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SOCIAL SECURITY REVIEWS OF THE MENTALLY DISABLED

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

FIRST SESSION

WASHINGTON, D.C.

APRIL 7 AND 8, 1983

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SOCIAL SECURITY REVIEWS OF THE MENTALLY DISABLED

THURSDAY, APRIL 7, 1983

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:40 a.m., in room SD-106, Hon. John Heinz, chairman, presiding.

Present: Senators Heinz and Cohen.

Staff present: John C. Rother, staff director and chief counsel; Frank McArdle, professional staff member; Isabelle Claxton, director of communications; Eileen Bradner, minority professional staff member; Tricia Neuman, research associate; Angela Thimis and Kim Heil, staff assistants.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. The Special Committee on Aging will please come to order.

Today the U.S. Senate Special Committee on Aging will examine the treatment of mentally disabled persons under the Federal programs designed to assist them.

The importance of social security and supplemental security disability benefits cannot be understated. For the nearly 6.2 million disabled workers and their families receiving social security or SSI disability, these benefits are the main lifeline of support. In addition to cash benefits, disabled workers who qualify for social security disability can qualify for medicare health benefits—and the receipt of SSI generally qualifies a needy, disabled individual for medicare. Cash and health benefits under four Federal programs serving disabled thus flow from a single definition of disability—embodied in the Social Security Act and administered by the Social Security Administration.

Over the past 2 years, nearly half of those selected for continuing disability reviews have been told by the Social Security Administration that they no longer meet the definition of disability—and that their benefits must cease. This statistic is striking because everyone currently on the disability rolls has already satisfied the requirements of an extremely strict legal definition of disability—a definition that has not been changed in law. In the 20-month period between May 2, 1982 and December 31, 1982, more than 300,000 disability beneficiaries lost their lifeline of cash and medical support as a result of the so-called continuing disability investigations. And, based on current projections, in fiscal year 1984 alone, another 250,000 people can be expected to join the ranks of those already kicked off the rolls.

These continuing disability reviews have drawn the attention of this committee because nearly 60 percent of all disabled workers are over the age of 55, and nearly 75 percent are over age 50.

In addition, the committee has been presented with repeated illustrations of specific cases where the reviews were clearly conducted in an inadequate manner. The treatment of disabled individuals in these cases falls far short of the standards that we should expect when such an important decision is at stake.

As chairman of this committee, I have convened today's oversight hearing because of specific concerns that I, Senator Cohen, and others of the committee have, regarding the quality of the reviews performed on individuals suffering from severe mental disabilities.

I am concerned, for example, by evidence that the social security review process has operated to single out people with mental disabilities for a disproportionate share of CDI reviews and terminations. Although the best estimates we have indicate that 11 percent of disabled workers suffer from mental disorders, between 24 and 28 percent of the CDI reviews and terminations have fallen upon the mentally ill.

I am concerned by the findings of a Federal judge in Minnesota, who ruled last December that the Social Security Administration had embarked on a new and illegal policy, one which the judge found to be, and I quote, "arbitrary, capricious, irrational, and an abuse of discretion." The policy in question relates to instructions from the Social Security Administration to its operating components.

I am concerned by evidence that severely disabled individuals have been terminated from the rolls because they can feed their dog, watch television, or play the piano. Individuals involuntarily committed to a State mental institution have been told they are able to work—even while they remain committed in such a mental institution, against their will, because of the danger they pose to themselves and to society. And severely disabled individuals, who don't wear their disabilities on their shirtsleeves, are not given a thorough and realistic evaluation of their ability to work, and are denied benefits because they make a neat, polite appearance.

I am concerned because such decisions are frequently made by personnel not qualified in psychiatry or psychology.

But most of all, I am concerned about the harsh human toll of the reviews on the estimated 600,000 to 700,000 individuals on the social security and SSI rolls whose primary disability is a severe mental illness.

This morning, we will hear testimony from a broad range of witnesses regarding the extent to which the concerns I have expressed are indeed characteristic of the administration of this review program.

We will hear from the General Accounting Office on the results of the investigation I requested last August 18; we will hear about the human toll of these reviews through the words of beneficiaries and individuals who work on a daily basis with the mentally ill; we will hear from State, county, and city governments about the impact of the Federal policies on their communities; and we will hear from a particularly well-known and renowned medical expert on the scientific validity of the criteria which social security uses to judge the severity of a mental disability.

Tomorrow morning, by the way, the Social Security Administration will get the opportunity to provide its perspective on the reviews of the mentally disabled, and also to respond to any specific charges that are made here today.

We have a very long list of witnesses this morning, of whom we will ask a large number of questions; so I would ask witnesses to be as brief as possible by summarizing their testimony within a 5-minute time limit, which we must strictly adhere to, as their full statement will be made a part of the committee's hearing record.

At this point, I want to call upon Senator Cohen.

Let me say that Senator Cohen really held the first Senate hearing into this subject in the Government Operations Subcommittee many, many months ago. He has been the real leader in this area. He has helped write some of the legislation recently enacted last year. He has continued to press for improvements in the program. He has taken a continuing interest in this issue, and it is a great pleasure for me to have him here at this hearing, and I yield to Senator Cohen for any remarks he has.

STATEMENT BY SENATOR WILLIAM S. COHEN

Senator COHEN. Thank you very much, Mr. Chairman. I shall try to be brief so we can hear from the witnesses. I want to welcome these hearings that are a complement to the hearings that I held last year. They show your continuing interest in the disability issue.

During the course of last year's hearings, we found countless cases of individuals who were wrongfully purged from the disability rolls only to have their benefits reinstated 12 to 15 months later, after a hearing was held before an administrative law judge. Many of those people had grave physical ailments which made them incapable of working; others had serious mental deficiencies. Since this hearing is focusing on the mentally disabled, I would like to share a couple of examples to illustrate the magnitude of the problem.

We learned of a 55-year-old woman who had been hospitalized 16 times for psychiatric disorders who was in the process of being involuntarily committed to a State institution for endangering herself and others by dancing in traffic when her benefits were terminated. The Social Security Administration's notice told this woman, "Though you may be nervous at times, your records show that you are able to think, communicate, and act in your interest." The notice concluded, "While we realize that your condition prevents you from doing any of your past jobs, it does not prevent you from doing other types of work."

We had another case where the treating doctors reported that the claimant could not carry on a conversation, manage his own funds, or function in a sheltered workshop, yet his benefits were terminated. A hospital social worker had to bring the disabled man to his appeal hearing before an administrative law judge. When the

ALJ saw the man, he found him to be incoherent and obviously unable to work.

These are just two of the unfortunate cases we have seen. We identified several deficiencies in the review process which permitted cases like the ones that I have described to occur. We found that beneficiaries received inadequate notices, that there were conflicting standards used by the State examiners and the ALJ's; that there was no personal contact between the disabled individual and the State claims examiner; that medical files were incomplete and inadequate, and the system could not handle the huge influx of cases. The result was that, in a number of cases, individuals whose medical conditions had actually deteriorated still were being terminated.

The Social Security Administration, I must say, has taken a number of actions to correct the deficiencies in their review process, such as improving the notice. In addition, last year several Senators, including the chairman, joined me in proposing temporary legislation, that has now become law, which enables individuals to have their benefits continued during the appeal process. Admittedly, that was only a stopgap measure. What we are trying to do is hold off the floodtide of cases that were coming until such time as we could propose comprehensive legislation which is now being developed by Senator Heinz, Senator Levin, myself, and others in the Senate. We hope that we will have an opportunity to pass such a bill through both Houses of the Congress and have it signed into law.

There is a good deal that remains to be done, and I know these hearings will help in moving comprehensive legislation along. So I welcome these hearings.

Thank you very much.

Chairman HEINZ. Thank you very much.

Senator John Glenn, the ranking minority member of this committee, and Senator Larry Pressler cannot be with us today because of prior commitments. They have, however, submitted statements for the record, and without objection they will be inserted at this point.

[The statements of Senators Glenn and Pressler follow:]

STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, I am pleased that the Special Committee on Aging is holding this oversight hearing on the Social Security Administration's continuing disability review program as it affects mentally impaired beneficiaries.

Every Senator and Representative has heard from constituents who are permanently or severely disabled and who have been terminated from the social security disability rolls since the continuing disability review process began in 1981. Many of these persons have successfully appealed their termination to an administrative law judge and their disability benefits have been reinstated. But the lengthy appeals process means financial hardship and physical and emotional stress to disabled persons, particularly those who are mentally disabled.

The periodic review of social security disability beneficiaries was mandated by the Social Security Act Amendments of 1980, which Congress passed in response to the widespread growth in government disability programs during the 1970's. Between 1970 and 1976, the number of disabled workers in the social security program nearly doubled, from 1.5 to 2.7 million, while the covered work force increased by only 25 percent during the same period. Rapid growth was also witnessed in disability claims for the supplemental security income (SSI) program in the 1970's. The 1980 Social Security Act Amendments grew out of concern that work disincentives in the system, combined with faulty administration, might be responsible for the rapid growth in the program. The 1980 amendments set out to enhance work incentives in the social security and SSI disability programs and to improve the administration of the programs to insure that benefits are only paid to eligible persons. The amendments require the Social Security Administration to review at least once every 3 years the cases of disabled workers on the disability rolls, except where the disability is considered permanent. The reviews were to begin in 1982, but the Reagan administration accelerated this review process in 1981 after the General Accounting Office and the Social Security Administration released reports which indicated that perhaps 20 percent of beneficiaries were not disabled.

Congressional action to improve the disability program by weeding out nondisabled persons was necessary and sincere. However, the administration's implementation of the 1980 amendments has been overzealous. Since the review process began 2 years ago, the Social Security Administration has terminated 45 percent of the beneficiaries reexamined. Instead of the $10 million in net savings that Congress estimated at the time of the 1980 amendments, the President's budget for 1983 projected savings in the disability program of $3.5 billion—or 325 times the original 1980 estimate. Investigations by several congressional committees indicated that many severely disabled persons are being erroneously terminated from the disability insurance program, only to wait, without benefits, through the lengthy appeals process. In my State of Ohio during 1982, 18,000 disabled beneficiaries were reviewed by the Social Security Administration and 42 percent of these persons were terminated from the rolls. However, if the terminated beneficiary appeals his case to the administrative law judge level, disability benefits are reinstated at a 67-percent rate. In the meantime, these persons suffer financial hardship and emotional trauma. Some disabled persons have committed suicide, others have died of medical conditions that were ruled "nondisabling," and others have lost their homes after being terminated from the disability program.

Congress passed emergency legislation in December 1982 to continue disability benefits to terminated persons during the appeals process. This legislation will help ease the financial hardship faced by individuals who are arbitrarily being removed from the disability rolls, only to be reinstated many months later. The legislation also permits the Social Security Administration to waive the 3-year review requirement in States where staff and resources are inadequate to handle the heavy caseload. This is only a temporary measure, which expires October 1, as Congress must enact reforms to improve the continuing disability review process.

The procedures employed by the Social Security Administration to judge the disabilities of mentally ill persons deserve congressional action. At the request of the Special Committee on Aging, the General Accounting Office examined 75 cases and interviewed about 200 disability examiners in Ohio and three other States. The preliminary results of the GAO study indicate that the procedures used to review the cases of mentally ill people are seriously flawed. Among the shortcomings in this process, GAO found that 10 States did not employ any psychiatrists for use in the review process, mentally ill persons were not given a realistic evaluation of their ability to work, and examiners were encouraged to stress the positive activities that a beneficiary could do—such as feeding a cat or watching TV. Severely ill persons without the capacity to relate to other human beings have been terminated from the disability rolls because of their ability to boil an egg or attend a movie.

I would like to share the story of some of my constituents, a family in Dayton, Ohio: Last year I was contacted by a woman on behalf of her 35-year-old schizophrenic son who has been terminated from the social security disability rolls. The family is now appealing the termination decision. The mother's letter raises many of the issues that we will discuss at today's hearing. She writes, "The biggest question in my mind, is how a 20-minute interview with a psychiatrist who has never had previous contact with him can decide that his schizophrenia is 'cured.' Previous psychiatrists who have attempted to treat him have needed numerous hour-long consultations over a period of 6 or 8 weeks in order to arrive at a definitive diagnosis and treatment program. * * * None of us can see any improvement in his condition and in some ways feel it has deteriorated."

Although this man's mental condition at times allows him to be extremely lucid and project an impression of normalcy, his mother explains his inability to keep a job: "His personality, disordered as it is, makes him very difficult to be around. Even some of our family members find it difficult to handle for more than short infrequent periods. Even in the best of times, no employer is going to tolerate anyone who is not rational, who cannot cope with the pressures of even the simplest of jobs or who cannot comprehend the importance of time and promptness a job requires. Most of all, an employer or fellow employees would find it nearly impossible to associate with an individual who is so extremely different from the norm that extended conversation is nearly impossible * * * he was considered disabled because of his inability to rationally cope with pressure of any kind, be it on a job or in day-to-day contact with people."

Yet this man, who has been treated by six psychiatrists or mental hospitals during the past 8 years, has been terminated from the social security disability rolls and is expected to go out and get a job.

I look forward to hearing the testimony from our distinguished panel of psychiatric experts, State and local government officials, and government investigators. Hopefully, with their help, we can determine what changes need to be made in the social security disability program to insure that mentally disabled individuals receive a thorough, fair, and scientifically accurate evaluation.

STATEMENT OF SENATOR LARRY PRESSLER

Mr. Chairman, the subject of this morning's hearing is an important and timely issue. The number of people being denied their disability benefits has grown to major proportions and I am extremely concerned about the ramifications of this change in policy. I am pleased to note that my home State of South Dakota had the lowest rate for cessation of benefits among all the States—only 22.8 percent—but I am concerned that even this figure may be too high. The national cessation rate for the period from October 1981 through July 1982, was 45.2 percent. In light of the fact that 61.2 percent of those who appealed the decision regained their benefits, I believe that we must consider the distinct possibility that these reviews are causing a great number of deserving people to lose their benefits.

The problem is especially serious with respect to the mentally impaired disability recipient. One South Dakota psychiatrist related to me the cases of two mentally impaired patients who were notified through the mail that they were to report for their disability review. One patient was a mentally retarded women who was unable to understand the request. She did save the notice, however, because she was so proud of having received a letter from her government. The second patient suffered from paranoia. He was not in the habit of opening his mail because he feared what it might contain. Both of these people lost their benefits because they did not "cooperate" with the review. I understand that the practice of notifying mentally disabled persons of their review through the mail has now been stopped because of the prevalence of problems like this. I believe that this typifies the kind of problems involved in the reviews, however.

The staff members of South Dakota's 11 community mental health centers now report that a significant amount of their time is being spent appealing the cases of patients who have lost their benefits. After an average of two appeals per case, the benefits are reinstated. It seems that this type of evidence points to the fact that the reviews have been conducted in an "arbitrary, capricious, and irrational" manner, to quote the Federal judge who reviewed the new procedures.

Several of the witnesses here this morning will elaborate on the inadequacy of the system to document true disability with respect to the mentally impaired. I look forward to their testimony and I thank you, Mr. Chairman, for giving us the opportunity to investigate this problem.

Chairman HEINZ. Our first panel this morning consists of GAO witnesses, led by Mr. McGough, the Associate Director of the Human Resources Division.

Mr. McGough, would you introduce your associates.

STATEMENT OF PETER J. McGOUGH, WASHINGTON, D.C., ASSOCIATE DIRECTOR, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY ROBERT WYCHULIS, ASSIGNMENT MANAGER; AND DR. BERYCE MacLENNAN, CLINICAL PSYCHOLOGIST

Mr. McGOUGH. I would like to introduce on my right, Robert Wychulis, who was assignment manager on the study that we did at your request; and Dr. Beryce MacLennan, who is GAO's full-time clinical psychologist and mental health adviser, and she provided e technical expertise necessary to develop the results.

We are happy to be here, Mr. Chairman and Senator Cohen, to share with you the results of the work that we did at your request, to look thoroughly at the Social Security Administration's decisionmaking process as it relates to the mentally disabled.

We began our work in September of 1982, by thoroughly reviewing the Social Security Act, the corresponding regulations, the decisionmaking processes, and so on. We conducted our work at five disability determination services—DDS—centers located in the four States of Illinois, Indiana, Ohio, and Pennsylvania; at Social Security Administration headquarters in Baltimore; and at SSA's regional office in Chicago.

At each of the DDS' we met with the director, the chief medical consultant, and the medical administrator. Overall, at the five DDS', we interviewed 38 claims examiners individually and more than 200 examiners in group discussions, 18 supervisors, 8 quality assurance chiefs, and 7 medical coordinators.

We reviewed a total of 159 mental disability cases that had been recently adjudicated. Of the cases selected, 40 denials or terminations were examined in detail by GAO's full-time clinical psychologist and mental health adviser, Dr. MacLennan.

Our detailed case review is not projectable to the universe of all mental disability cases adjudicated. However, our additional work and evidence gathered at Social Security headquarters strongly indicated that the results of our study have national implications.

I am going to skip through my 24-page statement quickly and I will refer to the pages that I am on, if that will help.

On page 5, I talk about the current conditions and the statistics that you alluded to in your opening statement. Data from SSA's files indicated that as of August 1982, and that was the most current information available, SSA had reexamined in its periodic review process, about 305,400 individuals and terminated benefits in about 134,500, or 44 percent, of the cases. SSA does not show the termination rate by types of disabilities but we were able to break down the termination rate for mental disabilities.

Seventy-four thousand eight hundred cases involved persons with mental impairments and 31,700, or 42 percent, of them were terminated. We provide some information on those that asked for reconsideration at the initial level, and there were 1,400 that had reached the administrative law judge appeal level, and it was quite startling. Although 1,400 who appealed to the ALJ represent a relatively small number, 91 percent of those decisions were reversed.

Chairman HEINZ. Ninety-one percent? Or 1 out of 11 was sustained; 10 were reversed?

Mr. McGOUGH. That is correct.

I have not included in my statement, but it may add an additional perspective, that overall there were 2.5 million initial and reexamination decisions. These are rough figures, but the initial decisions represent about 2 million and reexaminations represent about 520,000; and of the 520,000, about 321,000 were periodic reviews, those called for in the 1980 amendments, and an additional 197,000 were diaried cases where Social Security will schedule a disabled person for reexamination when that person's disability has a good potential for improvement. Of the periodic reviews that Social Security reexamined, 142,000, or 44 percent, resulted in denials and of the diaried cases, 98,500 resulted in terminations. A total, therefore, of 240,600 cases that were denied or terminated, which represents 46-plus percent of all cases Social Security looked at.

As Senator Cohen mentioned, we testified before him earlier on the continuing disability insurance investigations. Our current investigation found many individuals who had their benefits terminated despite having severe impairments and despite, in our opinion, having little or no capability to function in a competitive work environment. We had 40 denial and termination cases reviewed by our clinical psychologist, and she concluded that in 27 of the cases, the individuals could not function in their daily living without support, and could not work in a competitive or stressful environment.

In an additional 13 cases, she concluded that more medical or psychosocial information or trial work experiences were needed to make an informed decision. So in all of the cases that she looked at, she found questions or disagreed with the decisions. As an appendix to the statement, we have a number of cases which we think illustrate that point.

Chairman HEINZ. Just to clarify, would it be fair to say that the GAO psychologist could not agree with a single one of the denial decisions made—either because she actively disagreed or because of inadequate information?

Mr. MCGOUGH. That is correct. We go further in the rest of the statement, which deals with the weaknesses that we found and contributed significantly to these kinds of questionable decisions. My statement basically deals with the following problems: One, an overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities; two, it also deals with inadequate development and consideration of a person's residual functional capacity and vocational characteristics; three, inadequate development and use of existing medical evidence, resulting in an overreliance and misuse of consultative examinations; and four, insufficient psychiatric resources in most DDS'.

I speak briefly to each of those beginning on page 7.

SSA's regulations contain a set of medical evaluation criteria and the medical criteria for mental impairments has two parts, A and B, which are described on page 7. To be eligible for disability benefits, both parts A and B must be met. Although the criteria for meeting a medical listing for mental impairment has not changed substantially since 1968, it has become increasingly difficult to meet the medical listings.

As a result of our case reviews and discussions with examiners in five DDS', the problem focuses principally on part B of the listings. Examiners were concluding that individuals did not meet part B based on very brief descriptions of the individual performing only rudimentary daily activities, such as watching television, visiting relatives, fixing basic meals, and doing basic shopping activities. Often little else positive was contained in the medical evidence.

A good bit of this deals with the hard line that the examiners felt SSA was taking in examining the decisions. How the criteria is applied by SSA is of fundamental importance because the cases are evaluated by SSA's quality assurance system. The State agencies take the cases returned from quality assurance as a clear indicator of how the cases were to be adjudicated. State officials and examiners we spoke with unanimously perceive the disability assessment branch, which is the quality assurance branch of Social Security, returns over the past several years as intending to make it extremely difficult to meet the listings.

We reviewed some of these case returns where the DDS had determined the individuals were very severely mentally impaired and were disabled, but the cases were returned by quality assurance because the individuals had some daily activities, albeit extremely minimal ones. We give some examples. I won't take the time to read them. I think they illustrate clearly what the examiners were telling us.

The following comment in a December 1981 letter to SSA's Chicago regional office from the DDS Director in Wisconsin, again clearly shows the climate that we are talking about. I quote: "The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny," and the rest of the quote follows.

On page 12, we report that the American Psychiatric Association, in a letter to the SSA Commissioner, dated June 29, 1982, recommended a change in parts A and B of the listings for all mental disorders other than mental retardation. The APA also has serious concerns and reservations about the criteria.

In 1982, the Chicago regional medical consultant for SSA wrote that it is "practically impossible to meet the listings"—I will skip—"In fact, an individual may be commitable due to mental illness according to the State's mental health code and yet found capable of 'unskilled work' utilizing our disability standards."

Our group discussions with examiners produced comments to the effect that unless a claimant was flat on his back in an institution, comatose, or in a catatonic state, he or she would not meet the listings.

I will now talk about the residual functional capacity and vocational consideration aspects of the sequential review process.

When an individual fails to meet the listings but the impairment still limits his or her ability to perform basic work functions, SSA's process to determine disability requires that an assessment be made of the individual's residual functional capacity. We found several problems with the policy statement on how to implement this criteria. We traced it back to policy guidance in April 1979, which said that, "The capacity for unskilled work in and of itself represents substantial work capability and would generally be sufficient to project a favorable vocational adjustment for claimants with solely mental impairments."

In other words, this policy could very clearly be interpreted as saying that the person has the capability to work because he or she has some remaining residual capacity.

When we explored how this policy should be interpreted, we asked if a person had a mental ability to understand and do unskilled work, could not one logically conclude that a person can, in fact, work, if any unskilled job were available in the national economy.

One of SSA's psychiatrists told us that he can understand how the examiners would reach such a conclusion and that it is probably the message that is being sent out to them through the quality assurance case reviews.

The psychiatrist told us that he was currently reviewing a case involving a mentally retarded woman with an IQ in the low 60's. He assigned, according to present procedures, a No. 4 rating. That is a severe impairment but it doesn't meet or equal the listing. He said that the decision will result in a denial even though he knows that there is no way the individual could possibly work competitively.

Several examiners told us that quality assurance returns have given them a clear message to terminate benefits for younger workers who do not meet the medical listings.

As you mentioned in your opening statement, this was a subject of a court suit, a class action suit in Minnesota, in which the court decision went against the Social Security Administration; and, in part, the court decision said that by the use of this policy, SSA has terminated the benefits of, and denied new benefits to, class members without proper assessment of the individual's capacity to engage in substantial gainful activities.

As required by the court, the Commissioner of Social Security sent a memorandum to all regional commissioners in January 1983, stating, in effect, that to presume a person who does not meet or equal the listings maintains the residual functional capacity to perform unskilled work is contrary to Federal regulations.

In March 1983, SSA issued instructions to the DDS' dealing with mental impairments and their effects on individual workabilities. Just earlier this week, SSA issued additional instructions to reaffirm the criteria for adjudicating mental disability claims, and while we did not discuss the instructions in our statement because we did not have them in time, we are prepared to address them in the question and answer period.

I would like to go to the inadequate development and use of existing medical evidence.

When possible, all medical evidence should be obtained from existing sources, including treating physicians and institutions. That is the law and the regulations that Social Security is to follow. Of the cases we reviewed, the existing medical evidence of record, including evidence already in the case file, had not been appropriately considered. Rather undue reliance was often given to the consultant examination reports, using them as the primary evidence on which decisions were based.

In our group discussions with examiners, they told us they ordered CE automatically when they received the case folders. They pointed out that it is almost a waste of time developing thorough longitudinal histories on a young person who has some positive characteristics which they interpret as not meeting the listings.

Examiners also said that, because of production and processing time goals to adjudicate cases, they are reluctant to wait for or obtain all the historical data. They said it is much easier and faster to develop and justify a medical-vocational termination with a positive CE report.

On page 21, the problem of overrelying on a CE report is that the CE physician rarely has the complete medical history to assess the patient, which can result in the physician relying on the individual's condition at that particular point in time, and on the individual's description of his or her history and daily activities. The illness itself may prevent the claimant from accurately portraying such information. Also, if claimants want to appear normal, they may exaggerate their conditions or activities.

We have an example I would like to share with you, where the information in the CE report is laid out on page 21. We went behind the report and found a totally different story. When we visited the beneficiary, he was living in a restricted residential facility and participating in a sheltered workshop. He had misrepresented many facts concerning his living arrangements, daily activities, and work capabilities to the current CE physician.

The facility administrator, the floor nurse, the workshop plant manager, and a work evaluation specialist all thought he was incapable of independent living, and of obtaining and keeping competitive employment at any skill level.

Examiners told us that SSA's policy of focusing on daily activities often leads to an overreliance on CE examinations, which always describe claimant's daily activities.

CE reports usually describe the daily activities as he or she watches television, visits relatives, shops, cooks his or her own meals.

Senator COHEN. Can I interrupt you for a moment?

Are you saying that some beneficiaries may, in fact, try to put on a better face than really exists so they would stay out of an institution?

Mr. MCGOUGH. That is exactly right.

Senator COHEN. If I may make a comment, Mr. Chairman, this problem creates a greater irony. One of our major goals is to try to reduce costs in caring for the disabled. We hear a great deal about structural unemployment, and cyclical unemployment, and there was a very poignant moment on this morning's television, when one of the unemployed steel workers went up to President Reagan, giving him a copy of his résumé and saying he wanted to work desperately.

When you deal with mental disability, how much more difficult can it be?

Chairman HEINZ. I have an extra copy of the résumé here.

Senator COHEN. That is the difficulty we have. What strikes me as being shortsighted in this whole situation is the cost factor. We are reversing a policy decision which we made in the past 10 years of trying to move people out of institutional care into the community. This has been a deliberate, calculated policy, saying there are people whose disability is not so severe that they must be confined in an institution, but should be placed in the community and involved in community groups and activities.

You put them back into the community to reduce the cost and make them a better part of the community; however, if you take away their subsistence under a strict interpretation of the disability rules and guidelines, what you do is force them back into the institutions because they have no place else to go, and the costs are going to be dramatically higher, aside from the social factor. Costs are dramatically higher, which totally reverses the policy that we have pursued in the past decade. So it seems to me that one of the major problems we are faced with is a very shortsighted policy of trying to save money and terminating benefits for people who are going to be back into the institution.

Mr. McGOUGH. I know Dr. MacLennan feels the same way. I would mention that we have started a study to look at what has happened to the people who have been terminated from the social security rolls and what sources of support they are now under; and hopefully, we will be able to provide this committee and the Congress with some useful information in that regard.

Chairman HEINZ. On that point, isn't it also true that if you ask the Social Security Administration, they absolutely have no idea what has happened to the mentally disabled people that they have terminated? They have never looked, and based on their never looking, we can suppose that they do not want to know.

Mr. WYCHULIS. They do not feel it is part of their responsibility; it is not part of the law requiring them to do so.

Chairman HEINZ. Thank you very much.

Senator Cohen has a hearing he has to chair at 10 o'clock.

Mr. McGough, will you please continue?

Mr. McGOUGH. One of the other points we talk about in the statement, at the top of page 23, is that scheduling and performing CE's before the historical medical evidence is obtained can also result in unnecessary costs and detract from the CE physician's ability to accurately assess the severity of the impairment and the quality of the claimant's ability to perform daily functional activities. We believe this is an important point to make because in the next section we talk about the SSA and State psychiatric resources that are severely limited in reviewing mental impairment. We think that psychiatrists or psychologists have to be an integral part of the decisionmaking process for the mentally disabled, so this is a major point.

In three DDS' visited, there were no psychiatrists and limited psychiatric training was provided to examiners. Overall, we found that there is a shortage of in-house psychiatric medical staff available for advice within the SSA/State adjudicative system. Nationally, as of December 1982, four States and the District of Columbia had no in-house psychiatrists, and 36 others had, by SSA standards, a deficiency in the minimum psychiatric hours required.

SSA and State officials said the limited fee rates established by the State are significantly less than competitive rates and, thus, they cannot hire or contract with more psychiatrists.

That concludes my summary. We do have several cases and, if it pleases the chairman, I would be happy to ask Dr. MacLennan to summarize one or two of them, or we can go into the questions.

Chairman HEINZ. Let's do that in a minute. There are a few things I would like to ask first.

First of all, your entire testimony is a part of the record.

[The prepared statement of Mr. McGough follows:]

PREPARED STATEMENT OF PETER J. McGOUGH

Mr. Chairman and members of the committee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) current process for determining whether persons with mental impairments qualify for disability under SSA's two disability programs.[1] As you know, the actual adjudicative process is carried out by the various State disability determination services (DDS) following SSA guidelines and instructions.

In an August 18, 1982, letter to us, you requested that we thoroughly examine SSA's decisionmaking process. You expressed concerns that individuals, who were not found to qualify by meeting specific medical criteria, were not being afforded a realistic evaluation of their capacity for work. You also stated the concerns of mental health organizations that, (1) SSA's medical criteria do not reflect current professional standards and nomenclature, (2) the methods for evaluating an individual's capacity to work fail to reflect good professional practices, and (3) many decisions are based on insufficient medical documentation, often on one brief consultation examination.

We began our work in September 1982, by thoroughly reviewing the Social Security Act, the corresponding regulations, and the decisionmaking process and criteria used by SSA to adjudicate mental disability claims.

We conducted our work at five DDS' in Illinois, Indiana, Ohio, and Pennsylvania; at SSA headquarters in Baltimore; and at a regional office in Chicago. We visited Pennsylvania because your staff expressed interest in activities in that State. The other States were selected because of their proximity to our Cincinnati regional office, where we have staff experienced in auditing disability matters.

At each DDS we met with the director, the chief medical consultant, and the medical administrator. Overall, at the five DDS', we interviewed 38 claims examiners individually, and more than 200 examiners in group discussions, 18 supervisors, 8 quality assurance chiefs, and 7 medical coordinators.

Our work at SSA included reviewing disability cases previously selected for review by SSA's quality assurance staffs. We also discussed adjudicative policies and procedures with disability program officials and several SSA physicians, including the chief medical officer and the chief consultant for psychiatry and neurology.

In addition, we reviewed a total of 159 mental disability cases that had been recently adjudicated by SSA—130 of the cases were denials and terminations and 29 were allowances and continuances of benefits. We selected the cases from those available during our visits to the various locations and, as such, the results of our case reviews are not statistically representative of all cases adjudicated at the locations and are not projectable to the universe of SSA mental disability decisions. Of the cases selected, 40 denials or terminations were examined in detail by GAO's full-time clinical psychologist and mental health advisor.

Although our detailed case review is not projectable to the universe of all mental disability cases adjudicated, our findings have national implications. Our additional work and evidence gathered at SSA headquarters strongly indicate that what we found is happening across the Nation.

To provide a proper context for discussing the results of our review, I would like to explain briefly the evolution of events that preceded our review.

BACKGROUND—EVOLUTION OF EVENTS

In March 1981,[2] GAO reported to the Congress that SSA had not adequately followed up to verify that disability insurance beneficiaries remained disabled. The report said that, based on a nationwide sample case review conducted in 1979 by SSA, as many as 20 percent of the persons on the disability rolls were not disabled. SSA conducted a followup study in 1980 and 1981 and found that 2 percent of the beneficiaries on the rolls during July/September 1980 were not disabled.

Although we did not attempt to independently validate SSA's disability decisions in its initial study, our own study results showed that because of inadequate investigations and lack of followup on persons who were expected to medically improve, SSA had allowed many nondisabled persons to remain on the disability rolls. SSA's initial study, performed by experienced examiners and physicians, provided the only available estimate of the problem's magnitude.

Congressional concern over SSA's medical reexaminations and other inadequate review procedures led to the enactment of section 311 of Public Law 96-265, known as the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabilities have not been determined to be permanent.

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[1] SSA administers two disability programs—the social security disability insurance program and the supplemental security income program.

[2] "More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficaries," HRD-81-48, Mar. 3, 1981.

SSA began the reviews in April 1981. We said in our March 1981 report that resources were currently being used to review the continuing eligibility of supplemental security income (SSI) recipients, and suggested they be shifted to reviewing the disability insurance (DI) rolls because of the higher benefit levels.

In previous testimonies regarding SSA's disability reexamination efforts,[3] we discussed the high termination rate, which was in excess of 40 percent through 1981 and 1982 (currently the termination rate is about 44 percent). Part of this high termination rate included people who had recovered and others who perhaps should never have received disability benefits. We pointed out, however, that many individuals losing their benefits had been on the rolls several years, still had severe impairments, and had experienced little or no medical improvement. We concluded that many of the terminations were caused because of a changed adjudicative process and climate, and poor State agency medical development practices.

CURRENT CONDITIONS

Data from SSA's files[4] indicate that, as of August 1982, SSA had reexamined in its periodic review process about 305,400 individuals and terminated benefits in about 134,500 (or 44 percent) of the cases. About 74,800 cases reviewed involved persons with mental impairments and 31,700 (or 42 percent) of them were terminated. Of the 31,700 terminations, about 13,400 (or 42 percent) requested a reconsideration. Between June 1981 and August 1982, only 1,400 of the mental disability reexamination cases had their decisions reviewed by administrative law judges (ALJ's). At the reconsideration level the DDS' sustained the termination decision in 76 percent of the cases. At the ALJ level, 91 percent of the decisions were reversed and the claimants' benefits were reinstated.

Our current review reveals many of the same conditions we reported earlier and generally confirmed the concerns you raised in your August letter to us. Although the scope of our review was limited, we found many individuals who had their benefits terminated despite having severe impairments, and in our opinion, having little or no capability to function in a competitive work environment. We had 40 of the denial and termination cases reviewed by our clinical psychologist and she concluded that in 27 of the cases the individuals could not function in their daily living without support and could not work in a competitive or stressful environment. In an additional 13 cases she concluded that more medical or psychosocial information or trial work experiences were needed to make an informed decision. Several cases illustrating the reasons for our concerns about the appropriateness of the decisions to terminate benefits are summarized in an attachment to this testimony.

Our review revealed several weaknesses in SSA's and the DDS' adjudicative policies and practices. Specific weaknesses we identified were:

(1) An overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities.

(2) Inadequate development and consideration of a person's residual functional capacity and vocational characteristics.

(3) Inadequate development and use of existing medical evidence, resulting in an overreliance and misuse of consultative examinations.

(4) Insufficient psychiatric resources in most State DDS'.

These problems are discussed in more detail below.

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

SSA's regulations contain a set of medical evaluation criteria—referred to as the medical listings—describing impairments that are presumed to be severe enough to prevent an individual from working. If a person meets the criteria, he or she is awarded disability.

Mental impairments in the listings are categorized as: (1) Chronic brain syndromes, (2) functional psychotic disorders, (3) functional nonpsychotic disorders, and (4) mental retardation. With the exception of mental retardation, the listings for mental impairments include an "A" part and a "B" part. For example, the listings for a schizophrenic (functional psychotic) disorder include part A—"manifested per-

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[3] We provided testimony on May 25, 1982, to the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs. We also testified on Aug. 18, 1982, before the Senate Finance Committee.

[4] In December 1982, we obtained SSA's computer file (based on completed SSA form 883's—"Cessation or Continuance of Disability or Blindness Determination and Transmittal") of CDI actions for disability insurance recipients. The most recent data in the file were through August 1982.

sistence of one or more of the following clinical signs: depression (or elation), agitation, psychomotor disturbances, hallucinations, or delusions * * * ," and part B—"resulting persistence of marked restriction of daily activities and constriction of interest and seriously impaired ability to related to other people." To be eligible for disability benefits, both part "A" and all of the part "B" must be met.

Although the criteria for meeting the medical listings for mental impairments have not changed substantially since 1968,[5] it has become increasingly difficult for mentally impaired individuals to meet the medical listings. As a result of our case reviews and discussions with examiners in five DDS', the problem focuses principally on part B of the listings. Examiners were concluding that individuals did not meet part B based on very brief descriptions of the individuals performing only rudimentary daily activities—such as watching television, visiting relatives, fixing basic meals, and doing basic shopping activities. Often little else positive was contained in the medical evidence.

HARD LINE TAKEN BY SSA

We asked examiners why they were accepting a few positive signs as support that the individuals did not have a "marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people" (as part B requires).

The examiners we interviewed told us it is difficult for them to determine when restriction of daily activities, constriction of interests, and inability to relate to other people are severe enough to meet the listings. The examiners also said SSA is taking a hard line in interpreting the criteria.

How the criteria are applied by SSA is of fundamental importance because cases are evaluated by SSA's quality assurance system, and State agencies look to case returns from SSA's regional office disability assessment branches (DAB's) as the clearest indicator of SSA's intent. State officials and examiners we spoke with unanimously perceive DAB returns over the past several years as intending to make it extremely difficult to meet the listings, and they have responded accordingly in their decisions. Several examiners told us that it only takes a few returns before you change the way you evaluate evidence.

We found that SSA's quality assurance case returns to the DDS focused extensively on daily activities and current behavior. We reviewed some of these case returns where the DDS had determined the individuals were very severely mentally impaired and were disabled, but the DAB returned the cases because the individuals had some daily activities, albeit extremely minimal ones. The following cases that we reviewed are illustrations of minimal activities which were judged as precluding the individuals from meeting the listings:

(1) A 34-year-old man was diagnosed as having mild mental retardation (IQ 61)—chronic brain syndrome associated with convulsive disorder, and slight speech impediment. He has a 6th grade education plus 2 years special education. The only work he had done was as a bathhouse attendant and lost the job because he could not handle it. He was allowed disability in 1969. In 1982, he was reexamined and the DDS decided on a continuance, apparently for meeting the listings.

SSA's quality assurance staff reversed the decision on November 8, 1982, as a termination, because he did not meet the listings. They said he has no significant restrictions in his interest or daily activities, although he showed overt signs of psychotic behavior. The CE report dated September 9, 1982, said he spent his day, "reading, watching television, and taking brisk walks. He does some housekeeping and cooking." The CE report also pointed out that personality tests substantiated organic brain syndrome characterized by perceptual-motor impairment and gaps in thinking. Bender (test) figures were disproportionate and poorly done. He was hysterical in his personality orientation and had poor socialization. He could not trust his own performance and was easily stressed. He could follow simple instructions if there was no stress involved. He lacked intellectual dependability and emotional stability for regular employment.

In our judgment, he met the listings.

(2) A 50-year-old woman was allowed disability in June 1975, with a diagnosis of depressive reaction. She was reexamined (medical diary) in early 1977 and benefits were terminated in April 1977. She reapplied for benefits and was allowed in September 1978 with a diagnosis of schizophrenic reaction-chronic-undifferentiated type. She was reexamined in December 1979 and the DDS continued benefits. SSA's

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[5] The IQ levels for mental retardation were changed in 1979 to "59 or less," instead of "49 or less."

quality assurance review returned the case as a termination in January 1980 on the basis of a CE report that she got along with family and had a few friends with whom she visited and drank coffee. SSA concluded that she did not meet or equal the listings and had the residual functional capacity to do unskilled work. The same CE report, however, said she had suicide attempts, inappropriate behavior, was withdrawn, was unable to relate to others, could not do simple repetitive tasks for competitive fees, could not understand written or oral instructions, could not socialize with supervisors or coworkers, and could not tolerate work pressures for unskilled work.

We concluded that the CE report supported a decision for meeting the listings based on her impairment and adverse daily activities.

The following comment in a December 1981 letter to SSA's Chicago regional office from the DDS director in Wisconsin addresses the impact of the DAB reviews in setting adjudicative climate:

"The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny. The rationales for these denials as promulgated by DAB reviewers, seems to be based on the most minimal possible understanding of mental impairments in terms of their effect on individuals, on the fluctuations involved in the behavior of those with such impairments, and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capability of going out in the competitive world and obtaining and holding a job with the normal stresses, under supervision and with the necessity to be able to perform consistently."

We spoke to SSA's chief psychiatrist and two other SSA psychiatrists about our findings and about the difficulties in making medical assessments of an individual's daily activities (part B). They said to make a severity determination of a person's daily activities it is necessary to evaluate comprehensively the quality of the activity, how often it is done, whether independently or under supervision, with what degree of comprehension, and how appropriate the activity is. Other considerations should include whether the claimant is living independently or in a supervised/structured environment; or is on medication and the effects of it; and whether the claimant is in remission and the timespans between relapses.

CONCERNS RAISED THAT THE CRITERIA TO MEET THE LISTINGS ARE OVERLY RESTRICTIVE

The American Psychiatric Association (APA), in a letter dated June 29, 1982, to the SSA Commissioner, recommended a change in parts A and B of the listings for all mental disorders other than mental retardation. They recommended a change to part A to eliminate the current requirements that the claimant must manifest active symptoms upon examinations, and require, instead, that examinations recognize and evaluate the nature and severity of the illness even if the signs are not continuously present. The APA also suggested that, where a person evidences one or more of the clinical signs ("A") and demonstrates any two (for functional psychotic disorders) or three (for nonfunctional disorders) of the "B" criteria, that should be sufficient to establish disability. They also recommended that any evaluation of an individual's daily activities as stated in part B should consider such issues as "* * * frequency, appropriateness, autonomy, and comprehension."

In 1982, the Chicago regional medical consultant for SSA wrote that it is: "practically impossible to meet the listings * * * for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization. * * * In fact an individual may be committable due to mental illness according to the State's mental health codes and yet found capable of 'unskilled work' utilizing our disability standards * * *"

Virtually every examiner that we talked with echoed these observations. We were told that to meet the listings an individual had to be actively and continually manifesting clinical signs. Even claimants severely impaired, and currently or recently hospitalized, were found not disabled.

Our group discussions with examiners produced comments to the effect that unless a claimant was "flat on his back in an institution," "comatose," or "in a catatonic state," he or she would not meet the listings. While these statements may be exaggerated, they are indicative of the examiners' perceptions.

RESIDUAL FUNCTIONAL CAPACITY AND VOCATIONAL CHARACTERISTICS ARE NOT APPROPRIATELY CONSIDERED

When an individual fails to meet the listings but the impairment still lists his or her ability to perform basic work functions, SSA's process to determine disability requires that an assessment be made of the individual's residual functional capacity (RFC). In mental impairments an RFC should consider such factors as, "capacity to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting." If the RFC assessment finds the individual incapable of doing his or her previous work, an assessment must then be made of the individual's RFC and such vocational characteristics as age, education, and work skills to see if he or she can do other work in the national economy.

As difficult as it is to meet the criteria in the medical listings, the chances of a younger individual getting or sustaining benefits based on RFC and vocational factors is extremely slim. As we found in many of the cases we reviewed, when an individual does not meet the listings SSA's guidance to the States resulted in a virtual presumption that he or she has the RFC to do basic work activities or unskilled work.

We traced the evolution of this policy guidance back to April 1979 with SSA's publication of Informational Digest 79-32. The digest stated in part that "the capacity for unskilled work * * * in and of itself represents substantial work capability and would generally be sufficient to project a favorable vocational adjustment for claimants with solely mental impairments."

SSA's chief psychiatrist elaborated on this issue in a May 1980 memorandum to SSA's New York regional office, when he said that a psychiatric impairment rating below meeting the listings signifies the ability to engage in substantial gainful activity at a level of unskilled work or higher. He also said that making an RFC assessment would be "redundant."

This policy was reiterated by SSA's chief medical officer in a November 1980 letter to the Chicago regional office by stating:

"Where the overall psychiatric rating is less than meets or equals [the listings] the individual retains a mental RFC for at least some type of unskilled work activity."

This policy guidance was not confined to one or two regions but had national dissemination. At least six other SSA regional offices requested clarification of this policy. SSA's associate commissioner for operational policy and procedures responded similarly to the other regions, as indicated in a December 1980 response to the Kansas City regional office by stating:

"In reference to * * * question concerning adjudication of psychiatric cases short of listing severity, with a finding that a mental impairment does not (or does no longer) meet or equal the listing, it will generally follow that the individual has the capacity for at least unskilled work.

"Accordingly, where it has been concluded that the listing is neither met nor equalled and the inability to perform unskilled work is found, a second look at the medical findings is warranted. If the reassessment of the medical does not support a finding of 'meets' (or 'equals') then the restrictions indicated by the functional assessment are overstated and a reassessment of the actual residual functional capacity would be in order."

On March 3, 1981, the regional commissioner, Kansas City, wrote to SSA: "Following the logic described in * * * your memorandum, the likelihood of a vocational allowance for a mental impairment would appear to be extremely remote."

We discussed with SSA's chief medical officer, the chief psychiatrist, and two other SSA psychiatrists their rationale for saying that an individual with a severe impairment, who does not meet the listings, still maintains the mental RFC for unskilled work. First, they defined unskilled work (they refer to it now as basic work activity) as work that is tantamount to doing competitive work. They said that a person who does not meet the listings has the cognitive power to do "bottom of the barrel," simple, or unskilled type jobs. If an individual could not perform even unskilled work, he or she should be rated a "5" (meets the listings) on a psychiatric review form and presumed disabled. Less than a "5" means the ability to do simple work. They emphasized that they are not saying the person can, in fact, work. The physician's job, they pointed out, is to make the medical assessment. They told us that the decision to determine a person disabled or not is a vocational decision made by the examiners.

We asked the psychiatrists: "if the examiners are told a person had the mental ability to understand and do unskilled work, could not one logically conclude that a person can, in fact, work, if an unskilled job were available in the national economy?" One of SSA's psychiatrists told us that he can understand how the examiners would reach such a conclusion and that is probably the message that is being sent out to them through SSA's DAB case reviews. He said that he sees cases where individuals get a "3" or "4" rating (severe, but not severe enough to meet the listings) and are determined not disabled, when he knows the individuals are precluded from competitive work. For example, he said that he was currently reviewing a case involving a mentally retarded woman with an IQ in the low 60's. He assigned, according to present procedures, a "4" rating. He said the decision will result in a denial even though he knows that there is no way the individual could possibly work competitively.

Several examiners told us that DAB and other quality assurance returns have given them a clear message to terminate benefits for younger workers who do not meet the medical listings.

MINNESOTA CLASS ACTION SUIT

In May 1982, the Mental Health Association of Minnesota filed a class action suit against SSA's policies regarding mental impairments in the Fourth Division Minnesota District Court. The court concluded that:

"* * * A new policy was developed by SSA beginning in early 1980 concerning eligibility for mentally impaired claimants. In accordance with that policy, SSA determined that persons whose mental impairment does not meet or equal the listing of impairments retain sufficient residual functional capacity to do at least unskilled work."

The court ruled in favor of the association and said, in part, of SSA's policy that:

"The policy * * * is arbitrary, capricious, irrational, and an abuse of decretion.

"By use of this policy, the defendant has terminated the benefits of and denied new benefits to class members without proper assessment of the individuals' capacity to engage in substantial gainful activity."

As required by the court, the Commissioner, SSA, sent a memorandum to all regional commissioners on January 3, 1983, stating in effect that to presume a person who does not meet or equal the listings maintains the RFC to perform unskilled work is contrary to Federal regulations. The memorandum reiterated SSA's policy that "* * * the sequential evaluation process must continue in the claim with consideration of vocational factors in light of the claimants' residual functional capacity (RFC)."

In addition, in March 1983, SSA issued instructions to the DDS' dealing with mental impairments and their effects on individual work abilities. The instructions say:

"Where a person's only impairment is mental, is not a listing severity, but does prevent the person from meeting the mental demands of past relevant work, it may also prevent the transferability of acquired work skills. The final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base.

"Where there is no exertional impairment, unskilled jobs at all levels of exertion constitute the potential occupational base for persons who can meet the mental demands of unskilled work. These jobs ordinarily involved dealing primarily with objects, rather than with data or people, and they generally provide substantial vocational opportunity for persons with solely mental impairments. In a relatively few instances, persons with this large job base will be found disabled because of adversities in age, education, and work experience."

The instructions provided greater flexibility for determining the ability of a mentally disabled person to do work and may result in more accurate disability decisions. However, the instructions also provide guidance which can be interpreted very restrictively and, if so interpreted, "not disabled" decisions will continue for cases where severe mental impairments exist.

Also, earlier this week, SSA issued additional instructions to clarify the RFC criteria for adjudicating mental disabilities. We did not have an opportunity to review these new instructions at the time we were preparing this testimony.

INADEQUATE DEVELOPMENT AND USE OF EXISTING MEDICAL EVIDENCE

The Social Security Act requires that mental impairments causing disability be demonstrated by medically acceptable clinical techniques. When possible, all medical evidence should be obtained from existing sources, including treating physicians and institutions.

Often, treating sources cannot, or do not, provide enough information for the examiners to make a disability decision. The DDS must then purchase the medical evidence in the form of a medical examination, generally referred to as a consultative examination (CE). CE's are needed to clarify medical evidence, obtain necessary data not otherwise available, or resolve conflicts or inconsistencies in the evidence obtained.

In many of the cases we reviewed, the existing medical evidence of record, including evidence already in the case file, had not, in our judgment, been appropriately considered. Rather, undue reliance was often given to the CE reports, using them as the primary evidence on which decisions were based.

