers, and others working with people who are homeless, available on the Centers for Medicare and Medicaid Services’ website.

<http://www.cms.hhs.gov/apps/firststep/content/incomecategory.html>

National Organization of Social Security Claimants' Representatives (NOSSCR): <http://nosscr.org/>

Social Security Administration regional offices: <http://www.ssa.gov/regions/>

Social Security office locator – information and directions to the Social Security office that serves your area <https://s044a90.ssa.gov/apps6z/FOLO/fo001.jsp>

Social Security Online, Service to the Homeless – a special section of the SSA website that provides information of interest to homeless claimants and their advocates <http://www.ssa.gov/homelessness/>