Comments on the Social Security Administration's Revised Criteria for Evaluating Mental Disorders; Proposed Rule
[Docket No. SSA-2007-0101]

Thank you for the opportunity to submit comments on the revised criteria for evaluating mental disorders, proposed rule. The National Health Care for the Homeless Council is a membership organization comprised of health care professionals and agencies that serve homeless people in communities across America. In 2009, our members served nearly one million homeless patients, many of whom have disabling mental disorders.

Summary of Key Recommendations:

1. Eliminate standardized testing from the proposed paragraph B criteria or define specific testing that has been rigorously tested and validated in diverse populations including individuals who are homeless.
2. Add examples of structured settings to proposed paragraph C criteria that are relevant to individuals who are homeless (see examples below).
3. Expand the list of acceptable medical sources to include licensed nurse practitioners, psychiatric clinical nurse specialists, physician assistants, and licensed clinical social workers who are trained and qualified to make these types of assessments and may be the only providers available to homeless and severely underserved populations.
4. Explicitly recognize the unique circumstances of people who are experiencing homelessness, particularly individuals who are chronically homeless, and permit longitudinal evidence from social service workers such as those who work in shelters and other homeless service sites.
5. Repeal the Drug Addiction or Alcoholism policy which has become a significant barrier to entitlements for people who have co-occurring physical or mental health and substance use disorders.

Disability Precipitates and Prolongs Homelessness

People who have serious mental illness are far more likely to experience chronic or long term homelessness than people without mental illness.[1] A survey conducted by the U.S. Conference of Mayors in 2008 found that 26 percent of homeless individuals had a serious mental illness, compared to 6 percent of the U.S. population. [2,] HUD's 2009 Annual Homeless Assessment Report to Congress revealed similar findings.[3]

[1] Folsom, D.P, Hawthorne, W., et. al. "Prevalence and Risk Factors for Homelessness and Utilization of Mental Health Services Among 10,340 Patients with Serious Mental Illness in a Large Public Mental Health System." Am J. Psychiatry. 2005.
[2] http://www.huduser.org/publications/pdf/5thHomelessAssessmentReport.pdf
[3] http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#Intro

Physical and cognitive impairments are among the factors that increase the likelihood of becoming (and remaining) homeless if services to meet basic needs are not available.[4, 5] People who have disabling physical and cognitive impairments are at risk of becoming homeless from unemployment, loss of family support, severity of symptoms, and inadequate supports after institutional discharge. Indeed, people who have disabilities represent over 40% of the homeless population and constitute the entire "chronically homeless" population in America.[6, 7, 8]

Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) constitute a critical safety net for persons with disabilities, providing cash assistance and, usually, eligibility for public health insurance (Medicaid/Medicare). For many people living in poverty, the income from SSI entitlements prevents homelessness and assists in meeting basic needs. For people who are already homeless, SSI benefits can improve opportunities for finding and maintaining housing, including supportive housing.[9] By increasing access to housing and health care, people who are disabled and homeless have a greater chance at achieving stability and resuming productivity.

Currently, 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 1996, only 11 percent of homeless service users received SSI and 8 percent had qualified for SSDI.[10] Local studies conducted since that time suggest that homeless disability claimants are denied benefits at significantly higher rates than others, often for failure to negotiate the intricate application process, rather than for lack of severe medical impairments that meet SSA disability criteria.[11] Case managers working in Health Care for the Homeless programs have reported that as many as 80 percent of their uninsured clients should have qualified for SSI or other disability assistance but were instead denied.[12] People experiencing homelessness often fail to qualify for Federal disability assistance due to a variety of system barriers — lack of access to health services, insufficient

[4] HCH Clinicians' Network. (Oct. 2002). Dealing with Disability: Physical Impairments & Homelessness. Healing Hands. http://www.nhchc.org/Network/HealingHands/2002/hh.10_02.pdf

[5] HCH Clinicians' Network. (Mar 2003). Dealing with Disability: Cognitive Impairments & Homelessness. Healing Hands. http://www.nhchc.org/Network/HealingHands/2003/hh-0303.pdf

[6] According to the Federal definition, a chronically homeless person is defined as "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." A disabling condition is defined as "a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." (Notice of Funding Availability for the Collaborative Initiative to Help End Chronic Homelessness/Federal Register, Vol. 68, No. 17/Monday, January 27, 2003, 4019. This definition is shared by the U.S. Department of Housing and Urban Development, the U.S. Department of Health and Human Services, and the U.S. Department of Veterans Affairs.]

[7] HUD. (2008). Annual Homeless Assessment Report. http://www.hudhre.info/documents/4thHomelessAssessmentReport.pdf

[8] Brault, M. (2008). Disability Status and the Characteristics of People in Group Quarters http://www.census.gov/hhes/www/disability/GQdisability.pdf

[9] Rosenheck, R., Frisman, L., and Kasprow, W. (1999). Improving access to disability benefits among homeless persons with mental illness: an agency-specific approach to services integration. Am J Public Health, 89(4): 524-528.