Examiners we spoke to at the five DDS' visited confirmed this. In our group discussions with examiners, they told us they order CE's automatically when they receive the case folders. They pointed out that it is almost a waste of time developing thorough longitudinal histories on a person who has some positive characteristics, which they interpret as not meeting the listings. They pointed out to us that if a medical/vocational allowance is warranted they would have to develop the claimant's negative characteristics fully, which is time-consuming, and in the end they feel the case would probably be returned from the DAB because the person would be viewed as being able to do unskilled work. The examiners say they are then penalized on two counts—their backlogs increase and an error is charged against them.

Examiners also said that, because of production and processing time goals to adjudicate cases, they are reluctant to wait for or obtain all the historical data. They said it is much easier and faster to develop and justify a medical/vocational termination with a positive CE report.

Further, examiners said it takes much longer to obtain historical medical evidence for mental impairments than for other body system cases because (1) treating psychiatrists are more reluctant to turn over patients' files; and (2) hospitals and mental health institutions are not timely in providing patient reports, and in both instances time-consuming followups are necessary to get the data.

The problems with overrelying on a CE report is that the CE physician rarely has the complete medical history to assess the patient, which can result in the physician relying on the individual's condition at that particular point in time and on the individual's description of his or her history and daily activities. The illness itself may prevent the claimant from accurately portraying such information. Also, if claimants want to appear normal, they may exaggerate their conditions or activities.

For example, we investigated a claim involving a beneficiary with schizophrenia and mental retardation whose benefits were terminated based on a consultative exam. Two previous CE exams conducted a year and one-half earlier gave the beneficiary a prognosis of "poor" and "nil." The new exam found him to be functioning well. When we visited the beneficiary he was living in a restricted residential facility and participating in a sheltered workshop. He had misrepresented many facts concerning his living arrangements, daily activities, and work capabilities to the current CE physician. The facility administrator, the floor nurse, the workshop plant manager, and a work evaluation specialist all felt he was incapable of independent living, and of obtaining and keeping competitive employment at any skill level.

Examiners told us that SSA's policy of focusing on daily activities often leads to an overreliance on CE examinations, which always describe claimants' daily activities. As we said earlier, because of SSA's restrictive interpretations of the medical listings, any positive daily activities that the claimant does are likely to result in a disability denial.

CE reports usually describe the daily activities as he or she "watches television," "visits relatives," "shops," "cooks own meals," etc. Examiners, however, cannot assess the quality of a person's daily functioning and behavior from a simple description of activities.

For example, we investigated a periodic review case involving a schizophrenic who did not meet the listings and was terminated. A CE report based largely on the claimant's statements said he visited friends, played the piano, participated in family activities, and that his schizophrenia was controlled by medication. We talked to the claimant's treating psychiatrists and found (1) medication was an extraordinarily steep dose (100 mg. prolixin decanoate every 2 weeks)—by itself indicating a severe illness—and he still has frequent relapses; and (2) daily activities were overstated—friends turned out to be psychiatric social workers and piano playing consisted of aimless doodling.

Scheduling and performing CE's before the historical medical evidence is obtained can also result in unnecessary costs and detract from the CE physician's ability to accurately assess the severity of the impairment and the quality of the claimant's ability to perform daily functional activities. We believe this is important because, as we will explain next, SSA and State psychiatric resources are severely limited, and yet SSA and the States are not using purchased psychiatric resources to fill this void.

In a discussion with the SSA psychiatrists, they confirmed that it is unlikely that a thorough psychiatric evaluation can be performed on an individual in a CE session without the individual's medical history, prior work history, workshop evaluations, and history of daily activities. These necessary elements are often lacking in CE reports, and do not appear to be developed by the State examiners.

STATE PSYCHIATRIC RESOURCES ARE SEVERELY LIMITED

In the five DDS' visited, three did not have any psychiatrists reviewing cases and two were significantly understaffed relative to SSA's psychiatric training. Because the process encompasses a medical (psychiatric) evaluation that is highly complex, we asked SSA's psychiatrists whether a lay person or a nonpsychiatric physician has the expertise to make such an assessment. They said examiners would not be technically qualified nor would most physicians of other medical specialties.

The chief medical consultant at one DDS said neither he nor the other staff doctors feel qualified to make a severity or psychiatric review form assessment. At another DDS, the chief medical consultant said the same thing, except he added that a physician specializing in internal medicine might be qualified. The physicians on his staff, however, were not specialists in internal medicine.

Overall, we found that there is a shortage of in-house psychiatric medical staff available for advice within the SSA/State adjudicative system. An SSA study found all six States in the Chicago region were lacking sufficient psychiatric resources. The States combined had only 50 percent of the minimum number of psychiatric-hours needed for proper case review. Nationally, as of December 1982, four States and the District of Columbia had no in-house psychiatrists, and 36 others had, by SSA standards, a deficiency in the minimum psychiatric-hours required.

SSA and State officials said the limited fee rates established by the States are significantly less than a competitive rate and thus, they cannot hire or contract with more psychiatrists.

Mr. Chairman, that concludes my statement, and we will be happy to answer any questions you or the committee members may have.

EXAMPLES OF CASES WHERE GAO'S PSYCHOLOGIST QUESTIONED SSA'S DECISION THAT CLAIMANTS COULD WORK

A 32-year-old paranoid schizophrenic man with an IQ of 88 was on the disability rolls since 1976. The claimant takes psychotropic medication and lives at home with his family, who supervise his daily activities. He has no friends, is isolated, exhibits poor emotional control, and has phobias. He has difficulty comprehending and is incapable of managing his own funds. He works 5 hours 1 day a week as a janitor's assistant in a church, a charity job. He must be heavily supervised. He attends day treatment 3 days a week. He previously failed work rehabilitation. His prognosis is listed as poor.

This claimant's benefits were terminated in January 1983, when the DDS concluded that he retained the capacity for simple, repetitive tasks.

A 31-year-old man with an IQ of 68 was on the disability rolls since 1976. The claimant has a history of epilepsy and paranoid and catatonic episodes and was hospitalized in 1960, 1961, and 1980. The claimant lives with his mother and a brother (the mother is the claimant's representative payee) and is in treatment at a mental health clinic. Between 1973 and 1976, the claimant worked intermittently as a dishwasher in a sheltered workshop and hospital, terminating this work because it was too stressful. A psychological exam reported that the claimant exhibited high anxiety, confusion, poor auditory and visual memory, motor area deficits, and decompensated under stress. The mother and brother reported evidence of deterioration, seclusiveness, and inappropriate responses. CE psychiatrists reported the claimant does not appear capable of coping with even minimal stress. Claimant's judgment is evaluated as poor.

This claimant's benefits were terminated in October 1982 because the DDS concluded that the claimant had the RFC to understand, carry out, and remember instructions; to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting; and to do unskilled work.

A 30-year-old acute schizophrenic man with borderline mental retardation held several jobs as a gas station attendant prior to 1976, when he was adjudged incompetent to manage himself or his money and began receiving disability benefits. Institutionalized in 1978 and 1982, he has been in treatment since August 1982 at a mental health center. Treating psychiatrists have evaluated the claimant as restless, depressed, self-preoccupied, distractible, quarrelsome, ruminative, and disruptive. A psychological exam showed that the claimant was suspicious, paranoid, depressed, and unable to function under pressure. A CE report said the claimant "may not be able to do repetitive tasks. May not be able to understand stress and pressures associated with day-to-day activity. Probably not able to manage own funds."

This claimant's benefits were terminated in October 1982 because the DDS concluded that the claimant had the RFC to understand, carry out, and remember instructions; to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting; and to perform unskilled work.

A 33-year-old chronic paranoid schizophrenic man, who in the past worked intermittently at unskilled jobs. The claimant was hospitalized in 1973, 1974, 1978, 1979, 1980, 1981, and in April 1982. His disability payments began in June 1978 and he has a representative payee. Reexamined in June 1981, he met the listings and his benefits were continued. The claimant was again reexamined in July and August 1982. An August 1982, psychiatrist's report says of the claimant: "Client's paranoid and persecutory thinking would probably make it very difficult for him to tolerate the pressures associated with achieving production requirements. His ability to retain concentration long enough to perform tasks is also questionable. Hostility toward authority figures would probably cause him to have great difficulty carrying out instructions given by the supervisor. Medication, primarily phenothizines and antipsychotics, appears to help the claimant in controlling aggressive impulses and staying in touch with reality. Long-term chemotherapy, supportive psychotherapy, and hospitalization during crisis will be needed to maintain the client in the community."

This claimant's benefits were terminated in September 1982 because the DDS concluded that the claimant was able to care for himself, relate adequately to others, and understand and carry out instructions. He was determined to be able to do unskilled work.

A 53-year-old mildly retarded schizophrenic man whose benefits began in September 1975, had them continued after reexaminations in 1977 and 1978. The claimant was hospitalized in 1975, 1976, and twice in 1977. The claimant has advanced Tardive Dyskinesia, cannot sleep at night, and lives in supervised nursing home. The attending physician stated the claimant is unable to read or write, has anorexia, poor judgment, no insight, and limited comprehension. He fears that people plot against him and has no contacts outside of the nursing home. The claimant needs help in managing money. The CE report considered the claimant to be oriented to time and place and found that he spoke relevantly and coherently.

This claimant's benefits were terminated in November 1982 because the DDS concluded that the claimant was well oriented to time, place, and person; was able to understand, remember, and carry out simple one- or two-step job instructions; and could do unskilled work.

A 30-year-old paranoid schizophrenic man was in a partial hospitalization program and functioning at a basic level on medication, according to two psychiatric evaluations. The claimant, who has been on the rolls since January 1975, has a diminished effect, cannot manage his own funds (his mother is his representative payee), is withdrawn, has no interests, and exhibits poor thought process, insight, and judgment. He decompensates under stress.

This claimant's benefits were terminated in June 1982 because the DDS concluded that he could do relevant past work.

A 56-year-old registered nurse was diagnosed as depressed with paranoid features, complicated by alcoholism and possibly early Alzheimer's disease. She was institutionalized in 1967, 1970, 1979, and July 1982. The claimant worked as a registered nurse for 29 years until 1977. She was allowed disability in April 1978. A CE physician in 1978 felt the disability was sufficient not to establish a medical diary date. In 1980, the claimant was placed in Goodwill Industries as a nurse's aide. She had a breakdown in October 1981 and has been living in a nursing home. Though active and social and offering a normal appearance, the claimant functions under supervision with constant reminders. The nursing home is her representative payee. The claimant needs help dressing and taking medicine. She needs to be reminded to eat. She has a hobby and goes to yard sales with encouragement. Her treating physician and nursing home personnel say she is deteriorating and cannot function except in a structured supervised environment. When the claimant lived alone, she neglected her home, became depressed, and did not eat and did not keep herself clean.

Disability benefits were terminated in October 1982 on the basis that she is oriented in three spheres, has a satisfactory memory, has good contact with reality, is neat and clean in appearance, and functions adequately in daily activities.

Chairman HEINZ. Let me say that I think this testimony is a remarkable piece of work. You have produced it in a relatively short time frame for the GAO. Most of us who ask GAO to do studies find it takes a year or two. To my mind, this report is quite significant. You reviewed in great detail 159 cases and 40 denials. You do feel, based on a considerable amount of experience, that there are national implications, even though this was limited to a four-State review. To my mind, your report—which I read from cover to cover last night—is really damning evidence of a callously uncaring system that is unremittingly unfair.

When you also consider that there is a high reversal rate at the administrative law judge level, you are forced to conclude that there is a virtual holocaust being committed against the mentally impaired, the mentally disabled.

There are a number of questions that I would like to ask you—to get a few more facts on the record.

As you state in your testimony, you made visits to four States. Let me ask you, do you have any reason to believe that the serious problem you found in those four States, among them my home State of Pennsylvania, are not representative of what is happening nationally?

Mr. MCGOUGH. No; we have no reason to believe the same type of thing is not happening in other locations across the Nation.

Chairman HEINZ. So it is fair to say that this picture of callousness and unremitting unfairness is a picture of the way mental disabilities are evaluated in State after State in the 50 States all across the country?

Mr. MCGOUGH. A good bit of what we found is tied to the criteria that is being used, and the instructions that are going out, and the signals that are being sent by SSA for implementing those instructions. This is occurring across the Nation.

Chairman HEINZ. You are fortunate to have with you today a psychologist, Dr. Beryce MacLennan.

Dr. MacLennan, in your professional capacity, what significance is there in an individual who is mentally disabled—watching television, or frying an egg, or going to a movie, or playing the piano—what does that kind of functional activity indicate to you as to what that individual can do with regard to functional work in a competitive environment?

Dr. MACLENNAN. I do not think you can make a judgment. Even people who are very mentally disturbed in State hospitals play games, watch television, go on trips. I think you have to have the quality of the activity, and I think you have to have the full long-term medical history, and the patient history.

There has been a lot of evidence recently that the best predicters of whether people are going to be able to work now are their past work histories.

Chairman HEINZ. Their past work histories?

Dr. MACLENNAN. Right.

Chairman HEINZ. I realize that I interrupted you as you were going to go into some case histories, but I gather you have found that decisions are being made on the basis of unreliable indices of functional work capability.

Dr. MACLENNAN. I think very frequently some of the decisions are made without obtaining full histories and some decisions are made without evaluating the quality of what is going on. I thought I would summarize for you two examples.

The first, on page 1 of the attachment, is illustrative of a young schizophrenic. This is a 32-year-old paranoid, schizophrenic man with an IQ of 88 who has been on the disability rolls since 1976. He is on psychotropic medication and lives at home with his family who supervise his daily activities. He has no friends, is isolated, exhibits poor emotional control and has phobias. He has difficulty comprehending and is incapable of managing his own funds. As a charity activity, his local church allowed him to work as a janitor's assistant in the church 1 day a week for 5 hours. He had to be heavily supervised there and the minister said it took a great deal of time of the person who had to supervise him. The other days he attends day treatment and he had previously failed work rehabilitation.

Yet, in 1983, the DDS concluded that he retained the capacity for simple, repetitive tasks and, therefore, could be employed in competitive employment.

Chairman HEINZ. So what you have here presumably is a report to the reviewing authority that this person had nominally performed certain kinds of janitorial activities like sweeping the floor. Whether or not it got cleaned properly was not looked into. He had somebody standing over him most of the time, but simply because he was able to pick up a broom and move it around the floor with unknown results, that caused the reviewing authority to disqualify him for benefits?

Dr. MACLENNAN. Right. It is that kind of assumption.

Chairman HEINZ. Then I understand that the answer to my question is a very strong "Yes"; my question was that, in your review, did you find people being just thrown off the rolls onto the mercy of whoever, or whatever, simply because they could push a broom, or fry an egg, or maybe sit at a piano and hit a few of the keys?

Dr. MACLENNAN. Right.

Mr. WYCHULIS. Excuse me.

The problem I think is with the interpretation of the daily activities by the DDS examiners. When we get into evaluating daily activities, these decisions are, of course, technical, and require psychiatrists. In the absence of having adequate psychiatric assistance at the DDS, the examiners are forced to make these types of decisions and their perception is that SSA is taking a hard line, so their judgment is to look for minimal daily activities of an individual. The examiners, consequently, go out and purchase a consultative examination. The CE report usually has daily activities of the individual. If he is ambulatory, not institutionalized, naturally he or she has some kind of daily activities. A lot of the CE reports that we looked at were very damaging. Many CE reports, I would say, were 10 percent positive and 90 percent negative. But a psychiatrist asked, "what are your daily activities?" The claimant would tell him of positive activities. These CE reports are then used with no evaluation of the quality or intensity with which he or she is doing these activities.

Dr. MacLennan. The purpose of the deinstitutionalization is to try and assist the individual to work at the highest level that they can. The mental health people who work with chronically mentally ill try and help the patients undertake activities in the community. They try and get them to go to day treatment or have sheltered work or have a hobby or socialize. This does not mean that these people are capable of functioning in a competitive world without any support and I think this is where the two parts of the Government are at cross purposes.

Chairman Heinz. Let's go into some of the other problems a little further.

Now, I understand that in deciding a disability case, the assessment of the severity of an impairment is a very critical determination. You listed the steps on the right-hand side which you go through when a disability decision is made.

In the course of your investigation, did you find that the physicians in the State disability determination agencies are making thorough assessments of the severity of mental disability? Who really makes the decision in practice? Is it a nonmedically trained disability examiner, or is it a physician, or if many people like this exist—and I understand that there are not many—is it a psychiatrist or clinically trained psychologist at the State agency who makes the decision?

Mr. McGough. I think Mr. Wychulis is in the best position to answer that. But as our testimony pointed out, I will preface it by saying we found they have very limited technically qualified physicians in these areas.

Chairman Heinz. In your full statement, my recollection is that you found that if you took all of the available trained manpower and allocated a minimum amount of time for them to perform a disability review, that even under those very minimum conditions, there was only 50 percent of the amount of trained, analytical manpower necessary to make all of the decisions that are allegedly being made; the amount of time we are talking about is an inadequate amount of time in any event.

Mr. Wychulis. Yes, that is correct. To answer your question about who is making the decision, SSA makes a severity rating first. It uses a psychiatric review form which provides a psychological profile, and it gives numerical ratings to a series of 17 factors. If the impairment is noted a "1" or "2" it is not severe. If the impairment is "5" the claimant meets the listing, and is presumed disabled. But unfortunately, the quality of such an evaluation is lacking in the real world of the DDS. What in fact takes place is the examiner takes all of the historical or longitudinal evidence, and makes a decision without much of a consultative effort with the DDS physician. The reason for this is that the examiners do not have confidence in the physicians who are not psychiatrists. Three of the DDS' we visited did not have psychiatrists or psychologists. So the examiners make the decision whether the person is disabled or not, make up the due-process notice, and attach a psychiatric review form and a residual functional capacity form, which is a medical evaluation, and turn it over to the physician at the

DDS. The physician generally has a 1-day turnaround time to make an evaluation. We talked to some physicians at DDS' and they do not feel qualified to make psychiatric decisions and they pretty much go along with the decision of the examiner.

Chairman HEINZ. So here you have a system in which an SSA spokesperson will say that the forms should be filled out by a trained psychiatrist. To have any meaning they must be completed by a psychiatrist. Yet, nonmedical personnel, who are disability examiners, are filling out those forms, are making those determinations; and what you are saying is, when they do get to a medical review person, he rubberstamps them because he does not have the expertise to do otherwise. He rubberstamps them in a 24-hour period in a routine fashion, whether he has 1 or 100. Is that what you are saying?

Mr. WYCHULIS. Yes; and the problem is, we hear allegations from the examiners that the doctors are not making thorough reviews because their workload is very heavy. At one of the DDS' they said, if all their physicians were on hand, optimally, they would have 15 minutes to review a case. Usually that is not the case, where all the doctors are on hand. So you have technical decisions being made by nontechnical examiners. The examiners, of course, have a difficult time making the assessments because they do not know the quality of the individual's daily activities.

The other thing that gives examiners problems is dealing with medications. They say if the individual is on these different psychotropic medications, how does an examiner know the side effects such medications have on an individual? They do not know how to evaluate drug dependence or alcoholism. They do not know how to evaluate a person being in remission. These are very technical decisions that have to be made and it is being forced on the examiners. So it is imperative that you need a qualified technical person at the DDS to make the evaluations.

Chairman HEINZ. If the Social Security Administration should come in tomorrow and say, no, these reviews are being made by properly qualified personnel, what would be your one word reaction?

Mr. WYCHULIS. Go visit some DDS'.

Chairman HEINZ. Can you summarize that in one expletive that would be critical and accurate?

Mr. WYCHULIS. Untrue.

Chairman HEINZ. Thank you. That was well done.

One last question about the disability examiners who end up making these decisions.

What demands are placed on them in terms of the caseloads they have to process, and the processing and time goals they are given for CDI's? Do these goals put undue pressures on examiners to decide DDS cases and what effect, assuming that there is that kind of pressure, does that have on the quality of decisions in these cases?

Mr. MCGOUGH. I would like to start and then ask Mr. Wychulis to help me out.

I think there may be some misunderstanding in this area. I do not think SSA per se has time goals that it articulates and forces the DDS or asks the DDS to meet. However, they do send down a lot of cases. They send down cases regularly and the DDS does prepare monthly, and even more regular, reports that show what their caseload is, and what the backlog is, and how much of it is 45 days old, and how much of it is 70 days old.

So the people at the DDS do have serious time pressures on them. Whether you call them goals per se that they have to meet, I think is a question. I do not think SSA would agree that they are setting goals for the DDS but the examiners very much feel the time pressures. They feel it and it manifests itself in different ways. That is why they ask for the CE right away; because it is an expeditious way to make the decision.

Chairman HEINZ. How would you characterize the pressure and what is the result?

Mr. McGOUGH. I think the pressure is real from their perception. I don't think SSA has instructed the DDS that they have to process the case in *x* number of days, and I think the case workload impacts on them adversely in quality of the decisions because adequate time and resources are not provided to develop full medical histories.

Chairman HEINZ. In how many instances that you looked at did the examiner take the time to develop a complete medical history?

Mr. McGOUGH. Mr. Chairman, I do not think I can give you a percentage or number. I can tell you that examiners told us that they would automatically order a CE because it is an expeditious way to get the case adjudicated.

Chairman HEINZ. Would it be possible for you to go back and look at your 159 cases and determine the extent to which a complete and thorough medical examination was ordered?

Mr. McGOUGH. We will take a look at the feasibility of doing it. We did, however, return the case files.

Chairman HEINZ. Did you find any instance—tell me if you did not look—did you find any instances in which a complete medical review was developed by the examiner?

Dr. MACLENNAN. Yes, I saw some. However, among the cases I read, there could be a complete medical history and yet the examiner or the medical consultant staff might decide to ignore the recommendations of the people who were treating the patients, the applicants.

Mr. WYCHULIS. Let me interject. I want to make one point clear about the previous discussion about the technically qualified individuals.

When I said there are not technically qualified individuals or psychiatrists on staff, I am speaking only of DDS' we visited. I do not know what the situation is where States like Massachusetts have more than an adequate supply of psychiatrists. So in fairness to SSA, not all States have a shortage. There is a shortage of psychiatrists, however, in 36 States. So you have 14 States that have an adequate number. They may or may not be making better evaluations.

Chairman HEINZ. I would like to ask about the quality assurance system which Mr. McGough discussed at some length in his written statement.

Mr. Wychulis, you have spoken to many examiners in doing this investigation. You have spoken to them in my home State of Pennsylvania. You have some views on what drives the State disability examiners to take such a hard line on making their decisions and that was discussed by Mr. McGough in the written testimony.

You document, quite accurately I think, that there is a message received by the way Social Security simply sends right back to the State agencies any cases where they do not like the favorable determinations. What I would like to focus on in particular, is this: What does it mean to you when SSA, as they have in the past, testifies that its CDI decisions are more than 90 percent accurate?

I am sure that tomorrow Mr. Simmons will say, as they said last year, 97.5 percent accurate. How do you account for this high accuracy rate, particularly when there is this small, insignificant problem of the administrative law judges in so many of the cases reversing these accurate denials of benefits?

Mr. WYCHULIS. I think that figure is not an accurate assessment of the quality of the decisions at all. First of all, you have to remember when they are assessing quality at the disability assessment branch, the State DDS' are selecting the cases that they send up. So the cases submitted to the DAB's for evaluation may or may not be biased.

But the other point in the quality assurance assessment is how the DDS' perceive what SSA wants them to do. If they want to take a very restrictive look at the individual, like we alluded to in our testimony, what you are saying by the high accuracy rate is the DDS' are pretty much in line with what SSA wants to hear, and not if the decision is correct. The DDS' are very, very sensitive to the accuracy rates, so they fall in line.

Many examiners that we talked with said the decisions they are making to terminate benefits are incorrect. They feel sorry for the claimants. They feel restricted by SSA's quality assurance reviews and case returns that they have no alternative but to respond accordingly, regardless of whether the decision is proper.

One other thing I want to say. An SSA study shows that as of December 1982, the State of New Mexico was ranked the No. 1 State. It had a 99-percent accuracy rate, and did not have one psychiatrist on staff. You are not going to tell me——

Chairman HEINZ. That seems to be a good way of proving the accuracy, that is, to not have anybody that is qualified making the decisions. Would you agree with that?

Mr. WYCHULIS. Yes.

Chairman HEINZ. I think you have made that pretty clear.

I would like to get down to the nitty-gritty of this system. It is a complicated system. Not everybody understands how it works. For the second step in the process deciding whether the individual has a severe impairment, and whether that impairment meets or equals the disability described in the list of impairments—the Social Security Administration has regulations that set down how the disability decision should take age, education, and work experience into account when assessing physical disabilities.

Does Social Security, and hence the question of severe impairments and the listings—does the Social Security Administration have a set of vocational criteria specifically developed for mental impairments comparable to those which exist for physical impairments?

Mr. McGough, should I ask that of you or Mr. Wychulis?

Mr. McGough. We do have some indicators, but I would like to ask Dr. MacLennan to address your question.

Dr. MacLennan. No, I do not think they do have anything adequate. I also have some questions, however, whether it is really useful to have—to develop a vocational grid which can be used very mechanistically. It appears to me preferable that if the——

Chairman Heinz. Before you tell me what might work, let us just find out what they are doing. I will get to what might work in a moment. But let us be very clear.

What you are saying is that, regardless of whether it is a good idea or not, SSA does not have any list of vocational criteria that has anything to do with mental impairments, but they do use a list. So what is the list? It must relate to the physical impairments. Is that correct?

Mr. Wychulis. What they have is a vocational grid that was established in 1979 because the Congress wanted more uniformity and objectivity in the decision process. When SSA determines a claimant's residual functional capacity, that is, what a person can functionally accomplish with his or her impairment, they then place the claimant in an exertional category such as sedentary, light, medium, or heavy work. After you place an individual in such a category, you then consider his age, vocational characteristics of education and work experience. Applying the grid leads to a disabled or not disabled decision. You do not have any such grid per se for mental disabilities, other than telling the examiners to consider age, education, and work experience.

You have to remember, the examiners are not only adjudicating psychiatric cases, but do physical impairments as well. Examiners are conditioned to use the grid, and they are allowed to use the physical grid for mental cases.

Chairman Heinz. That is the key point. What you have is examiners, 89 percent of whose cases are physical disability cases.

They basically apply a vocational grid that is based on physical disability, because no comparable grid has been developed explicitly for mental problems. Is that correct?

Mr. Wychulis. That is correct.

Chairman Heinz. Just to keep moving along, I gather that what Dr. MacLennan was about to say was that it is not only unfair to apply that kind of grid, but it is not a good idea to try to judge mental impairments based on any mechanistic grid approach.

Would you elaborate on that, Dr. MacLennan?

Dr. MacLennan. I think when you start to apply factors such as age, there is really no correlation between many of these factors, and whether a person is competent or not.

Chairman Heinz. What is the best way to evaluate that?

Dr. MacLennan. To get a full medical history.

Chairman Heinz. I understand that the best way is to obtain workshop evaluations and work experience trials. Is that correct?

Dr. MacLennan. That is correct. If there is any question as to whether somebody can work, then a work trial is the most appropriate way to go.

Chairman Heinz. In how many instances did you find that the examining authorities used a workshop evaluation?

Dr. MacLennan. In the cases I read, there were no cases in which they had in the recent past. In the history of some of these people, there had been work trials at some time in their long history of disability. There were no cases that I read that they had used a work trial.

Chairman Heinz. Is there anything that prevents Social Security—SSA—from using a workshop evaluation?

Mr. Wychulis. No, nothing precludes SSA from using work evaluations. In fact, SSA's program operating manual indicates that they can use workshop evaluations as a positive thing, to go out there and purchase them, but they have not, through the last several years.

Chairman Heinz. Then they can do it, they should do it, and apparently they rigorously do not do it.

Mr. McGough. The new instructions going out talk about assessments that should include not only medical history, but past work successes and failures, and other relevant information. These instructions, however, do not say to go out and purchase work evaluations.

Chairman Heinz. One of the things here that is relevant to the committee, and we touched on this earlier, is what is happening to the people who get terminated unjustly or unfairly? I know you have not had a chance to look at it, but will you be able to investigate what does happen to the people terminated—and report back to us?

Mr. McGough. Yes. As I mentioned earlier, we are starting a study now. We will have a national sample, and we will find out what has happened to the people who have been terminated.

Chairman Heinz. You referred in your testimony to the Minnesota ruling.

Mr. Wychulis, the Social Security Administration has been telling us for some time, and I mean for months and months and months, that it has been reviewing all its policies and procedures in this area of mental disabilities. After the Federal judge's decision in the Minnesota case, Commissioner Svahn put out a memo clarifying SSA's policies on these matters.

First, have you reviewed those SSA initiatives in the course of the study?

Mr. Wychulis. Yes, I have.

Chairman Heinz. How would you evaluate them for the committee? In particular, in your judgment, do they correct the very serious flaws in the process which you have detailed this morning?

Mr. Wychulis. No. SSA issued a program operating manual instruction in late March, and because of the Minnesota trial, issued a circular to their regional offices.

Chairman Heinz. Is that this teletype? [1]

Mr. Wychulis. Yes. Going through these instructions, it gives the appearance that SSA is taking a lot of new positive steps, but if you really assess it, all they are doing is reinforcing their existing policies. It is nothing more than that.

Chairman Heinz. You lay out four key deficiencies in your summary of the testimony, right up front.

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[1] See appendix, page 190.

An overly restrictive interpretation of the criteria to meet SSA's medical listings; inadequate development and consideration of a person's residual functional capacity and vocational characteristics; inadequate development and use of existing medical evidence; and insufficient psychiatric resources in most State DDS'.

Does this teletype address any of those four deficiencies that you identified?

Mr. McGough. I would like to put it in perspective. Yes, it does address the second one, which deals with the residual functional capacity.

Chairman Heinz. But it does not address the other three?

Mr. McGough. It does not.

Chairman Heinz. In what way does it address the second one?

Mr. McGough. It points out and encourages the DDS to do that which we agree needs to be done to make accurate decisions on peoples' mental impairments.

The reservation that I have is that putting it out on paper, and getting it implemented are often two different things. We think it has to be very carefully monitored and evaluated, to see that it achieves what it is intended to achieve. It does not address the other three areas where we think additional actions are required.

Chairman Heinz. I want to thank all of you for some very detailed work, all of it very helpful, and I now know detailed answers to a lot of complicated questions. I do want to press you a little further on the kind of corrective action Congress should take in two areas: First, how to protect beneficiaries from a disability review which is clearly so basically flawed that it is not a valid indication of whether those beneficiaries can work; and second, what we should do to redesign the review process so that eventually we can come to a bona fide medical review of mentally disabled individuals that would give us good indications of their ability to work.

Can you tell us what are the principal options available to the committee in these two areas: Protecting beneficiaries and designing improvements in the review process?

Mr. McGough. We have some recommendations to share with you that we have put together as a result of our work.

[Subsequent to the hearing, the following was submitted by Mr. McGough.]

ACTIONS NEEDED BY SSA TO IMPROVE MENTAL DISABILITY DECISIONS

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

(a) A qualified physician should make the assessment of both parts A and B of the medical listings.

(b) When a claimant does not meet the listings because he or she does not meet part B, the quality of those activities that keep him or her from meeting part B must be determined and documented—in other words, one positive activity should not be the basis for deciding that the person:

Does not have a marked restriction of daily activities.
Does not have a constriction of interest.
Does not have a serious impairment in relating to others.
Does not have a serious deterioration of personal habits.

(c) Because the mental disability criteria have not been revised substantially in many years (1968), we believe SSA should undertake a comprehensive study of the criteria and where study results indicate changes are needed, make them.

RESIDUAL FUNCTIONAL CAPACITY AND VOCATIONAL CHARACTERISTICS ARE NOT APPROPRIATELY CONSIDERED

SSA's new instructions reenforce criteria that we believe are necessary for making accurate mental disability decisions. However, we believe that SSA needs to:

(1) Closely monitor the implementation of the new instructions and enforce compliance through the existing quality assurance reviews and reporting systems.

(2) Prepare, periodically, reports on the extent to which evaluation tools called for—i.e., workshop evaluations, etc.—are actually used in reaching a disability decision.

In addition, we believe that SSA needs to evaluate the vocational characteristics currently used to assess mentally disabled claimant's ability to work, especially the claimant's age. In mental disability cases, age has little direct relationship to a person's ability to realistically function in the "real world of work."

INADEQUATE DEVELOPMENT AND USE OF EXISTING MEDICAL EVIDENCE

Adequate development of medical information on mental disability cases is not occurring prior to ordering CE's; in fact, CE's are being used in lieu of developing the full medical history on cases.

SSA needs to enforce its existing policies that require:

A full longitudinal medical history be developed on each case prior to ordering a CE.

A CE be ordered when needed to (1) clarify medical evidence, (2) obtain necessary data not otherwise available, or (3) resolve conflicts or inconsistencies in the evidence obtained.

In addition, when a CE is ordered, the full medical history information should be given to the CE physician to improve the CE physician's ability to accurately evaluate the claimant's condition. Further, when a CE report conflicts with a recent treating physician's report, the CE report should be sent to the treating physician for comment and resolution of the conflict.

We believe the above actions by SSA will result in: (1) Savings through the avoidance of unnecessary CE's; (2) improved medical evaluations of claimants; and (3) the potential to augment the severely limited State and SSA psychiatric resources.

STATE PSYCHIATRIC RESOURCES ARE SEVERELY LIMITED

Because the mental disability decision process encompasses a medical (psychiatric) evaluation that is highly complex, a qualified psychiatrist or psychologist must be involved. However, neither the DDS nor SSA have adequate psychiatric resources to meet this need.

SSA needs to: (1) Work with the States to develop a competitive fee structure for hiring psychiatrists and psychologists; or (2) hire the needed psychiatric resources directly.

In addition, SSA should determine to what extent it can augment limited DDS resources through greater use of treating and CE physicians.

Mr. McGough. Basically, I think that SSA has to start sending different signals with regard to how the DDS' are to implement the criteria that are in the listings; and especially, emphasize the importance of the part B interpretation, so that watching television, or making a meal is not interpreted and used solely as an evaluation that the person has failed to meet that part of the criteria. We think that because the criteria is so subjective and has not been evaluated, that we have been able to determine, or changed substantially since 1968, SSA should undertake a comprehensive review of its medical listings. That addresses the first area that we looked at.

With regard to the residual functional capacity, as I mentioned, the circular does take steps in the right direction, if it is implemented fully and comprehensively. It should result in some better decisions.

Chairman Heinz. But you have some concerns about that. I see you winking and nodding.

Mr. McGough. We have some concerns, as I alluded to before. It is one thing to put out guidance, and it is another thing to have it implemented and have it accomplish what you are intending.

We think SSA should monitor closely the circular they have put out through their quality assurance program, just as they are now sending signals to take a hard line on these decisions. They ought to send signals on taking a hard line that these criteria are met, and that these additional steps, that test the quality of the person's ability to work, are fully assessed, and that the person not be judged not disabled just because he or she can cook a meal.

Chairman Heinz. How should they go about doing the monitoring you just described?

Mr. McGough. What they need to do is to look at the cases that are being adjudicated carefully, particularly the ones that are being denied or terminated. They should not just look at the ones that are being continued, which has been more of their practice in the past.

What they need to do is take more of a responsibility for the people that are on the rolls, than they have.

Chairman Heinz. Do you think it will take a major change in attitude?

Mr. McGough. I think it will take a change in attitude, and reinforced in the system that is now reinforcing the behavior that we have seen while we were out there. We also think that they need to reevaluate, as you suggested, the criteria used for assessing the vocational ability of these people.

We do not think age is very relevant to whether a person's mental ability permits them to work or not. We think that is another important step.

And the third area, the consultative exams, we think they need to do a much, much better job on getting a full medical history. They need to enforce their own criteria before ordering a CE. The criteria they have now is good. You should not order a CE unless you need it to (1) clarify existing medical evidence, (2) obtain necessary data not otherwise available, or (3) resolve conflicts and inconsistencies. If it was done for those reasons, then it would serve a useful purpose. CE's could also be used to augment SSA's limited technical resources, if it would rely on a better assessment done by CE psychiatrists.

Chairman Heinz. We know they have insufficient psychiatric resources in most States. It will take a while for them to address that problem. You cannot go out and hire a large number of competent, trained people as we have before us right now. Put it this way, how many trained psychiatrists does GAO have?

Dr. MacLennan. I am the only clinical psychologist that works in this particular area.

Chairman Heinz. That is a significant finding in itself.

My point is really this: Every single one of the things you recommended or suggested as an important item is going to take time to implement. Even if HHS is willing to, and is really committed to waving a magic wand, it would still, reality being what it is, take a great deal of time.

What happens to all of the beneficiaries that are being denied in the meantime? What are we going to do until all these changes are made? Should these people just be left hanging? Should they be guinea pigs in some cruel Federal experiment, as we fiddle around with the CDI's, or should we, and this is what I would really like your considered judgment on, should we not suspend these kinds of flawed psychiatric reviews until SSA has reformed itself, completed an overhaul of the process, and made the kinds of improvements you recommend?

Mr. McGough. There are a couple of points I would like to make in responding.

You pointed out the majority of the decisions are in the initial application. Those will have to continue. People are going to continue to apply for disability. I think the most important thing to do is to concentrate on the fixes that are necessary, and to reach agreement, and a plan of action to get those fixes in place as quickly as possible.

You are right, they will take time, especially on the medical resources question. We feel that SSA needs to develop with the States some basis to be able to contract for and hire the needed people, and if they cannot, then they ought to do it themselves.

Maybe as an option, an interim option, they can augment their limited resources through better use of treating physicians that are already involved with the patient, or use the consultative examination physicians that they are hiring.

With regard to scheduling reexaminations of people that are already on the rolls, if there is going to be substantial time involved, a suspension probably is in order.

Chairman Heinz. So we should, in your judgment, have a temporary suspension of these kinds of things?

Mr. McGough. There is another option that I can think of that would cover that a little bit, but I do not know if it is feasible. Some of the reexaminations are finding people who have very minimum impairments, ones that are not controversial, or they are finding many people that have worked, or even who have died.

GAO has put out reports where SSA is paying accounts of people who have died. Where it is a clearcut situation, terminate benefits that are not appropriate. But that is the only additional option I can offer at this time.

Chairman Heinz. I cannot help but remember, on page 13 of your testimony, where you state, "our group discussions with examiners produced comments"—this is with respect to the listing—"that unless a claimant was 'flat on his back in an institution,' 'comatose,' or 'in a catatonic state,' he or she would not meet the listings. While these statements may be exaggerated, they are indicative of the examiner's perceptions."

It sounds like you practically have to be dead to qualify under the listings. What you just said is ironic, that Social Security on occasion has a better record of paying people who are dead than people who are alive. Clearly, the system is more than a little out of whack than we would ever want to see a Federal Government system.

Thank you very, very much.

[Subsequent to the hearing, Senator Bill Bradley submitted questions in writing to Mr. McGough. Those questions and Mr. McGough's responses follow:]

Question 1. This country has significantly changed its method for caring for the mentally ill. We no longer warehouse most patients; hundreds of thousands of patients have been released to residential settings and to the community at large. We may be witnessing a collision between the DI program and the deinstitutionalization movement, and we may need to make changes in DI to account for these changes.

Many of the patients who have been released are still incapable of working or of supporting themselves. Some of these people have been denied disability coverage, but most who have appealed had their benefits restored at the ALJ level. Does the problem stem from the interpretation of the law and/or regulations by the reviewers?

Response. Our study did not evaluate the appropriateness of the ALJ decisions or draw any corollary between the ALJ and DDS decisions. In our testimony, however, we expressed concern about the appropriateness of the decisions for the mentally impaired because we found several weaknesses in SSA's and the disability determination services' (DDS') adjudicative policies and procedures. Specific weaknesses we identified were:

(1) An overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities.

(2) Inadequate development and consideration of a person's residual functional capacity and vocational characteristics.

(3) Inadequate development and use of existing medical evidence, resulting in an overreliance and misuse of consultative examinations; and

(4) Insufficient psychiatric resources in most State DDS'.

Question 2. Are changes needed in the DI law, regulations, and/or medical listings to insure that mentally disabled persons are protected?

Response. We believe changes are needed in SSA's regulations and in the manner the law and the regulations are being implemented. Specifically, we believe the following actions are needed:

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

(a) A qualified physician should make the assessment of both parts A and B of the medical listings.

(b) When a claimant does not meet the listings because he or she does not meet part B, the quality of those activities that keep him or her from meeting part B must be determined and documented—in other words, one positive activity should not be the basis for deciding that the person:

Does not have a marked restriction of daily activities.

Does not have a constriction of interest.

Does not have a serious impairment in relating to others.

Does not have a serious deterioration of personal habits.

(c) Because the mental disability criteria have not been revised substantially in many years (1968), we believe SSA should undertake a comprehensive study of the criteria and where study results indicate changes are needed, make them.

INADEQUATE DEVELOPMENT AND USE OF EXISTING MEDICAL EVIDENCE

Adequate development of medical information on mental disability cases is not occurring prior to ordering consultative examinations (CE's); in fact, CE's are being used in lieu of developing the full medical history on cases.

SSA needs to enforce its existing policies that require:

A full longitudinal medical history be developed on each case prior to ordering a CE.

A CE be ordered when needed to (1) clarify medical evidence, (2) obtain necessary data not otherwise available, or (3) resolve conflicts or inconsistencies in the evidence obtained.

In addition, when a CE is ordered, the full medical history information should be given to the CE physician to improve the CE physician's ability to accurately evaluate the claimant's condition. Further, when a CE report conflicts with a recent treating physician's report, the CE report should be sent to the treating physician for comment and resolution of the conflict.

We believe the above actions by SSA will result in:

(1) Savings through the avoidance of unnecessary CE's.

(2) Improved medical evaluations of claimants.

(3) The potential to augment the severely limited State and SSA psychiatric resources.

Question 3. Are the changes recently announced by the administration sufficient to resolve these problems?

Response. In March 1983, SSA issued instructions to the DDS' dealing with mental impairments. The instructions are a needed step in the right direction, but their effectiveness in bringing about improved decisions will depend on how well they are interpreted and implemented. We have offered the following suggestions to insure proper response to the new instructions.

SSA's new instructions reenforce criteria that we believe are necessary for making accurate mental disability decisions. However, we believe that SSA needs to:

(1) Closely monitor the implementation of the new instructions and enforce compliance through the existing quality assurance reviews and reporting systems.

(2) Prepare, periodically, reports on the extent to which evaluation tools called for—i.e., workshop evaluations, etc.—are actually used in reaching a disability decision.

In addition, we believe that SSA needs to evaluate the vocational characteristics currently used to assess mentally disabled claimant's ability to work, especially the claimant's age. In mental disability cases, age has little direct relationship to a person's ability to realistically function in the "real world of work."

Chairman **HEINZ**. Our next group of witnesses is a panel consisting of Dr. Beatrice Braun, Lois Jahsmann, and Janet Conser.

I would like to ask Dr. Braun to be our first witness. You may proceed as you desire.

STATEMENT OF DR. BEATRICE S. BRAUN, DIRECTOR, PREVENTIVE TREATMENT UNIT, ST. VINCENT'S HOSPITAL, HARRISON, N.Y.

Dr. **BRAUN**. Thank you.

My name is Beatrice Braun. I am a physician, and I acted as a family physician in Korea for about 18 years, with the most poor and destitute in South Korea. When I returned to the States, I specialized in psychiatry, and I am now working with the most poor and destitute among psychiatric patients. Maybe in many ways even more poor and destitute than those I saw in Korea.

I would like to say something about who are the chronic mentally ill that we are talking about, who need social security benefits.

In my written testimony I have shown how I arrived at the statistics I have. There are over 1 million patients who, in years past, before any public policy change, as the chairman indicated, would have been in the State hospitals. The State hospitals now have as their only criteria serious imminent danger to oneself or to others. All other categories of the mentally ill are being treated in our communities, and there are probably at least 1 million of them.

I would also like to say a little bit about the history which is typical of chronic mental illness. The onset is usually in high school or college years, very often very bright people whose families have great hopes for them and who have done very well up to the point when they become ill. They begin to withdraw, they cannot concentrate. They gradually become suspicious, and think that their classmates are talking about them, and then they will become acutely disoriented, and are usually hospitalized at that point.

A small number of those recover, and do not have any further problem, but a great many go on to deteriorate over the years. Once in a while, after the first hospitalization, they can return to college, but not usually. Often they get a job. They may work at it for a little while, and then they begin to get the same symptomology, suspicion of others, withdrawn, not being able to concentrate, and they are fired, or they cannot get work.

They might try another job, and then they are hospitalized again, and with each hospitalization—and many of these patients have had as many as 20 hospitalizations—they drop a little bit lower on the socioeconomic ladder, and become less and less able to socialize or to work. They begin to get into family conflicts.

We spend in our programs a great deal of time with the families, trying to help them understand the chronic patient they have in the family. Of course, they cannot work after several of these hospitalizations. They then, hopefully, and in past years have been able to, get their social security benefits. Their living situations are really deplorable, even with those benefits, and certainly no one who could possibly work and be in a better position would ever live in the kinds of places where these patients are.

Usually, as they are going through this downhill course, they go into a day program, hopeful that they might be able to get back to work. Even that is too much pressure for many of them. They cannot be punctual, they cannot keep appointments.

Programs that have been in the communities up until fairly recently were not geared to take care of these patients. The expectations of the programs for punctuality and participation caused the patients to withdraw and stop their medication. Then they become the street people that we all know so well, muttering to themselves, not in contact. Or sometimes they will hole up in their room, they will not eat, they will not sleep. They become more and more acutely disoriented.

I have one patient who thinks that she has something implanted in her brain, and the police can track her from helicopters, and police trucks. Such patients begin to scream in terror and, of course, eventually the police come to take them away, and then they become even more sure that the whole system is against them.

In 1975, we started our program, which is called preventive treatment unit. People ask us why do we call it preventive treatment unit. It is because we hope to prevent some of the deterioration, to stabilize the patients, so they will have some kind of stability in their lives. Our sad experience has been that the minute they become somewhat stable, and are not relapsing all of the time, they then are removed from the social security rolls.

We have 100 patients in the program. We have had 36 who first applied or were reviewed in the last couple of years; 29 of these were denied. We have had absolutely not one case that was not reversed at the administrative law judge stage.

We have had 23 who were reinstated, and 6 are still in appeal. We feel sure they will be reinstated when they reach that stage. But the effect of human suffering of this has been tremendous. These people already have a poor self-image. They are not good at anything, they feel.

I had a patient tell me, because she knew I was coming down here and is one of the cases I have, "Please help them understand that even though it does not show what is the matter with us; we are not blind, we are not lame, we really are ill." She told me that she had been in a sheltered workshop for 1 year, and she had been delighted that she had been able to reach that stage. Then she became acutely ill again, and had to leave. She was catatonic; she stared at the walls. We could not get her attention at all, because the pressures of sheltered workshop had been a little too great. It was at that point that she was turned down for the second time she had made application for social security benefits. She was told she could work when she could not even function in a sheltered workshop. I have been taking care of her for 9 years, so I have known her over a long period of time.

She told me the other day, "I wonder if people know what it means to think about suicide every day." She said leaving the sheltered workshop she felt totally helpless and worthless. When Social Security says you can go and work, and the person knows they cannot work, but other people think they should, and are looking at them as lazy, that has a serious effect on the patient.

Even in cash dollars, as the chairman was saying, it is a foolish way of handling things. One of our patients who had not been hospitalized for 15 years was hospitalized during the process of being denied, because he became so upset and so threatening to his mother. It took us 52 days to get that patient out of the hospital. Fifty-two days in the hospital is about like 52 months of social security benefits. So it is really not worthwhile to cause these patients to be hospitalized again.

Chairman HEINZ. Dr. Braun, you have in your testimony, starting on page 6, 12 very concise histories of patients who were initially denied or terminated on review. They will be a part of the record, and we do have some questions about them that I do want to ask.

I would like, if I may, to just summarize a couple of them, what I understand some of your main points are.

As you point out, these people are not defrauding the system.

Dr. BRAUN. Absolutely. They certainly are not.

Chairman HEINZ. You stated that these people are so ill that 10 years ago, or 20 years ago, they would have been in a State mental hospital.

Dr. BRAUN. That is right.

Chairman HEINZ. We only enacted the community mental health centers concept back in the midsixties, around 1965, as I recollect. So, literally, 20 years ago there was no alternative. They would have been institutionalized, and it would have been expensive. In each and every instance you have given us, these are people that have been denied in one way or another, and as you say in the summary, we can either turn the clock back, and open the State hospitals to the million chronic mentally ill, who are now in our communities, or we can recognize that the illness has not been cured by a policy change.

I think that is a marvelous summary of what you found, and with your permission, I would like to hear from the other witnesses and then come back to you.

Thank you very much.

[The prepared statement of Dr. Braun follows:]

PREPARED STATEMENT OF DR. BEATRICE S. BRAUN

My name is Beatrice Simpler Braun. I am a physician specializing in psychiatry. I am a diplomate of the National Board of Medical Examiners, licensed in New York State, and certified in psychiatry by the American Board of Psychiatry and Neurology. I graduated from Marquette University School of Medicine in 1949, and after internship practiced general medicine, caring for the poor and destitute in South Korea for 18 years. On my return to the States, I completed residency studies in psychiatry, and for the past 8 years again find myself caring for the poor and destitute. This time, those who suffer most among psychiatric patients, namely our chronic mentally ill, those who cannot cope with the ordinary demands of life that each of us take in stride every day.

Who are these chronic mentally ill, these emotionally disabled who need social security benefits to assure their continued survival? They are the patients who in years gone by would have spent their lives in State hospitals. In New York State, for example, there were 93,000 in State hospitals in 1955. With our population increase, this would have meant an expected 103,000 in New York State hospitals in 1982. In reality, the number was 22,000. This is not due to medical advances whereby we have cured or prevented mental illness. Schizophrenia, the most common cause of this condition, continues to afflict 1 percent of the population, not just in the United States, but worldwide. Many of its victims never recover sufficiently to function vocationally or socially. In State hospitals, they received not just medical care, but food, shelter, and clothing as well. Now they must rely on social security benefits for their food, shelter, and clothing. These chronic mentally ill are relative newcomers to the rolls of the disabled needing social security benefits, for only for the past 25 years have they not been relegated to State hospital to spend their lives.

Using our New York State figures of over 81,000 who are the chronic mentally ill in our communities instead of in our hospitals, we can estimate well over 1 million nationwide, a million persons whose mental illness in previous years would have meant a lifetime in an insane asylum. They still need food, shelter, and clothing as well as medical care until we find a cure for their disabling illness.

Because numbers are impersonal, let me tell you about the patients to whom I minister. Faced with growing numbers of young adult chronic mental patients who no longer were accepted for State hospitalization, but who were likewise not accepted in their local communities who could not understand their odd ways, or even by existing psychiatric outpatient facilities who were not equipped to treat them, I began a day program specifically geared to the care of these patients in 1975 under the auspices of St. Vincent's Hospital and Medical Center, Westchester Branch in Harrison, N.Y. The program has grown steadily to its present population of 100 patients. We have a waiting list, because again we have reached capacity and need to expand. We intentionally try to serve those who do not fit into other programs where expectations of their performance exceeds their capacity. For example, many programs require that a patient keep appointments, be on time and in a day program remain several hours and attend 5 days a week. Chronic mental patients often cannot adhere to schedules. If pressured to come on time, for instance, they become upset, discouraged at their own shortcomings and withdraw completely. Then without medication, feeling alone and unwanted, they wander the streets muttering to themselves in a world of their own, the homeless, the street people we all know so well in our large urban areas. Or they may respond to these pressures by "holing" up, afraid that the knock on the door is from someone who will kill them, that the helicopter overhead is the police tracking them for their imagined misdeeds, and eventually indeed the police must break in to take them to the hospital because they are screaming in terror all night. On the other hand, if they remain out of the hospital thanks to a low-pressure day program that gives them access to caring staff, who knowing their exquisite sensitivity to stress, do not require that they come on time, or stay all day, or attend every day or engage in multiple activities, the Social Security Administration decides they can engage in substantial gainful activity and terminates their benefits, a quantum leap, totally untested and untrue. Their level of function in our program has no relationship to that required in the world of employment. In fact few are ever able to engage in sheltered workshop, occasional volunteer work or rehabilitation training, despite our best efforts to help them achieve that functional level.

Perhaps this is the place to give you a thumbnail sketch of a typical patient among our 100. He would be a suffering, frustrated person, a male of about 30 years who is bright, probably with some college before the illness struck. He has never had a steady job and those he has held were well below his intellectual capacity, giving him a feeling of worthlessness, of hopelessness. He has been in a psychiatric hospital from six to eight times or more. He has never had a close friend and has serious conflicts with his family. He has entered our program on a downhill course, diagnosed now as chronically mentally ill, not hopeless in the sense of having a terminal illness, but disabled by a cruel disease that makes him unable to cope with life's demands, yet leaves no immediately obvious signs such as paralyzed legs or blinded eyes. Whether he is unkempt, disheveled, and unshaven, or clean, neat, and well-groomed, there is within him a terrifying world of fears, of irrational beliefs, of illogical thoughts, of overpowering moods. He has no control over these bizarre beliefs, these voices, these angry, anxious, or depressed moods. It is as if he had been injected with a hallucinogenic or mood-altering drug, while in reality it is an aberration within his own brain, one that we know little about and can do relatively little to alter.

With that description of our typical patient in your mind let me outline the experience of these patients of ours with the social security system over the past 2 years. Sixteen patients made their first application for benefits. Of these, 15 were denied. Twenty were reviewed, and of these, 14 were terminated.

Thus, of 26 patients for whom full reports of the history, clinical course, present mental and functional status were submitted, 29 had benefits denied or terminated. Of those 29, there are 22 for whom that initial denial has been overturned and benefits reinstated, and six whose cases presently are in reconsideration or appeal.

We have carried each case from one step to another with the extra hours of paperwork and communication entailed. Every one that has reached the administrative law judge has won their appeal. To initially deny benefits to 29 patients to 80 percent of those who applied or were reviewed, only to have this decision reversed in each instance, points up a flaw in the way this system operates. The expense in our staff time and the tax dollars involved in the whole appeal process, not to mention the stress, the hardship and the humiliation which each patient experiences, calls for some method whereby the initial evaluation or review can better determine the need of the patient for benefits.

The present criteria are totally inadequate to assess a patient's ability to engage in substantial gainful activity. The reversals at the administrative law judge stage in our experience have been because the judge really read the submitted material, then talked with the patient and with the accompanying staff member and realized that indeed this was an unrealistic expectation for the patient.

To make this presentation more graphic there follow several brief histories of some of our patients whose benefits were initially denied or terminated on review:

CASE NO. 1

This is a 41-year-old male who at 20 years of age was admitted to the State hospital because he was disoriented, confused, and was hearing voices. After 4 months in the hospital, he was able to live at home with medication and visits to the clinic. His thinking remained confused and he was unable to work, had no friends, and did not go out of his home. About 6 years later, he was again hospitalized when he became agitated and assaultive, pouring hot soup on his mother. His condition changed little over the years and he received social security benefits in recognition of his serious schizophrenic illness. At times, he was able to help his father who was a carpenter, but his demeanor and behavior prevented him from ever being formally employed. In late 1979, his father died and he was admitted to our day program which he can attend only sporadically because he cannot tolerate being with other people and being away from home. In 1981, his case came up for review, and his social security benefits were terminated with the following statement, "You were initially found to be disabled because of a nervous condition. The medical evidence shows that you have had a psychiatric problem. You have some difficulty in stressful situations. However, you still can perform a job with simple work duties. Based on your description of your usual job (remember his father whom he helped was dead 2 years at this time) your condition does not prevent you from returning to this work. Therefore you are not considered disabled according to the standards of this program." Obviously their standards had changed, for the patient had not changed except perhaps toward further deterioration over the years. He was rehospitalized during the appeals process, the first time in 15 years. The pressure had caused marked regression and he became confused, agitated, and threatening toward his mother. As with all our chronic mentally ill, the decision was reversed by the administrative law judge, but the denial had already done its damage to his dignity and self-esteem.

CASE NO. 2

This 32-year-old male was first hospitalized 8 years ago at the age of 24 because he couldn't concentrate, couldn't sleep, and was preoccupied with thoughts that evil was ruling the world. He had written a suicide note asking forgiveness of his family. Nine months prior to his hospitalization he had to quit his job as an assembly line worker because he couldn't concentrate. He tried other jobs, but lasted less than 2 weeks at each, quitting or being fired. He never recovered from this illness, and in fact with each of his following six hospitalizations his condition worsened with an increase of voices and belief that he was receiving messages from God. Yet he tried over and over to work so he could support his family, but was repeatedly fired because he could not concentrate on his duties. As he became more depressed, his beliefs that he was a prophet, and his messages from God increased, he began to carry a knife because all the world was evil and no one could be trusted. He was admitted to our program in August 1980. His case came up for review with Social Security in early 1981 and his benefits were terminated. The decision was reversed by the administrative law judge on appeal.

CASE NO. 3

This 35-year-old female had an alcoholic father who put a shotgun in her mouth and threatened to blow her head off when she was a child. She completed college away from home with the help of counseling but with grades far below her potential. She was able to work for a year before onset of serious psychiatric problems. She was hospitalized and came under my care in 1974, totally socially isolated, living with her mother, she trusted no one, believed everyone wanted to harm her and that her only defense was to be angry and destructive or to kill herself which she attempted several times. She began to receive social security benefits in 1974. With medication and psychotherapy twice weekly, she remained out of the hospital except for one brief hospitalization in 1978. However, her stress tolerance remained so low and her fears and hostilities so high that she made no friends and remained at home, often spending days in bed if she thought a neighbor had said an unkind word or there were words with her mother. She is of above average intelligence and with encouragement began to attend classes. She would do very well in one and then fail another because she thought the professor was plotting against her. In 1980, her social security benefits were reviewed and she was terminated, after a 15-minute examination by a psychiatrist paid by the Social Security Administration. Needless to say she gave up, withdrew from school and accepted this action as proof that everyone was out to get her, that there was no hope and that I was the delusional one not she. This case was appealed to the administrative law judge, part of whose report of April 1981, is as follows: "The medical record is replete with medical reports from Dr. Braun which essentially confirm her testimony given at the hearing as well as verifying the longstanding nature of the claimant's condition, which has required twice weekly psychotherapy and frequent regulation of medication. The record in its entirety well supports Dr. Braun's opinion that without such close medical supervision the claimant would have had prolonged psychiatric hospitalization and that her paranoid delusional ideation and recurrent depressions continue to result in inability to function in a work situation. The claimant's testimony, demeanor, and appearance (anger and low frustration level) at the hearing appears generally commensurate with the medical findings, in that her mental impairment would reasonably be expected to produce the type and degree of symptomatology alleged. So considered, the claimant's testimony of continued inability to work is found substantially accurate and credible. Thus, the medical evidence, expert opinion, and the claimant's credible testimony lead to the conclusion that the claimant continues to lack the residual functional mental capacity to perform substantial gainful employment." This patient has just received notice that she is again up for review. Again the notice has caused overwhelming anxiety, and this time she refuses to see the psychiatrist, for she fears losing control and physically harming him. She cries uncontrollably and cannot be rational about the situation. My reports have been sent to Social Security, but since their decision last time was based on the report of a strange psychiatrist seeing her 15 minutes, rather than my 6 years' experience as her therapist, I have no basis for hope that it will be different this time.

CASE NO. 4

This 38-year-old male was first hospitalized for an acute psychotic episode at the age of 25. Since then, he has had 11 hospitalizations, the last being in November 1982. The patient at first recovered enough between episodes to work, but for progressively shorter periods as his illness pursued its relentless course. Hospitalizations have been necessary because of nervousness, agitation, suicidal attempts, or assaultive behavior. When acutely psychotic, he becomes bizarre, delusional, and verbally abusive. He hears voices telling him to hurt someone else like his parents. He laughs inappropriately and is suspicious and paranoid. A year ago, he tried to go to a sheltered workshop but was not admitted because he became bizarre and psychotic during the interview. In our program he has been maintained for a year except for one brief hospitalization in November, when he became upset at home, heard voices, and struck his mother. This patient applied for social security benefits in February 1982. Full records were sent and then the following letter when more information was requested:

Pursuant to our phone conversation today I hope the following will be of help in your determinations.

"In August, 1981, * * * was referred after his last inpatient admission to our day hospital, a structured vocationally oriented day program. It had been hoped that he might improve enough to become employable. However, as months passed it became evident that he was unable to progress and that he needed a long-term day program.

"He was referred, therefore, to the preventive treatment unit, an open-ended day treatment program with goals of preventing or shortening inpatient hospitalizations and providing a low-stress environment to enable the patient to remain in the community rather than a State hospital. He began this program on March 26, 1982, * * * shows the unfortunately typical picture of a patient with chronic schizophrenia, namely gradual deterioration so that with each acute episode of his psychosis requiring hospitalization he has become less able to cope with the stresses of life afterward. While in program he can attend activities, but must proceed at his own pace. If any pressure is applied patient becomes agitated, confused, begins to hallucinate and has a past history of loss of emotional control leading to physical assault. The latter can be avoided in an unpressured environment such as ours, but these symptoms make him unable to meet the ordinary demands of a work situation. He is socially isolated and unable to relate to others beyond simple greetings as he becomes anxious then agitated and paranoid if one tries to speak with him at any length."

This letter resulted in denial of benefits. Appeal to administrative law judge was successful.

CASE NO. 5

This 42-year-old male was first hospitalized at 18 years of age because of anxiety and depression with inability to concentrate and fears of leaving the house, so he had been unable to complete the final year of high school. Two years later, he went to State hospital where he remained 6 months with a diagnosis of schizophrenia, simple type. He had multiple hospitalizations because of paranoid ideas, neglect of personal hygiene, weight loss, seclusiveness and feelings of hopelessness. He was referred to us in 1981 after hospitalization with the hope that involvement in an open-ended program would prevent hospitalizations and give some stability to his life. Despite our efforts, he bathes rarely, doesn't wash his clothes, and inappropriately tries to kiss female staff and women patients, making obscene sexually provocative remarks. At times he is confused and laughs to himself while at other times he can read, absorb and relate back news articles. He is unable to keep any schedule and if pressured, he withdraws, becomes paranoid, agitated and confused. His social security benefits were terminated after review, but reinstated following appeal to the administrative law judge.

CASE NO. 6

This 23-year-old male was first hospitalized at 17 years of age with a diagnosis of acute schizophrenia which he had been trying to treat with street drugs with multiple overdoses on heroin because of the fears from his delusions of persecution. Psychological testing showed superior intellectual endowment in this son of a college professor of engineering, but also showed his serious schizophrenic illness. Over the following 4 years he was hospitalized in State hospital 4 times, the last being the longest stay of 8 months. These were occasioned by bizarre thinking, agitation, sleeplessness. Once there were threats to kill his parents and another time a suicide attempt by jumping off a bridge. He was referred to our program by the State hospital in January 1982. With regular family meetings and with careful titration of stress factors in patient's environment, we have been able to keep him out of the hospital for over a year. He is marginally compensated, very fragile and with any pressure of demands on him, he would deteriorate to his previous psychotic state. This patient applied for social security benefits in late 1981 in anticipation of being discharged from the State hospital for further treatment in our day program. Benefits were denied, and reconsideration brought no change. Appeal to the administrative law judge reversed the decision, and benefits were begun.

CASE NO. 7

For this 31-year-old female her first schizophrenic symptoms began in her freshman year of college. She left college, tried to work several jobs, but each time she lost the job because she was unable to perform adequately. Four years later she completely withdrew to her room, slept poorly, cried, sometimes banged on the walls, and gradually deteriorated until she was brought by her mother to my care 9 years ago. She was then disheveled, hallucinating voices, making bizarre motions with her hands, and talking nonsense. Medication lessened the hallucinations and the hand motions, but as she began to communicate her abnormal thoughts and reasoning became evident. She believed the covering of her brain was disappearing that parts of her brain moved about, that she was directed from outer space and could not act on her own. Placed in a day program which was vocationally oriented she became so depressed because of her own disability, that she tried to kill herself with an overdose of drugs, and had to be hospitalized in an ICU for several days before transfer to the psychiatric hospital. Six years ago she was admitted to our day program for chronic patients, and since then has had only one inpatient hospitalization. She still hears voices telling her to say nasty things to others, is unable to persevere in any activity, and is unreliable in terms of punctuality and regular attendance. Last fall, she again became acutely psychotic and had to withdraw from the sheltered workshop to which she had been unable to return because of persistence of hallucinations, conflictual interpersonal relations and extremely low frustration tolerance. To prevent further deterioration, it is essential that she be kept in an understanding, accepting, pressure-free environment with the support of an available, caring staff. This patient applied for social security benefits in 1978 and was denied. She has received public assistance as her means of support since that time. She reapplied in December 1982 for social security benefits, was again denied, applied for reconsideration and was denied, and is presently in appeal to the administrative law judge.

CASE NO. 8

This 27-year-old male began to hallucinate 5 years ago and believed his father was going to kill him. After hospitalization for 2 months he was discharged to a vocationally oriented day program with the hope that he might recover enough from his acute episode to return to school or seek employment. Over time it became apparent that his illness was not abating. He was hospitalized three more times with acute psychotic episodes marked by grimacing and giggling to himself, bizarre behavior, sleeplessness, and irritability. In September 1981, he was admitted to our day program and has been more stable without the pressures and expectation for performance that he experienced previously. He continues to hear voices and his thinking is confused and concentration poor. In mood he is depressed and has intermittent suicidal ideation. He is frightened of other people, withdrawn, and unable to participate in group activities. He applied for social security benefits and was denied. Shortly thereafter, when the recertification notice came from public assistance, he was afraid of bad news and threw it out. Official looking letters are often either unopened or discarded by the chronic mentally ill, for they fear any contact with authority. As in this instance, we find out only when their check does not arrive and they are penniless. With our intervention he was reinstated for public assistance during the social security appeal process. The denial was reversed by the administrative law judge.

CASE NO. 9

This 35-year-old male had his first psychotic episode after induction into the Army during the Viet Nam war. He believes that because he did not serve his country in that conflict that he is a bad person, that President Ford wanted to kill him. He has persistent delusions of being watched and pursued by the FBI. These delusions cause him to be very suspicious of others, to have marked restriction of daily activities because he must continually be on guard and cannot participate with others in any endeavor. For example, although he comes to program, he cannot stay more than an hour or so at a time because he becomes very fearful and must be on the move eluding his enemies. To get him to do any task requires constant one-to-one supervision. If one leaves him he becomes frightened because no longer protected, drops whatever he is doing and leaves. In conversation with others he is engrossed in talking about his delusions or about his sexual preoccupations. He persistently talks about these subjects and cannot listen to others, seriously impairing his ability to relate to other people. Likewise, his interests are constricted as they do not extend beyond the above all-engrossing thoughts. Psychological testing revealed "while he may appear on interview because of retained information and verbal capacity to be capable of functioning at an average level, this is in fact not so and he scores in the defective to severely defective range when he is actually asked to complete a task particularly one that requires him to be self-motivating or to sustain effort." The above information is taken from my report to the Social Security Administration and from psychological testing both of October 1981. Social Security Administration's reply in November 1981 stated "you became able to do substantial gainful work in September 1981." This case was appealed to the administrative law judge and the decision was reversed.

CASE NO. 10

This 43-year-old son of a physician was completing his second year in medical school when he suffered his first schizophrenic episode. Despite the best available psychiatric care, including a year in a private psychiatric hospital, this patient has never been able to function socially or vocationally. He had eight inpatient hospitalizations during the 2 years prior to his admission to our program 7 years ago. Although he has not been rehospitalized during this period, he continues to suffer from severe functional deficits due to his schizophrenia. Although he bathes regularly, he rarely washes his clothing. He was evicted from his apartment because the stench was unbearable due to his having garbage uncovered in the room for a week at a time, and the apartment was generally filthy and overrun with roaches. He is unable to relate with others at all. He wears a hooded sweatshirt, he is unshaven and looks at the floor mumbling a few words of response to direct questions. If pressured to perform any function, he becomes very anxious and at times angry and is often unable to comply or does so only partially. On the weekends he goes to bed and stays there, not sleeping just daydreaming, not eating he has some crackers and fruit in his room. Although to preserve some shred of self esteem he talks about some time in the future going to work, his demeanor and behavior give a totally different message. When his case came up for review, his social security benefits were terminated. A hearing before the administrative law judge reversed this decision.

CASE NO. 11

This 34-year-old male was first hospitalized at 17 years of age because he had delusions that he was going to change the world, had persecutory auditory hallucinations, was not sleeping or eating, and was belligerent with his parents. He destroyed the furniture in his hospital room, giggled inappropriately and talked nonsense. After discharge, he completed high school, but 4 years later was again hospitalized, this time for a year, claiming to be the adviser to President Nixon, to Russia, to the FBI, and the CIA. After this hospitalization he was able to attend business school and then to help his father in the latter's automobile dealership. His ability to concentrate and perform these duties gradually lessened, however, and he was again hospitalized after he injured his father in an assault. Three more hospitalizations followed with progressive deterioration in functional capacity and he was no longer able to work between acute episodes. He was referred to our program in 1979, and although we have been able to prevent rehospitalization, his paranoid schizophrenic illness prevents him from meeting the ordinary demands of life. His personal grooming is very poor, with offensive body odor, he is unable to relate to others; and he cannot complete tasks without constant staff supervision and encouragement. Pressure to perform more adequately causes recurrence of hallucinations, and the belief that he has psychic powers and can project his thought through television, which explains to him why others are trying to plot against him. He then becomes agitated and his thinking totally disorganizes as his anxiety increases. Social security review resulted in termination of benefits in October 1982. The decision was reversed just this week by the administrative law judge.

CASE NO. 12

This 31-year-old male was first hospitalized at age 19 because he was hearing voices, and felt people could read his mind and were plotting to harm him. He had also expressed ideas that he had to kill his father who was alcoholic and had abused both his wife and the children. Over the next 10 years he had 20 hospital admissions because of sexual or aggressive behavior in response to his hallucinations and paranoid delusions. My letter to Social Security August 25, 1981, when his case came up for review reads in part: "* * * has been in our day program for long-term psychiatric patients since June 1979. As you are aware, he has a very long history of serious psychiatric illness and has been totally functionally disabled for several years. One of his major problems is sexual preoccupation and sexual confusion in his thinking. This results in serious behavioral incidents. Repeatedly he has exhibited his genital organs to young girls on their way to school and action on reported incidents is pending. Here in program he has gone into a rage when he hallucinated another patient pulling down his pants and he had to be restrained from assaulting the patient. The other area of his paranoid schizophrenic psychosis that especially interfers with his ability to function is his delusional system that he is being prepared by a group of men to secretly become President of the United States. In his grandiosity he believes that he is always right about everything and he develops strong hatreds for those he believes to be wrong or bad. One must constantly intervene to prevent his assaulting such persons including members of his family, and from their entering a fight when he provokes them. Often during the night he screams and yells, necessitating his mother calling in the crisis team. They give him extra medication and he quiets again, later explaining that "being tortured to prepare him for his important work in the future" has caused him to scream. Since even with reduction of stress to a minimum and careful titration of medication he continues to have these episodes of bizarre behavior which in some instances has serious impact on others, he is not capable of any type of employment at present or in the foreseeable future. Just last week he attempted to attend a street fair with a friend, but had to leave almost immediately because he "heard the people talking about me. I know they were going to gang up on me, rip my clothes off and torture me." To leave the scene before retaliating aggressively in response to his hallucinations was behavior we rewarded with positive reinforcement. However, the necessity thus to frequently leave the scene to prevent sexual and aggressive acting out demonstrates again his inability to be employed. If further documentation of this young man's functional disability due to his paranoid schizophrenia is needed, please do not hesitate to contact me." The response was termination of his benefits, which were reinstated by the administrative law judge.

The above 12 cases are typical of our 29 whose benefits were denied or terminated and from hearing the experiences of others, I believe they are typical of the problem nationwide. The information given you was submitted to the Social Security Administration in much more detail, of course. All fulfilled the criteria listed in "Disability Evaluation Under Social Security; a Handbook for Physicians" under 12.03, functional psychotic disorders A and B, yet all were denied or terminated. Are there unpublished criteria according to which these cases were decided? In any event, to me it is inconceivable that anyone would expect these patients to work and totally unrealistic to think anyone would hire them. Yet because the Social Security Administration denies or terminates their benefits, even though the decision is later reversed, the patients receive a message that others believe they are lazy parasites in the system, and thus their self-esteem is further eroded.

During the past summer, tragically, two of our patients killed themselves, both suffering from guilt and dispair as victims of this misunderstood illness. One was a young woman of 28 years. She appeared fairly normal, but she had not been able to sustain any effort to work or to study. With pressure she would become paranoid that those around her were talking about her, then would begin to come late or take days off until she was fired or flunked out. Over the past couple of years she had not been able even to initiate an attempt yet she spoke hopefully of returning to studies in the fall. Under her facade, somewhere deep inside she knew she would fail again, would not be able to meet the expectations of her family and some others who did not understand just how ill she really was. One Sunday morning she walked to the nearby dam, climbed up on the wall and jumped to her death.

The other was a young man of 31 who had always wanted to be a minister, but the voices told him he was a bad person, that he had committed unforgivable sins and should die. Often the voices tormented him, told him to kill himself because he was worthless; many times he had resisted, but one day he obeyed, and jumped from a window head first to the street below.

These people are not defrauding the system. They want to be well as much as the blind want to see and the lame to walk. They want to work and they may even tell you that they are going to get a job next week or next month as they strive to preserve hope, to build self-esteem. We need to remember that we now have among us over a million patients who if they had lived a generation earlier would have spent their lives in State hospitals with no pressure to work, and their food, shelter, and clothing supplied without question because their illness would have been accepted.

In actuality, there are 312,000 psychiatrically disabled on SSDI rolls which include some who are in State hospitals as well as those in the community. Furthermore, many of those on SSDI worked so briefly and at such low salaries that their SSDI must be supplemented by SSI if they live outside the hospital. Therefore, we cannot add together the number on SSDI and the number on SSI and come up with a total number receiving social security benefits in the community. The number of psychiatrically disabled receiving SSI is 396,000. To this how many can be added who are on SSDI alone and are not in the hospital? This number is not available, but might be estimated to be in the range of 200,000. If so, 396,000 plus 200,000 adds up to approximately 600,000 psychiatrically disabled persons presently receiving social security benefits to live in the community. Comparing this to the estimated million so disabled that if times were different, they might be spending their lives in a State hospital, perhaps we should be out there looking for the missing 400,000 instead of seeking to deny or terminate the benefits of those receiving them.

Either we turn back the clock and reopen our State hospitals to the million chronic mentally ill who are now in our communities or we recognize that the illness has not been cured by a policy change, that we have among us at least a million suffering persons who because of disabling mental illness cannot engage in substantial gainful activity and are entitled to social security benefits.

Chairman HEINZ. I would like to welcome from my own State of Pennsylvania, Lois Jahsmann, who, with great distinction, is the executive director of Hedwig House. She is accompanied by three of my other constituents whom I hope she will introduce.

Ms. Jahsmann, will you please proceed.

STATEMENT OF LOIS JAHSMANN, EXECUTIVE DIRECTOR, HEDWIG HOUSE, INC., NORRISTOWN, PA.; ACCOMPANIED BY ARTHUR CLYDE, COORDINATOR, HEDWIG HOUSE, POTTSTOWN, PA., AND SOCIAL SECURITY BENEFICIARIES MERRITT F. REISH AND JAMES STITELER

Ms. JAHSMANN. As you say, I am Lois Jahsmann, cofounder of Hedwig House, Inc., an agency serving persons with a history of mental illness. Hedwig House is in five locations in Montgomery County, Pa., adjacent to Philadelphia.

We focus on three special services: One, socialization programs to help emotionally disabled people learn or relearn basic living skills. These skills have been often lost or never learned because of lengthy or repeated hospitalizations in psychiatric institutions; second, housing programs to provide our members to live adequately and comfortably in supervised apartments; and three, ultimately, we have rehabilitation programs that assist the members in preparing for entry-level positions in competitive employment. These kinds of employment often include janitorial services, food services, stockroom work, et cetera.

Because Hedwig House philosophy centers on helping the members improve the quality of their lives, we work closely with them and frequently develop an advocacy relationship.

Our advocacy role is the reason we are pleased to appear before this committee today.

Because we have seen too often the utter dismay and distress caused by social security cuts and very quickly, the severe hardships experienced by the chronically disabled when they are without funds, we want to protest the often irrational termination of benefits to mentally disabled persons. Supplemental security funds allow mentally ill persons to survive in the community, and I do emphasize survive, because it is not a luxurious living, as you know, with but these funds survival is questionable, and costly psychiatric hospitalization is most likely the only viable alternative.

Two Hedwig House members appear before you today—Merritt Reish and Jim Stiteler. Both gentlemen have experienced emotional disabilities for many years, both of them have received social security benefits, both have gone through CDI—continuing disability investigation—and both were terminated by Social Security and deemed able to support themselves. I hope they will tell you of their anxiety, fears, frustrations, and distress during their long quest for reinstatement to social security rolls.

Assisting Mr. Reish and Mr. Stiteler today is Arthur Clyde, at the far end, coordinator of the Pottstown Hedwig House, who has ably helped them and others in the social security review process.

Thank you very much.

I would like to depart from the written testimony just for 1 minute, to tell Senator Heinz, and I am sorry Senator Cohen is not here, that I am absolutely delighted with the receptiveness and the pragmatic views that you seem to share with those of us that are on the forefront.

Dr. BRAUN. I want to second that.

Chairman HEINZ. Thank you, both. Mr. Clyde.

Mr. CLYDE. Senator Heinz, and members of the committee, as Lois introduced me, I am coordinator of Pottstown Hedwig House in Pottstown, Pa., where both Merritt and James attend.

My statement will be very brief in order that I might not distract from the very important testimony of these two persons who are with me, and who personify the focus of your investigation.

I would be glad to answer any questions, but suggest I might be most helpful in doing so after they have been heard, and perhaps in clarifying.

I have known Mr. Reish since November 1978 when he began attending the Hedwig House program; Mr. Stiteler, since July 1980.

Both of these men have one thing in common. They have, up to the present, made efforts through our transitional employment program to take steps toward a part-time job. Even with the structure that our program provides, these attempts have been unsuccessful. In the opinion of me, and my staff who work with them, their inability to succeed at a job is related to their pathology—that is, the psychiatric diagnoses which they had when they came to our center. Those diagnoses have not changed, even though their ability to function in the community has increased.

I believe the cutting off of these men from social security was an unnecessary act. It cost me many staff hours, not to mention the expenditures of the Social Security Administration, in reviewing the case. I wish to have you hear these men speak for themselves; but I need to add, that if one is going to tamper with a system of funding upon which human lives depend, one must be able to see the consequences of such actions as they affect the lives of people who may not have other options for survival. And second, to consider the undue burden it places upon agencies such as our own, who are the only safety net left after vital supports such as social security, have been withdrawn.

Earlier—I would also just like to comment on one thing talked about earlier, a work evaluation workshop. We indeed are that in a general sense, in that we provide work opportunities for people who have never worked, or need to get back to work. These are part-time approaches to work attitudes, not full-time jobs. We are, in effect, that workshop trial. But yet when it comes to that social security process, we are allowed to submit something, as we wish, on behalf of people, but never asked.

Chairman HEINZ. Mr. Clyde, thank you.

I believe Mr. Reish now has a statement.

Mr. REISH. Well this is my opinion, you know, of all the injustice that has been done to a lot of mentally disabled people. I have read in the newspapers that eight people killed themselves because of the unfair way that they were taken off the social security disability rolls. I also read in the newspaper that there were about 50,000 mentally disabled people who were helpless. They did not know how to—they did not know anything about it, so they were just wiped out, this 50,000. They were mostly helpless because they did not know the first step of how to appeal their cases.

In my opinion, a few people from Social Security must have a plan to help save the social security system, you know, and their plan was to wipe out a whole lot of mentally disabled people in a hurry, and this was done in a hurry, by sending notices, you know, through the mail to many people, and also another way it was done was by—to send us disabled people to see a doctor who never saw us in all our whole life, for a period of 10 minutes, and just asked us 10 different questions, and then Social Security makes their decision that we are no longer disabled on that basis. And, you know, because of this injustice, like I say, a number—a few mentally disabled people killed themselves.

Here is the way that I was affected by this injustice. I believed, and I thought to myself it was all planned, to wipe out a lot of mentally disabled people, and that there was nothing that I could do to defend myself. I even waited until the last day to file my appeal in the mail, figuring it is hopeless, what is the sense. But I done it. But I waited until the last day. I am kind of sure that some other people felt the same way I did.

For me, as to my mental condition, I suffer with severe depression, and I am paranoid and schizophrenic, and because of this injustice that happened to me, it made my depression even worse, and it made me worse because of the unfair way the Social Security done this and, you know, if it would not have been for my mom and Hedwig House, when I got taken off disability in this unjust way, if it would not have been for them, I would have felt I would have wanted to kill myself, because I had no place to turn to, other than my mom or Hedwig House. So that is why I felt that way.

OK. While it seems to me that a few people from Social Security said to us disabled people, it seems to me that they said either sink or swim, you know, like you are in a ship, you throw the guy off the boat. If you swim, OK. If you sink, so what.

Well, you know, like I have a plan of how Social Security can do it in a fair, honest way, and my plan would be, say, to have a panel of about three trained doctors, you know, psychiatrists, and force us disabled people to see these doctors, these psychiatrists for, say, a period of 1 year, and then they would evaluate us on a whole year, 12 months, and then if they would decide we were no longer disabled, then they could try to, you know, for the ones that are not disabled, if they make that decision, then they try to train them, say, for a job, and if they feel they are able to do that job, then place that person, you know, he or she, on the job, and if that person is able to hold a job, say, for a period of one time, a full-time, steady job, then I myself would say that person is no longer disabled, and to me that is justice, that plan.

And, you know, it is like I say, it is hard, you know, for secure, normal people, to find a job, and get a job, and hold a job, so how can anyone expect one who is mentally disabled to go out and get a job, and hold jobs, and succeed? It is hard. It is really hard, and being disabled is a big strike against a person.

I guess that is it, other than I hope you have a lot of questions to ask me, and I hope this does a lot of good, or—I just hope this does a lot of good.

Chairman HEINZ. I, myself, have appeared before congressional committees, and I always find it difficult. I know that people from my State who come down here get butterflies in their stomachs before they testify even if they have testified before.

I want to thank you for making this special effort. I think it will do some good.

Mr. REISH. If this does a lot of good, I will thank you, too.

Chairman HEINZ. Mr. Stiteler, may I ask you for any remarks you care to make?

Mr. STITELER. Well, Social Security, in 1981, I got a notice I had to see a psychiatrist in Norristown saying I can work, but I felt I could not work, and they took my social security away from me, and I had to go on welfare. Then I had a hearing in 1982, got my social security back, and it was very—I felt very hurt I lost my social security, and I am glad I got it back.

Chairman HEINZ. Did you go through a very difficult time?

Mr. STITELER. Yes.

Chairman HEINZ. How difficult? How did you feel?

Mr. STITELER. I had to go through steps. I had to get a lawyer, which cost me some dollars, and I had to go for welfare.

Chairman HEINZ. Now you are back on social security?

Mr. STITELER. Yes.

Chairman HEINZ. Now, Mr. Reish you are not yet back on social security?

Mr. REISH. I am waiting in the dark, wait, wait, wait. You know, I had a hearing about a month ago, and I think I have to wait another month for the judge to send a written decision. So, I don't know, I just wait, wait, you know.

Chairman HEINZ. What do you think is going to happen to you now?

Mr. REISH. Do you mean what do I think happened?

Chairman HEINZ. No, what is going to happen? Your case is up for grabs.

Mr. REISH. What is going to happen upon my case?

Chairman HEINZ. Do you think you will be reinstated?

Mr. REISH. You know, at the hearing, like this legal aide I had, you know, now she said 90 percent chance that I am going to be reinstated.

Chairman HEINZ. Ninety percent chance?

Mr. REISH. Even though she said that—I was not able to get a whole lot of money to get a lawyer to speak for me, and I did not have the money to get a psychiatrist to go to the hearing to speak on my behalf. If I had that, I would have felt my chances would have been a lot better, you see. I do not know. It is hard for me to believe people, even though she said 90 percent chance I would get it back, I do not know.

Chairman HEINZ. Mr. Stiteler, before you succeeded in getting your benefits back, did you think you had any chance of getting them back? How tough was it?

Mr. STITELER. I had to get it back, because June 1, 1982—will you help me?

Mr. CLYDE. You got a lawyer, and you worked with the lawyer.

Mr. STITELER. June 1 of last year we went and applied for social security, and August of last year I went and had a hearing.

Chairman HEINZ. When your benefits were cut off, how did you live?

Mr. STITELER. I was on welfare.

Chairman HEINZ. You went on welfare. And Mr. Reish?

Mr. REISH. Well, with me, like, I would stay with my mom, live with my mom, and then I too went on welfare, and to my surprise, I got taken off welfare accidentally, and then I had to wait to get back on. Sock it to me twice, social security and welfare. But then I got back on welfare, and I stayed home with my mom.

Ms. JAHSMANN. There have been instances in Hedwig House, in our housing program, in which we have carried a tenant, a member, while the hearing is going on, but we are gambling, because we are using taxpayers' money when we do that. We must be reimbursed, and sometimes roommates will help each other have food. We do all sorts of patchwork.

Chairman HEINZ. I want to thank you for responding to my questions. I think that is the best way of getting your experiences as part of the record, and I am most appreciative to you, Ms. Jahsmann and Mr. Clyde, and to Mr. Reish and Mr. Stiteler for your great help to the committee.

We have one other witness on the panel, Ms. Conser.

STATEMENT OF JANET A. CONSER, DIRECTOR, SENIOR CITIZENS LAW PROJECT, WILKES-BARRE, PA.

Ms. CONSER. I would personally like to thank this committee for the work it has done in this area, and I would also like to thank you on a personal level.

I have been a staff attorney at Legal Services for 3 years now. I have worked for Legal Services on and off for about 8 years. I have stayed with Legal Services' work because I always had a very strong belief that I could use access to the legal system to help people who are faced with great injustices. That belief is very strong, but the most serious challenge I have had to that belief occurred in the last 2 years when I started representing individuals that were faced with termination of social security benefits.

I found myself faced with a vast number of claimants which I felt were eligible for benefits, claimants who I knew would have successful cases once the case is before an administrative law judge.

Because of the backlog on social security cases, I also know it would take up to 1 year before it would be heard, and I had to sit with clients, and caseworkers, and families, and explain to them that there was nothing that I, as a lawyer, could do within our present legal system to prevent the injustice that was occurring to them.

You have asked about the continuation of benefits that these claimants receive pending an appeal determination. I found that despite the fact that benefits might continue under the SSI program, and the amounts on social security, the mere financial hardship is not the only concern.

As this individual said, despite whatever reassurances I as an attorney, or a caseworker can give, the stress associated with appealing the case, with fighting the Federal Government, and just wondering what is going to happen, has been overwhelming to a number of my clients.

I have some clients that have either been institutionalized, or in voluntary commitments, because of stress that they have had associated with the pending appeal. I have had a few clients that have attempted suicide, and a few clients also who have been placed in partial placement, or basically deteriorated before my eyes as I got to know them while the case was pending.

I also found that when I had an overwhelming amount of cases, and I was beset with the possibility of waiting a year, I tried to use the system as it existed, and I tried to provide to the State agency exactly what they would need to make a favorable decision, and I started from that level. I found that when the disability determinations division issues the notice that they are considering terminating your benefits, and allowing you the 10-day provision to provide additional information, you do not have a report upon which they are basing their decision.

Within that 10 days I would, one, ask an extension of time to get medical reports and, two, work with existing physicians or psychiatrists to get a report that met the standards for disability regulations.

I have a number of files where there is correspondence between me, the mental health caseworker, and the psychiatrist, where they give me one thing, and I would give them the regulations and say would you address the ability to take care of their personal needs, or their ability to relate to other individuals.

I spend time working with caseworkers to explain to them the definition of disability under social security, and how it differed from their other determinations of disability, and I would work in getting a report that could be written to support a finding of disability.

I would find that I would have no response from the State agencies, that most of the time if I called them I would be told the file had been sent to Baltimore, and it was waiting for a determination decision. The basic response was why bother, that the decision was already out of their hands, has been made, and no matter what I did, nothing was going to change that decision.

After the termination notice was received, I did the same thing at the reconsideration level, and again would submit the report, or the psychiatric evaluations, the hospitalization reports to the Administration at the reconsideration level, hoping that this would end the stress and suffering that my clients were undergoing pending the decision and again, in all of the cases I have, I have yet to have one termination decision overturned in the reconsideration process.

With the staff cuts at Legal Services, with the funding problems with mental health agencies, I began to realize what I was doing is basically wasting time, and that I did not have the time to submit this type of evidence and go through the process of instructing the staff on the mental health, going through the expense of obtaining hospital records, only to update those. In that sense I have stopped any participation, and await the administrative law judge process.

I have suggested my claimants indicate exactly what medical evidence is available. I have tried to work with the staff of the regional office in regard to the evidence below the administrative law judge level, but at this point I do not feel it has had any bearing, or effect, on the ultimate decision made at that level.

Of the cases that I have handled between 1980 and 1982, I had 46 cases before an administrative law judge. Every one of them had been overturned. Since July of 1982, I have had five cases in which the termination of benefits was upheld by the administrative law judge. Three of them are on appeal to the Appeals Council. One is on appeal to Federal court, and the administration, prior to filing an answer, has suggested that the matter be remanded for a second hearing.

I find that in dealing with the claimants, most of the problems are evident. Most of the referrals are from mental health staff workers or other agencies who cannot believe this person is being denied benefits, who cannot believe that someone else is saying that this person is capable of engaging in competitive work.

I have submitted evidence showing that the typical evaluation conclusion by the disability agency is in no way supported by their own reports.

I find encouraging the statements I have heard here from GAO, and also this committee's response. I have worked very closely with most of my claimants. I have gotten to know many of my claimants on a personal level, in order for them to get to trust me, and to continue to work their appeal.

I have also worked closely with the mental health staff, so they can explain the process to the individual claimant. A lot of referrals come from individuals in halfway houses, in some type of custodian arrangement, where someone is looking out for their interest.

I worry about individuals who do not know Legal Services exist, or do not have someone else that can take the referral, and make sure it is followed up. I have individuals that have attempted to file their appeals on their own. I have also had individuals who filed an appeal at the Social Security office with no success, and basically not pursue it on appeal of the matter.

The most drastic case I had is an individual who I had gotten involved with because of an overpayment, who received an internal check, who went to the Social Security office to file a request for a hearing, and when you look through the file, the Social Security office indicated that the man was so confused that they could not understand him. They did a computer check and found out that 2 years prior to that he had been removed from the SSI rolls because of employment, and instead of filing an appeal determination, they filed a reactivation of the SSI claim, got him on SSI without filing an appeal determination, created a subsequent overpayment 2 years ago, and cut off his appeals rights because the time period had not run in which to file.

I spoke to him about reopening the claim, and I told him I felt we had a good case, and he said he will have nothing to do with the Administration. He will have nothing to do with Social Security because of the problems he has had. He has chosen instead to live off welfare benefits.

In his case he had earnings from Social Security which he will lose if he does not qualify for disability within a period of time. I cannot get him to understand that concept, and I know he will lose his insured status because of Social Security's actions.

In regard to the recommendations made by GAO, I strongly support them. I believe from my experiences there is an unwritten and underlying policy within the State agencies to terminate.

The concept and the intent behind monitoring, of purging the rolls of people who are truly unqualified, is a good one. But it is not being used by the people who are enforcing that policy. This committee has been doing investigations. The subject has been coming up for some 2 years. Nothing definitive has been done in the State agencies.

The report I submitted includes a termination as of January 1983. That means as of 3 months ago this type of action was taking place, and despite the investigations, despite the raised concerns, there are still people who are being unjustly terminated, and who are suffering because of it.

In that regard, I would strongly support a complete halt to the review system until the reforms can be taken to make sure that individuals will not be terminated.

In conclusion, I would like to point out that one of the most frustrating things I have had to do is take an individual from the termination up to a hearing, and to wait for the hearing, in some cases for a year, to wait 3 months for a decision, and to sit down with that individual and explain to him that they have been found eligible, that their benefits will continue, and also have to caution them that under the present system there is a good chance that 3 years from now they will be faced with the exact same problem, and that cannot be changed by me or anyone else in the present system.

I would hope that this committee would allow me to tell my claimants that once they are successful, unless there is some type of change in their condition, or unless they truly are improved, they will not have to face the same problem.

Thank you.

Chairman HEINZ. Thank you very much.

[The prepared statement of Ms. Conser follows:]

PREPARED STATEMENT OF JANET A. CONSER

Accelerated disability reviews of social security disability cases began in 1980. Since that time, as a staff attorney with Legal Services of Northeastern Pennsylvania, Inc., I have personally represented approximately 75 individuals whose benefits have been terminated by the Social Security Administration. In addition, the staff of Legal Services of Northeastern Pennsylvania, Inc., continues to provide representation to certain individuals who are threatened with cessation of benefits.

A periodic review of SSI and social security disability claims is technically legitimate under the existing law but these reviews have become a device for cutting the disability roles at the expense of those least able to protect themselves. Approximately 80 percent of termination cases handled by my office have had the Social Security Administration's unfavorable decision reversed by an administrative law judge. In these cases, the majority of the evidence upon which the administrative law judge's decision is based was available to the State agency that conducted the continuing disability investigation (CDI). These facts lend support to the allegations that the Administration is conducting a perfunctory review aimed at the wholesale cutting off of disability benefits and not simply removing the truly ineligible. In this regard, the Administration is going well beyond congressional intent which was the basis for the establishment of a monitoring system that would safeguard the integrity of the social security and SSI disability programs.

Of particular concern is the targeting of the mentally impaired for review and subsequent termination under the existing system for CDI reviews. The majority of cessation cases I have handled involved persons suffering from a mental impairment. While the concerns addressed in this statement apply to the entire disability program, I would like to particularly address the issues involving the mentally impaired.

Severe mental illness, although disabling, is not easily measurable by objective tests. There is also likely to be a fluctuation of the individual's condition which can vary on a daily, weekly, or monthly basis. The mentally impaired are also the group least able to take independent, affirmative action to protect their right to continued receipt of disability benefits. They are most vulnerable to setbacks and actual harm as a result of the decision to terminate benefits.

The review system that now exists consists of a paper review of medical or mental status reports by an adjudicator who is employed by the State agency that has contracted with the Social Security Administration to conduct the review. Often the reports relied upon by the adjudicator are obtained through consulting examiners under contract with the Social Security Administration to perform evaluations of this kind. The consulting examiner renders an evaluation after one examination of the individual. The individual's prior medical records are not provided to the consulting examiner and the evaluation is not conducted for the purpose of treating the individual. The report of the consulting examiner is then sent to the reviewing agency. No copy of the report is provided to the individual and there is no opportunity for the individual or his treating physician to counter any of the statements in the report of the consulting examiner.

Often, no report is requested from the claimant's treating physician or in the event such information is obtained it is given less weight than the report of the one time, nontreating medical examiner. The adjudicator then provides his own interpretation of the existing reports and makes his determination as to continuing disability without ever meeting with the claimant.

There have also been instances in which the adjudicator's interpretation of the medical reports contradicts the report itself. Attached to this statement is a determination of cessation of disability by the Social Security Administration and the psychiatric reports upon which the determination is based. The adjudicator determined, for example, that "the claimant is capable of communicating in a spontaneous, coherent, and relevent fashion." The consulting pyschiatrist's report states that:

"The claimant starts talking about one thing and then would suddenly shift to another with no relationship at all. * * * Many times her productions have to be stopped because the patient just incessantly went on with her production and sometimes she goes into meaningless talk."

The consulting psychiatrist concluded that:

"This patient is still showing a great deal of psychiatric symptoms. She has disturbances in association. She has circumstantiality blocking and I feel that the patient is suffering from schizophrenia chronic undifferentiated type residual. I don't think that the patient's condition is in remission. There is a great deal of constriction in her social interaction, presence of thinking disturbance, flattened effects. I feel that this patient is not capable of gaining any employment."

Based upon this report the Social Security Administration's adjudicator concluded that the claimant:

"Remains capable of performing simple, routine, repetitive tasks under supervision. * * * Claimant has no relevant work experience but is capable of engaging in work activity. She has the ability to engage in work such as carton packer, small parts assembler or cleaning person. Accordingly, benefits are ceased as of 1/83."

On appeal, the administrative law judge reversed the Social Security Administration's determination that the disability had ceased.

Unfortunately, the attached example is not a unique one. Misreading reports in order to reach a conclusion that a disability has ceased in not an uncommon event. In the example, the claimant was fortunate enough to be a resident of a halfway facility whose staff pursued the appeal on her behalf. Many of the mentally impaired are not as fortunate. In instances where the impairment prevents the claimant from pursuing the appeal, the erroneous decision becomes final and the benefits cease leaving the individual with no means of financial support. In many of these instances the legal services or mental health advocate becomes aware of the termination after the fact because of a subsequent eviction or need for mental health treatment caused by the loss on income and ancillary problems.

In other instances the adjudicator redetermines a claimant's eligibility for benefits without reference to the basis for the original determination of disability. The State agency fails to apply a medical improvement test and instead the individual's claim is readjudicated. This places the entire burden on the claimant to continually prove eligibility for disability from the initial stage. This is a difficult task for a mentally impaired individual who has no reason to believe that the impairment he is suffering is not now sufficient for continual receipt of benefits. Most of the claimants do not view their condition as having improved and they therefore trust the government to continue their eligibility based upon the initial determination. They are not told that the mere fact that they are under review raises the presumption that they are not disabled and will have to pursue the matter as though it were an initial claim for benefits.

Steps have been taken to protect individuals facing termination of benefits from severe financial hardship. Recent legislation has been passed to allow social security disability claimants to continue to receive benefits pending a hearing decision on the case. SSI recipients also have these benefits continue pending the hearing decision. While these steps may ease the financial burden of an improper termination, they do not create a complete remedy for the problems created by the Social Security Administration's incorrect cessation determinations. The individual's suffering created by this decision is something that mere dollars cannot erase. I have witnessed the deterioration of the fragile stability many of my mentally impaired clients maintain which can be attributed directly to the concern over the termination proceedings initiated by the Social Security Administration. Despite reassurances by me and the continuing support of mental health staff some of my clients have required more intensive therapy including inpatient treatment solely because of their inability to cope with the stress created by the Social Security Administration's actions. Some of these individuals have been released from institutions and have struggled to survive within the community. They survive because of the creation of a protective and supportive environment. Many of them cannot face appearing at a hearing or "fighting" the government in order to obtain benefits. These are the people who are fortunate enough to have competent mental health advocates who will assist them. Many are not as fortunate. Often these individuals do not seek assistance in contesting the Social Security Administration's action and accept the financial hardships. More importantly, they do not seek assistance in coping with the additional stress created by the adverse determination until they are in extreme need. These matters cannot be remedied by the mere continuating of benefits pending appeal.