[10] Burt MR, Aron LY, Douglas T, Valente J, Lee E, Iwen B. (1999). Homelessness: Programs and the People They Serve: Summary Report – Findings of the National Survey of Homeless Assistance Providers and Clients, HUD Technical Report. Washington, DC: The Urban Institute. http://www.huduser.org/Publications/pdf/home_tech/tchap-05.pdf

[11] A review of disability claims submitted to the Disability Determination Services in Boston, 2002 – 2006, 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. 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 (see reference 10).

[12] Post, PA. (2001). Casualties of Complexity: Why Eligible Homeless People Are Not Enrolled In Medicaid. Nashville, TN: The National Health Care for the Homeless Council. http://www.nhchc.org/Publications/CasualtiesofComplexity.pdf

documentation of functional impairment, remote application offices, complex application processes, lack of transportation, scattered medical records— despite the high likelihood that they would meet eligibility requirements. These obstacles are exacerbated by mental impairments and the lack of stability necessary to see a complex application process through to completion.

Recommendations for the Social Security Administration's Revised Criteria for Evaluating Mental Disorders

We commend the Social Security Administration for many of the steps that are taken in the proposed rule to streamline the disability determination process. The proposed changes will eliminate the specific "A" diagnostic criteria. The listings will be divided into broad categories of impairments rather than specific diagnoses. We support this change, as it will broaden the listings to include more mental disorders. It will also bring the Listings in line with scientific thinking that diagnosis is less a determining factor in a person's ability to work than level of functioning. We also support the inclusion of traumatic brain injury as a mental disorder. People who are experiencing homelessness are five times more likely than the general population to have experienced traumatic brain injury at some point in their lives. A history of moderate or severe traumatic brain injury is associated with significantly increased likelihood of mental health problems and poorer mental health status.[13]

RECOMMENDATIONS:

Proposed Paragraph B Criteria

The proposed rule does not specify the standardized tests that would be considered useful in making determinations of marked and extreme limitation of one's ability to function in a work setting. It is not clear that any such tests exist now, or that testing itself has been proven to be connected to predicting work function. We are concerned about proposing a standardized test without indicating the specific instrument to be used, the research that validates that instrument as applied to individuals with mental disorders and their ability to work, and any evidence that this testing process would adequately assess the needs of vulnerable individuals. SSA should either rescind the proposal for use of standardized tests or clarify the proper use of such tests under the proposed B criteria, including guidance to adjudicators regarding how they measure functioning as it relates to the B criteria. SSA should also consider how such testing would be accessible for individuals who do not have benefits and depend on free clinics and emergency departments for care.

Proposed Paragraph C Criteria

The expanded list of highly structured settings and psychosocial supports provided in 12.00F(2) is very useful, but presumes that an individual has a regular and stable place to live. The example listed for (a) presumes that an individual is socially connected to family and friends, (b) through (e) presumes that an individual is connected to treatment and/or services, and (f) through (h) presumes an individual has housing (either alone or supported). Our clients are often socially isolated, disconnected from services, and live on the street or in homeless residential facilities. This list should be expanded to include examples relevant to people whose impairments have contributed to homelessness and infrequent access to supports (for example, receiving services from a homeless service organization, including attempts at engagement from outreach workers; living in a homeless residential setting including transitional and permanent supportive housing.) By adding examples that are more relevant to people experiencing homelessness, satisfaction of the criterion listed in C2 may be more easily determined.

[13] Hwang, S. et al. (October 2008). The effect of traumatic brain injury on the health of homeless people. CMAJ, 179 (8).

Evidence from Medical Sources
We appreciate the Social Security Administration's recognition of evidence from non-physician professional sources such as therapists and social workers. However, we believe that these non-physician professional sources should be considered "acceptable medical sources." Although most medical doctors and psychiatrists have the training necessary to determine addiction, they are not often found in high concentration in the programs that serve homeless populations. Instead, homeless patients receive much of their care from Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Physician Assistants, and Licensed Clinical Social Workers. These professions follow national standards of care and have the skills necessary to determine the source of functional impairment in their patients. We urge SSA to expand the list of acceptable medical sources to include Nurse Practitioners, Psychiatric Clinical Nurse Specialists, Physician Assistants, and Licensed Clinical Social Workers in order to expedite and improve access to SSI/SSDI entitlements.

Need for Longitudinal Evidence
We appreciate that the proposed rule on longitudinal evidence takes into consideration individuals who do not have an ongoing relationship with the medical community. For people who are experiencing homelessness, longitudinal evidence may be particularly difficult to acquire. The migratory nature of people who are experiencing homelessness as well as the difficulties in keeping appointments often create barriers in obtaining such evidence. This proposed rule would allow evidence to come from, for example, family members, neighbors, or former employers. However, many people who are homeless have not been able to maintain ties to family members, neighbors, or employers. We recommend that the proposed rule explicitly recognize the unique circumstances of people who are experiencing homelessness, particularly individuals who are chronically homeless, and permit longitudinal evidence from social service workers such as those who work in shelters and other homeless service sites.