Major reforms in the existing review system are required. The agency reviewing disability claims should utilize a medical improvement standard to determine whether the disability has ceased. The adjudicator should meet with the disabled claimant and also assist in order to obtain the existing medical evidence needed to properly review the claim. In the event a consultative examination is needed, the claimant's treating physician should be the source of such examination. If this is not possible, then the treating physician's report should be given more weight than the one time consultative evaluation in rendering a decision of this matter. Finally, in cases involving mentally impaired individuals, the Administration should insure that the claimant has an advocate available to protect his rights under the act and to insure the claimant's well-being in light of the adverse action taken by the Social Security Administration.

In conclusion, I believe that this committee must take action to make major reforms in the existing continuing disability review process. Until these reforms are initiated, the CDI's should be discontinued to prevent any further harm to the mentally or physically impaired claimants.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

DESTINATION: DO ☐ PSC ☐ DAB ☐ ODO-CO ☐ DIO ☐

ST

1. SOCIAL SECURITY NUMBER

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233.

2. A. NAME OF PAYEE (IF ANY)

3. WE'S NAME (IF CDB OR DWB CLAIM)

B. NAME OF DISABLED OR BLIND INDIVIDUAL
A R A

4. DATE OF BIRTH
12/26/43

5. DATE DISAB. BEGAN
08/22/63

C. ADDRESS
Wilkes-Barre, PA 18702

6. DO ADDRESS
20 N. Penna Ave
Wilkes-Barre, PA 18711

7. DO AND DDS CODES
213 392

8. TITLE II - DIB ☒ FZ ☐ DWB ☐ CDB ☐ CRD ☐ TITLE XVI - DI ☐ DS ☐ DC ☐ BI ☐ BS ☐ BC ☐

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED THAT THE APPLICANT'S DISABILITY:

A. ☒ CEASED 01/83 PD. OF DISAB. TERM AT THE CLOSE OF THE LAST DAY OF 03/83
B. ☐ IS CONTINUING
C. ☐ IS BLINDNESS AS DEFINED IN SEC.216(I) AND:
(1) ☐ WE NOT DISABLED FOR CASH BENE. PURPOSES SINCE
(2) ☐ BENE. TERM.
(3) ☐ WE UNDER DISAB. FOR CASH BENE. PURPOSES SINCE

10. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED THAT:

A. ☐ DISAB. CEASED ______ STATE PLAN LAST MET ______
B. ☐ ELIG. TERM. AT CLOSE OF LAST DAY OF ______
C. ☐ DISAB. CONTINUES
(1) ☐ MEETS FEDERAL CRITERIA
(2) ☐ MEETS STATE CRITERIA
DA or A ☐ (DOES) ☐ (DOES NOT) CONTRIBUTE TO FINDING.
D. ☐ BLINDNESS CEASED ______
(1) ☐ INDIV. NOT DISABLED/ELIG. TERM. AT THE CLOSE OF THE LAST DAY OF ______
(2) ☐ INDIV. DISABLED/ELIG. CONTINUES
E. ☐ BLINDNESS CONTINUES

BASIS FOR DETERMINATION

11. DISABILITY/BLINDNESS CEASED ON SHOWN DATE BECAUSE:

A. ☒ IMPAIRMENT NO LONGER OF SUFFICIENT SEVERITY TO PREVENT SGA
B. ☐ NO IMPAIRMENT FOUND BECAUSE OF FULL-TIME UNRESTRICTED WK.
C. ☐ ABILITY TO ENGAGE IN SGA DESPITE IMPAIRMENT - TWP COMP
D. ☐ ABILITY TO ENGAGE IN SGA DESPITE IMPAIRMENT - NO TWP
E. ☐ NO IMPAIRMENT - TWP COMP.
F. ☐ WHEREABOUTS UNKNOWN
G. ☐ FAILURE TO COOPERATE
H. ☐ OTHER (EXPLAIN IN REMARKS)

12. REASON FOR CONTINUANCE:

A. ☐ IMPAIRMENT DISABLING - NEW MED. EVID - NO WK ACTIVITY
B. ☐ IMPAIRMENT DISABLING - NEW MED. EVID. - WK NOT EVAL
C. ☐ WK NOT SGA - IMPAIRMENT DISABLING - NEW MED. EVID.
D. ☐ WK NOT SGA - NO MED. ISSUE - NO NEW MED. EVID.
E. ☐ STAT. BLINDNESS/TITLE II BENEFITS CEASE
F. ☐ TITLE XVI BLINDNESS TERM/DISAB. BEGINS
G. ☐ OTHER (EXPLAIN IN REMARKS)

13. ☒ CHECK IF SSA-834-US IS USED. *(USE SSA-834-US FOR EVIDENCE AND REASONING)*

14. WHY INVESTIGATION WAS MADE:

A. ☐ MED. RE-EXAM DIARY
B. ☐ TWP DIARY MATURED
C. ☐ EARNINGS POSTED - MED. RE-EXAM SET
D. ☐ EARNINGS POSTED - NO MED. RE-EXAM
E. ☐ VOL. REPT. OF RETURN TO WK. - MED. RE-EXAM SET
F. ☐ VOL. REPT. OF RETURN TO WK. - NO MED. RE-EXAM
G. ☐ VOL. REPT. OF MED. IMPROVEMENT
H. ☐ STATE VR REPORT
I. ☐ FPL REVIEW
J. ☒ OTHER (Specify in Remarks)

15. OTHER ENT
☐ TITLE II
☒ TITLE XVI

16. VR ACTION
SC. IN A. ☐ SC. OUT B. ☒
PREV. REF. C. ☐ RE-REF D. ☐

17. DIAGNOSIS.
PRIMARY: Schizophrenia, Chronic
CODE NO:
OTHER:

18. DIARY
TYPE: None
MO./YR.:
REASON:

19. ☐ RECON ☐ HEARING ☐ REOPENING

20. REMARKS
14 J Periodic Review CDI

JAN 17 1993

21. DISABILITY EXAMINER
22. DATE 1/12/83
23. SECOND DISABILITY EXAMINER
24. DATE
25. REVIEWING PHYSICIAN
Wi m H Kadis, M.D.
26. DATE 1/12/83
27. SECOND REVIEWING PHYSICIAN
28. DATE
29. LTR/PAR NO.
30. LIST NO
31. SSA REPRESENTATIVE
32. SSA COMPONENT
33. DATE

SSAL 951-399, T20 (1/83-3/83)

34. FOR PSC-DSS USE S, T27, T28, 842, 305, 901

MENT OF HEALTH AND HUMAN SERV
al Security Administration

DISABILITY DETERMINATION RATIONALE

Name of Claimant	SSN

The following reports were used to decide your claim. We did not obtain any other reports because the ones shown had enough information to evaluate your claim.

1. Oscar Villacrusis, M.D., Psychiatric examination of 12/14/82
2. United Health and Hospital Services, Inc., report of 12/13/82

You were initially found disabled because of a mental problem. You have indicated you are still unable to work because of schizophrenia and a leg problem. The evidence in file shows that you still have some limitations due to your mental problem, however you are capable of caring for your own needs and managing your personal affairs. You can communicate and interact with other people. You are capable of thinking and reasoning sufficiently well to be employed. There is no indication of any severe leg problem. While you could not do work that required you to perform complex job duties, you are capable of engaging in uncomplicated work that does not involve multiple tasks that require any prolonged training.

8156, 829 (1/83-3/83) 841, 152

JAN 1 [illegible] 83

WE's Name(If CDB or DWB Claim)	Type of Claim	sm (Initial and Date)					
Disability Examiner DDS	Date	Review Physician DDS	Date	Disability Examiner SSA	Date	Disability Examiner SSA	Date
RJ	1/13/83	MK	1/13/83				

FORM SSA - 4268 - U6 (8-80)

1. FOLDER COPY

MENT OF HEALTH AND HUMAN SERVICES
ecurity Administration

CONTINUATION SHEET
FOR DISABILITY DETERMINATION

CONTINUATION OF RATIONALE OF SSA-831 OR SSA-[illegible]3

NAME OF CLAIMANT	WE'S NAME (If CDB or DWB Claim)	SS.	TYPE OF CLA
			DIB/SSI

1. Oscar Villacrusis, M.D., Psychiatric Exam of 12/14/82.
2. United Health and Hospital services, Inc., Report of 12/13/82.

Claimant was originally awarded benefits due to paranoid schizophrenia. She alleges continued disability due to limitations associated with this impairment as well as leg problems. Current evidence indicates that claimant continues to manifest symptoms of a schizophrenic process. However there is no evidence of gross psychosis or other severe thought process disorder. Claimant is capable of communicating in a spontaneous, coherent and relevant fashion. Judgement, memory and intelligence are not seriously impaired. Claimant is capable of tending to her own personal needs and managing her daily affairs. Claimant displays an immature and blunted affect and an associative disturbance, however, she remains capable of performing simple, routine, repetitive tasks under supervision.

There is no indication of any severely limiting impairment of the lower extremities. Impairments impose non-exertional restrictions for work activity that involves independent judgement and assumption of responsibility and high complexity levels.

The severity of the individuals impairment does not meet or equal that of any impairment described in the listing of impairments.

Claimant has no relevant work experience but is capable of engaging in work activity. She has the ability to engage in work such as carton packer, small parts assembler or cleaning person.

Accordingly, benefits are ceased as of 1/83.

(INITIAL AND DATE)

DISABILITY EXAMINER DDS	DATE	REVIEW PHYSICIAN DDS	DATE	DISABILITY EXAMINER SSA	DATE	DISABILITY EXAMINER SSA	D
	1/12/83						

Form SSA-834-US (8-80) (FORMERLY SSA-834)
PRIOR EDITIONS MAY BE USED UNTIL SUPPLY IS EXHAUSTED 1-FOLDER COPY

WILKES BARRE

PSYHIATRIC EVALUATION December 27, 1982 (A 22)

Dr. Oscar Billacrusis
P.O. Box 134
Mountain Top, Pa. 18707

RE: [redacted]

AN:

Adjudicator: Ray Stephens

This 37 year old white female patient was seen on December 14, 1982 for psychiatric evaluation is referred by the Disability Determination Division. The patient claims that she is applying for SSI in that she has been living it step by step for three years now. The patient is a very poor historian and not much reliable background information can be gotten from her at this point. It seems that information she provides has to be questioned in view of the patients mental condition at this point. She claims that she has been hospitalized for breakdowns and for her nerves in the past. She claims that when she was 19 years old she was in coma and she was brought to the Retreat State Hospital and she claims that she has been in and out of that hospital for a long time. She could not remember the years or how many times she has been hospitalized. She claims that four years ago she was again at Retreat State Hospital and that at that time she claims she was given some medication. Presently she is going to the Mental Health Center and she claims that she has been going there for many years and she receives Pholixon injection every two weeks and some Cogentin tablets. She talked about having reached the ninth grade she stopped in order to work. Her mother is deceased, she does not know where her father is. She has a sister, she does not know where the sister is and she claims that the sister does not even know her. When she was 16 years old she claims that she worked in a factory but she has never worked since then. She claims that she has been in and out of the hospital and she had no opportunity to work at all. She claims that at present she lives it step by step and most of the time she would go out and take walks in the square. She would go into the resturants downtown and would usually stay there and chat with people otherwise she stays in her apartment. Ocassionally she goes to the Salvation Army for some recreation or activity.

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EXHIBIT 23 (3PP)

EXAMINATION

Patient was clean and relatively neat in her appearance. She was edentulous and she talked with an affect of a child. She appeared rather immature and her affect was blunted. She has certain degree of circumstantiality and her association was very poor. She starts talking about one thing and then she would suddenly shift to another topic with no relationship at all. She was talking about her hospitalizations in the past and then suddenly the patient started talking about why she stopped schooling. She would usually start talking about certain situations and it looked like the patient was going into a fantasy world and she has to be stopped and brought back to the interview situation. When she was talking about her schooling she went into details of everything that was going on in the school. She also related her activities in minute detail. She started talking about what time she wakes up and what she does after she wakes up, moving around the apartment and giving this in detail. Many times her productions have to be stopped because the patient just incesitantly went on with her production and sometimes she goes into meaningless talk. When the patient was questioned if she hears voices the patient answered "I hear good" and then claims that she does not have any delusions or illusions. She was oriented in all spheres. She was able to find her way to the Doctors office on her own. Her fund of general information and current events is very poor but mathmatical calculation was very poor ~~all in subtraction and addition~~. In monetary understanding though and exchanges and making changes from money and how it should be spent the patient seemed to be ~~dis~~capable of doing that. She became very uncomfortable when this questions was being asked and every time she feels uncomfortable the patient tends to give a very nervous laugh. In the problem two heads are better then one, the patient stated "two people with ideas, the more people the better the ideas". In the problem, A rolling stone gathers no moss, her interpretation was very concrete the patient stated "that when stone is rolling it just rolls". She has a fair insight into her condition and judgment at this point tends to be impaired in view of patients thinking disturbances, poor association, circumstantiality ~~and percise dutication to details when she talks~~.

IMPRESSION

This patient is still showing a great deal of psychiatric symptoms. She has disturbance in association.

She has ~~a~~ circumstantiality, blocking and I feel that the patient is suffering from schizophrenia chronic undifferentiated type residual. I don't think that the patients' condition is in remission. There is a great deal of constriction ~~co[illegible]n~~ in her social interaction, presence of thinking disturbance, flattened affect. I feel that this patient is not capable of gaining any employment.

The Background ~~above~~ history gives detail of her hospitalization at the Retreat State Hospital where she was out and out psychotic.

OVillacrusis
Dr. Oscar Billacrusis

OB/js
A411
This transcription was taken from the recording of the voice of Dr. Billacrusis

Date First Seen 10-6-72 Date Last Seen 10-6-12 Frequency of Visits Monthly
Height 5'3" Weight 156

1. Diagnosis and Onset: Psychosis

2.a. Please describe history and clinical course: The patient has a psychotic disorder. The psychosis is constant and interferes with activities of daily living.

b. Does your patient experience any lower extremity discomfort? YES ___ NO ✓ If "YES", describe character, precipitating factors, frequency, duration, and method for obtaining relief.

3. Indicate the presence or absence of the following physical findings by checking "YES" or "NO":

	YES	NO
Amputation		✓
Brawny Edema		✓
Other Edema		✓
Stasis Dermatitis		✓

	YES	NO
Incompetency of Deep Venous Return		✓
Obstruction of Deep Venous Return		✓
Varicosities		✓
Other		✓

If yes, describe in detail.

4. Does your patient have recurrent or persistent ulceration? YES___ NO ✓ If "YES", describe in detail. Has the ulceration healed following at least three months of prescribed medical or surgical therapy? YES ___ NO ___ If "NO", please explain.

5. Indicate pulsations of lower extremities on scale of 0 to +4 (normal). Were these established by Doppler testing or plethysmography? YES ___ NO ✓ If "YES", include report of results in item #6 below.

	Left	Right
Femoral Artery	+3	+3
Popliteal Artery	+2	+2
Posterior Tibial Artery	+2	+2
Dorsalis Pedis Artery	+2	+2

6. Please provide a report of or detailed description of laboratory data and dates supporting the evidence above (i.e. arteriogram, venogram, Doppler testing, plethysmography). If testing has been performed but reports are unavailable, specify dates of performance and where the reports may be obtained.

No tests performed.

7. Describe current treatment (including previous and anticipated surgery and dates), response and prognosis. Prolixin
Cogentin

HIBIT 22 (EPO)

8. Describe any other pertinent clinical observations.

The patient has a psychotic disorder. Please refer to the Wilkes-Barre Mental Health unit for further information.

Date 12-13-12 Mark Slukoski DO
Physician's Signature

A-Peripheral Vascular

Chairman Heinz. This is indeed a tragic set of tales that you have told us about.

I have a number of questions, some for Dr. Braun.

Dr. Braun, last October, the Social Security Administration, faced with expansion of the CDI process, issued instructions that face-to-face interviews are to be conducted by Social Security employees at the beginning of the CDI review. This change is designed to help people. It is an improvement over the earlier notices that arrived in the mail.

By next January 1, Social Security will be providing a face-to-face hearing at the first appeal level. In your judgment, will this face-to-face procedure be very helpful for the chronically mentally ill, all or most of them, and are there different changes that we in Congress should institute?

Dr. Braun. I think it may help to some extent, in that some people will obviously be found to be disabled at that point. I do not think the converse is true. I think that because the person has gotten dressed up, is able at that moment to be polite, and to appear fairly well, and perhaps to keep their self-esteem, to tell the person they are going to work next week, when in reality they are not ever going to go to work—I think those people will not be able to be judged in that face-to-face interview. So I think it is not going to help a whole lot.

Chairman Heinz. In your testimony you have given us an excellent profile of the population you serve at St. Vincent's. I would like to make sure I understand those statistics.

All of those people are chronically mentally ill?

Dr. Braun. Yes. The program is designed just for chronic mental illness.

Chairman Heinz. By that you mean there is very little improvement in their psychiatric condition that would permit them to work?

Dr. Braun. That is true.

Chairman Heinz. On page 5 of your testimony you state that 20 patients who were previously found to be entitled to disability benefits underwent a CDI review. Fourteen, or seventy percent of them were terminated as a result of that review. Is that correct?

Dr. Braun. Yes.

Chairman Heinz. Then of the patients in your clinic who applied for disability benefits, 15 out of 16, or 94 percent, were denied benefits. Is that correct?

Dr. Braun. Right.

Chairman Heinz. But the results change quite dramatically when you get to the administrative law judge level. Of this total of 29 denials, 14 reviews, and 15 applications respectively, 23, or 79 percent, have been reinstated by the administrative law judges. The other 21 percent are pending on appeal; they have not been decided one way or the other. You might have a 100-percent success rate.

Dr. Braun. I would hope so.

Chairman Heinz. So the result is that virtually every claim denied at the lower level, in your experience, has so far been reinstated at the administrative law judge level, and there is a good chance that it is likely to remain so.

Now, this experience dates to 1980, 1981, and 1982. My question is: Has it always been that bad? Were things that bad before 1981, and 1982?

Dr. BRAUN. No, no.

Chairman HEINZ. Why do you think the administrative law judges allow so many—so far 100 percent—of your patients who were denied by the State agency people making decisions for social security in New York State?

Dr. BRAUN. The administrative law judges do a comprehensive and a quality type of review. That is the first time one really feels that someone has read through the entire history, is really listening. We usually send a social worker along with a patient, and the administrative law judge asks how does this patient function day-to-day, can they come on time, can they stay all day, and can they complete tasks. When he finds they cannot do those things, he really understands the patient's inability to function in a work situation. Also, he talks to the patient.

Chairman HEINZ. So what you are saying is that, until you get to the administrative law judge level, no one takes the time to look carefully and thoughtfully at those cases. It is that simple?

Dr. BRAUN. Yes, exactly.

Chairman HEINZ. Dr. Braun, in your testimony you recounted the sad tale of two of your patients who recently committed suicide. Were any of those patients involved with a CDI review?

Dr. BRAUN. Yes. The young woman was involved in a CDI, and although she had been recently reinstated by the administrative law judge, I think you are seeing the results of the whole system in the sense that she felt that Social Security was telling her that she was lazy, that she really could work, that she should try again. Yet her own experience had been that she always failed and that made her feel both hopeless and not understood or believed.

Chairman HEINZ. I know it is probably impossible to say with certainty why someone would commit suicide, but are you saying that, in your judgment, the CDI review was a factor?

Dr. BRAUN. Definitely.

Chairman HEINZ. Now, you also provided some case studies where the State agency working for SSA has sent a person for a consultative examination with a physician whom the individual has never seen before.

One of my constituents, Mr. Reish, went through that and described it in some detail. I understand that those visitations are rather brief, 10 to 15 minutes in duration. So my question to you, as a physician, and as someone who works with the chronically mentally ill, is this: How well can a psychiatrist make a decision on a person's mental status based on a brief consultation of the kind described?

Dr. BRAUN. He cannot.

Chairman HEINZ. The Social Security Administration is apparently experimenting with sending mentally disabled to two different practitioners, for two short evaluations. What is the medical validity of such an approach?

Dr. BRAUN. I do not think it is going to be helpful at all.

Chairman HEINZ. Not helpful at all. So those kinds of quick consultations are not worth anybody's time, and cost the taxpayer a lot of money?

Dr. BRAUN. That is right.

Chairman HEINZ. Well, you know, after listening to all of you, and particularly Ms. Conser, it really sounds like Social Security is not paying any attention to the tremendous efforts, and the voluminous reports that you submit, and particularly after Dr. Braun's response to my last question, it sounds as if Social Security goes out of its way to place its emphasis on the source, nominally a medical source, which is least likely to know what the patient's real condition is.

Would you tend to agree with that?

Ms. CONSER. I agree with that, and also, in my area, there have been complaints about certain consultative examiners who—the most blatant incident is one in which a father took his own teenage son to a consultative exam for a mental capacity examination, and the child apparently was not filling out the forms fast enough, so the consulting examiner suggested the father finish the test for the son.

Those reports, through my office, have all been given to the State agency, with no results. The comment is that they cannot hire enough psychologists because of the low rate, and therefore the ones on staff are the only ones they can use, and they have not taken action to assure quality reports.

In addition, the problem I have is so many of the consulting examiners do not have any prior medical history for the claimant, and the claimant often is a very poor historian, and not much of what they say can be relied on as being true. There is no background.

One of my mentally impaired claimants went to Social Security, and when the question was asked on one of the forms as to why can you not work, she indicated that she had a sore big toe, and that was the only reason why she cannot work. She was actively psychotic, and had a longstanding history. That is not available to the consulting physician either. So the reliance on those physicians, and the treating physician's exam is totally ignored.

Chairman HEINZ. Dr. Braun, I gather you agree?

Dr. BRAUN. I agree strongly.

Ms. JAHSMANN. I concur with the desire here to cease and desist with the present review system. And what concerns me now is that the Social Security itself is instituting a review of their administrative law judges who have been reversing the decisions, and that really worries me.

Chairman HEINZ. Well; before we turn to our next panel, I want to thank each and all of you for traveling considerable distances, coming all the way down here to Washington, D.C., to be with us.

That is particularly true of Mr. Reish and Mr. Stiteler. I frankly want to say to you that I apologize for the callousness and insensitivity of your Government. I think we have displayed an absolutely insensitive, harsh, unfair, cruel policy toward citizens of this country, namely, you and Mr. Stiteler; and I think the least we can do, in addition to trying to reform the system, is to stress our own personal apology for the hardships and indignities that you and so many people like you have suffered.

What we have learned this morning is that the disability review system is not functioning the way it is supposed to. GAO looked at 40 persons who had been denied or terminated, and they found 27 persons could not function in their daily living without a great deal of support, and could not, by any stretch of the imagination work in a competitive or stressful environment. Your testimony has just reinforced all of those findings. And what you have all found with SSA, that which you testified to as being deficiencies, are the deficiencies found by the GAO. Wrong decisions are being made. They are being made by the wrong individuals. They are being made using the wrong criteria. Lives are literally being destroyed in the process, and regrettably, much of that damage is permanent.

Mr. REISH. I would like to ask a question. I read in the newspapers that three law judges got fired because they might have been kind enough to put people back on disability, and because they done that they got fired. I would like to know why they got fired. They might have got fired for doing a good deed. I do not know. But I would like to know if anyone got fired. Do you know about that?

Chairman HEINZ. We know about it. We have not looked into it in depth yet. There is more work to be done, and rest assured, we will do it.

Let me just conclude that I think the Congress and the Federal Government have a responsibility to stop inflicting the kind of damage we have heard about time and time again this morning, and to try to mend whatever it is that is mendable in the kind of damage that has been done.

It is for that reason that I want to thank you once again for your help and participation.

Thank you all very much.

We are running a little longer than anticipated.

Let me ask the next panel to come up.

I will ask Mr. Sachs to be our first witness.

Mr. Attorney General.

STATEMENT OF STEPHEN H. SACHS, BALTIMORE, MD., ATTORNEY GENERAL, STATE OF MARYLAND

Mr. SACHS. Thank you very much for the invitation to appear here, and to add the perspective of my State and my office to this important inquiry that you have undertaken.

I think the first thing I would like to say, Mr. Chairman, is that in addition to the many individual cases of hardship that have been testified to, and have been included in the various written documents that have been submitted to you, I think I have an additional piece of information that you will find relevant.

Last summer when representatives of advocacy groups on behalf of the mentally disabled brought to my attention what appeared to be, and we are now certain has been, a blunderbuss approach by the Social Security Administration in this problem, we began to make inquiries of the Social Security Administration, began to request information from them under the Freedom of Information Act.

We learned in August of the existence of an internal study that had been done by Social Security personnel, a special psychiatric study of Maryland denials and terminations done by them as a result of their reading in the newspapers about the meeting of myself with representatives of the groups, and the impending State inquiry into the problem.

After initially denying us the results of this special psychiatric study, and waiting some 5 months, from August until January, we finally did obtain the results, and I think you will find them interesting.

Notice, this is the Social Security Administration's own evaluation, not GAO, not the individual case histories that you have heard, but their own study of certain cases from branch offices in the Baltimore area, as well as one district office in Baltimore.

What they found was, of the 49 cases reviewed by the special psychiatric study, and including both initial denials as well as cessations, a total of 11 cases, or over 22 percent, were found by Social Security Administration study itself, to be improperly decided against the claimants.

Chairman HEINZ. That is a little bit out of whack with the so-called 97-percent accuracy rate.

Mr. SACHS. When I heard the 97-percent figure, I concluded to myself that there was an inconsistency, to say the least.

I might also say—well, let me continue with the numbers.

Some 22 percent were found to be improperly denied, and no cases were found to be improperly decided for the claimants. So the error rate is inconsistent. Two were returned to the State disability determination service, and I am quoting now, "for * * * continuance on the basis that the evidence in the file indicated that the condition was severe enough to meet listing."

So there is an absolute reversal, and a total of nine other cases were returned to obtain additional medical evidence which could lead to a reversal of the DDS decision.

In one of the cases the DDS originally denied benefits to one claimant, again quoting, "Her impairment has not resulted in any restriction of daily activities, constriction of interests, or impaired ability to relate to others."

But looking at the same study, the SSA reviewed and found that the claimant had:

> A history of many suicide attempts, constricted affect, limited interests and sociability, and many severe phobic and compulsive symptoms. After discharge from two recent hospitalizations, the patient has cycled into a severe chronic depression, with flat affect and constricted interests despite medication.

And on this basis, of course, the study team concluded that the severity met the listing 12.03 due to schizophrenia, schizo-affective type.

I might also add, Mr. Chairman, that we did not get everything we think we are entitled to. As you will see from the attachment to my full statement, there are obvious deletions in the report we received. I am not only speaking of deletions of names of individual patients, which are understandable and permissible, but there is at least one deletion that we think we are entitled to have filled in.

Perhaps this committee, when it hears from the Social Security Administration tomorrow, and after reviewing the exhibit we submitted to you, might decide to inquire what it is.

Our appeal time has not run on the deletion, and we might yet be asking for further information from them.

Finally, Mr. Chairman, let me speak, if I may, somewhat personally, and as a State legal officer who has been very much concerned about the problems, human and legal, of the mentally disabled.

I have walked the halls of our mental institutions. I have seen patients in the dayrooms, and in the back wards. I have seen the aimlessness, and I have seen the lack of responsibility, and I have seen the essential meaninglessness of the lives of some of the people in our institutions, and I know how close we are, and how far we have to go to realize some of the goals of this Congress and this country, expressed in the Community Mental Health Act of 1963.

But on a happier note, and that brings me to the problem I know your committee is facing. Just last Tuesday I visited and spent half a day in a place, a home in Frederick, Md., which calls itself Way Station. It is a club. Ex-mental patients are members there. It is a place in which people with mental illness have responsibility. It is a place where they plan meals. It is a place where they buy food. It is place where they shop for themselves. It is a place where they have to go every day, as opposed to being taken some place.

In short, it is precisely the kind of arrangement envisioned by all of us who think that community health and psychosocial rehabilitation programs are an important responsibility to the people among us that are so vulnerable.

And the irony that has been mentioned here by others is what we have said to these people who depend upon, in almost every case, SSI benefits, that if you are getting better, if you are coming out, if you are getting a hold of yourself, you run the risk of losing the very financial support that you need.

That message, of course, is an enormous disincentive. It tells them do not get well. It says it pays to get sick. I cannot imagine a more wrongheaded approach to the problem we face.

In my judgment, the Social Security Administration's review, while in its inception and original idea, a wise one—since no one wants fraud—has been the doing of delicate surgery with a chain saw. We are saying to these people, you are coming up the ladder, but we are going to kick the ladder away, and I repeat, it is something that merits the mandating of cessation of this conduct by this committee, and by the Congress, and I only want to say that I endorse emphatically the kind of sentiment that I know you stand for, and I hope the Congress will voice.

Thank you.

Chairman HEINZ. Thank you.

[The prepared statement of Mr. Sachs follows:]

PREPARED STATEMENT OF STEPHEN H. SACHS

My name is Stephen H. Sachs. I am the attorney general of the State of Maryland.

Since becoming attorney general, I have been particularly concerned about the plight of our citizens who are afflicted with mental retardation and mental illness. In the past, government—both Federal and State—has often ignored the needs of these groups or worse, by clumsy intervention, has made their lives more difficult. I have tried, within the limits of my office, to make a positive difference for this most vulnerable segment of our population.

We were able to make such a difference several years ago when we identified almost 300 mentally retarded Marylanders who were being illegally housed (not to say "warehoused") in State psychiatric institutions where they received none of the training and education to which they were legally entitled. All of these citizens are currently in more appropriate treatment surroundings. Many are in group homes in community settings.

This and other experiences as a public lawyer have taught me that our society generally does an inadequate job for those afflicted with mental illness or retardation. In Maryland, however, State government under Gov. Harry Hughes and some very talented and committed mental health administratiors has begun to make significant efforts to care for the mentally ill and retarded outside of large institutions and in community settings. These steps are difficult and the progress at times uncertain, but all in all State government in Maryland is beginning to work in positive ways for the mentally ill and mentally retarded.

We should find the Federal Government an eager partner—if not the leader—in this effort. Indeed, it has been the stated Federal policy since enactment of the Community Mental Health Center Act in 1963 to provide mental health services in community settings. At a minimum, we should expect that the Federal Government would not hinder our efforts. Unfortunately, this has not been the case and the subject of today's hearing—the termination of the mentally disabled from the social security and supplemental security income (SSI) disability rolls—now stands as a notorious example of the Federal Government—by direction or accident—hobbling earnest efforts by States to help our less fortunate citizens.

I first learned of the Social Security Administration's program to review the mentally disabled last summer when I was contacted by three Maryland advocacy groups, the Mental Health Association, Threshold, Inc., and On Our Own. They expressed to me deep concern about people they were seeing on a daily basis who had been terminated from the disability rolls despite the fact that they continued to suffer from severe mental illness and remained incapable of gainful employment.

As this committee knows, the controversy in Maryland and elsewhere arose when the Social Security Administration began implementation of the periodic review provisions of the Social Security Disability Amendments of 1980 (Public Law 96-265) which called for the review of all "nonpermanent" social security and SSI disability cases once every 3 years. In implementing this law, the Social Security Administration jumped from reviewing 120,000 cases in fiscal year 1980 to a planned 640,000 cases for fiscal year 1983. Since the beginning of this process, there have been repeated assertions that the accelerated review process was being conducted too rapidly with inadequate resources and with little care for the consequences to disabled people who have relied on these benefits for years and the States 'and local governments which must ultimately care for the needy.

Since last summer, my staff and I have reviewed the situation in Maryland and followed developments throughout the country. I have been keenly interested in the legal challenges which have been asserted in Minnesota and most recently in New York. While we are still in the process of evaluating the situation in Maryland, it is my sincere hope that the problems we and other witnesses have identified in these hearings can be remedied by adminstrative reform or legislation rather than litigation.

Since I was contacted by the three Maryland advocacy groups, we have received numerous complaints from both inside and outside of State government that many persons who are functionally disabled by any reasonable definition of that term have been summarily terminated from the disability rolls or denied benefits in an arbitrary fashion.

While we were initially primarily concerned about those cut from the rolls, we also began to realize that many chronically mentally ill persons including those institutionalized were having great difficulty initially qualifying for benefits. We have thus tried to look at the entire disability determinations system in our review.

Let me tell you about a few of these people found "not disabled":

(1) H.B., a 56-year-old woman suffering from recurrent major depression, has had several long-term hospitalizations since 1967; the most recent one lasted 9 years. She resides in the most chronic ward at Springfield Hospital—a State institution for the mentally ill. She has very poor independent living skills, severely impaired in-

terpersonal skills, and requires 24-hour supervision. The hospital feels that she could make progress in a community group home with a more normal living situation. They are attempting to place her in a group home but she has been denied SSI disability benefits because Social Security decided that she can do "simple, low-stress jobs." Her appeal may take a year or more, during which time she will remain institutionalized due to lack of funds, or will have to be placed with State project HOME funds, which are intended only to supplement Federal benefits for severely disabled people.

(2) B.W. is a 59-year-old male with a history of psychotic depression. His SSI had been reviewed and terminated in 1981. Although labeled nonpsychotic at the time, his condition rapidly deteriorated. He was not able to obtain public assistance or medical assistance because of his SSI status. In the meantime, his wife, who had organic brain syndrome, died at home. B.W. was delusional at the time and did not report her death. Finally, B.W. was certified to Springfield Hospital. It was the clinician's impression that the termination of SSI led to B.W.'s decompensation and possibly to his wife's demise. B.W. is still in Springfield Hospital.

(3) A.B. is a 50-year-old female who has been diagnosed as having clear and irreversible marked organic personality syndrome resulting from brain surgery to remove a tumor. She has difficulty obtaining the care she needs. She is totally unaware of her hostile-dependent, argumentative, and loudspoken manner. Her thought content is unfocused and mildly disorganized. Her thought processes are circumstantial, somewhat rambling and disorganized. Her perceptual processes are marred by olefactory hallucinations. Her insight poor. Abruptly and without explanation, A.B. was cut off of SSI disability benefits.

(4) F.B. is a young man in his early twenties, who upon the drug overdose death of a close friend, began to suffer from schizophrenic behavior and was admitted to Spring Grove Hospital. After being stabilized, he was ready to be released to a halfway house. F.B.'s application for SSI was denied originally and again upon reconsideration. By the time F.B. was to appear at his hearing before an administrative law judge, he was incapable of attending and wrote a note to the judge stating that he just couldn't function any longer. The judge dismissed the case. By the time Legal Aid attorneys were asked to provide representation and could request the appeals council to remand the case, F.B. suffered a breakdown and had to reenter Spring Grove Hospital. F.B. has begun to improve and has returned to a halfway house. The appeals council has now agreed to remand the case.

(5) B.T. is a young woman who suffered a nervous breakdown following the birth of a child. She now hears voices which tell her to kill herself and her child. She has spent time in the psychiatric wards of several Baltimore general hospitals. B.T.'s application for SSI, which was submitted by B.T.'s sister, was denied originally and again on reconsideration. Legal Aid is now representing B.T. in her appeal, but the case has not yet been scheduled for hearing. After again hearing voices during the February snowstorm, which told her to take her child out into the snowstorm, B.T. is back in psychiatric inpatient care.

These five cases are only illustrative of the many individuals we have been told about in Maryland in which clearly erroneous and unfair decisions seem to have been made by the Social Security Administration.

The fact that substantial error infects the process can also be deduced from other information we obtained directly from the Social Security Administration.

Last fall, we learned that the Social Security Administration's Office of Assessments performed a "special psychiatric study" of certain cases from branch offices in the Baltimore metro area, as well as one district office in Baltimore in response to articles in the Baltimore newspapers which stated that the three advocacy groups had asked my office to look into this issue.

Of the 49 cases reviewed by the special psychiatric study team,[1] including both initial denials as well as cessations, a total of 11 cases (or over 2,296) were found to have been improperly decided against the claimants. No cases were found to have been improperly decided for the claimant. Two of the eleven cases were returned to the State Disability Determination Services (DDS) "for * * * continuance on the basis that the evidence in the file indicated that the condition was severe enough to meet [the] listing." A total of nine other cases were returned to obtain additional medical evidence which "could reasonably lead to a reversal of the DDS decision."

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[1] Our first request under the Freedom of Information Act for a copy of the study results was denied and we obtained it only after filing an administrative appeal with the Department of Health and Human Services. A copy of the study's results are attached for the committee's consideration.

In one of the cases, the DDS originally denied benefits to one claimant because "her impairment has not resulted in any restriction of daily activities, constriction of interests, or impaired ability to relate to others." Looking at the same case, the study team found that the claimant had "a history of many suicide attempts, constricted affect, limited interests and sociability and many severe phobic and compulsive symptoms. After discharge from two recent hospitalizations, [the patient] has cycled into a severe chronic depression with flat affect and constricted interests despite medication." On this basis, the study team concluded that the "severity meets listing 12.03 due to schizophrenia, schizo-affective type."

In other cases, the report reveals that denials and cessations were made without obtaining necessary information about the claimant's response to current medication, descriptions of daily living activities, evidence from the treating physician, evaluations of ability to relate to others and current mental status examinations.

The results of this study provide us with little assurance that the SSA system for determination of mental disability claims can be trusted to produce fair decisions in accord with the law.

It is clearly not my intention to cast the blame for these inaccuracies on the individual claims examiners who decide whether to deny or terminate the cases. Indeed, I must credit these workers for attempting to handle a tremendous increase in the number of cases with totally inadequate resources. Indeed, as I will discuss later, the real fault for error lies not with the individual examiners but with basic flaws in the disability determination process and the way disabling mental impairments have been defined by the Social Security Administration.

The human misery caused by erroneous decisions in mental disability cases is great. Many persons suffering from chronic mental illness who live outside of institutions rely totally on these monthly benefits to maintain themselves. The loss of benefits even for a few months can be devastating financially and a cause for great stress often leading to a deterioration of progress that was hard fought for by the patient and those supporting him.

Often, the claimant—by the very reason of his or her disability—is unable to take the very steps necessary to counteract the erroneous decisions. The reasons for this are many. First, the claimant may not understand or be able to comply with the requests for evidence. A claimant may have spent the duration of his mental illness trying to convince doctors, social workers, and himself that he is "fine" or is "getting better." He may not be able to comprehend the determinations made or appreciate the effect of the adverse action taken. Second, the claimant will often have no one to turn to assist him. Legal Aid offices to which such people have turned in the past are now an endangered species through lack of Federal funding and this administration hopes to soon make it altogether extinct. Third, even if the claimant acts to protest his termination he may be unable to meet the strict burden of proof since he cannot afford to obtain the type of "hard" evidence, e.g., detailed psychiatric reports, that Social Security prefers to base its decisions on. Even if he does persist in the appeal, it may be many months or even a year or more before he obtains a final decision.

Not only are the individuals deeply affected by erroneous decisions made in this process, but arbitrary and inexplicable terminations and denials tend to undermine carefully planned efforts in Maryland and other States to provide humane mental health care outside of institutions and in the community.

A major part of any responsible program of deinstitutionalization is the need for the patient leaving the institution to have a steady and reliable source of monthly income to help support himself in the community. These funds will be needed for extended periods while the patient adjusts to a community setting and sees whether he or she can "make it." Historically, social security and SSI benefits have been the primary source of such subsistence funds. Receipt of these benefits are also the usual preconditions for patients to become eligible for medicaid or medicare health benefits.

Patients and their families are now expressing unwillingness to try more independent and community-based living arrangements because of the belief—well founded it seems—that the Social Security Administration may well view any less restrictive living environment for the patient as evidence of "recovery" and the cause for termination of benefits. Community programs—already strapped for funds—have also found it impossible to plan their future when the main financial support for clients is so uncertain. In fact, many community programs reasonably have become reluctant to take on persons for whom payment is uncertain.

Another example of SSI's built-in disincentives to deinstitutionalization is the 30-day time limit imposed upon the "prerelease program for the institutionalized." This program was intended to coordinate a person's receipt of benefits with his expected discharge date from an institution. However, in practice, the program ignores the reality that appropriate community housing is not always available and does not always become available within the 1-month time limit. And, if a person does not actually leave the institution within 1 month from the date that SSA sends a notice indicating the person's potential eligibility, SSA closes the file and this lengthy and frustrating application process has to be repeated. A new application, according to one State hospital social worker, can take up to 4 months to process.

It is not too farfetched to suggest that a "Catch 22" situation prevails: (A) If you are in a State institution with the State paying for your care, you are likely to receive monthly disability benefits for your subsistence. (B) However, if you attempt to leave the institution, to try a community living arrangement where you will really need steady monthly income, you immediately risk losing the critically needed monthly benefits.

The current situation is particularly ironic in light of the pressures being exerted on the States by other parts of the Federal Government to improve mental institutions. For example, the Department of Justice under the Civil Rights for Institutional Persons Act, 42 U.S.C. § 1997 et seq., is currently investigating two of our institutions and has demanded substantial improvements including decreased number of patients housed in institutional settings. We are attempting to work out a reasonable accommodation of the Department's concerns, but we now find that our efforts are being impeded by the Social Security Administration's apparent views that patients outside of institutional settings should be presumed nondisabled.

The reasons why the current disability determination system produces results that seem so often to be arbitrary, unfair, and at odds with the overall remedial purposes of the Social Security Act are many and complex. We believe some of these are the following:

1. SPECIAL NATURE OF MENTAL DISABILITY CASES

Unlike cases dealing with physical disabilities such as cardiac or pulmonary impairments, mental disabilities rarely have the clear "objective" signs and symptoms which disability examiners favor. They are inherently more subjective and require different methods of analysis. By treating mental illness as simply another impairment like any other, SSA has largely ignored the unique nature and manifestations of mental illness and repeatedly resisted the idea that it must treat these cases differently than physical impairment cases.

2. NEED FOR PSYCHIATRIC EXPERTISE

It is clear that mental impairment cases require the medical expertise of psychiatrists and psychologists to properly evaluate the disability. When compared to the States which have no psychiatrists on their DDS staff, Maryland appears fortunate to have three part-time psychiatrists who together fill one full-time position. Without funds to employ additional psychiatrists, the State's DDS' have to "make do" with their limited resources, resulting in inadequate reviews of some cases. And, although SSA has emphasized the need for "consultative examinations" by outside doctors in psychiatric impairment cases, these so-called "one shot" evaluations consist of little more than a question and answer session for about 20 to 30 minutes with a psychiatrist totally unfamiliar with the patient's history. This is clearly an insufficient way to determine whether or not a patient is suffering from a disabling mental condition.

3. INADEQUATE AND OUTDATED PSYCHIATRIC STANDARDS

According to Maryland's top mental health officials, the medical criteria which forms the basis for determinations of psychiatric impairments are unreasonably strict and inconsistent with current psychiatric standards. Both the American Psychiatric Association (representing over 27,000 psychiatrists nationwide) and the National Mental Health Association Liaison (consisting of 14 other interested organizations) have written to SSA to urge the revision of the listing of impairments for mental disorders to reflect current standards and nomenclature. For example, these experts challenge the current requirement that claimants must suffer (A) a "manifested persistence" of one or more of certain clinical signs, in addition to (B) a "resulting persistence of marked restrictions of daily activities and constriction of interest and seriously impaired ability to relate to other people."

The accepted professional practice in psychiatry and psychology is to take into account medically documented persistence of symptoms and signs, even if those signs are not continuously present and thus not evident at the moment of the examination. The current regulation and practices of SSA do not fairly assess mental illness which is characterized by intermittent behavior or behavior which is temporarily masked by medication. Moreover, experts state that if a patient demonstrates any two of the three "B" criteria (i.e., marked restriction of daily activity, constriction of interest, or impaired ability to relate to other people) in the presence of documented intermittent signs or symptoms—the illness is disabling.

The current listings make no mention of such issues as the frequency, appropriateness, autonomy, or comprehension with which the individual performs daily activities. If a person is able to perform an activity only infrequently or inappropriately or without comprehension—such ability to perform should not be used to deny the existence of a disabling mental illness.

To make matters worse, the listings for mental impairments utilizes terminology that has long been abandoned by the psychiatric profession. The APA and the NMHA Liaison strongly recommend that SSA use the terminology used by practicing professionals as set forth in the Diagnostic and Statistical Manual of Mental Disorders III.

4. INADEQUATE EVALUATIONS OF ABILITY TO WORK

Even if a mentally disabled individual does not meet or equal the medical criteria set forth in the listing, that individual is entitled to disability benefits under the law if after assessing residual functional capacity (RFC), the person is found incapable of work. 20 CFR §§ 404.1545 and 416.945.

Assessing the RFC of mentally impaired individuals is uniquely difficult when compared with physical impairments since chronic mental illness is often characterized by an extreme sensitivity to stress.

A mentally ill individual may appear to function reasonably well in certain types of work activity in workshops, volunteer programs, or work adjustment programs. It must be understood, however, that this level of functioning is achieved only by artificially low psychological pressure, medication, highly structured day care programs, social work services, and other similar assistance.

A determination of whether such an individual is capable of performing "real work" must be based upon a meaningful work evaluation and cannot be presumed.

We have been following with great interest the legal challenges which have been asserted by the Minnesota Mental Health Association and most recently by the city and State of New York. As the committee may be aware, these challenges concern SSA's apparent policy and practice, at least in the Chicago and New York regions, of presuming that mentally ill individuals (18 to 49) who do not meet or equal the listing retain a residual functional capacity for at least unskilled work.

It is clear from our review of SSA memoranda between various regional offices and the central office, that there was, at least, serious misunderstanding and confusion as to how to assess the RFC in mental impairment cases which do not meet or equal the listing. The confusion dates back to April 1979 when SSA's Office of Operational Policy and Procedures issued Informational Digest No. 79-32, which was intended to illustrate: "How do we adjudicate claims involving solely mental impairments which don't meet or equal the listing * * *?" Due to the uncertainty which resulted from this bulletin as well as other official pronouncements, requests for clarification were sent to the central office by several regional offices.

A typical response from the central office to the New York regional office, dated May 1, 1980, included the following "clarification": "With a finding that a mental impairment does not (or does no longer) meet or equal the listing, it will generally follow that the individual has the capacity for at least unskilled work."

This response strongly suggests that disability examiners were being instructed to virtually ignore the evaluation of RFC for mentally impaired persons, thus robbing them of an opportunity to have their claims fully evaluated under the most liberal test required by the law.

5. LACK OF FACE-TO-FACE CONTACT BY THE DECISIONMAKER WITH THE CLAIMANT

Those who actually decide the cases in the State Disability Determination Service virtually never meet or talk with the claimant before deciding to allow or deny the claim. Arguably such "face-to-face" interviews may not be critical where the impairments involved are physical in nature and can be readily calibrated or defined and reduced to a paper record. However, with mental impairments it is extremely difficult for the decisionmaker to accurately evaluate the person's claim without having some personal contact with the individual.

SSA claims to have recognized this need by allowing, since October 1982, for face-to-face interviews between the district office and the disability recipient at the start of each continuing disability investigation. Although the interview enables the district office personnel to see the claimant for purposes of explaining the termination process, the individual is not seen by the State DDS examiner who decides the claim. Unless these face-to-face interviews are conducted by the State agencies prior to reaching a determination in each case, as is currently proposed in Senate bill 476, State agencies will continue to conduct mere "paper" reviews of psychiatric impairment cases.

Beginning January 1, 1984, SSA will begin to conduct face-to-face reconsiderations in disability benefit terminations for all impairments pursuant to Public Law 97-455. Given the particular difficulties of determining mental impairment cases without first having a chance to meet the claimant, and the apparently large number of glaringly erroneous initial determinations, SSA should provide that the face-to-face interviews with the State DDS examiners who will decide whether to continue or terminate the beneficiary occur at the start of the continuing disability investigation.

The need for human contact between the claimant and the decisionmaker at the initial determination in both continuing disability cases as well as in new applications is expressed in Senate bill 476. Although not limited to mental impairment cases, what Senate bill 476 proposes for all impairments would be a welcome and necessary change in the process for determining mental disability claims.

These are only a few of the many problems with the current system that lead to inaccurate results. The list could go on and on and I am sure other witnesses will brief the committee on these.

We believe there are some immediate steps that need to be taken by SSA and Congress to protect those suffering from mental illnesses who are involved in the social security review process.

(1) Congress should mandate that in mental impairment cases face-to-face interviews with the claimant should be conducted by the examiners who actually decide the claim before even an initial decision is made on the claim. This is proposed in S. 476 introduced by Senators Levin and Cohen.

(2) SSA should immediately undertake a comprehensive review and modernization of its psychiatric criteria for deciding cases. The review should be made in conjunction with groups familiar with the mentally ill such as the American Psychiatric Association and State mental health administrators. If necessary, Congress should mandate that this review be accomplished and completed within a specified period.

(3) SSA should provide for more comprehensive and in-depth psychiatric examinations by its consultants to insure that the psychiatrists are given a full picture of the patient. Opinions rendered should be based on multiple visits, a full review of the patient's history, and direct consultation with the patient's treating psychiatrist.

(4) SSA should make certain that those mentally ill persons who are terminated from the rolls or initially denied benefits are clearly advised orally and in writing of all sources of legal assistance available to appeal the denial. Claimants should be encouraged to seek assistance with their appeals.

(5) Where free or low-cost legal assistance is unavailable to a poor claimant, SSA or the Legal Services Corporation with specially appropriated funds should fund local legal service programs to provide free representation for mentally ill clients.

(6) SSA should make sure that State mental health administrators are fully advised and consulted in advance about all programs or policies that have an impact on patients under their care. A system should also be devised by SSA that alerts mental health administrators to the fact that individuals in their care are being reviewed and may be terminated from benefits. This would allow the administrators to assist the claiment in proving his or her claim.

(7) Congress should make it crystal clear—if SSA will not—that the fact that a claimant may have transitional periods where the symptoms of mental illness are not apparent should not lead to denial of the claim if the claimant's illness, in fact, prevents him or her from holding a job for any sustained period.

(8) Congress should enact an amendment to the Social Security Act which would allow a previously institutionalized chronic patient a "trial adjustment" period of up to 2 years during which the former patient could obtain disability benefits even if there are signs that the patient was recovering and beginning to function on his own.

(9) Finally—and most importantly—Congress should mandate an immediate moratorium on all social security and SSI terminations of the mentally ill until SSA can produce and implement a detailed plan to correct the deficiencies in its current process.

For generations, the needs of the mentally ill and mentally retarded have been neglected by government. During the last decade a gradual awakening as to the needs and rights of these groups has occurred so that government at all levels has had to respond. The process has been painful at times, but dramatic progress has been made to bring these groups out of the back wards and into their rightful place in the world.

We as a society can ill afford any disruption of this progress. It is particularly painful when the disruption is caused by the Federal Government's mishandling of its most important benefit programs for the mentally ill.

Hopefully, the Social Security Administration will act immediately to correct this situation, but if it does not, then Congress must intervene.

QA-4

AUG 24 1982

TO : Andrew J. Ciulla

SUBJECT: Special Maryland Psychiatric Study--INFORMATION

<u>Executive Summary</u>

We reviewed 42 denials of psychiatric claims completed by the Maryland DDS with the following results:

- One case was returned for reversal to continuance on the basis that the evidence in file indicated that the condition was severe enough to meet Listing 12.03.

- Seven cases were returned for additional medical evidence after we agreed with the Medical Consultant Staff (MCS) that the evidence in file was not sufficient to permit independent assessment of the severity of the impairment, and additional development could reasonably lead to a reversal of the DDS decision.

Total error rate	-	19 percent
Decisional error rate	-	2 percent
Documentation error rate	-	16.6 percent

We also reviewed seven cessations of psychiatric claims completed by the Maryland DDS with the following results:

- One case returned for reversal to continuance on the basis that the evidence in file revealed a severe impairment that meets Listings 12.03 A 4 & 5, and 12.03B.

- Two cases returned for additional medical evidence necessary to permit independent assessment of severity with probable reversal of the decision of likely prospect.

Total cessation error rate - 42.8 percent
Decisional error rate - 14.2 percent
Documentation error rate - 28.5 percent

I. Background

On July 26, 1982, an article appeared in the Baltimore Evening Sun reporting certain citizens groups in the State of Maryland were alleging discrimination by SSA towards the mentally impaired. The article indicated that the groups believed that SSA was unfairly ceasing mentally impaired individuals currently on the benefit rolls and making it difficult for mentally impaired individuals seeking initial entitlement to qualify for benefits. A subsequent article on August 18, 1982, indicated that the State would seek information on disability cessations and initial entitlements via Freedom of Information Act.

it was decided to review a grab sample of initial denials and cessations in psychiatric cases to determine if any discrimination was evident.

Through contacts with the Philadelphia regional office, we were able to send DDQO staff to branch offices in the metro area, as well as the district office in Baltimore to locate and review initial denials. At the same time, we screened ODO files to select and review cessations. Our contacts with the DO/BOs yielded 45 primarily mental system denials. The screening of ODO files yielded seven psychiatric cessations. A subsequent screening of the office files in the Catonsville and Westminster Branch Offices failed to turn up any current cessations. We have made further contacts with ODO to secure additional cessations to no avail.

Total cases reviewed by both the MCS and our examiners were: 42 denials and 7 cessations.

II. Review Procedures

Special arrangements were made with Dr. Herbert L. Blumenfeld, Chief Medical Officer, to obtain psychiatric review of the case folders. The medical staff was requested to complete an SSA-3474 (Quality Assurance Review Form) and an SSA-2506 (Psychiatric Review Form) on each cases. An SSA-416 was required on all cases not rated 01 or 02 and a residual functional capacity statement was required for all cases rated 03 or 04. Following medical review, the cases were reviewed and analyzed by disability examiners in the branch applying the standard operating procedures. A special form was prepared on all cases to tabulate the necessary data.

III. DDQO Findings

Of the 42 denials reviewed, 8 were found to contain returnable deficiencies. One case required reversal of the denial to an allowance and seven cases required additional medical documentation to permit an independent decision. These cases were returned to the Maryland DDS via SSA-1774 for corrective action. In addition, three cases contained nonreturnable deficiencies, i.e. probability of reversal if additional evidence received was nil.

The seven cessations yielded three returnable deficiencies, one for reversal of the cessation to a continuance and two for medical development (see attached case summaries for particulars).

Paul E. Daingalis

Attachment

cc:
Mr. Bukamp
Mr. Hughes
Mr. Ballard
Mr. Smith
Mr. Weinacht
Mrs. Farmer

Jim Keelan/bb/8/23/82

Attachment

1.

DDS - Denial N30-920(c) Bi-polar affective disorder.
CDI-CR - Group I, Category 1 (reversal to allowance)

The DDS denied this year-old claimant because her impairment has not resulted in any restriction of daily activities, constriction of interests, or impaired ability to relate to others. CDI-CR finds a history of many suicide attempts, constricted affect, limited interests and sociability, and many severe phobic and compulsive symptoms. After discharge from two recent hospitalization, has cycled into a severe, chronic depression with flat affect and constricted interests despite medication. Severity meets Listing 12.03 due to schizophrenia, schizo-affective type.

2.

DDS - Denial H1-1520(e) Schizophrenia
CDI-CR - Group I, Category 4 (medical documentation deficiency

The DDS found that this year-old claimant with schizophrenia is capable of caring for own personal needs and has no severe constriction of interests or inability to relate to others. Even though is restricted to jobs that do not require to work closely with others, can return to past work as a kitchen helper. CDI-CR finds that has a history of , uncooperativeness, irritableness, agitation, delusions, hallucinations, suspiciousness, and a potential for violence. After of hospitalization, is still seclusive and behavior is erratic. There also are indications of limited intelligence and regressive behavior. Current mental status and WAIS-R should be obtained.

3.

DDS - Denial H1-1520(e) Mental deficiency, chronic stosi ulcer
CDI-CR - Group I, Category 4 (medical documentation deficiency)

The DDS denied this year-old claimant because (performance) IQ is and . Therefore, can return to past work as a kitchen helper. CDI-CR finds that has had numerous hospital admissions because of emotional difficulties, which appear to limit still. Current evaluation of mental status by psychiatric examination, as well as current status , is needed.

4.

DDS - Denial G1-1520(f) Seizure disorder; mental retardation
CDI-CR - Group I, Category 4 (medical documentation deficiency)

The DDS denied this year-old claimant on the basis that is only mildly mentally retarded. Although has frequent seizures, he does not always take his medication. is able to care for personal needs. can do heavy work, but cannot work in high, hazardous areas or around moving machinery; and is restricted to simple tasks. CDI-CR finds that full scale IQ is , but there is conflictive evidence of neurological disorder. Development should show frequency of seizures, response to medication, and cooperation in taking medication.

5.

DDS - Denial N32-920(f) Mental retardation
CDI-CR - Group I, Category 4 (medical documentation deficiency)

The DDS denied this year-old claimant because has a full scale IQ of and no other physical or mental impairment. can do simple, repetitive tasks. CDI-CR finds that a hearing impairment was alleged. The results of an otological examination and audiological testing should be obtained.

6.

DDS - Denial J2-1520(f) Mental retardation; trauma to right leg
CDI-CR - Group I, Category 4 (medical documentation deficiency)

The DDS denied this year-old claimant because is only mildly mentally retarded and

is capable of performing light work not requiring a high level of intellectual functioning. CDI-CR finds that had been at
IQ was estimated as . Development regarding diagnosis, intellectual functioning (WAIS testing) and activities of daily living are needed.

7.

DDS - Denial N30-920(c) Paranoid schizophrenia
CDI-CR - Group I, Category 4 (medical documentation deficiency)

The DDS denied this year-old claimant because incidences of nervousness, agitation and affective disorder improved during hospitalization. Although still is undergoing treatment, has no condition which would affect ability to work. CDI-CR finds a history of several hospitalizations. showed poor concentration, child-like behavior and seclusiveness. On discharge, hallucinations and delusions were said to be reduced but to what extent is not known. No subsequent information was given. Follow-up evidence from the treating source or a consultative examination regarding mental status is needed.

8.

DDS - Denial N31-920(e) Schizophrenia
CDI-CR - Group I, Category 4 (medical documentation deficiency)

The DDS denied this year-old claimant on the basis that he retained the ability to perform past relevant work as an assembler as long as avoided stressful situations. CDI-CR finds that additional documentation is needed to determine if is able to function outside the hospital and/or supervised setting. Evidence regarding current adjustment, treatment and living arrangements should be obtained. Contact should be made with the for progress notes on habits, daily activities and compliance with prescribe treatment. Because of long history of mental illness, frequent hospitalizations with recurrent deterioration of condition, may be unable to return even to past sporadic, unskilled work.

9.

The DDS found that disability had ceased effective May 1982.

Medical evidence in file shows a chronically disturbed and socially isolated person. The claimant suffers from a psychotic thought disorder and probably hallucinates. There is some indication of suicidal thoughts. We agree with MCS that the claimant meets Listings 12.03 A 4, 5 and 12.03 B. A reversal to continuance was requested.

10.

The DDS conducted a scheduled CDI and found the evidence warranted a cessation effective December 1981.

Claimant has a long history of schizophrenia with many state hospital admissions. History indicates maximum adjustment while hospitalized and rapid deterioration when released. Common problem is

We agreed with MCS that current evidence in file did not permit independent assessment of severity. Suggested securing a current mental status examination, description of daily activities and interests, and ability to relate to others.

11.

The DDS terminated the period of disability and benefits effective with June 1982.

The diagnosis of manic depressive with paranoia was well-documented in various hospital reports. However, cessation appeared to be based on a sketchy response to specific questions offered by the treating physician.

We agree with MCS that the evidence in file is not sufficient for an independent assessment of severity. It was suggested that the DDS secure a current mental status examination, and a detailed amount of daily activities and interests in order to allow such assessment.

Chairman HEINZ. Commissioner Treadway.

STATEMENT OF LOUIS O. TREADWAY, COMMISSIONER, ORANGE COUNTY, FLA., REPRESENTING THE NATIONAL ASSOCIATION OF COUNTIES, WASHINGTON, D.C.

Mr. TREADWAY. Mr. Chairman and members of the committee, I am pleased to be here today on behalf of the National Association of Counties—NACo. With me today is Matthew Coffey, executive director of NACo. We appreciate the opportunity to testify at a time when county, State, and Federal Government representatives, and our colleagues in the private sector, seek better ways to administer the programs that serve our disabled citizens.

County officials have a particular interest in the disability problems that the committee is addressing, and I am glad to share some of our concerns with you. Nationwide, county governments will provide over $2 billion this year in health and welfare services. Although there is no uniform pattern across the country, almost all counties fund and administer some aspect of the social safety net that supports mentally disabled persons, such as: Community mental health centers; board and care or nursing home facilities; social rehabilitation programs; adult protective services; and general assistance to support needy people who do not qualify for SSI or disability insurance benefits.

It is the county government, as provider of last resort, that picks up the pieces when mentally disabled persons—and others—fall through the cracks of some Federal or State system. Some rather graphic examples of such systems failures are coming to our attention at the local level. You have already been presented with them today.

The impact is seen in our hospital emergency rooms, our county clinics, our police stations, crisis intervention centers, and acute psychiatric facilities. The results are being felt by our county programs and budgets, as well as by our needy citizens.

Perhaps during the question and answer period we can bring out the impact even more.

Many counties are not equipped to step in and provide for all the needs of disabled persons when Federal assistance is disrupted. For others, the burden of local assistance which they must bear represents a shift of Federal fiscal responsibility to county budgets. Given the fiscal condition of counties today, this shifting of Federal costs is an intolerable burden. Fortunately, it can be relieved by an improved Federal approach to disability determination and review. I am sure most of you recognize that most of our revenue comes from a property tax, and I am sure you must recognize all of the propositions going around the country regarding limitations on the amount of property taxes that can be collected by counties.

The National Association of Counties has long supported the Federal programs for disabled people under titles II and XVI of the Social Security Act, commonly known as social security disability insurance—SSDI—and supplemental security income—SSI. We have also consistently supported the premise that these programs should benefit those disabled people who are truly unable to maintain themselves in substantial gainful employment—whose disability precludes their being able to get a job and keep it. In the interest of the program's integrity, it is clear that there must be periodic reviews of beneficiary claims to assure that the disability continues. I think that part of the paragraph should be underscored.

As reports have come in from counties around the country the past year or so, however, it has become clear that federally initiated efforts to weed out beneficiaries who are employable, by speeding up reviews and tightening eligibility for disability benefits, have resulted in excessive termination or denial of benefits to persons who in fact, are not employable and who remain disabled. For various reasons, people with mental disabilities have been particularly adversely affected. For the individual client unable to work, the loss of disability benefits—and corresponding health benefits—can provoke personal tragedy, as you have heard. For the county governments who must step in to provide the needed services, it represents another step toward fiscal catastrophe.

In Orange County, Fla., where I serve as chairman of the board of county commissioners, we have had a particular problem with increasingly restrictive eligibility for the SSI program, especially for the mentally disabled applicant. Somewhat later than other States, Florida is attempting to depopulate its State mental hospitals; Orange County is working with the State to help our mentally disabled citizens return to the community as they are discharged after many years of hospitalization.

Based on their medical records, their inability to live independently, and their lack of vocational training, we had assumed that these people would be eligible for SSI, at least until they could readjust to the real world. As the tighter eligibility interpretations have been made, however, we have found that only 5 to 10 percent of the applications are approved, even after the decision is appealed.

This year such denials, to disabled people who appear to have no current chance of employability because of their disabling conditions, will cost Orange County over $300,000 in unreimbursed health and welfare services. We are a relatively small county. Additional costs will be shifted to State government once the full course of appeals is exhausted.

Chairman HEINZ. I think you have made clear it is Orange County, Fla., not Orange County, Calif.

Mr. TREADWAY. That is right. Although that is one of our sister counties.

One of the generally recognized factors contributing to these problems, Mr. Chairman, is that mental disabilities do not always lend themselves to straightforward assessment of employability, at least as it is reviewed under the present system. In some instances the mental disability itself may interfere with the client's progress through the system.

Let me cite some other examples. Sacramento County, Calif., addressed these problems by setting up its own advocacy program. Since 1975, the county has assisted disabled general assistance recipients to followthrough on their SSDI and SSI applications, especially if the person is mentally disabled, and has problems understanding the procedural requirements.

As the speeded up reviews and tightened eligibility have swelled Sacramento County's general assistance applications, the county has expanded its advocacy program to insure that disability examiners have access to all relevant information. The county estimates that these efforts will prevent approximately $2 million in cost shifting to county taxpayers this year alone. Similar efforts have been developed in Los Angeles County, where computerized tracking of new general relief applications has revealed that termination of Federal disability benefits is a significant factor. By following through with mentally disabled clients and helping them obtain necessary documentation, inappropriate denials have been cut in half.

The picture in Ramsey County, Minn., is somewhat different. Following observation of the same phenomenon, for example, over 100 new general assistance enrollees by fall 1982, as a direct result of loss of SSI or SSDI benefits, the county initiated a special advocacy program similar to Sacramento County's, with a projected savings in cost shifts to the county of approximately $150,000. Many of the new general assistance applicants were mentally disabled; all seemed clearly unable to move into competitive employment.

By the beginning of 1983, however, the situation had improved to the point that Ramsey County canceled its plan to expand the advocacy service. At least in Federal region V, the combination of face-to-face interviews and—one may speculate—the impact of the pending litigation, has slowed the review process and made it more responsive to individual factors warranting attention.

The National Association of Counties has considered various approaches to insure that disability programs support those who are truly eligible, and that mentally disabled people are not inadvertently singled out for overly restrictive procedures. At its meeting on March 1, 1983, the NACo board of directors approved reform of the present SSI and SSDI systems that would incorporate the following principles: Individuals may not be terminated from disability programs unless there is clear and convincing evidence of significant improvement, employability, or total failure to cooperate in the review process without good cause; disability reviews should consider all available vocational information as well as medical information; people with mental impairments should be provided with assistance in completing the review process if necessary and should have a vocational assessment based on the realistic experience of competitive employment; provisions of Public Law 97-455 relating to a reasonable pace of reviews and continuation of medicare eligibility through the hearing level, scheduled to expire in October 1983, should be made permanent; and reviews and hearings should be in buildings and at locations and conducted in a manner that makes the proceedings accessible to the client.

We would also support efforts to include consultative examinations specific to the mental disability, for people so affected. It is significant to note that while problems continue, there has been some improvement over the past few months. While not as dramatic as the improvement in Ramsey County, other counties report that the interim reforms of Public Law 97-455 and the Social Security Administration's requirement of face-to-face contact in the continuing disability investigations program have slowed down the rate of cost shift to counties. We strongly support this Congress attention to these problems and the search for permanent reforms through needed legislative changes.

Mr. Chairman and members of the committee, we will welcome the opportunity to work further with the committee to provide additional information and to discuss the impact of legislative proposals. If it would be helpful to the committee, we would also be able to provide information on specific cases that illustrate the need for the kinds of reforms we support.

I will be happy to answer any questions on the principles I have outlined at this time.

Thank you very much, sir.

Chairman HEINZ. Thank you.

Mr. Perales.

STATEMENT OF CESAR A. PERALES, ALBANY, N.Y., COMMISSIONER, NEW YORK STATE DEPARTMENT OF SOCIAL SERVICES

Mr. PERALES. In view of the hour, my oral testimony will be as brief as possible.

Let me begin by saying as commissioner of the New York State Department of Social Services, I wear two hats—one as chief administrator of the State agency responsible for serving the needs of the poor and vulnerable segments of our population, and two—as an agent of the Federal Government, particularly in programs such as disability. These two roles sometimes conflict; a conflict I believe should not occur. It is my view that Government, at all levels, has an obligation to assist those who, for whatever reason, cannot take care of themselves. We should be working together, not against each other, to serve our needy and vulnerable population.

Despite that, we find it necessary to participate in strict and harsh mental illness standards set by Social Security Administration.

I would like to briefly discuss the implementation of the disability amendments of 1980. This legislation requires a review of each recipient's disability eligibility every 3 years. As you know, the law provided that these reviews would begin in January 1982, which would have allowed for orderly planning and implementation. It actually began in early 1981, without sufficient planning, research, or resources.

Data used to justify this major effort appear to have been faulty and unreliable. Certainly, the data we received from SSA regarding the numbers of recipients to be affected through review of their eligibility were frequently changed during the first 12 to 18 months of the program. During this same time, new or revised procedures were needed to implement constantly changing program requirements and processes. In addition, numerous revisions to our spending plans for fiscal year 1981 and fiscal year 1982 were required. In each year, our final allocation was at least $8 million less than was necessary.

Our concern for the client impact is coupled with a concern for the fiscal impact on the State, local governments, and other agencies that serve the disabled community. It appears to us that the implementation of the disability review program has resulted in the single largest shift from Federal to State and local resources; and that without benefit of statutory authority.

The department has estimated that as much as 50 percent of all disability recipients ceased from benefit status will eventually fall back on State and local medical assistance and public assistance programs.

We are most appreciative of the disability provisions included in the Virgin Islands Tax Act passed in January 1983, which provided for continuation of benefits through the administrative law judge level for title II recipients. While this provision is effective only through September 30, 1983, it was a large step in the right direction. The provision for extension of the 3-year review period and face-to-face reconsideration are proposals New York State has advocated and supported, and we welcome their passage.

While we acknowledge that change has been initiated, we believe very strongly that more needs to be done. In this regard, we propose and would support congressional action to accomplish the following:

First, in order to insure that those that are unable to work are treated fairly under the review process, we would propose a change in the age designation to allow for more consideration of vocational factors, and we would require evidence of mental improvement in order to remove individuals.

Second, in order to insure nationwide consistency in the application of disability criteria, we would support congressional action to require SSA to appeal all adverse judicial rulings, or otherwise conform nationwide to that ruling that they lost. We believe it important for SSA to be responsive to changing needs. This is evident not only in the CDI program, but other programs as well.

It has recently come to my attention that normal guidelines do not exist for certain disabilities, such as those suffering from AIDS. We strongly urge the SSA to establish these so that individuals suffering from this can receive the benefits to which they are entitled.

These are some of the major actions we believe are necessary to improve the disability program. We have discussed many others with SSA, and have submitted a wide variety of materials. We will continue to work closely with the Social Security Administration and Congress to obtain changes, while at the same time performing to the best of our ability within the limitations and resources available.

Thank you very much. I will be happy to answer any questions you might have.

Chairman Heinz. Mr. Perales, thank you very much for the suggestions.

[The prepared statement of Mr. Perales follows:]

PREPARED STATEMENT OF CESAR A. PERALES

I am very pleased that you asked me to appear before this committee to speak about the disability program. I welcome the opportunity to share with you the perceptions and concerns of New York State regarding the program. The result of the present administration of the disability program has been the creation of serious and harmful health and financial burdens for ceased beneficiaries, and substantial administrative and financial impacts for New York State, its localities, and those agencies which provide services to our disabled citizens.

As commissioner of the New York State Department of Social Services, I wear two hats—one as chief administrator of the State agency responsible for serving the needs of the poor and vulnerable segments of our population, and two—as an agent of the Federal Government, particularly in programs such as disability. These two roles sometimes conflict; a conflict I believe should not occur. It is my view that government, at all levels, has an obligation to assist those who, for whatever reason, cannot take care of themselves. We should be working together, not against each other, to serve our needy and vulnerable population.

I would like to briefly discuss the implementation of the disability amendments of 1980. This legislation requires a review of each recipient's disability eligibility every 3 years. As you know, the law provided that these reviews would begin in January 1982, which would have allowed for orderly planning and implementation. It actually began in early 1981, without sufficient planning, research, or resources.

Data used to justify this major effort appears to have been faulty and unreliable. Certainly, the data we received from SSA regarding the numbers of recipients to be effected through review of their eligibility was frequently changed during the first 12 to 18 months of the program. During this same time, new or revised procedures were needed to implement constantly changing program requirements and processes. In addition, numerous revisions to our spending plans for financial fiscal years 1981 and 1982 were required. In each year, our final allocation was at least $8 million less than was necessary.

With this as general background, I would like to address more specifically some of New York's most serious concerns. These can be loosely categorized into three major areas: client impact, fiscal impact, and administrative impact.

We have all read and heard about disabled recipients whose benefits were ceased, who died within weeks as a result of their disability or who have been severely affected as a result of the cessation; of others who have been forced back into institutions, and still others who have been forced to turn to public assistance programs for support.

Most of the media attention has been focused on those persons with psychiatric impairments. The mentally ill are particularly vulnerable under the disability review program. The nature of the disability is frequently difficult to observe and document. Chronic mental illness is cyclical and, therefore, symptoms are not manifest at all times, especially when treatment and medication regimens are followed. In addition, just the threat of, let alone the actual loss of benefits, can cause enough stress to the mentally ill to make them incapable of functioning. In many cases, they are unable to understand what is happening to them and take the necessary action to protect their interest.

This group, while a very important and large segment is only one of the groups affected. We should not ignore the very real trauma and despair caused by potential or actual loss of disability benefits to persons with all kinds of disabling conditions.

We must remember that when one's disability benefits are ceased, so is their medical coverage.[1] Many beneficiaries have had to rely on these benefits for their support and treatment. When these benefits are ceased, a fairly high proportion of former beneficiaries would be expected to have to turn to public assistance to maintain themselves and their families.

In a study conducted by the department of a sample of 1981 title II cessations, we found that 25 percent of those who lost their benefits made new application for public assistance. These people, in addition to loss of financial benefits, have also suffered a loss of dignity and esteem which will make their full participation in society that much more difficult.

Our concern for the client impact is coupled with a concern for the fiscal impact on the State, local governments, and other agencies that serve the disabled community. It appears to us that the implementation of the disability review program has resulted in the single largest shift from Federal to State and local resources; and that without benefit of statutory authority.

The department has estimated that as much as 50 percent of all disability recipients ceased from benefit status will eventually fall back on State and local medical assistance and public assistance programs. Our original estimates indicated that after the entire SSDI and SSI disability caseloads have been reviewed, there will be an annual impact on State welfare programs of at least $115 million (State and local shares), based on the assumption that 20 percent of the CDI cases reviewed would be ceased. When estimates were based on a 35 percent cessation rate, the potential impact increased to as much as $234 million. There would be additional financial impact on the Office of Mental Health as a result of reinstitutionalization and the

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[1] Medicare and medicaid.

potential breakdown of private mental health agencies, which depend upon disability benefits for part of their funding. The annual impact on OMH is estimated at $165 million.

In addition, the revision to the funding formula for rehabilitation services for titles II and XVI beneficiaries resulted in loss of approximately $5 million to the Office of Vocational Rehabilitation and $1.2 million to the Commission for the Blind and Visually Handicapped. The net result is that fewer people are now served.

Despite SSA providing less funding than we believe is necessary, we are expected to produce more than we believe we can with the resources provided. We believe that SSA has not taken into account in their funding formula, the serious and significant impacts the major recent program changes have had on operational realities. In addition, there has been insufficient time allowed for realistic planning and implementation of the many recent program changes. As an example, New York State has been under continuing pressure from SSA to increase the number of weekly CDI decisions it does.

When the accelerated CDI program was begun, New York State made a policy decision, which has been repeatedly reaffirmed that cases would be reviewed based on the following priority scheme: (1) Initial cases, (2) reconsiderations, and (3) CDI's.

We will continue to follow this policy.

Under our present organization, CDI's can only be done by senior grade level staff. Trying to shift resources to fill this gap only creates gaps in other areas. We have just received the necessary approvals for our staff upgrading plan which would allow nonsenior staff to do CDI's. We will be implementing this plan over the next 12 months.

Although New York State has made significant efforts to improve its productivity, most of these efforts will only produce results over time, as a result of our increasing reorganization efforts and experience levels of staff; others are constrained by factors such as uncertain budgets, and changes in requirements.

There are two current lawsuits originating in New York State which challenge the procedures and standards used to establish disability. In the *Schisler* v. *Schweiker* case, which challenges the procedures utilized by SSA and ODD to conduct the disability determination process, we are a defendant. As an agent of SSA, we are required to conform to the standards they set. However, because we have been troubled by the sometimes arbitrary or rigid interpretation of standards espoused by SSA, we joined the city of New York as a plaintiff in a lawsuit which challenges the eligibility standards and seeks a change in those standards. We have repeatedly, during the last several years, proposed the need for a change in the standard and have called for legislative action in this area.

Case processing time standards (mean processing time) for both titles II and XVI initial decisions were published in regulation during 1981, based on 1979 data. These standards are totally unrealistic in 1983.

SSA has agreed that MPT standards should be revised, but this is likely to be a time-consuming process.

Although our concerns about these matters are serious and we believe these factors serve as impediments to our ability to do the job as effectively and efficiently as we can, we have made substantial progress in improving our ranking regarding quality of decisions. New York State has moved from 52d to 20th place in the Nation and stabilized at that level. In CDI's, we are ranked No. 2 in the Nation in quality. We will, of course, continue our efforts toward improvement, but our efforts will be tempered by our concern for the individuals affected by the program.

New York State has been very sensitive to the harmful potential and actual effects of the CDI review process and has therefore been extra careful to insure that our decisions are as appropriate as possible. In this regard, New York State has undertaken a variety of special efforts to make the process as harmless as we can to the affected beneficiaries.

These efforts include, but are not limited to:

(1) Implemented a maximum assurance program which involves a 100 percent review of all cessations, prior to releasing the cessation decision, to review completeness of documentation and correctness of decision.

(2) Initiated a program to train the medical community in the medical criteria and documentation standards used to establish eligibility for disability.

(3) Instituted a policy of not ceasing benefits for psychiatric cases for failure to cooperate without assurance that the required followups were performed by SSA.

(4) Expanded the use of psychiatric social worker home visits when adequate medical documentation was not available.

(5) Initiated a major effort to locate and develop direct contact with all private agencies who provide care for the mentally ill.

Lest you think I appear before you only to air a list of grievances, I want to assure you that I and other New York State officials are gratified by and supportive of a variety of actions taken by Congress and SSA.

We are most appreciative of the disability provisions included in the Virgin Islands Tax Act passed in January 1983, which provided for continuation of benefits through the administrative law judge level for title II recipients. While this provision is effective only through September 30, 1983, it was a large step in the right direction. The provisions for extension of the 3-year review period and face-to-face reconsideration are proposals New York State has advocated and supported, and we welcome their passage.

We must also acknowledge positive actions taken by SSA, e.g., the early implementation of up-front, face-to-face, interviews with recipients to explain the PRCDI process, the conduct of home visits to psychiatrically impaired cases prior to termination, and acknowledgment that MPT standards are not realistic and need revision.

We believe that these provisions and changes would be of substantial benefit to the States as well as beneficiaries. Our major concern is that no action has been taken to implement the review period delay. Further, it appears that States will not be allowed to undertake the face-to-face reconsiderations.

Through our discussions with SSA, we are also aware that many changes in all areas of the program are being studied or implemented at this time. The extent of those changes would by themselves make it wise and humane to quickly implement the delay so as to stabilize the program and prevent large numbers of beneficiaries from being penalized by precipitous, poorly planned actions.

While we acknowledge that change has been initiated, we believe very strongly, that more needs to be done. In this regard, we propose and would support congressional action to accomplish the following:

(1) Change in the basic definition of disability to allow more consideration of the vocational impacts of a disability, e.g., allow consideration of time spent on disability, revise "any job in the economy" criteria.

(2) Require mandated appeal or national compliance with all court decisions in which SSA does not acquiesce (we support this provision of S. 476). As an example, the La Bonte principle, which requires medical improvement, was discontinued in 1977. However, we are aware that Massachusetts is now following the La Bonte principle, New York State is not. There needs to be a consistent approach used nationwide.

(3) Reinstitute medical improvement as a basic requirement for cessation of disability benefits. Currently, CDI cases undergoing review are treated as if they are new cases and are required to meet current restrictive criteria. We believe that unless a current recipient has shown improvement, benefits should not be ceased because current rules are stricter than they were when the recipient was allowed.

(4) Provide for permanent continuation of benefits through the ALJ level for both titles II and XVI (we support the provision related to title II in S. 476). We understand that there may be an effort by SSA to introduce legislation to cut off benefits at the face-to-face reconsideration level. Benefits must be continued through the ALJ level. Further continuation of benefits through the ALJ level for title XVI is a regulatory provision. We believe this should be incorporated into statute.

(5) Extend to 6 months, the period for which adjustment benefits will be provided to ceased recipients.

(6) Provide adequate funds to be used for vocational purposes to assist ceased recipients to return to the labor market (including some revision to the rehabilitation reimbursement formula, funds for demonstration projects).

In addition, I cannot overstate the need for the following actions to be taken by SSA:

(1) Implement the PRCDI review delay authorized by Congress. This is critically important to insure that the major changes underway and planned do not unfairly penalize disabled individuals by applying rules that will be changed in the near future.

(2) Allow States to exercise the option to perform mandated face-to-face reconsideration hearings. The statute clearly provides that States may choose to perform these hearings. SSA, however, despite substantial interest by many States, has indicated that these hearings will be conducted by SSA. We believe this is inappropriate.

(3) Review of all disability criteria and documentational requirements to eliminate the present harsh/restrictive nature of the program. As an example, in many cardiac cases, a treadmill stress test is required to document disability. Frequently, the treating physician or other medical provider will not give this test based on their

determination, it would be life-threatening. SSA often insists these cases should be denied if the test has not been given.

(4) Provide State DDS' with greater latitude in judgment-oriented decisions. We believe that SSA should not impose their decision over the decision made by the State where there is simply a difference in interpretation of the documentation, where there is no clear indication that there is anything wrong with the State decision.

(5) Establish more realistic State negotiated productivity and time standards. Rather than establish standards, by using national averages and publishing them in regulation, each State's unique operational features should be incorporated into the standards.

(6) Provide States with adequate funds and time to prepare for and perform level of work required. New York State has consistently received less money than requested to meet our goals. In addition, program changes, particularly with regard to the CDI program, have been implemented frequently and without adequate time to do planning and obtain necessary resources, and allow for expanded documentation requirements.

These are some of the major actions we believe are necessary to improve the disability program. We have discussed many others with SSA and have instituted a wide variety of special efforts to improve the process. We will continue to work closely with SSA and Congress to obtain change while at the same time performing to the best of our ability. New York State has sometimes been criticized for adopting a careful, cautious approach to implementation of the frequent program changes. We are fully aware of our program responsibilities, however, we will not ignore our responsibility to insure protection for those persons impacted by the program.

Governor Cuomo has talked about the State of New York as a family. We are committed to providing for those members of our family that are disabled and need our help.

I hope you share the view of our task best expressed by Hubert H. Humphrey, a view which I saw proclaimed in a building named after him in Washington where I spent my time as Assistant Secretary of HHS. I quote, "The moral test of (any) government is how it treats those who are in the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadows of life—the sick, the needy and the handicapped."

Thank you again for providing me with this opportunity to share our perceptions and concerns with you.

Chairman HEINZ. Before I ask President Bellamy to proceed, I just want to acknowledge that she is something of an expert on this. Her experience goes back a number of years.

I do not know if Gettsyburg College in Pennsylvania can claim any role in the formation of your interest in mental health, but I think it is worth noting that Ms. Bellamy was named assistant commissioner in the department of mental health and mental retardation services prior to her election to the State senate in 1972. So she comes with a very long tradition of interest, commitment, concern, and expertise.

Welcome.

STATEMENT OF CAROL BELLAMY, CITY COUNCIL PRESIDENT, NEW YORK CITY, N.Y.

Ms. BELLAMY. Thank you.

Of course, appearing before you I attribute all of the good work I do to having been schooled in Pennsylvania.

Chairman HEINZ. We do, too.

Ms. BELLAMY. I do appreciate the opportunity to be here on behalf of New York City.

As my colleague from this association has stated, in most cases health and human services are funded through county government, but for many of the larger cities in this country, it is the municipalities themselves.

Chairman HEINZ. And especially in the case of the Big Apple, we would consider it nothing less than all encompassing.

Ms. BELLAMY. It does. Actually, we are five counties, so I appreciate the opportunity to speak from the municipal level.

If properly carried out, the eligibility review process could be fair both to the disabled and to Federal taxpayers. But this is not what is happening. Instead, you have heard today, as you know, eligibility standards are being misapplied and unfair procedures are being followed in a singleminded pursuit to save Federal dollars regardless of the consequences. All too predictably, this has led to many unfair terminations—terminations which are a personal tragedy for our society's most vulnerable members.

I will give just one example, that of Richard Roe, which is what we call him, a college-educated, 36-year-old man suffering from paranoid schizophrenia. Last year, he was found by a social service agency while living as a vagrant in a city park. He is now being sheltered by the city. Mr. Roe has frequent hallucinations and talks to himself constantly. He is so obviously disturbed that he was found to be unsuitable to continue in a psychiatric rehabilitation program. Ironically, his application for SSI was denied on the grounds that his condition does not prevent him from working.

I must emphasize that decisions like the one made in the case of Mr. Roe are now the rule rather than the exception. The sad truth is that termination of the truly disabled, as the GAO report so effectively demonstrated, is the new Federal policy norm.

It is totally unrealistic to expect the mentally ill to negotiate the complex review and appeals process on their own. Yet that is what the SSA is doing. When recipients do manage to comply, many are still denied benefits due to the Federal Government's narrowing eligibility criteria.

In fact, in New York, we have seen cases where individuals who meet New York's, and indeed most State's criteria for commitment to a psychiatric hospital, have been found capable of unskilled work by SSA and, therefore, ineligible for benefits. Similar problems appear to exist with the standards for physical disability benefits as well.

Indeed, I found one gentleman who was informed that his eligibility had been denied at the very time he was in the intensive care ward for a triple bypass heart operation. The truth is, most employers would not dream of hiring disabled persons now defined as employable under Federal guidelines.

Moreover, many disability beneficiaries could not work, even if a job were available. Yet, to date, 17,000 social security disability recipients in New York State have been terminated, with 15,000 cases still pending. We anticipate that when the backlogged cases are reviewed 6,000 more people will lose benefits.

It is no wonder then that New York decided it was time to fight back on some of these cases. As Commissioner Perales has mentioned, February 8, 1983, New York City and State filed a lawsuit in Federal court. We seek to restore benefits to more than 5,200 mentally impaired New Yorkers, and to protect the rights of more than 60,000 others who could lose benefits within the next 5 years if the eligibility standards and procedures are not changed.

The suit, joined by six individuals on behalf of a class, is the first in the country filed by State and local governments. It charges the Social Security Administration with violating the Social Security Act by imposing unlawfully restrictive eligibility standards.

We believe that SSA is misusing its psychiatric "listing of impairments" by automatically inferring that a person can work—and is therefore ineligible for disability benefits—if his or her condition appears to be less severe than the listed level. These overly restrictive listings have been described by a regional SSA medical adviser as covering only applicants who are completely disorganized, blatantly psychotic, or having a psychiatric emergency requiring immediate hospitalization.

When someone's condition does not meet the listing, Federal regulations require SSA to make an individualized evaluation of the person's ability to work. But SSA has ignored this requirement and communicated a new standard to regional offices and State agencies: Mentally impaired claimants who do not meet the listing should be presumed capable of at least unskilled work. We think this violates the intent of Congress.

We understand that the Social Security Administration has just issued a new circular. We are told that it states that all prior instructions to the region are rescinded. If actually implemented, this will be a welcome step forward. However, it by no means solves all of the problems.

First of all, the new policy is arbitrarily directed at the Chicago region. What about the thousands of New Yorkers already terminated and denied benefits? The same serious situation also exists in many other regions.

The vague standard as to whether claimants retain the residual functional capacity to work remains undefined. Without this definition, I am afraid there will be no meaningful change.

Yesterday afternoon, SSA, only under duress of the Federal inquiry and this Senate hearing, issued this circular. We cannot expect the SSA to reverse itself on the basis of an internal memorandum. This would require retraining personnel and modern decisionmaking.

Much more needs to be done, given these procedure's unfortunate history. In the meantime, beyond our lawsuit, we will continue to seek relief. The mobilization for youth legal services office in New York, for instance, received $370,000 in city funds to provide protection to the disabled, particularly the mentally ill. This pilot project will save us money, since for each dollar allocated to Legal Services, we project that the city will save $8 in local public assistance.

We have also sponsored public education campaigns, training sessions for lay advocates, and have worked with the medical community. But these activities are only a stopgap solution. Further congressional action is required. New York City fully supports S. 476, which, if adopted, will go far toward protecting the disabled.

We hope you will go further, and in my written statement I have submitted a series of additional recommendations. I offer them to you on behalf of the city of New York, and hope you give them positive consideration.

Thank you, again.

Chairman HEINZ. Thank you.

[The prepared statement of Ms. Bellamy follows:]

PREPARED STATEMENT OF CAROL BELLAMY

Chairman Heinz, members of the committee, I am Carol Bellamy, president of the New York City Council. On behalf of myself and Mayor Koch, I want to commend the committee for convening this hearing and for your leadership in amending the Social Security Act to continue disability benefits through the administrative appeals process. I appreciate this opportunity to discuss the severe human and fiscal impact of the wholesale terminations of social security disability and SSI benefits in New York City. And New York is not alone. The problems I will describe today are mirrored in municipalities throughout the country. I also want to share with you some of New York City's initiatives to assist affected individuals and to recommend urgently needed reforms.

In 1980, Congress amended the Social Security Act to require periodic review of all disability beneficiaries. But the valid aim of insuring that benefits go only to eligible individuals is being undermined by overzealous Reagan administration officials.

If properly carried out, the eligibility review process could be fair both to the disabled and to Federal taxpayers. But this is not what is happening. Instead, eligibility standards are being misapplied and unfair procedures are being followed in a singleminded pursuit to save Federal dollars regardless of the consequences. All too predictably, this has led to many unfair terminations—terminations which are a personal tragedy for our society's most vulnerable members.

The Social Security Administration would have us believe that these tragic stories represent the rare exception to an otherwise fair process. But the sad truth is that termination of the "truly" disabled is the new Federal policy.

As ombudsman for the city of New York, I began an investigation in response to calls from recipients terminated in the first months of this Federal initiative. We focused on the mentally disabled since this was the largest category of beneficiaries, but people disabled from heart disease, respiratory illness and other physical impairments have complained about similar problems.

My report, "Passing the Buck: Federal Efforts To Abandon the Mentally Ill" (January 1982) documents the fact that benefits were being cut simply because mentally disabled individuals could not cope with the hurdles created by Reagan administration directives. I am submitting the full report for the record,[1] but let me share with you just one finding.

As the first step in the review process, the mentally disabled are required to fill out a three-page form. Among other questions, they are asked the following: "Do you feel your medical condition has improved so that you are able to return to work?" Now, any mental health professional will tell you that most psychiatric patients lack the insight and judgment to evaluate their own illness. In fact, delusional or hallucinating patients often deny they are sick at all. Yet, if the patient checks the wrong box, his or her benefits could be summarily terminated.

It is totally unrealistic to expect the mentally ill to negotiate the complex review and appeals process on their own. Yet, that is what SSA is doing.

Even if disability recipients manage to comply with the procedures, many are still denied benefits due to the Federal Government's narrowing of eligibility criteria. Under current Federal disability standards, individuals who meet New York's and, indeed, most State criteria for commitment to a psychiatric hospital could still be found capable of unskilled work and therefore ineligible for benefits. Similar problems appear to exist with the standards for physical disability benefits as well.

The truth is most employers would not dream of hiring disabled persons now defined as "employable" under Federal guidelines. Moreover, many disability beneficiaries cannot work, even if a job were available.

Yet, to date, 17,000 social security disability recipients in New York State have been terminated, with 15,000 cases still pending. I anticipate that an additional 6,000 people will lose benefits when the backlogged cases are reviewed.

These numbers can only grow as the Reagan administration accelerates case reviews in fiscal years 1983 and 1984. Next, they plan to review SSI recipients. Unless this process is overhauled, tens of thousands of New York State residents will be forced off Federal disability support programs within the next 5 years. The escalating dimension of this problem underscores the importance of today's hearing.

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[1] See appendix, page 228.

Not surprisingly, when their only source of income is terminated, many disabled apply for locally funded home relief. These applicants will cost New York City and State an estimated $4 million in fiscal year 1983 alone and, but for Congress recent action to continue benefits pending appeal, this added local welfare responsibility would have cost $8 million. Others end up on our streets or in city shelters for the homeless. What began as a laudable effort to insure the proper expenditure of Federal dollars has instead become a ploy to shift responsibility and program costs from the Federal Government to States and localities.

These problems are compounded by the increasing difficulty of obtaining Federal disability benefits in the first place. In 1980, many disabled home relief applicants referred for SSI or SSD benefits were accepted into the Federal programs. In 1982, acceptances dropped to about 20 percent. This not only means a larger caseload for home relief. Because of increased denials, patients are also staying longer in city and State psychiatric hospitals, and are turning to city shelters.

With all this, it is no wonder that New York decided it was time to fight back.

On February 8, 1983, New York City and State filed a lawsuit in Federal court in Brooklyn. We seek to restore benefits to more than 5,200 mentally impaired New Yorkers and to protect the rights of more than 60,000 others who could lose benefits within the next 5 years if the eligibility standards and procedures are not changed.

The suit, joined by six individuals on behalf of a class, is the first in the country filed by State and local governments. It charges the Social Security Administration (SSA) with violating the Social Security Act by imposing unlawfully restrictive eligibility standards.

We believe the SSA is misusing its psychiatric "listing of impairments" by automatically inferring that a person can work—and is therefore ineligible for disability benefits—if his or her condition appears to be less severe than the listed level. These overly restrictive listings have been described by a regional SSA medical adviser as covering only applicants who are "completely disorganized," "blatantly psychotic," or "having a psychiatric emergency requiring immediate hospitalization."

When someone's condition does not meet the listings, Federal regulations require SSA to make an individualized evaluation of the person's ability to work. But SSA has ignored this requirement and communicated a new standard to regional offices and State agencies: Mentally impaired claimants who do not meet the listing should be presumed capable of at least unskilled work. We think this violates the intent of Congress.

The suit also charges that the SSA avoided public notice of these changes by communicating with the States through internal directives, memoranda, and letters rather than by publishing the new eligibility standards in the Federal Register.

The named plaintiffs in our lawsuit illustrate the problems with this callous Federal policy.

For example, Richard Roe III (a pseudonym) is a college-educated, 36-year-old man suffering from paranoid schizophrenia. Last year, he was found by a social service agency while living as a vagrant in a city park. He is now being sheltered by the city. Mr. Roe has frequent hallucinations and talks to himself constantly. He is so obviously disturbed that he was found to be unsuitable to continue in a psychiatric rehabilitation program. Ironically, his application for SSI was denied on the grounds that his condition does not prevent him from working.

I must emphasize that decisions like the one made in the case of Mr. Roe are now the rule rather than the exception. Interviews with scores of psychiatrists and social service agencies in the New York area reveal that literally hundreds of the mentally ill have been denied benefits—even when they were living under 24-hour-a-day supervision, or in some cases were actually hospitalized. Though too disabled to work, the SSA has advised many of these people that there are "many jobs that you can do." It is administrative decisions like these that violate the intent of Congress and form the basis of our lawsuit.

The city has taken additional action as well. A legal services office has received $370,000 this year in city funds to provide representation to the disabled population, particularly the mentally ill. We estimate that this pilot project will save the city and State more than it costs; for each dollar allocated to legal services, it is projected that New York City will save approximately $8 in local public assistance.

The cost savings are so large for several reasons. First, terminated clients with lawyers win about 85 percent of their administrative appeals, compared with an overall 50 percent success rate in New York State. Equally as important, many of the disabled do not appeal in the first place. This project will make legal advocates more accessible and we hope, will increase the number, as well as the favorable disposition, of administrative appeals.

This pilot legal services program is only one of our initiatives to encourage appeals. We are negotiating additional contracts with legal services programs. We have sponsored training sessions for lay advocates, initiated public education campaigns, and worked with the medical community.

But these activities are only a stopgap solution. Congress has already demonstrated its concern with this problem-ridden program by passing legislation in December to continue SSD benefits through the appeals process. But more comprehensive reform is urgently needed. If adopted, the Social Security Disability Amendments of 1983 (S. 476), introduced by Senators Cohen and Levin, will go far toward protecting the disabled.

Most importantly, the bill would require SSA to prove that recipients have improved medically before benefits could be terminated. This alone would end the current practice of terminating large numbers of beneficiaries based on unpublished and restrictive interpretations of the eligibility standards.

Moreover, the bill's other provisions—requiring SSA to develop a complete medical history for the last 12 months, mandating a face-to-face interview, eliminating the rubberstamp reconsideration review, and subjecting all new eligibility standards to public notice and comment—will end many of the abuses that now plague the review process.

New York City supports this legislation and urges you to adopt these reforms. But we hope you will go further.

In testimony submitted to Congress last year, Mayor Koch and I made a number of additional recommendations for reform:

(1) Appoint an independent board of medical experts to review and revise the current eligibility standards.

(2) Require the SSA to fund State agencies to assist the mentally disabled in complying with the complex review procedures, and provide legal representation to the poor for all appeals.

(3) Allocate funds for vocational rehabilitation and job placement for disability recipients who are judged newly ineligible, and extend benefits during the training period.

(4) Place primary emphasis on reports by treating doctors in determining disability, rather than heavily relying on paid consultants who hardly see the beneficiary.

(5) Exempt recipients from review who are 59 and over, or who have been out of the work force due to a disability for more than 15 years.

The city of New York does not question the need to maintain strict procedures so that only the needy receive benefits. But the present system is clearly penalizing the most vulnerable members of our society. Unless action is taken by Congress, these people will continue to suffer, and all Washington will have accomplished is to shift a fiscal burden to State and local government. New York City looks to Congress for leadership. We stand ready to assist in any way possible.

Thank you very much.

Chairman HEINZ. Thank you.

I am particularly grateful for the representation of the big cities, like Philadelphia, which has a coterminous form of government like New York City. I am also glad to have testimony from both the States—represented by Mr. Perales and by Mr. Sachs—and from the counties—that are not so fortunate as to have a city—represented by Commissioner Treadway.

I would like to spend a moment or two on the medical improvement issue and I address this question to Mr. Perales, but that does not mean the rest of you should not address it as well.

On page 8 of your testimony, Mr. Perales, you state that the State of Massachusetts is following the La Bonte principle that SSA used to follow and then dropped. SSA dropped it at the State agency level in 1976, and then dropped it at the regulatory level, in 1980. It required a finding of medical improvement before terminating benefits.

Mr. Perales, you state today that Massachusetts is following the La Bonte principle. New York is not. Why is one State using a medical improvement standard, and others not? All of you on the panel, for that matter—do you believe it makes sense for Social Security to terminate people who have been properly put on social security rolls when they have not improved medically since then?

Mr. PERALES. Let me indicate the rather strange position I find myself in, or anyone who represents a State before this committee.

We actually carry out, in the first instance, the rules and regulations set forth by SSA. I am in the strange position of representing the State of New York, who presently ranks second in terms of accuracy, according to SSA—in other words, they think we are doing a great job. The reason we are doing a great job, apparently, is because we are being very, very tough, and have found ourselves terminating more and more people from the rolls.

So that while we have carried out our legal responsibilities expertly, we think it is wrong. We note that other States, States like Massachusetts, have not been as consistent in following out the instructions of SSA, so that we face the choice.

Chairman HEINZ. Consistency is the hobgoblin of what?

Mr. SACHS. Of small minds.

Chairman HEINZ. I know.

Mr. PERALES. Basically, my position is I would like to emulate what Massachusetts is doing. I represent a State that is doing exactly what SSA told me to do, in carrying out my responsibilities, and I think it is wrong. So the course we chose was to sue in the Federal courts, saying you ought not force us to carry out these policies which we think are wrong.

Chairman HEINZ. How can Massachusetts get away with it?

Mr. PERALES. I cannot answer that question.

Chairman HEINZ. What would happen if New York just adopted the La Bonte principle?

Mr. PERALES. Two things can happen. One is that we would have the Federal Government begin to turn back more and more of our determinations and, as I indicated, we would not be doing as good a job in theory as we are supposed to under our contractual relationship with the Federal Government.