Evaluating Evidence
In 12.00G, the proposed rule describes the type of evidence that SSA will consider to assess the existence and severity of a mental disorder and its effects on one's ability to function in a work setting. However, SSA does not describe how this evidence will be evaluated. Including SSA's criteria for evaluating evidence would likely improve the quality of documentation from acceptable and other medical sources and increase consistency in determinations.

Standardized Electronic Decision Templates
We recommend that information from the standardized electronic decision templates be made available to applicants and their case workers so that they may address reasons for denial.

Drug Addiction or Alcoholism Policy
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 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 view of addiction as a chronic brain disorder with intrinsic behavioral and social-context components, similar to other forms of mental illness.[14] 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.

[14] World Health Organization (WHO). (2004). Neuroscience of Psychoactive Substance Use and Dependence. http://www.who.int/substance_abuse/publications/en/Neuroscience_E.pdf

The co-occurrence of mental illness with substance use disorders is not unusual, regardless of housing status, but individuals with co-occurring disorders who are homeless are particularly vulnerable. Estimates of the number of homeless people with co-occurring behavioral health disorders vary, depending on the population studied and the definition of co-occurring disorders employed. In a national sample, 75% of homeless clients with a past-year drug disorder had a comorbid nonsubstance related mental illness.[15] The National Alliance on Mental Illness (NAMI) cites an estimated 50% of homeless people have co-occurring disorders.[16] SAMHSA's Co-Occurring Center for Excellence (COCE) cites 32% of homeless men and 37% of homeless women have comorbid mental illness and substance abuse disorders.[17]

Medical research suggests chronic distress as a central construct underlying the association of psychiatric disorders with substance use disorders.[18] Such findings shed light on the disproportionate numbers of people who are homeless who have co-occurring mental illness and substance use disorders. On a daily basis, people who are homeless deal with discrimination, violence, inadequate access to health care, and constant stress in trying to meet basic needs such as shelter and food. Moreover, we know that most people who are homeless have experienced significant trauma from severe physical, sexual, or emotional abuse at some point in their lives.

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 that include substance use disorders. 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. Inconsistent interpretation and application of the DAA policy combined with the complexities of determining whether DAA is material to disability have prevented many people with severe disabilities from accessing assistance. One study found that over half of the people who lost their benefits due to the DAA policy had severe physical health disabilities that required hospitalization the year before termination. Another 15% of the population had been hospitalized for schizophrenia and psychosis unrelated to substance abuse.[19]

The intent of the DAA policy was to reduce economic dependency on public programs and improve incentives to work. However, research shows that individuals who met DSM-IV criteria for addiction and who had their benefits terminated did not experience a significant change in their rates of employment; instead more disturbingly, arrest rates increased for this population.[20] Given these outcomes, **we recommend that Congress and SSA repeal the DAA policy which has become a significant barrier to entitlements for people who have co-occurring physical or mental health and substance use disorders.**

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[15] Kertesz, S. G., Madan, A., Wallace, D., Schumacher, J.E., Milby, J.B. (2006). Substance abuse treatment and psychiatric comorbidity: Do benefits spill over? Analysis of data from a prospective trial among cocaine-dependent homeless persons.
Substance Abuse Treatment, Prevention, and Policy, 1(27), 1–8. www.substanceabusepolicy.com/content/1/1/27

[16] National Alliance on Mental Illness (NAMI). (2003). Dual diagnosis and integrated treatment of mental illness and substance abuse disorder.
http://www.nami.org/Template.cfm?Section=By_Illness&template=/ContentManagement/ContentDisplay.cfm&ContentID=13693

[17] Substance Abuse and Mental Health Services Administration Co-Occurring Center for Excellence. (2007). Addressing co-occurring disorders in non-traditional service settings. http://coce.samhsa.gov/cod_resources/PDF/OP4-SpecialSettings-8-13-07.pdf

[18] Brady, K.T. and Sinha, R. (Aug 2005). Co-occurring mental and substance use disorders: the neurobiological effects of chronic stress. *Am J Psychiatry,* 162(8):1483-93.

[19] Hanrahan, P., Luchins, D., Swartz, J., et al. (Jan 2004). Medicaid eligibility of former Supplemental Security Income recipients with drug abuse or alcoholism disability. *Am J. Public Health,* 94(1): 46-47.

[20] Chatterji, P., Meara, E. (March 2010). Consequences of eliminating federal disability benefits for substance abusers. *J. Health Econ., 29(2), 226-240*

Respectfully submitted,

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The National Law Center on Homelessness and Poverty has expressed its support of these comments.