Chairman HEINZ. So you are saying to them you are wrong. Mr. Sachs just found out that deep down they know they are wrong, at least 22 percent of the time.

Mr. PERALES. I suppose the ultimate sanction which many of us fear is that the Federal Government would say we are going to do it ourself. We are going to break our contract with you, the State agencies, and we will carry out, make these determinations, and quite frankly, in view of the way the Social Security Administration has been acting of late, that would be the worst thing that could happen to the disabled in this country, if we let SSA make the determinations on their own.

Chairman HEINZ. I suppose that would be worse, but I find it hard to imagine a situation worse than it is now.

Mr. PERALES. It would be if SSA would handle the issues themselves.

Chairman HEINZ. One thing that all three of you testified to is this: Because of what is happening, people who are being taken off the rolls are being thrown onto local assistance and eventually they will end up on the State rolls, but in that transition, there will be a lot of hardship for local government, and there may be some very real false economies here of a potentially large, but undetermined magnitude.

It is my hope that when GAO comes back to us with a report of what has happened to the individuals who have had their benefits ceased, and have been thrown off social security, that we will get some hard evidence on that question.

Do you want to comment?

Mr. PERALES. We made projections in New York State that indicated the cost to us at the end of all these reviews, at the end of 5 years, will be approximately $200 million a year, just in the State of New York.

Chairman HEINZ. That is a lot of cost shifting, and it does not take into account the human hardship.

Ms. BELLAMY. I just wanted to support what has been said. There is no question that the dollars of local government get lost in the cracks. They do not disappear. They show up somewhere, and if you add up the implications of the SSI reviews along with the SSD, the estimates are astronomical.

Chairman HEINZ. Can you repeat the cost to the city of New York?

Ms. BELLAMY. I basically used State figures. We are talking about 5,000 people on public assistance rolls in the early part of SSD. We anticipate at least, based on this projection, another 6,000 people losing their benefits when backlog cases are reviewed. So we are talking about very substantial numbers.

Chairman HEINZ. Mr. Treadway.

Mr. TREADWAY. In Orange County, Fla., just recently, we passed the 500,000 population mark, and last year we spent $8.9 million on social service welfare programs, part of this and part of the disability thing that I have already mentioned comes under that.

Out of that $8.9 million, $5.7 million is a direct impact on the general fund of the county in taxation. Orange County, Fla., is not unlike many other counties in this country, where their prime source of revenue comes from property taxes, and so, therefore, that is $5.7 million in property taxes that is being impacted by this program.

Chairman HEINZ. What is your local revenue base?

Mr. TREADWAY. Our local revenue sources are primarily from property taxes. We just recently, last year, had an allowance to enact a one-half percent local option sales tax, but restrictions were put on that as to what those dollars could be used for.

Chairman HEINZ. What do they add up to?

Mr. TREADWAY. $60 or $70 million.

Chairman HEINZ. So what you describe is 10 percent?

Mr. TREADWAY. This total program represents about $7.2 million of our budget, of our overall tax budget.

Chairman HEINZ. It is a very significant number.

Mr. TREADWAY. Yes, and, of course, it permeates itself throughout the other counties. Another aspect in the State of Florida is we are becoming a retirement community for the rest of the country. People are moving to Florida, and, obviously, the population increases, and you are going to get more and more of the impact that will show up at the local government level, and we are at the last level of resort, when it falls through the cracks. You got to pick them up. You cannot turn them away.

The problems remain the same. You have just shifted.

Chairman HEINZ. I have one last question for the attorney general, Mr. Sachs.

As regards one of the cases that was brought to our attention, a gentleman from your State of Maryland has submitted a confidential statement to the committee about the continuing disability of his son.

One of the things that comes out of the statement is the following: His son has been involuntarily committed to a Maryland State mental hospital. While still an inmate of the hospital—and we have heard earlier today about people being, if you will, in halfway houses and sheltered workshops—but in this instance an individual who had been involuntarily committed to a mental hospital in your State—he received a notice of disability termination. The notice said that the son could work. The only work I understand that this individual did in the hospital was deliver coffee and medications to other inmates.

I assume, unless Maryland is quite unique, that it is not that easy to be involuntarily committed in the State of Maryland. Is that correct?

Mr. SACHS. Absolutely correct. For the individual in my State noted to be involuntarily committed—there must be findings that he has a mental illness, that he needs inpatient care for the protection of himself or another, that the individual is unwilling or unable to be admitted voluntarily, and there is no other less restrictive form of treatment available. This is the normal standard around the country. We are aware of the grotesqueness of the case that you referred to, and I am afraid it is just another example of the insensitive approach.

If I may add one thing to the question before, it is this. It is not the cost of unnecessary care. We are not only dealing with the impact of plans that have been visited upon the States, or the attempts to deinstitutionalize, but the Federal Government is at odds with itself because we, like many States, have been visited by representatives of the Justice Department pursuant to the Civil Rights for Institutionalized Persons Act, and I think it is a very wise piece of policy, and on balance, a very constructive force with regard to the State management of their institutions.

But we are told with respect to Spring Grove and others, we are told the places are too crowded. We are told we are not measuring up and there is potential for a lawsuit against the State. That, from the Department of Justice, at the same time from the Social Security Administration has made it doubly difficult, and in many ways impossible to, in a humane way, reduce the crowding in our mental institutions, short of dumping people in the street, which would be the worst possible alternative.

So we have a Federal Government that is of two different minds.

Chairman HEINZ. Any other comment? I expect you agree?

Mr. TREADWAY. I think you got the point.

Chairman HEINZ. I want to thank you all for coming.

[Subsequent to the hearing, Senator Bill Bradley submitted questions in writing to Ms. Bellamy. Those questions and Ms. Bellamy's responses follow:]

Question 1. This country has significantly changed its method for caring for the mentally ill. We no longer warehouse most patients; hundreds of thousands of patients have been released to residential setting and to the community at large. We may be witnessing a collision between the DI program and the deinstitutionalization movement, and we may need to make changes in DI to account for these changes.

Response. While I do not think that major changes are needed in the DI program, I do believe that there is a pressing need to revise the SSA's unrealistic eligibility standards. Many patients are denied or terminated from benefits solely on the basis of hospital reports that they are well enough to be discharged. Progress in socialization and life skills, made by deinstitutionalized patients enrolled in community care programs, is often used as an excuse to find these beneficiaries employable. In short, SSA often blurs the distinction between the low-functioning skills needed to live outside an institution, with the higher functioning skills needed to hold a job. Realistic criteria to measure job skills must be developed.

The reality is that the DI and SSI programs have been the major funding sources for the living expenses of deinstitutionalized patients. States have, by and large, abdicated their financial responsibility to care for deinstitutionalized patients. When the Social Security Administration began to terminate the mentally ill from the disability rolls in 1981, the financial underpinnings of the community mental health system began to erode. The fortunate minority living in community residences or stable apartments could no longer pay their rent. Many lost medicare or medicaid coverage and could not continue treatment. Loss of income triggered relapses of previously stabilized patients; many were rehospitalized.

Without the availability of Federal disability benefits for this population, community care for the mentally ill in this country could collapse, and that would be a tragedy.

Question 2. Many of the patients who have been released are still incapable of working or of supporting themselves. Some of these people have been denied disability coverage, but most who have appealed had their benefits restored at the ALJ level. Does the problem stem from the interpretation of the law and/or regulations by the reviewers?

Response. The problem is twofold. First, the listing of impairments in the regulations, describing those mental illnesses which are always disabling, are too narrow. They don't take into account the cyclical nature of chronic mental illness. If the applicant or beneficiary is not manifesting severe symptoms and restricted function at the time of the review, they are ineligible under the regulations, regardless of the long history of their illness and/or their demonstrated inability to deal with stress.

Second, the reglations have been misinterpreted, which is the major allegation in the New York City and State lawsuit against SSA. If a patient does not meet these narrow listings, they are still entitled under the regulations to an individualized review to determine whether their illness has substantially impeded their ability to work. The SSA communicated, through internal memos to the States, that if the mentally ill individual does not meet the listings, he or she is probably capable of work. The city and State of New York are charging that this is a misinterpretation of the law and regulations.

In other internal documents, SSA has communicated its position that those psychiatric patients who have developed minimum self-maintenance skills also have the capacity to work. This assumption again runs contrary to the statute, the regulations and accepted medical doctrine.

Question 3. Are changes needed in the DI law, regulations and/or medical listings to insure that mentally disabled persons are protected?

Response. In my opinion, the Social Security Act does not require change, but the regulations, including the medical listings, must be revised to be more realistic and in conformity with current medical doctrine. A panel of psychiatric and rehabilitation experts (perhaps under the auspices of the Institute of Medicine) should be convened to develop recommendations for revising the regulations and listings.

Question 4. Are the changes recently announced by the administration sufficient to resolve these problems?

Response. The administration's recently announced changes are not sufficient to resolve the problems. The recent memo rescinding the old policy will not end the abuses. Retraining of personnel and monitoring decisionmaking is urgently needed. Most important, however, is the promulgation of a new set of published, realistic standards to provide guidance to the States in making proper eligibility determinations.

Senator **Heinz**. Our last witness this morning is Dr. Arthur Meyerson. We welcome you, and please proceed.

STATEMENT OF DR. ARTHUR T. MEYERSON, VICE CHAIRMAN AND CLINICAL DIRECTOR, MT. SINAI SCHOOL OF MEDICINE/HOSPITAL, NEW YORK, N.Y., REPRESENTING THE AMERICAN PSYCHIATRIC ASSOCIATION, WASHINGTON, D.C.

Dr. **Meyerson**. Thank you, Mr. Chairman.

The witnesses before me have been so eloquent, both in portraying the political consequences in a broad sense, as well as the personal tragedies that I will scrap my written statement and try to get what I can contribute which might be a bit different.

Let me start with Attorney General Sachs' last statement about the role of the Federal Government, and I have participated as an expert for the Justice Department, in critically assessing mental institutions around the country for their failure to provide adequate treatment, planning, and opportunities in the community for discharge. These failures continue at the same time that SSA is removing one of the essential financial bases on which that discharge has taken place. This is perhaps the final assault in a wave of difficulties the Government has wrought on the chronically mentally ill, beginning with, unfortunately, the Community Mental Health Act of 1963.

The opportunity to discharge masses of patients from State mental institutions, which State governments pounced upon with glee because of the possibilities of reduced costs, threw literally over 450,000 patients into our communities, with little or no planning for local provision of substitute care. These are patients, human beings, who literally needed every aspect of life cared for in a mental institution.

Now they were out in the community. The Community Mental Health Act services provided some care, but as an earlier GAO report demonstrated, the CMHC's could not touch the problem, and in many instances did not attempt to do so. Moneys remained tied up in State mental institutions, and do so now.

In my own State, well over 70 percent of the budget remains in mental institutions, although only one-third of the original caseload is there. And that is true around the country.

On top of that assault, the lack of community systems, treatment systems, lack of funds for those systems, we now have this new assault on our patients.

What is the scope of this problem? What does psychiatry, in its scientific aspects, have to tell us about the scope of the problem? If we take schizophrenia as a model, we know not only for the United States but worldwide, that approximately 1 percent of the adult population will suffer from schizophrenia. In the United States that is 2 million schizophrenics at the present time.

We know from data collected around the world that over 60 percent of such people will be at least partially, and possibly severely vocationally disabled. That includes countries that do not have social security and patients are not defrauding anybody. They simply cannot work.

In the case of psychiatric disability, we know that those enrolled before these periodic reviews represented a small percentage of the patients who are in the community and disabled, and even that small percentage is under assault at the present time.

If we add, among the psychoses, major depressive and manic illnesses, the so-called major affective illnesses, there is another 4½ percent or 9 million people in the United States. We do not have accurate figures as to how many of these are vocationally disabled, but many are, and these too are being thrown off the rolls of SSDI.

What is wrong with the listing? What is wrong with Social Security's current policies and procedures insofar as psychiatric expertise can determine?

First of all, the listings demand—in order to be met or equaled—that one meet both A and B criteria. A criteria is a list of symptoms. B criteria is a list of what might be called social disabilities.

That approach is unscientific insofar as it bears on the capacity to work, on vocational adaptation. We have a number of lines of research, international, national, and some coming from your own State, that indicate the following:

First, the work of Strauss and Carpenter, which is based on a multinational study of schizophrenia, indicates that vocational disability, social disability, and symptoms of an illness all proceed apace, independent of each other.

A patient, therefore, may be acutely psychotic at some point, and in a rare instance be able to work. Much more common, in fact, grossly much more common, are patients who are not symptomatic at any one moment, and who may not have major social disabilities at any one moment, can come to a program, watch TV, talk to other patients——

Chairman HEINZ. Visit a Social Security office.

Dr. MEYERSON. Yes; and talk reasonably lucidly. As you saw two human beings today, yet despite the asymptomatic picture, they are totally disabled from work. That is the natural history of the disease as such, and is not compatible with the policies of SSA.

Second, we have literally hundreds of studies of the effect of psychopharmacological agents, so-called antipsychotic drugs.

Chairman HEINZ. I wanted to ask you about that. I might say, just to be of assistance, on May 25, 1982, Paul Simmons of the Social Security Administration testified before a committee hearing chaired by Senator Cohen, and what Mr. Simmons said was, and I quote:

> Aside from statutory changes in the definition of disability, advances in medical science have resulted in many de facto changes. Due to the availability of * * * new medications for mental impairments, for example, certain medical impairments which were previously disabling in the past may not be disabling today. Thus, medical advancement may require changes in the continuing disability investigation procedures, since people considered permanently disabled when they came on the rolls 10 or 15 years ago may no longer be disabled in the eyes of the law, and in view of the advances in medicine and therapy which were not even thought of as recently as 10 to 15 years ago.

I gather you do not exactly agree with Mr. Simmons, that this profusion of medications means that the chronic mentally ill can now return to work?

Dr. MEYERSON. I would love to agree, and many of my friends who work in psychopharmacology would now be Nobel Prize winners if that statement was true.

Chairman HEINZ. How many are Nobel Prize winners?

Dr. MEYERSON. I have some friends who are Nobel Prize winners, but not for that work. Unfortunately, what the data indicates is that while we can well control, in many instances, what can be termed the symptomatic axes, a part of the listings, the influence on the B part of the listings, and in particular on the capacity to work—residual functional capacities—is in most studies negligible or absent. In a few instances patients in these studies seemed to show some vocational improvement, some ability to work, but the great majority of patients who were on medication and present before a claims examiner, might be controlled in terms of delusions, hallucinations, bizarre social behaviors, inability to focus and concentrate, cooperate with the interviewer, yet the capacity to work will not have improved.

Chairman HEINZ. In a practical sense, and I am every bit of the layman I appear to be in this area, but what I gather you are saying is that while the symptoms may disappear somewhat, the underlying illness is still there, and when put into a stressful situation, the individual, just as he was before medication, is just as likely to come apart at the seams.

Dr. MEYERSON. Yes; I would say perhaps not just as likely, but when it comes to the work situation, just as likely.

Chairman HEINZ. I prefaced that by saying a stressful situation.

Dr. MEYERSON. Yes, absolutely. From your own State, to go to that point, the work of Goldberg, Hogarty, Leff, and others, indicates that if you take a population of patients well controlled on medication, and put them into not a stressful work program, but into a day hospital program designed to improve functioning to such a degree that they can work, 20 percent of those patients, within a few months, gets worse. This is just from the stress of a day program, not the kind of pressures the work situation imposes.

Leff has demonstrated in a recent article in the British Journal of Psychiatry, that if you return patients to family situations, where the family pushes the patient toward high functioning, and is dissatisfied with the low-functioning schizophrenic patient; 44 percent of those patients will be back in a hospital within a year, as opposed to those placed in a low-push environment where 9 percent are back in a year.

The cost differential of rehospitalization versus SSDI, let alone the human misery that is caused by SSDI procedures is horrendous. Thus, we have three lines of evidence.

Finally, I would like to comment on SSA's residual functional capacity assessment, and in particular the new circular which I was privileged to read yesterday.

These guidelines, indeed all of SSA's periodic review procedures and the original assessment of qualification for disability insurance, are probably capable, although they have major difficulties, in determining that someone cannot work and is therefore entitled to disability insurance. They are totally incapable of determining that someone can work. None of those guidelines that SSA put out yesterday in response to the hearings, and to the findings in Federal court will help SSA be any fairer if they are going to be used to determine that someone can work who is mentally ill.

What is necessary, is a full-scale work assessment, in a work or worklike setting, done by professionals. Most patients who this committee is concerned with, cannot work. If SSA were to do a proper assessment and based on reasonable criteria, they would have to utilize a work assessment program to demonstrate that such a patient could work to my satisfaction, or to any reasonable person's satisfaction.

Chairman HEINZ. What you are saying, in sum, is that the determination of residual functional capacity, as currently made, simply has no relationship to whether an individual can work. It might be able to tell you if the individual could not work, but it cannot tell you if he can?

Dr. MEYERSON. That is correct.

Chairman HEINZ. And in terms of being predictors of behavior, these residual functional capacity criteria are worthless?

Dr. MEYERSON. Yes; they have to be—the criteria I am suggesting cannot be reviewed by claims examiners, or physicians, or psychiatrists sitting face to face with a patient. They require taking that patient into a work or worklike settings; with appropriate supervision, moving him/her step-by-step over a 2- to 6-week period at a minimum; seeing whether they can tolerate the stress; and what kind of support is necessary to do so. Even then, unless it is an actual work situation, you do not know what the final independence will mean to such patients when they are cut off from treatment and actually are in the work situation. However, one would allow that is at least a reasonable approach.

Chairman HEINZ. I gather you feel the same way about the listing of mental impairments.

Dr. MEYERSON. Yes.

Chairman HEINZ. How urgent is it that the criteria be reformed?

Dr. MEYERSON. I think it is absolutely imperative. I think what SSA published in that circular yesterday, and whatever face-to-face meeting—once or twice—they are suggesting, will not substitute for an adequate change in what constitutes the listings for mental impairment, and an adequate assessment of residual functional capacity.

Chairman HEINZ. Dr. Meyerson, I have two somewhat different questions to ask you.

One is, in reading the medical reports, frequently a physician will say that a mentally disabled patient's condition is "in remission," or "in a partial remission."

Those phrases apparently are being interpreted as meaning that the individual is no longer under a mental disability.

What do those terms mean? What is the correct interpretation of their significance with respect to the mentally disabled?

Dr. MEYERSON. Even in the medically ill, that term is used in two ways. You may be talking about Hodgkin's disease, a form of leukemia, if you will. In that case, what one means is there are no signs or symptoms of the disease present at the current time. The patient has had one or another form of treatment, or spontaneously the disease has disappeared.

In that case, it might be a fair inference that that human being, at least until and unless the illness returns, will be able to work. A different instance would be congestive heart failure. A patient comes to a physician's office, and may be totally unable to make the three steps from the couch to the physician's examining room without being short of breath. Obviously unable to work under those circumstances.

If one were able to medicate that patient so that the patient at rest, and while walking three steps, was able to breathe comfortably—and then rest again, and then walk some more—then that patient would be said to be in remission. However that patient cannot work, except under the most extraordinary circumstances. Many such patients exist.

In psychiatry, remission almost always refers to the symptoms alone. This patient is not hallucinating any more; this patient is not bizarre any more; not posturing; not sitting and staring at the walls, totally withdrawn; not thinking the FBI is after them—when they are not. Unfortunately, as I testified, "remission" has little or no bearing on whether a person regains, or gains any capacity to work. Thus, the utilization of the term "remission" by the claims assessor—if they find it in the medical record—as a sine qua non for the patient's cure and ability to work, is totally fallacious.

Chairman HEINZ. I guess my last question is this: There are some people under the law whom SSA does not have to review every 3 years, those who are considered permanently disabled.

We asked the Social Security Administration what categories of individuals with severe mental impairments are classified permanently disabled. They told us, and I quote, "Those with psychiatric impairments which have required institutionalization in a licensed mental hospital for the past 2 years without release that would indicate improvement."

My question to you is: Is that a generous, reasonable, just, or fair definition, a realistic approach, for determining which psychiatric patients should be considered permanently disabled?

Dr. MEYERSON. Clearly not.

Chairman HEINZ. Why is that?

Dr. MEYERSON. At the present time, as previous witnesses have already testified, the major criteria for hospitalization is danger to oneself or others. There are literally millions of persons with major mental illness, and vocational disability, who will not—following deinstitutionalization—have spent the last 2 years in a mental institution, and who are totally disabled from work.

Many of those, by the way, will still be actively psychotic. I have testified that many who are not psychotic may still be disabled, and do not meet those criteria. In no other impairment does SSA have such restrictive criteria for permanent disability. It is clearly a concern of the American Psychiatric Association, that a prejudice on the part of the administration and SSA toward the mentally ill, and a most unfortunate one, is embodied in these policies.

Chairman HEINZ. Dr. Meyerson, your testimony has been outstanding. I want to say for the record that you are one of the most expert, reknowned people in this field. Your testimony should, I think, be given maximum attention and weight by anybody in the administration or in Congress who is in the least bit in doubt, or concerned about any of these issues.

We are extremely indebted to you for sharing your expertise with this committee, and for taking the time to be of such great assistance. You have submitted a very substantial statement.

I also note you are appearing here on behalf of not only yourself, but also the American Psychiatric Association, and I am indeed grateful both to you and the association for the time and preparation involved.

Dr. MEYERSON. Thank you very much, Senator.

If I may say one word, the views I have expressed are shared not just by the American Psychiatric Association, but I have represented before SSA a consortium of many organizations, including the National Association of Social Workers, the American Psychological Association, and so forth. There is really a unanimity of opinion among mental health providers, if you will, around this issue, and I, therefore, insofar as I am able, thank you and this committee for its attention to this issue on their behalf.

Chairman HEINZ. Thank you very much.

[The prepared statement of Dr. Meyerson follows:]

PREPARED STATEMENT OF DR. ARTHUR T. MEYERSON

Mr. Chairman, members of the committee, my name is Arthur T. Meyerson, M.D. I am associate professor and vice chairman of the department of psychiatry at Mount Sinai Medical School and clinical director for psychiatry at the Mount Sinai Hospital.

On behalf of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrists nationwide, and as chair-designate of the APA's Committee on Rehabilitation, I am pleased to present our views and concerns regarding the administration's ongoing efforts to review the current social security disability insurance (SSDI) rolls.

These concerns were first expressed by the APA in a letter to then Secretary Schweiker, in testimony before the Senate Finance Committee, and in comments on proposed revisions to the so-called "medical listings," the SSA's regulations regarding the determination of disability based on medical criteria alone. Further, we have met on numerous occasions with SSA officials regarding our concerns. Unfortunately, our concerns persist—perhaps they even grow deeper.

We are very much aware that periodic review of disability cases is necessary not only to reduce fraud and abuse, but also to confirm that SSDI recipients continue to meet eligibility requirements and remain unable to work. However, the administration's current approach—an approach instituted in March 1981—in an apparent excess of zeal to reduce Federal expenditures, we believe, is contrary to both the letter and the spirit of the careful review that was mandated by Congress in the Social Security Disability Amendments of 1980. Moreover, SSA's reviews, both in terms of their actual conduct and the policy underlying them, are being conducted in a manner contrary to sound medical practice, sound professional clinical practice. Not only is the program administratively confusing and awkward for the recipients, physicians, health and mental health professionals, State officials and judges involved in it, but it works a special hardship upon the mentally ill SSDI recipients who, by virtue of their illness itself, are particularly vulnerable.

Not only are the mentally ill themselves hurt, but SSDI terminations have affected spouses and children—entire families. The ripple effect of SSDI termination is tremendous, taking a toll on health coverage, other means of support provided at either the Federal or State level—including SSI and State welfare. For the spouse or parent of a chronically mentally ill individual, the burden of care alone is substantial. Oftentimes, employment is difficult under the best of circumstances, but in this economy, the ability of a caring family member to seek and retain employment to replace a relative's lost SSDI payments is severely hampered. SSDI is and must remain part of the so-called social safety net for the Nation's populations least able to help themselves. It is important to remember that the disability program is like workers' compensation, as contrasted to welfare. Disability insurance is earned; it is not a handout. To terminate these benefits to which a worker is entitled by virtue of his or her illness, is wholly inappropriate, wholly misguided.

THE MENTALLY ILL AND THE CDI PROCESS

The nightmare has been greatest for the beneficiary and specifically the mentally ill SSDI beneficiary. The review procedures have not been and are still not designed to respond specifically to the very special limitations of these SSDI beneficiaries. Until recently, when a case was pulled for CDI review, the State agency mailed the disability recipient a three-page form seeking detailed information about his or her medical condition and employability.

Many of the severely mentally ill, the disabled capable of living in community-based settings as long as they receive proper therapeutic services, medication (if necessary), and social services to control their symptomology, are unable to understand that their only source of income is being threatened, that their medicare benefits (or medicaid in the case of SSDI beneficiaries receiving SSI supplementation)—the source of payment for their continued treatment—is being threatened. They often do not understand the complexity of the forms, or the necessity of such forms being completed. They either neglect to return the forms, or to complete them adequately and, as a direct result of their disabilities, lose their monthly support (a sum far lower than that associated with hospitalization, often the only recourse when SSDI benefits are terminated). The problem has been compounded by the failure to provide the appropriate followup in cases in which forms were not completed, to attempt to ascertain why such form was not returned, to seek the advice and counsel of an attending physician who has previously attested to the continuing disability of such person.

Moreover, given the nature of mental illness itself, it is often inappropriate if not impossible to receive an accurate self-evaluation from a mentally ill SSDI recipient using such forms. It is the very nature of the illness which causes a patient to deny or distort the medical significance of such illness. In a sense, the completion of the CDI form requires a person to make statements about him or herself which, based upon the serious mental, as opposed to physical, nature of the illness, are almost by definition going to be inaccurate.

While Congress and concerned organizations exerted substantial pressure on SSA to change their procedures (and we should note that the chairman and other members of the committee had a great deal to do with that pressure), if the form were not completed and returned within 35 days of mailing, benefits were often terminated, notwithstanding SSA directives to "go the extra mile" for the mentally ill.

We understand SSA has implemented a new procedure to help screen SSDI beneficiaries under CDI review by having them visit local SSA offices for evaluation and aid in completing their forms. How well that is working—since it has only just begun—and what effect it can and will have upon the mentally ill SSDI beneficiary remains to be seen. We do not know, for example, how "no shows" are handled—frequent problem in the chronic mentally ill. The "profiles" developed by SSA to help local claims officers screen out the obviously severely disabled, we understand, are themselves a problem. Are they appropriate "yardsticks" against which to measure? If someone is not a precise-reflection of such profiles, yet is obviously disabled, what happens? What does the report of the local SSA official which is sent to the State DDS look like? What weight is it given? If the claimant is mentally disabled, how can the local SSA official appropriately and adequately advise that person of the procedures and the very nature of the CDI process itself?

Thus, while we view the new "interview" in the local SSA office as a generally positive gesture, we remain concerned that it is just that, a gesture.

Yet another "process" problem has been that the case record of SSDI recipients have not been appropriately and accurately reviewed by State agency medical staff sufficiently qualified to make an appropriate (if necessarily different from the claims examiner) judgment about a mentally ill patient. We know, for example, from a July 1982, letter from then Secretary Schweiker, following a meeting by the medical director of the American Psychiatric Association with the Secretary on the SSDI issue, that fully 27 States did not at that time have sufficient numbers of psychiatrists on their medical staffs to perform appropriate reviews of mentally ill SSDI recipients' records. While the APA has undertaken a targeted effort across its district branches to seek means of relieving this tremendous shortfall of personnel with some success to date, we find the practice which still tends to disregard an existing clinical history to stand in clear opposition to procedures assuring a full and sound professional evaluation. The requirement that a medical record be wholly redeveloped upon notice of a CDI, further places an undue hardship upon the patient and his or her treating professional, if one exists. We have heard most recently from our Nebraska district branch which expressed particular concern about the duplicative and burdensome nature of the case redevelopment—redevelopment often unnecessary in view of prior SSA-maintained records on the same people.

In a May 1982 statement reporting on their review of SSA's continuing disability investigations, GAO expressed a shared concern in this regard:

"One aspect of State agency medical development that we feel needs to be changed is the practice of developing the CDI/periodic review cases as if they were new claims. SSA has issued no specific development guidance for these cases, but rather has instructed the State to adjudicate these claims in generally the same manner as initial claims. As a result, State agencies are gathering only current evidence—generally no more than 2 or 3 months old—and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. *This practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision.* It also helps explain the high consultative examination purchase rate. While the need for current evidence is obvious, we also believe there is a need for a historical perspective in these CDI cases. Many of these individuals coming under review have been receiving benefits for several years. To base a decision only on the recent examination—often a purchased consultative examination—could give a false reading of that person's condition. *This is especially true for those impairments subject to fluctuation or periodic remission, such as mental impairments.*" (Emphasis supplied.)

Again, as the result of pressures brought by the GAO report itself, by Congress, and by organizations such as the APA, SSA has altered its practices. It has restored to its policy directives the requirement that claims examiners develop a medical record extending back at least a full year. We remain concerned, however, that in the case of the mentally ill disability beneficiary, a year may not be sufficient for case development, particularly in view of the fluctuating nature of such illness. Further, SSA has begun an experiment in New York and Georgia designed to respond to the second of the GAO comments—a concern shared and voiced by the APA: The value of consultative examinations for the mentally ill. While we are not cognizant of any effort to assure that the duration of the examinations is of a more appropriate length (certainly they should be longer than 15 minutes), we do know that SSA has, in those two States, implemented the practice of two consultative examinations, spaced several weeks apart. SSA has indicated that this has been implemented in an effort to ascertain whether such multiple consultative examinations may better "capture" the actual condition of the mentally ill SSDI applicant or recipient under CDI. We understand that these consultative examinations are scheduled approximately 2 weeks apart. We applaud SSA's attempt in this regard, but, as in their prior activities, we have concerns about the efficacy of this new mechanism. First, we are not certain that a 2-week span is sufficient to "capture" the changes and fluctuations in the medical as well as functional aspects of the mentally ill. Second, we are not certain that the beneficiary is seeing the same examiner on both occasions—something we believe should occur if the value of multiple consultative examinations is to be accrued.

We are gratified by SSA's efforts to make procedural changes which will better manage the case development for the mentally ill SSDI beneficiary. However, it is important to recognize that all of these changes are in the practice of how a beneficiary is processed through either the initial placement on the SSDI rolls or the CDI process.

REGULATIONS AND SSA POLICY IMPACT

Yet far beyond the "process" difficulties is a more serious flaw—a flaw not addressed by SSA's most recent procedural changes: The regulations (the "medical listings"), secretarial rulings, and subregulatory procedures (the program operation manual system (POM's)) governing the determination of continuing disability.

Members of the American Psychiatric Association's Committee on Rehabilitation, myself included, have rewritten a chapter of the AMA's "Guide to the Evaluation of Permanent Impairment" which addresses mental and behavioral disorders. It provides invaluable advice and sets forth principles which may well be more appropriate guides upon which claims examiners should rely when interpreting the "medical listings." Indeed, the listings bear little relationship to our chapter, and the POM's even less.

It is important to understand that the medical listings—or listing of impairments—is a list of conditions, signs, and symptoms which are deemed by the Secretary to be so severe that their presence alone, without further evidence of inability to work, justifies a finding that an individual is entitled to disability benefits. If someone "meets or equals" the listings, he is held to be per se disabled. If he does not, the law requires that capacity to work be examined. I will discuss these in turn.

Last summer, the SSA republished the listings in draft form for public comment. Regrettably, the draft made no substantive changes in the mental impairment section, notwithstanding the publication over 2 years before of a new "Diagnostic and Statistical Manual of Mental Disorders" (DSM-III) which sets forth current psychiatric nomenclature. Thus, the terminology utilized in the listings bears little resemblance to the nomenclature utilized in medical case histories of mentally ill SSDI recipients. SSA State claims examiners, in effect, are forced to "translate" case record statements to language contained in the regulations and POM's before they can begin the evaluation process. Since they are not trained in the psychiatric nomenclature, such translation is difficult if not impossible. Thus, case histories which are wholly complete, may be found to be insufficient based on the discrepancies in terminology utilized. The only safeguard could be the professional medical staff in the State agency, but as mentioned earlier, many are not trained psychiatrists and are therefore not current on DSM-III nomenclature.

The draft regulations posed yet other problems in their construction. The APA commented, both on behalf of the membership of the Liaison Group for Mental Health as well as in our individual organizational capacity, to SSA, on the precise changes we recommended in the medical listings. These included: Changes in the requirement that certain signs and symptoms be manifest at the time of the evaluation—not necessarily the case in most forms of mental illness which is characterized by intermittent persistence—(part A)—and a modification in the impairments which, in combination with the signs and symptoms, form the basis for a determination of medical disability (part B).

Notwithstanding our comments, the regulations were not altered. Thus the same listings—inappropriate listings—still control.

The listing has a number of mental subcategories: Functional psychotic disorders, functional nonpsychotic disorders, etc. Within each of these categories, generally two (and in one case, three) sets of criteria must be met to qualify a beneficiary for disability based on the listings alone.

The first set, the "A" section, generally deals with what are traditionally called signs and symptoms of acute mental illness or psychotic mental illness in the case of a functional psychotic disorder. These signs and symptoms must have "manifest persistence" that is, be presently active and visable at the time of the review. These include such symptoms or signs as depression, agitation, hallucination, etc.

The concept of "manifest persistence" of signs or symptoms would indicate that a patient must be manifesting psychiatric symptomology at the moment of the evaluation. Requiring that acute clinical signs be manifest at the time of the examination fails to assess fairly and adequately that mental illnesses are characterized by an intermittent pattern of symptoms and signs or mental illnesses where overt symptoms and signs are controlled by medication. Moreover, the absence of such signs or symptoms is a poor predictor of ability to work.

After such signs and symptoms are found to be manifestly persistent, the second set of criteria—the "B" section—is then reviewed. That section requires that a beneficiary meet three specific requirements relating to activities of daily living, social adjustment. Specifically, the beneficiary must demonstrate that he has "persistence of marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people."

Unfortunately, "B" is generally assessed either in a consultative examination or by claims examiners' review of records examining such questions as: Was the patient on time for appointments? Can he or she take tests? Was he or she well groomed, etc.? These questions do not say anything about a person's ability to work. They cannot form presumptive evidence of capacity to work. Indeed, claims examiners have been instructed to disregard any notes in a medical record of a treating physician regarding a patient's capacity to work based upon sound medical judgment.

A beneficiary must meet both "A" and "B" in order to be said to "meet or equal" the medical listings and therefore be determined to be disabled based on medical criteria alone. If he does not, SSA is supposed to then look at work capacity (residual functional capacity) and vocational factors which might disqualify a person from work. Regrettably, recent SSA policy has been to "deem" those mentally ill who do not meet or equal the listings to be able to perform unskilled labor.

On January 25, 1982, the regional medical advisor for the Chicago region, Dr. Sandor Berendi, wrote that it is "practically impossible to meet the listing * * * for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization * * *". Dr. Berendi, a psychiatrist certified by the American Board of Neurology and Psychiatry and defendant's witness, noted that "* * * In fact an individual may be commitable due to mental illness according to the State's mental health codes and yet found capable of unskilled work utilizing our disability standards. * * *"

In a recent court appearance—on behalf of the plaintiffs in the Minnesota case (in which Federal District Court Judge Larson ordered a preliminary injunction against SSA's policy of terminating those mentally ill disabled if they did not meet or equal the medical listings, based on a belief that those not meeting or equaling the listings were capable of performing unskilled labor)—I testified to the relative lack of utility of the current medical listings in determining ability to work in the psychiatrically disabled. In direct response to a question "are the listings of mental impairment * * * sufficient to measure the ability of a psychiatric patient to work," I responded unequivocally that they were not.

I noted that there were three basic lines of research and clinical findings upon which I based that statement. The work of Strauss and Carpenter and others would indicate that one must examine a patient for signs and symptoms of illness (part A), then for their social capacity (part B), and then for their capacity to work. They cannot be considered in tandem. Rather they are separate axes in the determination of impairment, of disability.

There are patients who, over the course of an illness, may be without symptoms. In fact, some may even be without much social impairment. They can, for example, in a day hospital setting, socialize well with the staff, get themselves dressed in the morning and do their activities—but cannot work independently.

We have studies from the Illinois Psychiatric Association which discuss the natural history of schizophrenia. They indicate that as you follow 100 to 200 patients in treatment who are manifesting early states of schizophrenia—manifesting signs and symptoms of the disorder—a full 60 to 70 percent of those patients will develop major vocational and social disabilities within 2 years. The three axes must be considered separately.

Second, we have, over the past 20 to 25 years accumulated a myriad of studies evaluating the use of antipsychotic medications in controlling signs and symptoms. Many of the over 20 drugs which have been introduced are very effective in controlling signs and symptoms such as agitation, hallucination, major depression. However, the bulk of data—30 to 40 studies conservatively—show that while these drugs may be quite effective in controlling signs and symptoms, they do relatively little in terms of social and vocational adaptations, particularly the latter. Thus, you have many patients who may appear at an interview and may have their symptoms controlled, and who may not meet either parts A or B, yet they are vocationally disabled.

The very stress of trying to live independently and work at the same time may overwhelm many patients and they become sick again, despite the medication to control signs and symptoms. This is not the exception. It is the rule.

Third, studies at the Western Pennsylvania Psychiatric Institute at the University of Pittsburgh have shown that if you take a well-controlled schizophrenic on medication, and place him in a day program—not even a work situation, but a program designed to improve social and vocational functioning—anywhere from 15 to 25 percent of such patients will actually get worse. The stress of the program seeking to help them become socially and vocationally capable, actually causes them to decompensate—to get worse.

While this evidence has not been persuasive to SSA, it is the best evidence we have, and there is no evidence on the other side to suggest that the absence of signs and symptoms, coupled with social functioning and vocational capacity cannot be considered a sine qua non of the ability to work.

Indeed, Dr. Berendi, whom I have mentioned before, noted that:

"Currently, a significant number of psychiatric patients who clinically manifest an inability to engage in persistent substantial gainful activity are being denied disability benefits due to the fact that they fall short of the listings. Many individuals with serious residual symptoms (mostly chronic schizophrenics) have made marginal adjustment to everyday demands of semi-independent living outside of a mental institution, only while they are not under any psychological stress. Usually they also require various supporting services * * * The overwhelming majority of these individuals are currently denied as having a severe impairment with a RFC (residual functional capacity) enabling them to do at least unskilled work."

Perhaps it can be put in better graphic detail, if I provide an example. I see literally hundreds of patients over the course of a year or two. Many, suffering from psychotic illnesses, are on medication and have well controlled symptom pictures—they have no "A" criteria, and since you must meet A and B, are not considered to be per se disabled. Yet other patients fail to meet both "A" and "B" criteria, and as long as they are not in a stressful situation and are on medication, have no active psychotic symptoms and seem to be able to "manage" many social situations. However, such persons under stress, even in the slightest way—a volunteer job in the hospital for example—decompensate rapidly. These patients are the rule rather than the exception.

Let me draw an anology here to the cardiovascular patient. If you sit in a room with such a patient, there are many such patients who may be able to function—breathing at a normal rate, responding to questions. However, if you put them in even the least stressful situation, walk down the hall, walk down three steps (not three flights), there is shortness of breath and so on. If your criteria are viewed in the nonstress situation, you are measuring nothing.

Thus, in and of themselves, the listings cannot and should not be viewed as a means of determining a person's ability to work—particularly a person suffering from a serious psychiatric disorder.

SSA's policy of utilizing the listings as a measure of ability to work has been halted in the Chicago region as the result of the Minnesota suit. It has been found by the court that there are factors which reliably predict whether a chronic mental patient can work. Where work is not obviously precluded by severe symptoms or other factors, analysis of recent prior work history, analysis of the reaction of the patient to stressful situations, and evaluation in a work setting or worklike setting can identify mentally impaired persons who, as a result of their illness, cannot work.

Yet, SSA resists the establishment of a better test of residual functional capacity. We do not argue with the criteria which have been established by SSA for evaluating capacity to work. We are, however, concerned that SSA has not articulated techniques for evaluating an individual's capacity to work against these criteria. The criteria alone do not permit adequate response. Capacity to work must be viewed within the context of present illness and treatment. There must be some sort of worklike evaluation to assess whether the skills a person was able to perform in the past when employed either can still be performed or that other work can be performed.

SSA has argued against workshop or worklike evaluations on the basis of cost. However, I would suggest that to assess whether a psychiatric patient has the capacity to work—to either be denied SSDI or terminated from the SSDI rolls—should not cost substantially more and probably less than some of the cardiac-pulmonary assessments required by SSDI for heart disease. If you add up the cost of electrocardiograms, scanographs, stress tests, physician's fee for all of that and compare it to the cost of an adequate work assessment program, I would imagine that the latter is not as expensive.

The APA does not believe that every patient suffering from a psychiatric disorder and undergoing a CDI or initial SSDI review needs to go through an entire work assessment. There will be patients who obviously cannot work, based on the listings—though as I have mentioned, these are very few in number as the listings are now constructed. However, those applicants who fail to meet the listings and for whom an evaluation of their work history, course of illness, etc., does not lead to a finding of disability, should have the benefit of a work assessment before they can be terminated. We believe that absent other findings which would remove someone from the SSDI rolls (such as current employment, substantial medical improvement, etc.), terminations based on capacity to work should only occur upon a full work evaluation.

The APA believes that Congress took an appropriate first emergency step in an effort to resolve a number of the problems now facing the SSDI program—particularly as it affects the mentally ill—in adopting SSDI emergency legislation at the close of the 97th Congress. However, the measure is severely limited in its approach, providing only short-term relief for a problem of tragic magnitude.

We continue to believe that Congress must adopt legislation which would address the problems identified in my testimony today as well as other ongoing problems in the SSDI program which have been identified in earlier testimony in the 97th Congress but were not included in the emergency legislation. They included:

(1) Shifting the burden of proof to SSA to prove evidence of medical improvement (or that the original decision granting benefits was erroneous) based on the standards in effect when the patient was placed on the rolls, before SSA may terminate benefits. (This could have an appropriate chilling effect upon such major policy

changes as were instituted regarding the "deeming" of ability to work for the mentally ill who do not meet or equal the listings.)

(2) Mandating work or worklike evaluations as a realistic means of assessing capacity to work in cases in which someone does not meet or equal the medical criteria for establishing per se disability.

(3) Assuring that the conduct of consultative examinations is done so as to assure that adequate time is devoted to case development and a clear assessment of the patient's status.

(4) Requiring that the medical listings, both in nomenclature and substantive content be consistent with current medical nomenclature and practice.

Mr. Chairman, we have presented what we perceive to be the continuing critical problems in the current practice of the SSDI program as it affects the mentally ill. We have posed several important legislative solutions. I hope Congress will act promptly on the necessary legislation to protect both beneficiaries and the continuing vitality of the SSDI program—as it had hoped to do in the 97th Congress.

I am grateful for the opportunity to have appeared before the committee, and would be pleased to respond to any questions you may have at this time.

[Whereupon, at 12:55 p.m., the committee recessed until 9:30 a.m., April 8, 1983].

SOCIAL SECURITY REVIEWS OF THE MENTALLY DISABLED

FRIDAY, APRIL 8, 1983

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to recess, at 9:30 a.m., in room SR-385, Hon. John Heinz, chairman, presiding.

Present: Senator Heinz.

Staff present: John C. Rother, staff director and chief counsel; Frank McArdle, professional staff member; Isabelle Claxton, director of communications; Eileen Bradner, minority professional staff member; Robin L. Kropf, chief clerk; Tricia Neuman, research associate; and Angela Thimis and Kim Heil, staff assistants.

OPENING STATEMENT BY SENATOR JOHN HEINZ, CHAIRMAN

Chairman HEINZ. The hearing of the U.S. Senate Special Committee on Aging will come to order.

Yesterday, our committee heard very powerful testimony from a variety of sources, adding up to the conclusion that the social security disability reviews of mentally disabled beneficiaries have systematically terminated benefits for individuals who cannot possibly work and therefore meet the statutory definition of "disability."

The General Accounting Office, in a report of an investigation I requested as chairman of this committee last year, which was reported to us yesterday, looked at a sample of 40 cases in very careful detail. They were analyzed, by the way, by a trained psychologist, Dr. MacLennan, and in each case of the 40, a denial had been made by the Social Security Administration or by the State agency. Of those 40, the GAO concluded that 27 cases should not have been terminated, and the remaining 13 lacked sufficient evidence on which to base an informed decision. In brief, the GAO told us that the wrong decisions were being made, based on the wrong criteria, being made by individuals not properly trained in psychiatry or clinical psychology.

The particular impact of this pattern of denials on individual psychiatric patients came through quite eloquently from our second panel of witnesses. Dr. Beatrice Braun told us that virtually all of her patients were chronically mentally ill and would be in a State institution if times were different; of this group of people, virtually all of them who applied were denied benefits. Virtually all of them who were reviewed were denied benefits. Yet, all of them eventually had their disability benefits reinstated by the administrative law judges.

This pattern of infectious error came through even in a special psychiatric study conducted by the Social Security Administration in the Baltimore area—what you might call "the fox auditing the chicken coop"—but even with the fox auditing the chicken coop, Attorney General Stephen Sachs of Maryland was able to share with the committee the internal SSA report he received, with much difficulty, from the SSA under a Freedom of Information Act request. This study of denials and terminations that SSA made of itself found an error rate of 22 percent, and three of the seven CDI terminations it looked at were incorrect.

These erroneous denials are ruining lives; they are shifting enormous costs onto the State, county, and city governments. They are forcing people back onto welfare and back into State hospitals. Some of them, the committee learned, are pushed beyond the brink to despair and suicide.

Finally, a renowned medical expert from the Mount Sinai School of Medicine, representing the American Psychiatric Association, told the committee that in the opinion of his association and all the associations of professionals who deal with the mentally ill, the medical criteria which Social Security uses are not valid predictors, in any sense of the term, of whether someone can work. And of course, if someone can work, he should be denied benefits, but if he cannot work, he should not be denied benefits—and that is the law. He testified that SSA's reviews, in the judgment of the American Psychiatric Association, are being conducted in a manner that is—and I quote—"contrary to sound medical practice, sound professional, clinical practice."

This morning, the committee will hear the Administration's response to yesterday's testimony. I look forward, and I know the committee looks forward, to the chance to explore these issues with those responsible for their implementation. And I will want to ask our witnesses this morning to address some of the fundamental questions raised by yesterday's hearing. At least five of those questions come to mind:

Why has the Social Security Administration apparently singled out mentally impaired individuals for a disproportionate share of CDI reviews and hence, terminations?

Second, why has the Social Security Administration been withholding information about the impact of this process from the Congress and from other public officials, such as Attorney General Sachs?

Third, how can the Administration square the testimony we heard yesterday and, as a matter of fact, on other days, with earlier claims that the reviews were producing accurate decisions? Senator Cohen received testimony from the Social Security Administration that their reviews were 97.5 percent accurate last year.

Fourth, what does the Administration intend to do in the light of the critical testimony given yesterday regarding the treatment of the mentally disabled?

And finally, in light of the seriousness of yesterday's testimony, why shouldn't Congress move immediately to place a moratorium on the reviews and terminations of the mentally disabled to prevent what I think is becoming, if it is not already, a national scandal?

Our first witness today is surrounded by many able people, and I know there are some other people from the Social Security Administration behind him. Paul B. Simmons is the Social Security Administration Deputy Commissioner for Programs and Policies. He has been up before the Congress on what, to his mind, is probably all too many occasions. We are very pleased that he is here.

Commissioner Simmons has indicated that he wants his entire statement submitted for the record and that he will make an opening statement that supplements what is in his official testimony.

[The prepared statement of Mr. Simmons follows:]

PREPARED STATEMENT OF PAUL B. SIMMONS

Mr. Chairman and members of the committee, I appreciate the opportunity to appear before your committee to address the issue of evaluation of mental impairments in the social security disability program. Before I do so, however, I would like to take a few moments to place in perspective our efforts to carry out the mandate of the Congress to periodically review the social security disability rolls. I also want to outline our continued administrative efforts to improve the entire disability process so that it is as fair to the recipients and as responsible to the taxpayers as we can make it.

The social security disability program represents SSA's biggest administrative and policy problem and is far more complex and controversial than any other program administered by this agency. We spend over one-half of our administrative budget to run the social security and SSI disability programs, which account for only 17 percent of the comparable beneficiary population.

The social security disability program grew significantly in the early and mid-1970's; from 1970 through 1977, the number of worker beneficiaries increased by over 52 percent. This program growth occurred, in part, because SSA did not have an effective review process. Before the Congress mandated the CDI reviews in 1980, SSA reviewed only a limited number of expected medical improvement cases each year. A 1981 GAO report indicated that about 18 percent of individuals on the disability rolls were not disabled under the law. The report pointed out that the cost to the social security trust funds of incorrect payments to people who are not disabled could be as much as some $2 billion per year. The old system of CDI reviews was clearly not designed to identify cases in which the initial determination of disability was incorrect, or those in which, because of medical advances, the impairment might no longer be considered disabling.

BASIC PROBLEMS WITH PERIODIC REVIEW

While there was an obvious necessity for greatly increased reviews, I am sure that neither the Congress nor SSA understood just how many substantial problems would come to the surface when SSA took on the enormous task of reviewing all nonpermanently disabled beneficiaries in only 3 years in addition to keeping up with the initial disability claims workload.

In undertaking periodic review, SSA and the State agencies had to deal with a substantial increase in the number of CDI's conducted each year. Prior to the congressional mandate for periodic review, SSA conducted CDI's of only 155,000 cases a year. We started the periodic reviews in March 1981 and since that time we have completed 180,018 reviews in fiscal year 1981, 496,848 in fiscal year 1982, and 183,146 in fiscal year 1983, with a projected total of 640,000 reviews for all of fiscal year 1983.

A significant reason for problems with the CDI process (and with the disability program generally) has been a lack of public understanding of the fact that the definition of disability for social security disability benefits is very strict and can only be met by the very severely disabled. Partial disability, which is recognized in some other benefit programs, is not sufficient for social security disability benefits.

The Social Security Act provides that a claimant's impairment must be so severe that he is not only unable to do his previous work but cannot, taking into consideration his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy. So long as this work exists in the national economy, it does not matter whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. Also, the disability must be expected to result in death or must have lasted, or be expected to last, for a continuous period of 12 months or more. This is the statutory language, not SSA's interpretation of the statute. The same definition of disability applies to those initially filing for benefits and also in determining whether beneficiaries should remain on the rolls.

The adverse reaction of some disability beneficiaries to periodic review, while not unexpected, is also based on a misunderstanding. Most beneficiaries never expected to have their cases reviewed again; in their own minds they had "retired" on disability. As a result, beneficiaries whose benefits stopped have had to make tremendous psychological adjustments. Economic conditions which have made jobs scarce have added to their anxieties.

The second major reason for problems with periodic review is deficiencies in the administrative process. Since periodic review began in March 1981, about 340,000 beneficiaries have been terminated because they were found not to be disabled at the initial review level. (To date, about 7 percent of the disability rolls have been finally terminated after appeal.) The current termination rate upon initial review is 45.2 percent. (It is 41.5 percent if cases screened out from the CDI process—permanent disabilities, beneficiaries over age 62, and SSA local office curtailments for obvious disabilities—are counted.) Although the CDI termination rate before periodic review was not significantly different from the current rate, the number of terminated beneficiaries was much smaller and there was little publicity or concern about the CDI process.

But with the volume of reviews and terminations multiplying, stories about the plight of individual beneficiaries whose benefits were stopped began appearing in the press and congressional concern about the process became acute. Congressional oversight has been intense. During the last year and a half, there have been 13 hearings in Washington and around the country at which we have testified or submitted statements on the disability program.

As a result of the impact of the CDI periodic review process, it became clear that the 27-year-old disability program that this administration inherited was too bureaucratic—too focused on paper rather than people. When the reviews were first begun, CDI's were largely paper reviews and there was little or no personal contact between the bureaucracy's decisionmakers and the beneficiaries.

With the benefit of hindsight, we can say that this program which focuses on the human condition is not as humane as it needs to be. It is clear that the CDI process must no longer be paper oriented and must be reformed further to better serve the large numbers of beneficiaries being reviewed.

This administration strongly believes that improvements are needed in the CDI process. The system we inherited was plainly and simply not adequate to administer the program in a fair and humane way. We have supported reform legislation and worked with the Congress for over a year on remedial legislation. We supported the essential legislation (Public Law 97-455) the Congress enacted in December and had been supporting similar legislation for many months before that. I want to emphasize our willingness to continue working with the Congress.

ADMINISTRATIVE REFORMS

However, in addition to pressing for legislative changes, we moved on our own, given the limitations in the law now on the books, to take a number of important administrative steps to reform the CDI process and make it more humane—people oriented rather than paper oriented. These administrative reforms are a top priority. We have detailed many of these steps at various congressional hearings and I will not describe them all here again. (A complete list is attached to my testimony.) However, I will mention a few that are especially important and describe some of our newest initiatives.

The most important administrative reform involves getting more personal contact between the beneficiary and SSA employees into the CDI process at an earlier stage. Since October 1, at the start of each CDI, we are conducting face-to-face interviews with disability beneficiaries in local Social Security offices. The interviewer explains the reasons for the review, the steps in the review process, the rights of the beneficiary and the beneficiary's responsibilities. This face-to-face interview is relieving a number of our most troublesome problems with the CDI process:

(1) It helps to improve the documentation of the beneficiary's current condition which leads to better disability decisions. The SSA employee can record information about the beneficiary's condition based on talking with him and observing his condi-

tion. The SSA interviewer can help the beneficiary by eliciting complete information about his current medical condition and sources of medical treatment.

(2) The personal interview makes the CDI process more humane. Face-to-face contact with the beneficiary is instrumental in helping to avoid errors in dropping people from the disability rolls despite glaringly obvious disabilities. The personal explanation of the CDI process at the face-to-face interview is intended to reduce strain and anxiety for beneficiaries and to improve public acceptance of the reviews. Anxiety is also reduced for beneficiaries who are still clearly disabled because the interviewer is able to end the CDI process at the time of the initial interview. Finally, the curtailment of some CDI's frees up State agency resources and improved documentation is helping the State agencies to do a better job on the cases they review.

In this context, I might mention the importance of the provision in Public Law 97-455 which provides the opportunity for a face-to-face evidentiary hearing between the beneficiary and the disability decisionmaker at the first level of appeal (reconsideration). Prior to the legislation, SSA had been planning to implement this change on an administrative basis. We are now testing the evidentiary hearing. We have established pilot programs in three States—California, New Mexico, and Texas—so that we can more smoothly and effectively implement the provision nationwide before January 1984. The first hearings under the pilot program are already being held.

This reform is important because it will convert the reconsideration process from a paper-oriented review into a people-focused review and help assure that the first level of appeal in CDI termination cases is equitable and more meaningful and results in prompt and accurate decisions. A more meaningful reconsideration process should also reduce the very heavy ALJ hearings workload. However, the beneficiary will still have the right to request an ALJ hearing, with all the rights he has now, if he is dissatisfied with the outcome of the reconsideration hearing.

Another initiative that we think will reduce the number of incorrect decisions is to remove a bias in the program toward denials. When disability adjudicators know that their decisions are more likely to be reviewed if they make a favorable decision, they are more likely to deny a borderline case. To alleviate this bias, we have doubled our quality reviews of State agency decisions to cease benefits, and we are conducting our quality review of termination cases before benefits are stopped. We are also studying terminations to find out what kinds are especially error-prone and are subjecting these kinds of cases to a more intensive quality review before a final decision is made.

I should mention here that the most important step that would remove the bias toward denials requires legislation. The 1980 disability legislation required that after fiscal year 1982 we review at least 65 percent of favorable State agency decisions on a preeffectuation basis. We asked Congress for the flexibility to review unfavorable disability determinations as well as favorable ones and to review whatever percentage of cases would result in the best quality of decisions in the most cost-effective manner. A provision permitting more flexibility was included in legislation reported by the Ways and Means Committee last year (H.R. 6181) but was not enacted as part of Public Law 97-455. We again urge Congress to provide us with the flexibility necessary to remove the statutory bias toward denials.

To modernize the disability program generally and the CDI process specifically and to make it more responsive to beneficiaries' needs, we have been reaching out to many public interest and professional groups to discuss their concerns about the disability program and to obtain their suggestions for improvement. Their professional experience and firsthand knowledge of the needs of the disabled (including people with mental impairments) are proving very helpful to us in reorienting the disability process to better serve disabled people. As recently, as 2 weeks ago we met with our State agency administrators for the express purpose of getting their input on ways to improve progam administration. We view the State agencies as working partners in Social Security's unique Federal-State disability determining program and we are going to continue to act upon many of the good suggestions they have made. We have also involved SSA field personnel in several work groups to exchange ideas for improvements.

We are stationing State agency employees to serve as disability consultants in 50 to 60 SSA local offices with the highest disability workloads. Some State agency disability consultants are already onsite. We have issued new interview forms and guides to local office interviewers and are providing them with ongoing disability training to enhance the role of field offices in the disability determination process. We are doing this to insure that SSA is as fair, helpful, and effective as possible in dealing with those applying for disability benefits and those on the disability rolls.

We are refining our selection criteria for periodic CDI reviews so that more beneficiaries who are permanently disabled are identified and exempted from the 3-year review process. Last May, we identified several new categories of impairments which should be considered permanent; last February, we identified one more, and as additional experience is gained, we will add additional impairments to the list. For example, we are looking at screening out cases involving additional types of impairments, and cases where the beneficiary is older and has been on the rolls for a specified period. We expect to be able to significantly reduce the number of cases to be reviewed by State agencies.

MENTAL IMPAIRMENTS

Now I want to talk more specifically about the effects of the CDI process on people with mental impairments. I have already said that the disability program is SSA's biggest problem. Well, within the disability program some of our most troublesome problems concern cases involving mental impairments. The reasons for this are twofold—the reactions of people with mental impairments to CDI's and the difficulty in making disability decisions in cases of mental impairments, especially in making assessments of residual functional capacity (remaining ability to do work-related activities). SSA must be sensitive to the special needs and problems of people with mental impairments and treat them in a humane way.

Because of the nature of their impairment, mentally ill people often have a very difficult time in understanding the CDI process and in responding to SSA's requests for information which will help us to determine if they are still disabled. They may ignore our requests for information or fail to turn to family or support groups for assistance or reassurance.

Initiation of a CDI can arouse great anxiety for mentally ill persons and it may be difficult to quell their fears. Their illness may also affect the information they furnish to SSA. For example, a beneficiary who has been released from an institution may, out of fear of being reinstitutionalized, describe his condition as much better than it really is. Or the institutions may describe a beneficiary's status in positive terms to facilitate placement in employment or the community.

DECISIONMAKING DIFFICULTIES IN MENTAL IMPAIRMENT CASES

Cases involving mental impairments are among the most difficult to adjudicate for several reasons. First, the medical signs of mental illness are often dependent on observations of behavior rather than on the more precise, often numerical, findings available for physical impairments. The degree of consistency in the claimant's behavior and symptoms over time may also be hard to determine. Some mental conditions vary more over time than do physical conditions. A considerable degree of medical judgment is required to evaluate the illess over time. Further, it is often difficult to obtain a consistent prognosis from mental health practitioners. As a result, State agency personnel often have the difficult task of making decisions based on findings which do not always agree.

I should emphasize here that proof of disability must be based only on objective medical findings and not on either mere allegations of symptoms or conclusions by treating physicians, and within each of our State agencies a physician-examiner team works together to reach these decisions.

The variable effects of medication can also complicate the evaluation of a mental impairment. The medication may alleviate obvious symptoms in which case detailed evidence and educated judgment on the remaining symptoms is needed. In other cases, the medication may itself produce adverse reactions which must be weighed in the context of the total illness.

The inherent difficulties in making disability decisions in cases of mental impairment have naturally made CDI terminations in these cases especially controversial, but the controversy has been aggravated by the effects of the recent trend to have people with mental impairments live in communities rather than hospitalizing them for long periods. This trend has resulted from advances in treatment—including drug therapy and short-term crisis intervention therapy—and court holdings that people with mental impairments must be treated in the "least restrictive" environment.

It was apparently assumed by the courts that community treatment and support programs would adequately meet the needs of people with mental impairments who were deinstitutionalized. While there are obvious benefits from deinstitutionalization, there have been difficulties in meeting the needs of the persons involved. Deinstitutionalization has placed a heavy burden on community programs, especially since they are competing with other programs for limited government health service resources. The termination of benefits under periodic review for some deinstitutionalized people with mental impairments has placed added pressure on community resources and understandably caused great anxiety for the beneficiaries involved. However, continuation of benefits during appeal, as authorized under Public Law 97-455, should help to alleviate this situation.

The last problem in making decisions in cases of mental impairment that I want to discuss is assessment of residual functional capacity. This has been a most troublesome and controversial area. In physical impairment cases, we measure limitations in areas such as walking, standing, pushing, and reaching and how they affect the person's ability to do basic work-related activities. In mental impairment cases, we currently attempt to measure limitations in the claimant's ability to respond appropriately to supervision, coworkers, and customary work pressure and to understand and carry out instructions. It is difficult to adequately evaluate daily activities and relate them to activities required in an actual work situation because there is just no definitive statement of the mental requirements of work. Another problem is that since some mental conditions fluctuate, a snapshot assessment may not be an adequate evaluation of a person's residual functional capacity over time.

A recent court case in Minnesota (*Mental Health Association of Minnesota* v. *Schweiker*) illustrates some of the problems with disability decisions in cases of mental impairment and how SSA deals with them. The U.S. District Court for Minnesota found that in the Chicago region disability decisionmakers applied a presumption of nondisability for workers aged 18 to 49 whose mental impairments do not "meet" or "equal" in severity the listings of impairments in the regulations and assumed that such workers retained the residual functional capacity to do at least unskilled work. The court based its decision, in part, on the its findings that Chicago regional policy issuances did not provide for a full vocational evaluation in this type of case.

As a result of the court's decision the Commissioner took prompt action to correct the mistaken interpretation of national policy which appears to have occurred. While such misreadings of national policy do unfortunately occur in a large, complex program like social security disability, whenever we discover an error, we take immediate action to correct it.

In this instance the Commissioner took the unprecedented step of personally issuing a specific statement setting out SSA policy in cases of mental impairments, reemphasizing that SSA policy and instructions will only be issued at the national level, and clearly directing that erroneous and unauthorized policy statements be rescinded. We are sending out a program circular to all regions reiterating that the disability evaluation procedure in the regulations must be followed and that residual functional capacity assessments must consider all available evidence (e.g., past work history) not just medical evidence. We have also instructed all SSA's local offices to accept requests for reopening cases of people who believe that their claims for benefits on the basis of a mental impairment were improperly handled.

SELECTION OF CASES FOR REVIEW

Some community services, mental health and professional groups have charged that SSA is targeting reviews on people with mental impairments with the result that a disproportionate share of terminations involve the mentally ill. This charge is untrue. The type of impairment is not a criterion for selecting a case for review. SSA chooses cases for review based upon profiles, developed through special studies, of the characteristics of nonpermanent disability cases in which beneficiaries are most likely not to be disabled. These characteristics include such things as age, sex, year of entitlement, and benefit amount, but not type of impairment.

Two factors may account for what seems to be a large number of cases of mental impairment that are subject to periodic review. First, cases selected for periodic reviews in 1981 and 1982 were targeted primarily on people under age 50 and a disproportionately large share of beneficiaries with mental impairments are under age 50.

Second, impairments such as neuroses and psychoses cannot be presumed to be permanently disabling and new modes of treatment have made improvement more likely in many mental illness cases. Thus, few cases involving mental impairments are included in the list of permanent disabilities and so are not screened out from review.

ADMINISTRATIVE INITIATIVES TO IMPROVE PROCESSING OF MENTAL IMPAIRMENT CASES

The last topic I want to discuss this morning in some detail is the numerous administrative steps we are taking to improve our adjudication of cases of mental impairment, and specifically CDI's. Beginning each CDI with a face-to-face interview in the local Social Security office should be especially beneficial to the mentally impaired. This personal contact with SSA should help them to cope with the stress of a CDI, and the contact enables us to identify their special needs and provide extra assistance if warranted. Also, the interviewer is able to provide observations about the mentally impaired beneficiary's conduct, appearance, and apparent ability to comprehend and to relate to other people. This information is helpful to the State agency in making the disability determination. And where the beneficiary is obviously still disabled, the interviewer can end the CDI process.

As I mentioned, one of the reasons disability determinations are difficult to make is that there can be wide variations in the behavior and symptoms over time of a person with a mental impairment. Several initiatives will help to assure that we obtain an accurate picture of the beneficiary's condition over time in cases of mental impairments.

First, since May 1982, in all CDI cases we have been requiring State agencies to develop all medical evidence of record listed by the beneficiary for the past 12 months. Further, we specifically require that chronic mental impairments be evaluated in a long-range context in both initial and CDI cases; a person's longitudinal history must be considered and all available medical evidence, past and current, must be obtained to determine the frequency of symptoms and the adequacy of a person's functioning.

We are testing the use of multiple consultative examinations in psychiatric cases to see whether this will give us a better picture of the claimant's condition over time and avoid a snapshot of the claimant that may not be typical. This should help to improve our assessment of residual functional capacity. Also, when a State agency purchases a consultative medical examination, the State agency is required to supply the consulting physician with the beneficiary's medical history. We are revising the medical listings for certain mental impairments to clarify that the level of severity specified does not have to be present continuously as long as it is present over a long period of time. Finally, we are exploring the need for other changes with concerned groups.

Some State agencies have had difficulty in hiring psychiatric consultants for their staffs and/or obtaining sufficient numbers of psychiatric consultants to perform consultative examinations. These shortages occur because State fee schedules are often too low to provide an incentive for physicians to participate in the disability program. SSA has encouraged the State agencies to increase the number of psychiatrists and psychiatric consultant hours available and has supplied resource materials which they can use in their recruitment. We have also been working with the American Psychiatric Association to encourage recruitment. The APA has sent out letters to all its members encouraging their participation.

There are other areas where we are working closely with the APA to improve the disability process:

(1) We are working with the APA on suggestions for improving our psychiatric review and residual functional capacity forms (which are completed by physicians in the State agencies). Our object is to make the forms more effective in eliciting the information necessary to decide cases involving mental impairments and to improve the consistency of decisions.

(2) We have agreed with the APA to exchange research and development information in the field of mental illness.

(3) The APA is setting up a special task force on social security disability. The task force will educate APA members on the evaluation of disability under social security and will work with us on making improvements in our evaluation of mental impairments. For example, the APA is preparing a checklist for use by a physician who performs a psychiatric consultative examination.

(4) We are exploring the use of a mental impairment advisory group which will consist of psychiatrists, psychologists, and consumer and legal group representatives. We have asked the APA to identify academicians in the psychiatric field for this group.

(5) We are exploring the idea of contracting with the APA in our regions to provide peer review services for cases involving mental impairments.

We are also meeting with and soliciting suggestions from other groups about how we can improve our decisionmaking in cases involving mental impairments. A list of these groups is attached to my testimony.

Another area where we have made considerable improvements concerns consultative examinations purchased by the Government where medical evidence is unavailable or incomplete. Rather than discussing all of these changes today, a description of them is attached to my testimony.

As I mentioned earlier, it is difficult to assess residual functional capacity in cases of mental impairment. Therefore, we have issued a number of instructions to clarify this evaluation process and have also initiated several special studies. For example:

(1) With the Department of Labor, the National Institute of Mental Health and others, we are seeking data on the relationship of occupational characteristics and psychiatric findings so that we can design guidelines for better identifying the mental requirements of jobs.

(2) We are determining the best use of assessment centers or workshop evaluations in assessing residual functional capacity in cases involving mental impairments. We hope to develop a profile of the types of cases most suitable for workshop evaluations, a data base on workship availability, and a protocol and standards for workshop testing.

CONCLUSION

In closing, I want to reiterate that the Social Security Administration is committed to improving the CDI process. We will continue to work closely with advocacy and professional groups to get suggestions for change so that we can make our program as humane and fair as possible.

This concludes my statement. I will be glad to answer any questions you may have.

[Attachment 1]

MAJOR STEPS SSA IS TAKING TO REFORM THE CDI PROCESS

1. In October 1982, SSA started using a new procedure for beginning a CDI review: each beneficiary has a face-to-face interview with an interviewer in the local Social Security office. The interviewer explains how the review works and what the beneficiary's rights are, obtains information about the beneficiary's medical care and treatment and current condition, and—in some cases—concludes the review process where it is clearly warranted based on the beneficiary's current medical condition.
2. SSA is stationing State agency employees to serve as disability consultants in 50 to 60 SSA local offices with the highest workloads. This will help to insure that SSA personnel are as fair, helpful, and effective as possible. New interview forms and guides have been issued to local office interviewers and numerous State agency disability consultants are already onsite.
3. SSA has established pilot programs in three States so that SSA can smoothly implement the provision in Public Law 97-455 providing an opportunity for a face-to-face evidentiary hearing at reconsideration. Prior to the legislation, SSA had been planning to implement this change on an administrative basis.
4. In March 1982, SSA initiated a policy of determining that, in general, a person's disability ceases as of the time the beneficiary is notified of the cessation. This change reduces situations where the beneficiary is faced with the need to pay back past benefits because of a retroactive determination.
5. Since May 1982, SSA has mandated that States review *all* medical evidence available for the past year—a directive which insures that every State is looking at every piece of evidence that might be pertinent to a case.
6. SSA has taken many actions to improve the quality of consultative examination purchases by the Government in cases where medical evidence from a person's physician is unavailable or incomplete.
7. Since March 1982, SSA has required State agencies to furnish detailed explanations of their decisions in all cases in which a person's disability has ceased.
8. To improve the quality of determinations in difficult cases where it is necessary to determine a person's capacity to do work-related activities despite a severe impairment, SSA is requiring that the determinations as to residual functional capacity be more detailed and explicit so that the basis for the final decision is clear.
9. To insure quality in CDI cases, SSA conducts a quality review of a sample of cases before benefits are stopped. In June 1982, SSA doubled the number of quality reviews of termination cases. In addition, to demonstrate the importance of quality in the CDI process, SSA established an interim accuracy goal for the State agencies. SSA is also studying terminations to find out what kinds are especially error prone.
10. SSA has consistently monitored State agency resources and workloads closely and adjusts the flow of cases to the individual States to avoid backlogs when problems have arisen in their acquiring adequate resources. Since October, all new CDI cases have been sent directly to the local Social Security offices for the face-to-face CDI interview; this also helps States to reduce backlogs.

11. SSA is refining the selection criteria for CDI reviews so that more beneficiaries who are permanently disabled are identified and exempted from the 3-year review process. Based on findings in the first year of the CDI program, SSA has broadened the definition of the permanently disabled. We expect to be able to significantly reduce the number of cases to be reviewed by State agencies.

12. To modernize the CDI process and make it more responsive to beneficiaries' needs, SSA has reached out to many public and private interest and professional groups to discuss their concerns about the disability program and to obtain their suggestions for improvements. SSA has also met extensively with State agency administrators and field personnel to exchange ideas for improvements.

13. SSA has concentrated efforts on the need for special handling of cases involving psychiatric impairments:

(a) SSA has met with mental health groups to obtain their recommendations for improvements in our guidelines for evaluation of mental impairments.

(b) SSA has also encouraged the States to increase the number of psychiatrists on their staffs and has asked the American Psychiatric Association (APA) for assistance in recruiting psychiatrists for the States.

(c) SSA is setting up a mental impairment advisory group which will consist of psychiatrists, psychologists and consumer and legal group representatives and has asked the APA to suggest the names of some academicians in the psychiatric field.

(d) The APA has agreed to set up a special task force on social security disability to educate APA members and help us make improvements in our evaluation of mental impairments.

(e) SSA and the APA have agreed to exchange research and development information in the field of mental illness.

(f) SSA is exploring the idea of contracting with the APA in our regions to provide peer review services for mental impairment cases.

14. SSA has underway, in two States, a study to test the value of obtaining more than one special mental status examination in cases where evidence from the beneficiary's treating source is incomplete or inadequate. This is intended to determine whether a person's mental condition can drastically change from one day to another. One criticism of SSA's practice of getting only one mental status examination is that it gives a misleading "snapshot" of a person.

15. SSA has been issuing social security rulings to make sure that all disability decisionmakers—State agencies, ALJ's, and the appeals council—follow the same standards of adjudication. These rulings are in accord with existing law and regulation and do not establish new standards.

16. SSA has added more than 140 administrative law judges to what is already perhaps the largest single administrative adjudicative system in the world, bringing their total number to more than 800 and providing them with significantly more support staff to help reduce the backlog of cases that has been a chronic problem in past years.

[Attachment 2]

INTEREST, SERVICE PROVIDER, ADVOCATE, AND PROFESSIONAL GROUPS SSA HAS CONTACTED

AMERICAN PSYCHIATRIC ASSOCIATION

Consortium for citizens with developmental disabilities:

American Coalition of Citizens With Disabilities.
Council of State Administrators of Vocational Rehabilitation.
Epilepsy Foundation of America.
Mental Health Association.
National Association of Developmental Disability Councils.
National Association of State Mental Retardation Program Directors.
National Easter Seal Society.
National Society for Autistic Children.
New York City—D.C. Office.
National Senior Citizens Law Center.
National Rehabilitation Association.
National Association of Rehabilitation Facilities.
United Auto Workers
United Cerebral Palsy Association.
National Multiple Sclerosis Society.
Goodwill Industries of America.
Mental Health Law Project.

Mental health liaison group:

American Academy of Child Psychiatry.
American Nurses Association.
National Association of Counties.
National Association of State Alcoholism and Drug Abuse Program Director.
Public Committee on Mental Health.
American Association of Psychiatric Hospitals.
Association of Mental Health Administrators.
National Association of Private Psychiatric Hospitals.
National Committee Against Mental Illness.
American Health Care Association.
American Hospital Association.
National Association for Retarded Citizens.
National Council of Community Mental Health Centers.
American Psychological Association.
National Association of Social Workers.
American Psychiatric Association.
Child Welfare League of America.
American Federation of State, County, and Municipal Employees.
Mental Health Law Project.
Association for the Advancement of Psychology.
National Association of Rehabilitation Facilities.
Scallet, Zweig, and Associates (Leslie Scallet is local counsel for several of these groups).
National Alliance for the Mentally Ill.
American Mental Health Councillors.
International Association of Psycho-Social Rehabilitation.
National Association of State Mental Health Program Directors.
National Mental Health Association.
National Institutes of Mental Health.
Psychiatric Outpatient Centers of America.
American Association for Marriage and Family Therapy.
American Medical Association.
American Occupational Therapy Association.

[Attachment 3]

SSA ACTIONS TAKEN TO IMPROVE MANAGEMENT OF CONSULTATIVE EXAMINATIONS

Listed below are brief summaries of a wide range of actions taken to improve consultative examinations (CE's). These actions have been directed toward providing clear program direction on CE report requirements and maintenance of a quality process as well as establishing a more formal program of monitoring State agencies in this area:

(1) Basic SSA policy was issued in Social Security Ruling 82-14, which covered CE physician qualifications, independence of CE physicians from other program or claimant relationships, content CE reports, and physician signature on CE reports.

(2) Detailed instructions have been issued to State agencies in the SSA Program Operations Manual in order to achieve improved CE reports nationally. These instructions cover a broad range of aspects of the CE process including: Selection of CE sources; arrangements for a CE, including provision of pertinent materials in file; report content and signature requirements; guidelines for review of CE reports; and specific medical specialty report requirements.

(3) In the initial monitoring by SSA of State agency CE management processes, all States provided general descriptions of their practices for oversight of CE's as well as specific data on the "top 10" providers. These responses were analyzed and weaknesses in handling complaints, keeping records, maintaining ongoing oversight and other areas were identified. Regional Commissioners (RC's) then worked with each State to improve oversight. Status reports have been submitted from all regions.

(4) In the second stage of SSA monitoring efforts, an in-depth protocol was developed for reviewing all aspects of a CE provider's operation and the State agency's oversight of it. Joint SSA-State onsite reviews of 30 CE providers were completed by the end of April.

(5) Administrative guidelines were issued to State agencies in a Fiscal and Administrative Letter. These specify what States must do in their oversight of CE providers. In addition, specific instructions were issued to RC's regarding the need to monitor State compliance with the administrative guidelines.

(6) State agency administrators and staff from 45 Disability Determination Services attended the first disability programs management forum in March 1982. The forum included a series of workshops designed to allow administrators to share problems and solutions for managing the CE process.

(7) Additional technical policy guidelines will be issued in the near future. Such issues as whether CE providers are bound by the Privacy Act and how CE providers should respond to requests for interrogatories by claimant's attorneys have been raised as we have explored the complaints of the legal community concerning CE providers.

(8) We are developing a methodology for quality review of CE providers through the case review process. At present, review procedures do not provide for the sampling of cases by CE provider.

(9) We are providing the regional offices (RO's) on an ongoing basis with reports of providers suspended or terminated by the Health Care Financing Administration for fraud or abuse of Federal funds.

(10) The States were surveyed to determine whether it would be advantageous to negotiate fee schedules with large CE providers. Because of poor public perception, it was deemed not desirable/advantageous.

(11) A central reference file is being developed to coordinate claimant/physician/attorney complaints and to coordinate responses and information with the regions.

(12) In December 1982, the States submitted their plans for CE management to the RO's. The RO's reviewed the adequacy of those plans and assured that they complied with SSA guidelines.

Chairman HEINZ. Commissioner Simmons, thank you for being here. We obviously do have a lot of very valuable, even critical, information that was brought to the committee's attention yesterday. We hope you can shed some light on what has become an era of darkness for many of the mentally disabled.

Please proceed.

STATEMENT OF PAUL B. SIMMONS, WASHINGTON, D.C., DEPUTY COMMISSIONER FOR PROGRAMS AND POLICIES, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; ACCOMPANIED BY LOUIS B. HAYS, ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS; PATRICIA M. OWENS, DIRECTOR, OFFICE OF DISABILITY PROGRAMS; AND DONALD A. GONYA, ASSISTANT GENERAL COUNSEL, SOCIAL SECURITY DIVISION, OFFICE OF GENERAL COUNSEL

Mr. SIMMONS. Thank you very much, Mr. Chairman.

May I say I am accompanied today by Louis B. Hays on my left, who is our Associate Commissioner for Hearings and Appeals; Patricia M. Owens, who is the new Director of our Office of Disability Programs; and Donald A. Gonya, who is our Assistant General Counsel for the Social Security Division for the Department of Health and Human Services.

As you indicated, I do have a rather long and detailed statement. I believe it does answer almost all of the questions that you raised in and of itself. I would commend it to the committee's and to the public's attention because I think, as you say, we do have to shed light on this subject, and some of the light that has been coming out of various and sundry hearings that have happened is less than illuminating.

In this statement that I am submitting for the record, sir, it makes several points that we have made several times before, in about a dozen hearings before Congress on this subject. The central point is that nothing in the program itself—the basic rules, regulations, the law, et cetera—have changed all that much over the past 4 or 5 years. What has changed is a system that had over the years become overly bureaucratic, overly paper-oriented, and overly looking away from what is happening with people. It used to go along at about 155,000 CDI reviews per year, but now has been called upon to review four times that number. No one ever noticed problems in the system because the system would correct itself, or there just was not any attention paid to it, and then suddenly, with the CDI process mandated by the Congress, where the volume doubled and then tripled, then the problems came to light. And we are concerned about them, because this program after all needs to be the most humane of all the programs that our agency administers. We have 41 million people who receive some sort of cash income support from our agency. Seventeen percent of those people are involved in disability programs, either SSI or title II disability, and this program, ironically—and it has been this way for over 27 years—is probably the least humane, or at least it has been in the past.

There is a lot of misinformation that has been coming out—and I do not blame the committee—I know where everyone is coming from on this thing. There are a lot of people who misunderstand the program, and that is why I do recommend our testimony to them. There is a lot of misinformation that is clouding the kind of creative national debate that I think we should have on what it is we are going to do about this program.

In yesterday's hearings, for example, the first thing that comes to mind, looking at the papers this morning—and I talked to the GAO about this last night—the GAO testified that it had found that our own administrative law judges are reversing 91 percent of all mental impairment cases that reach them, and then the GAO went on to say that this is proof positive that the program is unfair to the mentally impaired. Now, the GAO witness, to his credit, said that this number was quite startling. Well, it was startling to us, too, because it does not exist. They read the wrong table. There is no difference in the reversal rates that we know of between mentally impaired cases and physically impaired cases among our ALJ's. The number just does not exist. I discussed this with the GAO last night, and unless something was done in their manipulation of the numbers, we just cannot discover how they arrived at it. We worked on it all night and could not duplicate that number or come anywhere close to it. The General Accounting Office generally shares its findings with us when they make a finding like that, up front, and that helps us, because if there is a problem, and it is uncovered by them, and they have done this time and again, then we want to get at it right away and not wait for the headlines. And it also helps them because sometimes, using our data can be confusing. In this case, we were told that they were instructed not to share the material with us, and so we did not have a chance to discuss it with them before it happened. And I am sure the GAO is going to be nonplussed by that, and I look forward to straightening it out with the GAO when our staffs can get together.

[Subsequent to the hearing, the committee received the following letter and enclosure from Peter J. McGough of the General Accounting Office:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

May 3, 1983

The Honorable John Heinz
Chairman, Special Committee
On Aging
United States Senate

Dear Mr. Chairman:

On April 7, 1983, I testified before you concerning the Social Security Administration's program for reviewing the disability of persons with mental impairments. During the hearing, I said that in the near future we will begin a study to examine what happens to individuals removed from the social security disability rolls as a result of a continuing disability investigation. We will work closely with your Committee as our work on that study progresses.

I also want to take this opportunity to respond to a number of comments made by Mr. Paul Simmons, who testified on April 8 on behalf of SSA.

In his testimony, Mr. Simmons expressed general agreement with the concerns we raised, and with our overall findings and conclusions. However, Mr. Simmons began his testimony by criticizing one sentence included on page 5 of my 30-page statement. The sentence, which was presented as background data, said that "At the ALJ level 91 percent of the decisions were reversed and the claimants' benefits were reinstated."

With regard to the 91 percent ALJ reversal rate, as my testimony indicated, this figure was attained from SSA's "833 file," a computer file based on completed SSA forms 833--"Cessation or Continuance of Disability or Blindness Determination and Transmittal"--which are prepared after continuing disability investigation (CDI) decisions are made. We developed our methodology for extracting and sorting records from the file, and although we checked and verified our data manipulation, we did not validate the completeness or the accuracy of SSA's 833 file. Our attempts to validate the ALJ data by comparing them with data from the Office of Hearings and Appeals (OHA) were unsuccessful as explained below.

We requested computer tapes from OHA on January 25, 1983. Although we requested that the tapes be furnished no later than February 4, 1983, it was not until March 23 that the tapes were transferred to SSA's computer building for our use. Even then, we learned that we had only seven of the eight tapes--one was missing. In view of the short time before the April 7 hearing, we were unable to resolve the missing tape problem and make effective use of these files.

In summary, we used the 833 file because it was, in our estimation, the only system that we believed could provide us statistical data to distinguish between individuals with mental impairments and individuals with other impairments. Since the hearings, we have reviewed various instructions for the 833 file, and talked with many people involved in preparing, distributing, and using the 833 form. It is accurate at this point to say that there is a significant amount of confusion and conflicting information concerning the form. However, it still remains, to our knowledge, the best source of CDI data.

Also during his testimony, Mr. Simmons said that GAO did not disclose the 91 percent figure or its source to SSA prior to the testimony. He also said that, when we pointed out the figure in our testimony, we "went on to say that this is proof positive that the program is unfair to the mentally impaired." These statements by Mr. Simmons are not accurate and the record needs to be clarified.

On March 22 we held an exit conference with SSA officials (see enclosed listing of attendees), and we provided a detailed description of our findings, including the ALJ reversal rate figure. We told the officials that we used SSA's 833 file to develop the ALJ figures and that we made the assumption in our methodology that third-level decisions in the 833 file were ALJ decisions. The SSA attendees did not raise any objections; did not point out any problems; and did not ask for any clarification of the figure.

Concerning the statement attributed by Mr. Simmons to GAO that the ALJ reversal rate was proof that the program was unfair to the mentally impaired, I made no such statement and find no basis for Mr. Simmons' statement. I would hope that any attempt to tie our findings to the ALJ reversal rate would be seen in the context that our findings were based on 7 months of detailed review work at five DDSs, SSA's headquarters, and the Chicago regional office; extensive interviews with more than 200 claims examiners, supervisors, and medical coordinators; and a detailed examination of more than 150 mental disability cases.

Because of Mr. Simmons' statements, on April 22, 1983, we again met with SSA officials--Louis Enoff, Deputy to the Deputy Commissioner; Louis Hays, Associate Commissioner of OHA; Jean Hinckley, Deputy Director, Office of Disability Programs; and John Snee, Acting Director, Office of Disability Program Quality--to obtain SSA's specific concerns. These individuals indicated that our reporting of the ALJ reversal rate was erroneous because the 833 file only captured ALJ continuances (reversals) and not cessations (affirmations of earlier decisions), except in those instances where the ALJ revised the cessation date. They said, however, that SSA does not know what the ALJ reversal rate is for mentally impaired persons. The officials acknowledged your request that SSA prepare you a report on the ALJ reversal rate for mentally impaired persons. We offered to work with SSA to avoid later questions on the data sources used and the accuracy of the resulting report. We also advised the officials of your request for us to validate the SSA report should it disclose a substantially lower ALJ reversal rate for the mentally disabled.

I trust that this clarifies the facts included in my testimony and removes any misconceptions that may have been caused by Mr. Simmons' statements.

Sincerely,

Peter J. McGough

Peter J. McGough
Associate Director

Enclosure

Meeting Report

Subject: Exit Conference on GAO Survey of SSA's Adjudicative Process for Determining Disability for Mentally Impaired Persons

Date and Place: March 22, 1983 - GJ24 Operations

Participants:

SSA	Eleanor J. Bader*	OGA
	Carol Butler**	OGA/OPC
	Herbert L. Blumenfeld**	OOPP/ODP/MCS
	Lenore Carlson**	OOPP/ODP/DPATP
	Bob Hall*	OOPP/OAC
	Al Harrison	OOPP/ODP
	Jean Hinckley	OOPP/ODP
	Hugh Meade**	OOPP/ODP/DPP
	Stewart Streimer	OOPP/ODP
	Jeanine Wooden	OOPP/ODP
	Kathy Collins	OP/OLRP
	Gil Fisher	OP/OLRP
	Rosanne Hanratty	OP/OLRP
	Tom Arvin	OA/OORI/DAML
	Thomas Connors	OA/ODPQ
	Steve Kelly	OA/OORI/DEQR
	Jeff Lumianski	OA/OORI/DEQR
	Tom Newby*	OA/OORI/DAML
GAO	E.C. Shepherd	HRD
	Barry Tice	HRD
	Bob Wychulis*	HRD

* Contact point.
**Designates head of unit.

Mr. SIMMONS. Many people yesterday said that we are singling out the mentally impaired, and this is one of the questions that you have raised as a general question. I point to the allegation that we are doing more CDI's as a proportion of the mentally impaired than their proportion of the number of people on the rolls. Well that is a misconstruing of some basic facts. First of all, we are not singling out the mentally impaired. We have no capacity to pull them out of our computers. We do not have an impairment code on our master beneficiary records. It is one of the symptoms of the aging systems that we have. What we do have on that tape is how old the person is, how high the benefit is, which indicates usually how much of an education the person has and how recently he or she was in the work force—all indicators that this is a likely person for a review of the disability determination.

Now, the age is one of the biggest factors in that profile, and the fact is that since we are limiting the initial reviews to those under 50, and since 81 percent of the mental impairment allowances are under 50, versus only 47 percent of all other allowances, that is why they show up in CDI's in a disproportionate number.

The second big factor in the reviews of the mentally impaired is that there are only two disabilities that we can really regard as permanent among the mentally disabled, and I think this is probably in consonance with most professional practice. The first is that if they are institutionalized and they have been for some time, then that is obviously an indication of a permanent disability. The second is if the person has an extraordinarily low IQ. That is a nonreversible fact of life. Other than that, neuroses and psychoses—most mental diseases—are either treatable or controllable with drugs, so that is why those people are being looked at.

Third, the main charge, I think, out of these hearings and out of many other forums has been that we, the Reagan administration, have toughened the program up, and we have changed the standards and changed the rules. Well, that is not true by any indicator that really counts.

Chairman HEINZ. Did you say that someone alleged that that had been done in the last year or two?

Mr. SIMMONS. Yes.

Chairman HEINZ. Who?

Mr. SIMMONS. That has been said time and again, that we have changed the rules.

Chairman HEINZ. Did anyone say that yesterday?

Mr. SIMMONS. I will have to go back through the testimony, but that was the recurring theme coming out of the newspaper stories this morning.

Chairman HEINZ. I would urge you to review the testimony carefully. I do not think anyone was accusing you of changing the rules. What you were being accused of is maintaining a set of rules that had become more obviously flawed, more obvious because of the pace of the reviews being speeded up by act of Congress, even though last year, we gave you at HHS discretion—and asked you to use it—to slow down the reviews on a State-by-State basis. The general thrust of the testimony yesterday—and I hope any of you there will feel free to correct me—was not that the Reagan administration or the Carter administration had changed the rules.

Rather, the rules—some of which date all the way back to 1968, when the medical listings were last established, have been proven by experience over this period of time to be absolutely inappropriate and, for all intents and purposes, a functionally illegitimate set of rules that give, when read, the wrong answer. Where you are really vulnerable is not that you wrote the rules or that you changed the rules, but that we have not faced up, and you have not faced up, to the growing evidence that the rules are totally inadequate to the task that is demanded of them. That is where I would say there is some vulnerability.

But in fairness, it was not until last year that the American Psychiatric Association—the spring of last year, as I recollect—came to you and officially said for the record, "Listen, these rules are just not the right rules, and you need to reevaluate them."

So that is my understanding, and if you have a different understanding based on the record yesterday, please so state it.

Mr. SIMMONS. Well, let me just point out a couple of things. As you state, yes, we have not changed the rules. I appreciate that you recognize that. Many people do not recognize that. I would point to the fact, for example, that on continuing disability investigations, where people keep pointing to the cessation rates that we are finding—the number of people who are being taken off the rolls at the initial level—our cessation rate is less than the last year of the Carter administration. For example, the reversal rates among the ALJ's is less than it was in 1979. And there are all kinds of other indicators. But one of the things that we do agree with you very strongly on, is whether or not the rules, which were last changed in 1979, and then only to bring them into line with current medical technology, et cetera, need to be changed. And we are looking at them very intensely within the agency and with the APA, as I will point out in a moment, but the rules may well be at fault. These are rules that have been in effect for 27 years of the program, and as I said earlier, no one ever really noticed how this program works. An even more serious problem, I think, with the program, is the administrative procedures that grew up over those 27 years, and those are the things that we have addressed administratively and in legislation, and I will tick off a few of them here. We have addressed them by administrative action, short of legislation.

In terms of the American Psychiatric Association, I met with the leadership of that group myself, with my staff, including our medical staff, 2 weeks ago, and talked to Dr. Hammersly as late as Wednesday evening. I think we are getting into a new era in our relationship with some of the medical professions, and nowhere closer is that going to be than with the APA. For example, they have agreed to set up an ad hoc committee to look at government disability programs, particularly ours, of course, because it is the largest. They are going to give us a blue ribbon committee for our purposes, an advisory committee, to go through those medical listings which you are talking about with a fine-toothed comb, and try to come up with some really constructive changes. They are going to encourage their membership— they have done this before, and they are going to do it again—to participate with the State agencies in servicing the disability program. And as you know, that has been a real problem, because the rates of payment to psychiatrists are set by the States and not by the Federal Government. We cannot set them, because that would upset rate schedules for other programs at the State level. In the GAO's own report, for example, they used a psychologist and not a psychiatrist, because they do not have one on staff, to look at the same cases that we are asking a psychiatrist to look at, and it is for the same reason. It is very difficult to find a psychiatrist who is willing to devote that much time.

I think it is to the credit of the profession that so many of them do give us so many hours of their services, but it is a continuing problem, and it is something we can only get at through persuasion and education of the membership.

We are also exploring the idea of doing something with the American Psychiatric Association that I am personally excited about, and so is our staff, and that is—I did not know they had this until 2 weeks ago—they have developed a nationwide peer review system where psychiatrists are given case folders on cases of other psychiatrists and cases generated by insurance companies and by the CHAMPUS program in the Defense Department. Those cases are reviewed on a peer basis, and comments are sent back. We think that there is some potential in that for us to send some of our cases for review to them, which would do two things. One is, it would either validate or invalidate the way we do business, and two is, it would point to ways to improve it. We are talking with the American Psychiatric Association about doing a pilot study on that, probably in a rural and in an urban area. It is going to cost us a lot of money, I think, to do that, but I think it is well worth it, and we are talking with them now about doing that.

We are also, in answer to their suggestions, and in answer to our own concerns after seeing the first 2 years of experience of this program, reemphasizing to the field that a longitudinal history on every psychiatric case should be developed to the extent possible; that is an absolute must. And we are sending out, I think it is this month, clear instructions on that.

In two areas, we are trying an experiment on a pilot basis, asking for two consultative examinations on each case, in order to see if that materially changes the composition or outcome of the case.

We are meeting with a whole range of special interest groups who are involved in the mental health area, and I think most importantly they are seeing a new era of cooperation with us. We are meeting with the people out there, the State directors, who are working where the rubber hits the road, so to speak, on this program, in an effort to educate them, and more importantly, to get ideas from them on how to run this program better. Since they run this program day-to-day, they have good creative ideas, and I do not think that they have been listened to that much in the past. I am an old State administrator myself, and I have always hated the Feds; the typical Federal attitude in the Federal-State programs is, "Don't bother us. We will send you instructions." But we think we ought to get more feedback. Two weeks ago, we spent 3 days in Denver doing just that, and some of them have gone back home and have told their people it is the first time they ever talked to Feds, and the Feds seemed to be talking back to them and not down to them.

We have done a number of things in the disability program in general which, if anything, are liberalizing the program, primarily in the organizational and structural details. For example, first and foremost, we have expanded the definition of the permanently disabled generally, in order to get a 20-percent reduction this year in the number of continuing disability investigations to be done. We are doing that for two reasons. One is to relieve some of the pressure on the States and therefore to improve, we hope, the quality of the decisions they make on those remaining; and second, to reflect the experience that we have now in looking at a large number of cases. We are looking for even more than a 20-percent reduction, if we can do it, without damaging the integrity of the program. We are doing that by expanding the definition of permanent disability.

We have been insisting since last May—this is something that the Commissioner personally did when he discovered that we were not looking back for even a full year at medical evidence—that the States do that wherever practical in every single case, for both physical and mental impairments. We are also insisting, as I said a moment ago, on a long-term longitudinal look at any information available on mental impairment cases.

We have instituted on our own, without legislation, face-to-face interviews at the front end of the process, and some of the obvious horror stories that you have been seeing over the past 2 years should be caught by that process, which only began last October. But already, we are taking about 5 percent of the people who come in the door off the review program altogether and saying, "You are not going to be reviewed. You are still disabled. Go home."

Chairman HEINZ. Five percent with mental disabilities?

Mr. SIMMONS. No; 5 percent of all disabilities. About 5 percent has been the early experience. And even more importantly, we are moving even ahead of the legislative schedule to institute the face-to-face reconsideration process. We hope to have that in place by late next fall, instead of waiting until January 1, as under the law, and we are very excited about that, because in pilot tests that we are doing now, we are finding a significantly higher number of continuances at the State agency level now with those processes in effect. We are doing the pilots in three areas—in the San Francisco Bay area, in most of Texas, and all of New Mexico. We think this gives us a proper mix of urban-rural, and so forth, and in those early results, we are finding almost a doubling of the number of cases allowed at the reconsideration level. Those are very early figures and based on only a few hundred cases so far, but we think that there is a lot of promise in this, and we think it proves our point that we started making a year and a half ago, that if we could beef up the reconsideration process, we could get a much better quality of decision. So we think that is going to do a lot.

We are also supporting, as you know, payment of benefits to those until they get to the reconsideration process, even if that process is lengthened out to 6 months. We supported that in the bill last year, and we will continue to support the concept. We think that at least up until the first time a person has an opportunity to come face-to-face with a decisionmaker, that the benefits should be continued, no matter what the person's status is.

We are also pressing for further reforms in legislation, and we are looking forward to hearings of Congressman Pickle and Senator Dole on such things as, for example, under the law, we have to look this year at 65 percent of all State agency decisions allowing benefits, but we do not have to look at decisions where benefits are denied. We do that on our own.

However, moving to a 65-percent review of allowances from the 35 percent that we were at last year is not a bright idea, even though the Congress passed it. I say it is not a bright idea because what that does is it skews the system in favor of discontinuing benefits. If you are a State examiner, and you know that if you discontinue the benefit, you are not going to be reviewed by the Federal auditors, you are more likely to discontinue a case that is in the grey area. What we want to do is have the flexibility to go to, for example, a 10-percent review of all cases and make that mix a proportional mix of disallowances and allowances, so that the system itself does not militate against the claimant. We think that is a fatal flaw in the program, a very serious flaw in the program. It is one that we have grappled with; it is one that, time and time again, you see charges that our auditors are making policy by returning too many cases to the State examiners. That may be true. We have got a team out now, looking at all 10 regions to see if this is indeed happening. We are hoping to get this legislation and get it soon, so that instead of reviewing two-thirds of all cases that are continued, we are going to be reviewing whatever percentage would give us the right mix of allowances and disallowances. We think that is only fair.

The State of Maryland yesterday—and you mentioned this in one of your questions—called upon you, apparently, I am told, to demand that we release a blanked out paragraph in a memo that we gave them, based on our own study. Well, I will release those paragraphs today. I saw this for the first time last night, and I was astounded that we did delete these two paragraphs, and then on further questioning, I discovered it was because first of all, this was not released immediately because it was an internal study that we did. As soon as Attorney General Sachs announced that he was going to undertake a review, we did it just to check for ourselves on what was going on. And the State of Maryland in years past has had very serious internal problems in its DDS unit. We have been working with them since last May, I believe, to correct those problems. We have a management assistance operation that goes in and helps State agencies that are having problems——

Chairman HEINZ. If you think the State of Maryland has problems, how about its last Governor?

Mr. SIMMONS. I understand he is a Beach Boys fan.

Chairman HEINZ. More and more people are becoming Beach Boys fans.

Mr. SIMMONS. I took a poll this morning, and all four of us are of that generation.

Chairman HEINZ. The Beach Boys are getting a little older. Secretary Watt does not have much more hair to lose.

Mr. SIMMONS. I do not particularly like Wayne Newton. [Laughter.]

Anyway, the paragraph was deleted out of a feeling of sensitivity for the Maryland agency, since they are doing better now, and what those paragraphs said was—and this is our people talking—

> We were unable to discern any pattern of discriminatory practices in either development of cases or handling of cases. The high error rates seemed to coincide with the recent findings of generally poor quality determinations issued by the Maryland DDS for many and varied reasons.

That is what that paragraph said. I apologize to the State of Maryland for making it public, but since a State official of Maryland has made a point of it, I think we should.

The other two paragraphs say almost the same thing—"We do not believe any discrimination against mentally impaired individuals is evident, based on our limited review," and the half-sentence that was deleted says that, "While the Office of Assessment"—that is our office—"was aware of the generally poor quality of medical decisions made by the Maryland DDS as a result of the ongoing review * * *," et cetera, and it went on.

Those are the secret paragraphs that we were pilloried for.

And finally——

Chairman HEINZ. They are not secret anymore.

Mr. SIMMONS. Not secret anymore, and as I say, I do apologize to the State of Maryland.

One other point that occurs again and again is the people complain that we accelerated—they always use that word, "accelerated," in quotes—the review on our own, and that is proof positive that we violated the intent of Congress, and we went too fast, and all that. Well, in fact——

Chairman HEINZ. Did anybody say that yesterday?

Mr. SIMMONS. Almost every time you saw a reference to the CDI process, it said accelerated.

Chairman HEINZ. Well, it has been accelerated, but as you know, it was mandated by the law Congress passed in 1980.

Mr. SIMMONS. It was mandated by the law that Congress passed in 1980. It said to start it no later than January 1, 1982. We began it in March 1981. The point I want to make is that that was at the direct urging of the General Accounting Office, which made a draft report available to the Carter administration, really, which was putting that budget together—we were not at the time—in December 1980. The GAO report was published formally in March 1981, and it said, "Redirect resources now, including the supplemental appropriation. Take the resources off the SSI program, put them on the title II program, because you are losing all this money." And then the Congress endorsed that in its budget ceilings and in the bill, and I do not understand why it keeps coming back up.

Between fiscal year 1980 and fiscal year 1982, for example, we gave the States 64 percent more money, and that enabled them to hire 33 percent more people to handle the increased workload, and almost all of the States were able to staff up. There are some that have had problems, and that is why we are adjusting the caseload in some of those States. Some of them still do because Governors, for political or budgetary reasons, have imposed hiring freezes, and since these people are technically State employees, even though they are fully federally paid, they show up in their bottom line, their body count. And so a Governor faced with having to furlough his own State employees resents it when the Federal Government comes down and says, "Here, hire 20 more in your DDS unit."

Chairman Heinz. My own view on the fact that SSA accelerated the periodic reviews, a function required eventually to be performed by Congress, is that it cuts two ways. On the one hand, one can say—and some people have charged—that the administration used that acceleration as a budgetary tool. And who knows what your motivations were? Knowing the administration's feelings about the budget, I would not be surprised if that were true. On the other hand, I think it can also be said that accelerating what Congress told you to do has brought to light, much more quickly than otherwise, problems that have existed all this time, and we are, if you will, 9 months further ahead than where we would otherwise be as a result of this.

So I think there is some good news and some bad news, and I think it would be inaccurate to let the record reflect only the bad or only the good.

Mr. Simmons. Well, in fact, one of the points that no one ever notices about that so-called acceleration and getting a 9-month headstart on the program, is that, in effect, that gave us 3 years and 9 months to do a job that Congress said do in 3 years. One of the byproducts of that was, because we were ahead nationwide, we were able on our own, even without legislation that was finally passed last December, to slow down the cases going to some of the States that have peculiar problems, staffing problems or performance problems. Also it enabled us to spend a little more time working with States that were having management problems. And it is something we just could not have done, unless we had started early. And we can argue over budget impacts and all that, but GAO's advice was pretty clear, and there are some times when we listen to GAO more than others.

Chairman Heinz. Does that more or less complete your statement?

Mr. Simmons. Yes, sir. I am sorry I took so long.

Chairman Heinz. No; I think it was a very helpful statement.

Let me start with some things you said at Senator Cohen's hearing last May, because I want to be sure I understand what you are saying today. Last May, you told Senator Cohen at his Government Operations Subcommittee hearing:

> In the vast majority of cases, the reason people are being taken off the rolls is not because there are deficiencies in the process, but because they are not disabled under the terms of the law. Many of them are on the rolls erroneously to begin with, and many of them recovered after they came on the rolls, but were never previously reviewed. We are now paying the price, because the necessary emphasis was not put on quality in original decisions.

Now, with respect to the mentally impaired: Although they are 11 percent of the total disability population more than one-quarter—one out of four of all those reviewed and denied—have mental disabilities. They are, therefore, a very significant group from the standpoint of CDI reviews. We learned yesterday that the quality of the decisions—that is, the review decisions, the CDI redeterminations—is frankly terrible, for a vast number of reasons. One, the listings are irrelevant; and two, the people doing the reviews are unqualified to do the review. Where a clinical psychologist or a psychiatrist should be evaluating these people, they are being evaluated instead by a disability examiner or a State examiner of some kind, who is not able to judge, either at the initial level or at the reconsideration process, and even now with the new face-to-face interview, exactly what a mentally disabled person really suffers from.

And what we also found is that, to the extent that any additional procedures are being used or are being proposed to be used, they, at least in the opinion of a variety of experts in the field—such as Dr. Meyerson, the American Psychiatric Association, and others—are inadequate. Procedures of having somebody kind of look at a file to determine permanent disability or sit down with the patient for 10 or 15 minutes, even on two separate occasions, are not valid predictors or valid mechanisms for finding out whether that person is, in fact, unable to work.

Now, we all want people who are able to work to go back into the marketplace. But, clearly, I cannot imagine anybody who wants people who are not able to work either to go into the marketplace or be knocked off of the Federal programs so the States will have to take care of them. My question to you is this: Have you had a change of heart since you testified before Senator Cohen, or do you still believe what you said to Senator Cohen?

Mr. SIMMONS. Well, I still believe that the vast majority of people who are being taken off the rolls are being taken off the rolls for valid reasons.

Chairman HEINZ. Now, we are talking about the mentally impaired.

Mr. SIMMONS. Well, on the mentally impaired, let me go through a couple of points here. First of all, no examiner in a State is allowed to make the final decision on a case without medical input from somewhere. And, as you know, and as the APA has testified, and, as I have indicated, there are some States where there simply are not enough psychiatrists available who are willing to work for the State on a contract basis or whatever.

Chairman HEINZ. The testimony we received yesterday respecting medical input was as follows: It is almost universal that the evaluation form is prepared by a nonmedical person—and not a psychiatrist or clinical psychologist, because of the way the system works; then, that form is reviewed rather briefly by a medical person a good deal of the time. That is the testimony that we received in instance after instance yesterday. So you are technically correct when you say there is some medical input. But the actual person who goes over the file, who does the workup, if you will, is not trained to deal with the mentally impaired. In fact, we know 9 out of 10 times, that disability examiner, normally, if he does initial processing, is dealing with somebody who has a physical as opposed to a mental impairment. And that is what those people are specialized in, understandably, and obviously, it is a lot easier to evaluate because what you see is, to a much larger extent, what you get—physical impairments as opposed to what is inside our heads.

Mr. SIMMONS. Well, let me point out that, as I said earlier, we are working with the American Psychiatric Association on a number of problems. One of them is, of course, getting psychiatrists involved in the program. That is an almost insoluble problem——

Chairman HEINZ. But my question is this: If we went back to last May, and Senator Cohen's hearing was only on those people who were mentally disabled, would you stand by the statement that you made then?

Mr. SIMMONS. Do you mean the statement that the vast majority are being taken off properly or should not be on the rolls in the first place? I would stand by that part of the statement. But I understand a lot more about the program now, particularly the part of the program affecting the mentally impaired, since we have been concentrating on that over the past several months, and I would say that there are aspects, inevitably, in our review of mentally——

Chairman HEINZ. Now, let us be clear what you are committing yourself to. What you are saying is that the vast majority of the mentally impaired being taken off the rolls are being taken off the rolls not because there are deficiencies in the process, but because they are not disabled under the terms of the law.

Now, if that is your point of view, I challenge you, given the testimony we had yesterday, to demonstrate that a bare majority, let alone a vast majority, of those people who are mentally disabled are indeed able to work.

Mr. SIMMONS. Well, I do not understand how you can—I mean, if you want to talk numbers, 91 percent was mentioned yesterday. Our judges are overturning cases "9 out of 10 times, and therefore, the system is wrong." That is not true. There are a lot of numbers that are not true. There are a lot of perceptions that are not true.

Chairman HEINZ. What is the right number?

Mr. SIMMONS. I do not know what the right number is. One of the reasons——

Chairman HEINZ. Well, then, how can you say the vast majority of them are disabled? If you do not have a number—vast majority is at least 51 percent, could be 91 percent, but if you say you do not have any numbers, how can you make the statement that the "vast majority" of them are disabled?

Mr. SIMMONS. Because if you accept the premise of the Congress and the previous administration and this administration, that about one in five people on the rolls are not disabled, and therefore, the rest of them are, and if you are approaching numbers that show that that is probably correct, then you can say that the majority being taken off are being taken off legitimately. We have never said that there are no mistakes in this program. We have never said that we did not want to improve the program and make it more humane. That is why we went to the face-to-face interview. That is why we pushed for legislation on the face-to-face reconsideration process. That is why we agreed to the payment of benefits to the face-to-face hearing. That is why we are working with the American Psychiatric Association—this is one thing I mentioned before, and I believe you extracted—that we are going to enter a contract with them to experiment with their peer review system. Let me explain how that system works, because it works very much like our system works.

A doctor gets a file. He spends between 15 minutes and 2 hours on it, which is what happens in files in our cases. We encourage the States to budget a minimum of 15 minutes per case. Some cases very obviously only take a few minutes. Some cases may take 2 hours. We encourage States to do everything they can to develop every bit of medical evidence possible, and we allow no decision to be made without the physician's input. And if somebody is filling out some kind of a form that codifies and tries to make sense out of things that appear disparately in the file, that is not the medical decision. That is fitting something to a form that physicians have developed to help organize the file. You have to have some kind of tool like that.

Now, I will not vouch for every single decision that is made in every single DDS around this country, and I would say that they are doing the best they can in an impossible situation. We are doing the best we can to make it easier. We are getting into this thing in great depth, especially the psychiatric part, because that is the toughest one we have. We have people, for example, who come in, and the only thing in the file is a piece of paper they got from their State hospital saying, "This person is fine. Go home." Then they come in and apply for disability. Now, you have to have some kind of objective evidence, and the deinstitutionalization program that has been going on over the past 10 years is at cross-purposes with the definition of disability, because by definition, if you are deinstitutionalized, then you are more apt to be able to go back to work.

Chairman HEINZ. Well, my concern is that you are saying that in the vast majority of cases, the system by which these reviews are being made is yielding correct decisions—that is what you think?

Mr. SIMMONS. Yes, we believe that.

Chairman HEINZ. But you also say you do not have any information, as I understand it, to support that. Isn't that what you said a minute ago?

Mr. SIMMONS. Well, there is no information to support——

Chairman HEINZ. You said that the 91-percent reversal rate is wrong.

Mr. SIMMONS. Right.

Chairman HEINZ. But when I asked, "What is the reversal rate?" you said you do not know.

Mr. SIMMONS. Well, the real reversal rate is about the same as it is for the physically impaired.

Chairman HEINZ. Well, what do you think it is?

Mr. SIMMONS. It is around 60 percent at the ALJ level. But the important number with the administrative law judges is the bottom line number——

Chairman HEINZ. Now, when you say it is 60, just so I understand the number, 60 percent is the overall reversal rate?

Mr. SIMMONS. Sixty is the overall reversal rate of those CDI cases that are appealed.

Chairman HEINZ. Now, I know you have been up before the Congress on a number of occasions to testify about the whole program, but this hearing is only about the reviews of the mentally disabled. Do you know what the reversal rate by administrative law judges is for mental disabilities?

Mr. SIMMONS. It is about the same as it is for the others.

Chairman HEINZ. Can you support that statistically?

Mr. SIMMONS. Sure.

Chairman HEINZ. OK. We would like to see those figures.

[Subsequent to the hearing, Mr. Simmons supplied the following:]

To determine how frequently ALJ's reverse State agency cessation decisions in mental impairment cases, we undertook a study of 2,285 cessation decisions, which were randomly selected from all cessations in the first calendar quarter of 1982. Of the 537 mental impairment cessations in the study, 290 were appealed to the ALJ level. ALJ's have made decisions on 257 cases and 33 cases are pending an ALJ decision. ALJ's reversed 188 of the 257 cases, for a cessation rate of 73 percent. In comparison, the ALJ reversal rate for all cessations in the study was 66 percent, which means the reversal rate for mental impairment cases during that period was about 7 percent higher than the rate for all cases appealed. The great majority of the cases in this study were decided by ALJ's in 1982, when the overall ALJ reversal rate on CDI cessations was about 65 percent. By way of contrast, the overall ALJ reversal rate during this fiscal year for CDI cessations is about 60 percent.

Mr. SIMMONS. And the further point—the ALJ reversal rate becomes a football every time it is discussed, almost—the further point is that in 80 percent of the cases on the rolls or who are kept on the rolls after review, they are put there by State agency decisions; only 20 percent are put there by administrative law judge decisions.

We are trying to construct a system that would improve the decisionmaking capacity at the State level to reduce the number of cases that even have to go to the administrative law judges. They were originally intended to handle the really tough cases. They should be reserved for that, just as the court system is for tough disputes, or crimes, or whatever. What we would like to do is to relieve the pressures on the administrative law judges, give them just the tough cases, the ones that really require extensive knowledge of the law or a higher level of training, judgment, and have the system perform better. And one of the things that we are getting out of the very early returns from that face-to-face reconsideration program, as I mentioned before, is we are almost doubling the number of reconsideration affirmations at the reconsideration level, and if that holds up, if that is what the experience is, that is a tremendous advancement.

Chairman HEINZ. I would agree with that.

You said to Senator Cohen last May—and I quote—that, "The high allowance rate is due to incorrect decisions by the administrative law judges." Is that——

Mr. SIMMONS. I do not believe I said that it was due to incorrect decisions. In many cases, there are incorrect decisions made, and that is why we are doing the Bellmon review, which was mandated by the Congress, to look at the quality of judges' decisions. But I do not believe I would say "vast majority," or any appreciable number.

Chairman HEINZ. Well, I am glad to hear that you have changed your mind. You may want to edit page 10 of the hearing record——

Mr. SIMMONS. Did I say "one of the reasons" or "most of the reasons"?

Chairman HEINZ. I will quote. "However, to a large extent, we believe the high allowance rate is due to incorrect decisions by administrative law judges."

Mr. SIMMONS. Well, I do not know what the context was of that. There are some judges who have——

Chairman HEINZ. Without getting into great detail, why don't you take a look at the hearing record, when you have a chance. Let us not do it right now.

Mr. SIMMONS. All right. But in defense of myself, though, because I think this point is not getting across, there are some judges who have extraordinarily high allowance rates, as opposed to the normal allowance rates, and in those cases, the Bellmon review study found a high incidence of error—a 46-percent defect rate and 18 percent, in terms of procedural error. Some of the errors were serious enough to remand the case back to the judge from our appeals council. So in that sense, in some cases, yes, but the idea that a 60-percent ALJ allowance rate means that they are making incorrect decisions in all of these cases is just not correct, and I would not support that.

Chairman HEINZ. You, in your remarks, mention horror stories. And to me, one of the horror stories that we received yesterday was—what I, at least, thought was a horror story—we heard from an organization that ran, what I will call a halfway house, and in this program, Dr. Beatrice Braun, as I mentioned in my opening statement, told us that virtually all of her patients, who are chronically mentally ill, are being called up for continuing disability review, and they are being denied, and in every case so far, they have had their benefits restored by the administrative law judge. There are still some cases that have not been decided.

Now, to me, when almost without exception, this ax is falling on a group of people who have been deinstitutionalized, not because they have necessarily had any medical improvement, but because it is a more humane way to deal with the problems of the mentally ill, rather than locking them up in padded cells and letting them lie there in a comatose or cringing state, it seems to me that something has to be wrong with the system.

What do you think we can do promptly to deal with that situation—which is continuing at this particular facility and at ones like it across the United States? There are people who are just clearly unable to function, let alone hold a job, who are being put into the meat grinder of this process. And you yourself know how long and indeterminate—these people are schizophrenics, many of them are paranoid schizophrenics, and let me tell you, I have never known anybody, even a healthy mental person, who, when they run into somebody from the Federal Government, has the immediate reaction that, "We are from the Federal Government, and we are here to help you"—especially this time of year——

Mr. SIMMONS. I did that for 10 years.

Chairman HEINZ. The effect is scarcely one that I am sure even you or anybody we could think of, would want to——

Mr. SIMMONS. Before I answer that direct question, let me clarify something that I said earlier. I was talking in shorthand, and I do not want to be called up again next year and told, "Now, you said that what I said was that the——"

Chairman HEINZ. Listen, no matter how hard you try, we will do it, so do not worry about it.

[Laughter.]

Mr. SIMMONS. I was involved in New York State government. I was deputy welfare commissioner in New York. As a matter of fact, the man who testified yesterday, Mr. Perales from New York—I was deputy to one of his predecessors. And before that, I was in the State health department, and I was there at a time when the deinstitutionalization business began. I do not believe, personally or professionally, that just because a person is deinstitutionalized, that that person is able to go to work. What I was echoing earlier is a statement by the DDS administrator in New York, who put it very succinctly. He said, "You know, one of the great problems we have in this business is, you have people coming to you, on the record, who say that they have improved so much that they have been deinstitutionalized." They are not in any kind of a shelter or anything, and that is because of the shortage of such shelters, and a lot of people who should be in them obviously are not in them, and that is a problem that State and local governments and I suppose, ultimately, the Federal Government, are going to have to address over time. The State has people come in, and they will lie to them when the State asks: "Well, you want disability, but how are you?"

"I am fine." And that is because that may be in the nature of whatever the neurosis or psychosis is that they have. So States have great difficulty in developing sufficient background on such a case to demonstrate disability, as you can in a physical case. You can tell more easily when a person is physically ill.

One of the things we are hoping, in the instituting of the face-to-face, upfront interview, is that where you have someone who obviously cannot cope who is brought in to the Social Security office, or you go to that person's home, or to a halfway house, or wherever that person is, and see that person, we are hoping that a commonsense approach at the very front end will catch some of those and we can just say to them, "Well, you should not be reviewed." This is obvious. You get out of the review process.

The second thing we hope is that the face-to-face reconsideration hearing, which will replace the totally paper-oriented hearing we now have, will get those at the State agency level. And as I said, we are accelerating, to use the word, the implementation of that, hoping to start it by October 1, and not waiting until January 1, which the Congress gave us to do.

We think those two things, plus what we are doing, in reopening our examination of the entire listings phenomenon, a reopening of all of our procedures, we think we are going to get at a lot of these problems. It is taking time, but I think we are making very rapid progress now, and having started face to face already, we are already seeing some results of that. Any system that catches 5 percent of the people upfront and gets them out of the review process, just with a commonsense, eyeball look from a person who is reasonably trained in disability but not a professional, I think shows that (a) we were right in doing it, and (b) people are going to get a better shake out of the system.

Chairman HEINZ. With respect to the GAO report, which you got yesterday, one observation and one question. With respect to the fact that you say it was not available, or it had not been discussed with your people, I am advised that within 1 or 2 weeks ago, the

GAO did brief administration personnel, including a person named Jean Hinckley——

Mr. SIMMONS. On March 22, I have a memo from the file on that. They told us generally what the findings were, and did not mention the 91 percent, and then said, in parentheses, "Senator Heinz has instructed us not to give SSA an advance copy of the testimony."

We did not see the report itself. All we had was an oral briefing on it generally. They said, "We found problems with the listings," and so forth.

Chairman HEINZ. Well, first of all, we did not have the testimony back then. We did not have the testimony until just yesterday——

Mr. SIMMONS [interrupting]. Well, I am not pointing that out. I was just——

Chairman HEINZ [continuing]. And second, I do not know whether your file memo reflects an opinion of your staff or a statement of GAO regarding any instructions I gave, but for the record, I gave no such instructions.

Mr. SIMMONS. I would not expect you would have.

Chairman HEINZ. Neither did my staff.

Mr. SIMMONS. Well, we did not have that. We did not know about the 91 percent number. We were never told that number was there, and had we been told, we would have pointed out that it was a wrong number.

[See GAO letter on page 126.]

Chairman HEINZ. Now, the question I have with respect to the report is that, as I recollect, on page 6 of the report and then on following pages in the report in more detail, there are four specific recommendations that the GAO has made. I do not imagine that you have had a chance to fully review them——

Mr. SIMMONS. No; but I am very familiar with the issues because these are recurring issues, and I can give you a thumbnail on each one, and then submit for the record more detailed answers, if you would like.

Chairman HEINZ. Well, let us do this. Why don't you give us, for the record, your reaction to those four recommendations as quickly as possible. I have a list of questions that will cover some of them, in a somewhat more structured way, perhaps, than if you simply react to them now.

[See page 152 for questions submitted by Senator Heinz to Mr. Simmons and Mr. Simmons' response.]

Mr. SIMMONS. I will tell you up front that we agree with 1, 2, and 4, right off the top, and that No. 3 is a matter for professional discussion between our medical staff and people like the APA and the rest of the medical fraternity.

Chairman HEINZ. No. 3, in your listing, being the limitation of psychiatric resources?

Mr. SIMMONS. No; the inadequate development and use of existing medical evidence.

Chairman HEINZ. The inadequate development and use of existing medical evidence.

Mr. SIMMONS. It is No. 3 on page 6 of the GAO statement.

Chairman HEINZ. Yes; you say you have some disagreement with that. What is that?

Mr. SIMMONS. Well, the disagreement mainly is a readout of No. 4. If you cannot get enough psychiatric resources or any other professional resource because the marketplace is such that you cannot get them, then you have to use consultative examinations. That is the next best thing that we can do. There is absolutely no other recourse; we just cannot do it any other way.

Chairman HEINZ. It may even be the best thing.

Well, let us go through a few of the things that are implied here. Let us talk first about the public law we passed last year, that authorizes a slowdown, Public Law 97-455. You say you support it. The question, I guess, is since we do provide you with the discretion to make slowdowns on a State-by-State basis based on the personnel and resource situation of those States, have you used that authority thus far this year? Do you intend to use it specifically for mental disability cases, and if so, when will you use it?

Mr. SIMMONS. Well, we used it in up to 18 States last year, even before the law was passed, because we did have the extra 9 months of leadtime, so we did have the flexibility. We are now using it in three States. We have no plans to use it specifically for mentally impaired cases, but it is an interesting concept that if we run into some States where there may be a serious problem, maybe we would change the mix of the cases. I will look at that.

Chairman HEINZ. We were told yesterday that there does not appear to be adequate psychiatric personnel in most States. That would argue, at least with respect to the mentally impaired disability cases, that there might be indeed a large number of States where use of this authority selectively for mental disability cases would be appropriate.

Mr. SIMMONS. There are three State agencies—Delaware, New Mexico, and Pennsylvania—I believe, who have no psychiatric help and who have to go out and beg, borrow, and steal, and so forth. The other States all have at least some. Some do have chronic problems of attracting other medical specialties for the reasons I have said before.

Chairman HEINZ. So, as I understand what you say, you will take a look at this idea——

Mr. SIMMONS [interrupting]. We will take a look at it.

Chairman HEINZ [continuing]. And where you find a scarcity of resources, you——

Mr. SIMMONS. Well, if we find a scarcity of the ability to do it, by whatever means, then we would seriously consider it.

Chairman HEINZ. All right.

Mr. SIMMONS. Just because there is no psychiatrist full time on staff does not mean that psychiatric help is not available.

Chairman HEINZ. I understand, I understand. I would use the term, "resources," not necessarily on staff, resources.

Now, let us talk about the medical listings. I take it that you agree that the medical listings as they exist for the mentally impaired fall very short of being a meaningful predictor of people's ability to work.

Mr. SIMMONS. Well, I would not say that. I would not have the expertise to say that, and I do not have my medical staff with me today to say that. But I do know that we are actively talking with professionals in a renewed sense of urgency now, because of the problems we are seeing. We are exploring the use of work groups involving both lay people and doctors, et cetera, and we are getting active support from the APA.

Chairman HEINZ. You mentioned that in your testimony. I assume the reason you set them up is that you have some problems with the existing listings.

Mr. SIMMONS. I have problems with the listings in the sense that they are coming under a lot of criticism from a lot of quarters, and I think they ought to be looked at. I do not think anything should be static, and I have always been under the impression that our program has been moving with the times. If there is any area where something has crept in and just stayed there, that should not be there, then we should take it out.

Chairman HEINZ. Well, are you going to revise those medical listings for the mentally impaired?

Mr. SIMMONS. I would guess within a matter of months, you will see some substantial revisions coming out.

Chairman HEINZ. And when you say "a matter of months," 3 months, 6 months?

Mr. SIMMONS. I do not know. I mean, I am not going to put a deadline on it, but I am going to say that we are moving as fast as we can, and we have an interest in doing it.

Chairman HEINZ. Well, you may not be prepared to put a deadline on it, but I know you are a good manager, and good managers do put deadlines to achieve goals. Could you think very carefully about how long it is going to take you to do the major revisions you intend to do in medical listings and let us know? I am sure you will be able to get at least a rough idea of that.

Can I ask this question, please? Why didn't you revise those medical listings for mental impairments last year when you proposed to revise the other medical listings?

Mr. SIMMONS. Well, there are some revisions to those listings in the current group of changes that are going through the regular clearance process. Those are going to be helpful, I think, but even more helpful might be an in-depth study, with more outside help. That is what we asked the APA for, and they have agreed to give us some names of people who would be willing to spend some time, practically pro bono, because we cannot pay them an awful lot of money, just expenses, but we are going to try to sit down and say, "OK, you people have said this, and these people have said this, and groups have said this. Now, where is the common ground, and where can we get terminology and concepts that we can all agree to within the realm of possibility?" We are very interested in doing that, and we are taking active steps to do it, and we will.

Chairman HEINZ. Will you share the drafts of proposed changes in medical listings with this committee and other committees of Congress?

Mr. SIMMONS. We could do that.

Chairman HEINZ. Thank you.

Just this week, you issued a new circular implementing decisions of a Minnesota court case, as I understand it. How are the instructions contained in your circular different from your previous procedures and what effect is the circular going to have on people—that is to say, how many more people will be continued in benefits as a result of the changes in the circular, rather than be denied? Do you have any feelings about that?

Mr. SIMMONS. I do not think I have an estimate on that. I will say that this is one of the points touched on in the GAO recommendations, and they are exactly right, and so was the court in that case, on the one principle that there was a misunderstanding of policy, at least in that one part of the country, based on a misreading of intent from the central office, et cetera. And there were some people who were reviewed who did not have the full vocational review they should have had because of that misunderstanding. And we are going to go back and look at some of those cases to see whether or not doing the procedure that was not done will change the outcome. I suspect it will, in some cases. And our talking with the court now is on the details of how you do what, and there are some points of it we are going to appeal. That is all the legal stuff. But the basic principle was that there was a bootleg policy out there, and on January 3, I believe it was, the Commissioner put out a very strongly worded statement to all 10 regions saying, "Program policies will be issued only by the Baltimore office—in any program." He specifically singled out the medical impairment listings and said, "Here is how you do it," and then went through the whole RFC and all of the five or six points of the process, and he said, "That has to be done by every State, everywhere, all the same."

Chairman HEINZ. My understanding is—GAO told us, at least—that you distributed that statement nationally. Is that right?

Mr. SIMMONS. Yes, that was a Commissioner's bulletin or directive; it was the strongest piece of paper we have in that organization.

Chairman HEINZ. Now, implicit in that is you are going to have to retrain quality assurance and disability examiners to some substantial extent, if the court's judgment is accurate.

Mr. SIMMONS. Well, we have ongoing training needs in this program all the time, but it is not a question of retraining them. It is a question of reminding them that they are supposed to do this and to do it right. And wherever we have problems, if we spot problems where the quality of decisions is not good or people are not following steps, and all that, then we send in extra training.

Chairman HEINZ. I am not an expert, and I have not been the State head of what you have been head of, but can I be therefore so bold as to suggest that where you are talking about, once again, people, examiners, who see 9 out of 10 times a physically disabled person, and who have no particular psychiatric or clinical psychological expertise, that training is indeed a very big problem for these people, right from the start. And based on what we know, the situation does not seem to be any better today than it was at the start.

It would be my guess that the people out there in the field who have been doing this, by your own testimony, and the testimony of every credible witness we have had, not just 1 year or 2 years, but for a dozen or more years, who have gotten into a pattern of behavior that, frankly, is flawed, and that the training is a very real problem, and that in a sense, the Minnesota court decision has finally brought a little bit more than the very tip of the iceberg to light.

So my question to you—and again, I have to keep reminding you, we are talking about the mentally impaired people who are difficult to judge under any circumstances—that maybe there is some training here that goes beyond the normal kind of training process that you have?

Mr. SIMMONS. Well, I am told by Ms. Owens that we have directed the DDS' to train wherever necessary, if there are any deficiencies in their staff, because that is part of the reemphasis in the mentally impaired; this is part of the problem of the longitudinal history-gathering that we have directed them to do, and part of our whole push to get a better quality of material in the file.

Now, you have to keep in mind that the people you are talking about, the bureaucrats who are not medical professionals—they are disability examiners, but they are not making medical decisions; their job by and large is to make sure that there is ample evidence in the file for a medical decision to be made; they make no decision without the concurrence of medical input, and that could be a physician, it could be a psychiatrist, it could be any one of the professionals who is a specialist in that case. And there is no program that can train lay people—I would not make a good doctor. I could not be trained to be a doctor. But I could be trained to know enough about the file that I have to know to take it to the doctor. And in every case, they have to anyway. It has to go through medical review one way or the other. In cases where there are not enough psychiatrists or psychologists or whatever the specialty is, that is a problem. They have to find it, somehow. But the rule is no decision without a doctor.

Chairman HEINZ. With respect to the mentally impaired, the testimony we have, especially from the clinical psychologists and the psychiatrists—which included Dr. Braun, Dr. MacLennan, and Dr. Meyerson—was, that a doctor, looking at the typical file prepared by a disability examiner, could not for the most part be able to decide when such a person should be continued in benefit status. The testimony was nearly unanimous on the point that, given the way those files are prepared, the doctor most of the time cannot tell with any certainty at all whether that person, in fact, should be discontinued; that it is not possible, based on those evaluations, to tell whether the person can work.

Now, remember, that is the judgment we are trying to make here. The question is: Can these people work? And the testimony, which came from a variety of sources and was very authoritative, says there is just no way that the existing system, which you have just accurately described, can make good judgments about whether mentally impaired people can work.

Mr. SIMMONS. Well, as you know, that is one of the things, obviously, that we are going to look at in connection with the whole listings thing, because the listings drive the forms, drive the process, et cetera. That is one of the things we are doing. But we have psychiatric people available to us, who are on our staff either as consultants or as full-time employees, and they think that the procedure that has been in place is adequate. Now, we have to reconcile the two opinions. Professionals will differ. I happen to side more on the side of those who think that we ought to take a very hard look at that system and see if we cannot make some changes that would get broader acceptance and produce a better quality of decision, and that is what we are doing. But I would not prejudge and say automatically, "Oh, yes, we are going to do that, and it is going to be done by 2 weeks from today." I cannot say that. But I can say that we have a very real interest in doing that, that we have got the mechanism in place to do the review of our policies.

I get the impression sometimes, that some Members of Congress, and some people in the groups, think that we are standing still, that we do not want to do something. We do want to do something. We want to do something that is rational. And we are trying the best with the tools that we have to do that. And one of the things that would help us a lot in the very process you are talking about would be to get passage of the change in that preeffectuation review mechanism that we have to put in place, where we are looking at two-thirds only of allowances, not disallowances. It is something that skews the system against the claimant, and it puts pressure on the State agencies to disallow more cases because they know they will not be penalized, whereas, allowances that are errors in the eyes of the auditors, are returned for additional evidance or corrections and these returns are perceived as demerits.

Chairman HEINZ. Could I return to something that you said in your remarks about the payment of benefits, that the administration favors the payment of benefits through reconsideration. That certainly is an improvement over preexisting law—I say "preexisting law" because under current law, people terminated prior to October 1 of this year will receive benefits through the administrative law judge process, at least up until the middle of 1984.

Mr. SIMMONS. That is right.

Chairman HEINZ. There would appear, at least with respect to the mentally disabled, to be a problem with only paying benefits through reconsideration. The problem is that at reconsideration, you are basically going to the same kind of people—the disability examiner.

Mr. SIMMONS. No. At reconsideration, you will now be going face-to-face with a much more trained Federal hearing officer.

Chairman HEINZ. Trained in psychiatry or clinical psychology?

Mr. SIMMONS. No more than an ALJ is. You are counting on the system to produce the evidence that, in the medical judgment of those who make the judgment, this person should be continued or disallowed. That is the way the system works now, and the ALJ's have no special expertise in psychiatry any more than any claims examiner does. When the ALJ has a question on a case, he can turn to the doctors who are available to the Federal agency and ask for their advice and their input. So medical services are available at every step of the process and will be at every step in this other process.

What we are hoping is that by putting the face-to-face reconsideration process into effect, you will get a better quality of evidence pushed into the case file at an earlier point. One of the problems we have now is——

Chairman HEINZ. There is no doubt it is an improvement over the existing system. That is not what I am really trying to bring to your attention. I am trying to bring to your attention—and there is more than one way of solving the problem, but let us try and focus on the problem. The problem is that, as you state, these people may be somewhat more expert, but they are still, with respect to the mentally impaired, rather amateur, no matter how good they are.

Mr. SIMMONS. Well, they are amateur with respect to somebody with appendicitis, too, but you just cannot have a system where the doctors sit there.

Chairman HEINZ. I understand that you have a point you want to make. You have made it twice. Let me make the case—I am not trying to get you to agree with me; I just want you to hear what I have to say—a hearing in reverse, all right? You can listen for a moment.

The point is that these people are not clinically trained and that there is a difference between the way they approach the issue, at least currently, versus the way an administrative law judge approaches the issue. The administrative law judge will go out and get a very careful evaluation from a trained psychologist or psychiatrist, of the medical condition of the person. But in the reconsideration process, that is by no means guaranteed. It is an allowable activity, as I understand it, but it usually does not take place.

Mr. SIMMONS. It is not guaranteed for the ALJ to do it, either.

Chairman HEINZ. It is not guaranteed by the ALJ. But what I am saying is, when the ALJ is in doubt, the ALJ on the record will quite frequently take advantage of that resource. On the record, the examiner at reconsideration does not, to any substantial degree, take advantage of that resource, as I understand the record. If my understanding of the record is wrong, please correct me.

Mr. SIMMONS. No. Your understanding of the record is what happens now—and one of the problems that we have in the reconsideration——

Chairman HEINZ. Yes, that is what I mean, what happens now.

Mr. SIMMONS. Yes, what happens right now is that the reconsideration person—who is not seeing the person; all he is seeing is the file—is usually at a higher level in the agency and more experienced, has been doing this longer, and that is how you get to make the more critical judgment that that person makes——

Chairman HEINZ. Now, when we have the face-to-face reconsideration, how is that going to be substantially different?

Mr. SIMMONS. Because in that case, two things happen—the same thing that now happens at the ALJ level. Two things will happen. One is you see the person face-to-face. The person can be represented if the person wants to be.

Chairman HEINZ. Right, that is why it is called "face-to-face" reconsideration.

Mr. SIMMONS. Yes—well, that is a big factor, though, in the ALJ reversals, because there are some people that you can see, and you say, "My God, that person is disabled and should not be here." You cannot always do that from a file, when a file is not complete, when a person is not cooperating, when the physician just sends you a letter and says, "This person is disabled," and does not say why——

Chairman HEINZ. Yes, I am not minimizing that. We know that that is different.

Mr. SIMMONS. Yes, so this makes a large difference. And the second thing that is going to happen is that the very fact of having this hearing officer there, and this mechanism that we are setting up in place, we are hoping—and we are seeing it in the early pilot results that Mr. Hays could describe for you—we are hoping to build a much better record on the way to that hearing.

The way it happens now, most people who file for a reconsideration are just doing it pro forma in order to get over that hump to go to the ALJ. We even have people in the legal fraternity who are out there, advertising:

> Don't worry about recon. You will probably be turned down again. But then, come to us, and for a fee, we will take you to the ALJ, and it is a short and sweet environment, and you can see him face-to-face.

All of the good things that are going to happen in the face-to-face recon, they are pushing as a reason not to go to recon now. And they are right, in that sense. I think the States do a very good job, but I think they are limited by the notion among the legal community out there and among claimants in general—and people are pretty savvy about this system after awhile—that the recon is not going to be as good a shot for you as going to an administrative law judge. Well, the recon should be your best shot. That should be where you go all out to develop all of the evidence possible, and it is our responsibility and the claimant's responsibility to develop that evidence. And we are hoping they will do it.

Chairman HEINZ. I do not think anybody would quarrel with that as an objective, if we can actually achieve it.

Mr. SIMMONS. Well, that is what we are seeing. In the very early results, as I said, we are seeing a much higher continuance rate, almost double in one of the offices. Now, if that holds true, if that is what is going to happen, then half the problems you are talking about here today are going to go away.

Chairman HEINZ. I have a few additional questions I would like to submit to you for response for the record.[1] I guess my last question starts with an observation I would make concerning one of my constituents who came down yesterday, from Hedwig House, Mr. Reish. He came down to testify in public about what he characterized as the injustice of the treatment he had received through this disability review process. He has currently been denied benefits. He is clearly having trouble coping with a lot of pressures. He has seen many of his fellow mentally disabled people at Hedwig House go through this process, and in his statement, he was rather eloquent and moving, because he really closed with a question. He interrupted the hearing just as I was about to dismiss the panel, and he said, "Senator, I want to ask you a question. Is all of this going to do any good?"

And I guess my final question to you would be this. Is this going to do any good?

Mr. SIMMONS. I hope so, because as I said, we are genuinely interested in fixing any part of the system that is not in the best in-

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[1] See page 152.

terest of the claimant and the taxpayer. We are trying to humanize the system, and I cannot overemphasize how inhumane it had grown to be over the years, when it was not a big program and it was paper-oriented. I think we have to inject more elements of humanity into the system. It still has to be a very rigorous system because there are other mechanisms for people who are not in the condition that the law says a person on disability must be. If Congress wanted to change the definition of disability and make it less strict than it is, that is a congressional prerogative, obviously. But we do have a program that, by its definition, is very strict, and yet it has got to be administered humanely. And any system that does not allow a person to see a decisionmaker, and any system that does not allow a person the best shot at getting all their evidence in and getting the best medical opinion possible is just not a good system, and we are doing our best to make it one.

Chairman HEINZ. In my judgment, the hearing record of yesterday and today, including your part of the hearing, makes to me a very strong case with respect to the mentally impaired beneficiaries, for a moratorium on discontinuances for the mentally impaired—a temporary moratorium—until such time as you are able to revise the systems—the listings, the process of dealing with the mentally impaired. This is so because many people, including yourself, have characterized the system as having some serious problems, some serious flaws. There are some obviously nightmare results.

My question to you is: Why wouldn't a reasonable man conclude that with respect to those with mental impairments that do not permit them to be able to work, should we not, until you are able to get a better system in place, have a moratorium on the mental impairment cases?

Mr. SIMMONS. Well, I do not think that we need a moratorium per se on the cases. I think we need to do a lot better job. I think we are doing a better job than we were even 6 months ago. The larger question, of course, is that of equity for the other kinds of cases, and would you have to put a moratorium on other impairments that are in the program. How would you handle people today, coming into the system, while you are in the midst of changing rules, et cetera, and waiting for a wholesale turnover? And that is the grandfather approach to the thing, and that is something that Congress would have to decide within its own budget ceilings, et cetera, and would have to work out, if you want to do that. But I think you are raising a very large question of public policy.

I think there are problems. I have acknowledged them. Everybody can point to them. I think some of the problems are not as serious as some think, and I think others are being remedied right now. I think things are happening out there.

Chairman HEINZ. Is it possible that some of them are larger than you think?

Mr. SIMMONS. It could very well be; it could very well be. I suspect if you look into any program, any Government medical program—CHAMPUS, for example, which uses the APA peer review system—you may find problems. We are going to be using that very shortly on a pilot basis to see if it will help us (*a*) get some more psychiatric input, and (*b*) to validate or invalidate what we are doing. And this system, we think, will do it. But in any big Government program, any private disability insurance program, you may find problems. There are bigger public policy problems around any and all of these programs. We cannot solve them all, but we can do our best to make sure that our program is doing its job and doing it humanely and fairly, and treating the people well and treating the taxpayer responsibly.

Chairman HEINZ. Well, I commend you on looking for ways of solving this problem. You are consulting with the American Psychiatric Association and other interested expert groups. You are trying out new programs and procedures. You are testing a variety of approaches. All that is to the good. But the other side of that coin is that your efforts signify that there is a serious problem. That means that the present system is not working properly. In my judgment, it means that we would be acting irresponsibly in the Congress if we did not address those problems properly and promptly. In my judgment, that should be through some kind of temporary moratorium until you get the results of those tests, those experiments, and that expert opinion. I am distressed with the performance of the system. I have seen too many cases in my own State where the system is driving people literally to the brink of death, and since we never know exactly why someone takes their own life, I cannot exactly say that it drives them over the brink, but there are some strong suggestions that it has. And clearly, I do not think we should just sit back and wait for the improvements to be made.

Mr. Simmons, you have been very forthcoming in your testimony. We appreciate having you here.

Thank you very much.

Mr. SIMMONS. Thank you.

[Subsequent to the hearing, Senator John Heinz and Senator Bill Bradley submitted questions in writing to Mr. Simmons. Those questions and Mr. Simmons' responses follow:]

QUESTIONS FROM SENATOR JOHN HEINZ

Question 1. Mr. Simmons, you have stated before several congressional committees, most recently before the House Social Security Subcommittee last December, that the Federal/State partnership in deciding disability claims is a very fruitful one.

The committee has obtained a series of "quality assurance reports" from the Disability Determination Section of the State of Utah. These reports discuss the so-called "1774 returns," which are the forms the quality assurance units in SSA—the so-called DAB's—use to return cases to the States.

A Utah report for the quarter ending September 1981 reads: "Analysis of the 1774's according to the decision yields the obvious conclusion that the reviewers want denials, not allowances. Although the State agency allowed only 38 percent of the claims adjudicated, 82 percent of the 1774's were on these favorable decisions. This may be fiscally expedient, but it appears statistically invalid."

Here is an excerpt from a March 1981 Utah report: "A reasonable conclusion from the above would be, if an impairment does not meet or equal the listing, set the RFC (residual functional capacity) to result in a denial. Perhaps our medical consultants need to realize that when they enter Disability Determination Services they leave the world of private practice with its compassion and patient interest and enter the world of Federal regulations with fiscal responsibility and budgetary restraints."

The report from the quarter ending September 1980 reads: "Denver DAB continues to emphasize the psychiatric area by having 46 percent of their total returns in the mental category. This is the fourth straight quarter where DAB has returned such a disproportionate number of cases in this category as to skew the entire sample."

The report for the quarter ending June 1980 echoes the other reports "* * * We wish to point out again, for the third quarter in a row, the disproportionate number of cases in the mental category being returned by Denver DAB. There seems to be no justifiable reason for this category to have one-third of the total 1774's or for DAB to return 12 times the number of cases as Baltimore Office of Assessment."

Mr. Simmons, these reports clearly indicate that, in the view of the State agency officials in Utah, the mental impairment area was being singled out by the reviewing officials—and that the bias was toward denials, not allowances. We have evidence from disability examiners in other States—including my own State of Pennsylvania—of the same pattern. Examiners have told us that because of so many case returns, they have become—and I quote—"gunshy" about awarding benefits to mentally disabled individuals.

How did this come about? Why did it come about? And what will you do to reverse this "message"?

Response. The DAB's in the regions are intended to insure consistent application of national policy, adequate development of evidence, and correct decisionmaking in disability decisions made by the State agencies. Because mental illness is often more difficult to document and evaluate than physical illness, it is not unexpected that the DAB's would return a larger proportion of mental impairment cases to the State agencies.

Several factors account for Utah's perception that mental impairments were singled out for review and that there was a bias toward denials.

Before October 1980, the DAB's were reviewing SSI and concurrent SSI-DI cases, while DI cases were reviewed in SSA central office. Since the SSI program has a higher concentration of mental impairment cases, such cases were likely to represent a correspondingly high proportion of the cases the DAB's returned to the State agencies. (Mental impairment cases accounted for about 30 percent of the Denver SSI sample in 1979, but only 10 percent of central office review of Denver region social security disability cases.)

Starting in October 1980, mental impairment cases were targeted under preeffectuation review (PER), which was mandated by Congress in the 1980 amendments, because it was one of six body systems where decisions had been found to be error-prone in the Denver region. Since the number of targeted PER reviews of initial allowances (4,179) in the Denver region exceeded the number of initial allowances (1,003) randomly selected for review in fiscal year 1981, it is not surprising that the State agency received what it perceived as a disproportionate share of allowed mental impairment cases returned for further development or revised determinations.

The majority (over 60 percent) of initial State agency allowed mental impairment cases that were returned under PER in fiscal years 1981 and 1982 were returned because additional medical evidence was needed to establish the severity and duration of the impairment. Extensive documentation is needed in mental impairment cases because:

(1) The mental impairment listings criteria relate in part to the claimant's private daily life and are expressed in relative terms (e.g., "marked restriction") and, therefore, difficult to support with acceptable evidence.

(2) A mental impairment varies in severity over time, and evidence covering an extended period of time is sometimes difficult to secure.

(3) Mentally impaired individuals may be less able than others to provide adequate medical evidence from their own treating sources because the individuals may receive less frequent medical attention than persons with physical impairments.

Nevertheless, we share your concern regarding the adjudication of mental impairment cases and the "message" the State agencies have perceived. To help to counter this, we have stressed to each regional office the need for the State agencies to follow our recently issued guidelines concerning the evaluation of mental impairments. Moreover, the administration has recommended a legislative change in the PER requirements, which would help to eliminate any bias toward denials in general and in mental impairment cases in particular.

Question 2. Mr. Simmons, in mental impairment cases, what percentage are found to meet the medical listings in severity?

How many people with mental impairments are found to equal the severity of the medical listings?

People who don't meet the medical listing can be allowed on a medical vocational basis. What percentage of mental impairment cases have been allowed on the basis of medical vocational allowances? And how do all these percentages compare to what the experience was before 1981?

Response. Based on quality assurance data from a random sample of initial decisions (both allowances and denials), we estimate that in 1982, 26 percent of such decisions in mental impairment cases met the listings, while 1.7 percent equaled the listings and 3.3 percent were medical-vocational allowances. The comparable estimates for 1980 are 28.8, 3.4, and 5 percent. These estimated are not very different from the experience for initial decisions for all body systems.

Question 3. SSA issued a new circular just last week, implementing the decision of the Minnesota court case. How is this different from your previous procedures? What effect will it have on people, i.e., how many more people will be continued in benefits rather than be denied? What are you going to do to retrain quality assurance and disability examiners to make sure they understand the new policy? And how will you make sure it is being followed in practice?

You say, in the circular, for example, that in making a determination as to residual functional capacity, the State agencies should consider "available" medical evidence, including a workshop evaluation. GAO told the committee that SSA has given State agencies the option of using this workshop evaluation all along, but DDS' don't make use of the option. Are you actually going to seek workshop evaluations or merely look at them if they were previously performed, And if they haven't been previously performed, are you still going to use daily activities in the way you have?

Response. The new program circular, which we issued nationally, does not change national procedures. Its purpose is to make sure that disability decisionmakers clearly understand current instructions on evaluating residual functional capacity (RFC) and on considering vocational factors in cases of mental impairments. For example, the circular points out that if the instructions are properly followed, some younger workers who do not have adverse vocational factors but whose RFC shows that their ability to engage in work-related activities is significantly limited will be found disabled under the law. We cannot predict how many beneficiaries will be continued on the disability rolls as a result of issuance of the circular, but we think it will reduce the likelihood of erroneous decisions.

To make sure the policies discussed in the program circular are understood and followed, we will maintain our regular quality assurance reviews and study a special sample of cases from all State agencies in which RFC and vocational evaluation are material to the disability determination. Also, we have asked the State agencies to submit to the regional office for policy review any mental impairment cases they think present problems.

We will continue our present policy of permitting State agencies to use workshop evaluations as they think appropriate until we complete our evaluation to determine the best use of workshop evaluations in assessing RFC. As part of this evaluation, we are working with concerned interest groups to determine the types of mental impairment cases for which workshop evidence is most likely to be pertinent. We also hope to determine the availability of workshops throughout the Nation and to develop standards for workshop testing. We expect to make decisions on this in the next 2 to 3 months.

In evaluating daily activities in mental impairment cases, the State agencies have been instructed to take a long-range view since a person's level of daily functioning can vary considerably over time. Thus, the adjudicator must make special efforts in mental impairment cases to obtain descriptive information from sources that have treated the individual in the past, as well as from current sources, and must resolve any inconsistencies, e.g., between information furnished by the individual during a consultative examination and the findings described in the clinical record.

The instructions also make clear that mere participation in an activity is not a sufficient basis for a decision—quality, independence, frequency, and appropriateness of the activity must be considered. Finally, the instructions emphasize the importance of using information concerning the person's behavior during work attempts in assessing the person's ability to function in a work setting. This information can help an adjudicator assess the person's ability to understand, carry out, and remember instructions, and respond appropriately to supervision, coworkers, and work pressures.

A training package is in preparation and should be available to all users during May 1983.

Question 4. According to SSA's medical staff, does a person whose mental disability fails to meet or equal the listing have the remaining functional capacity to do basic work activity, i.e., the cognitive understanding to do simple work?

Response. Beneficiaries who have a severe impairment that does not meet or equal the listing are assumed to have a significant restriction in their ability to engage in basic work-related activities. At this point in the sequential evaluation process, our regulations, rulings, and program operating manuals all require adjudicators to perform a full residual functional capacity (RFC) and vocational assessment before making a decision that the person is or is not disabled.

Allegations have been made that there have been several instances where our national policy as to RFC had not been carried out because of an apparent misinterpretation as to whether the full evaluation was required. We are very concerned about these allegations because of the serious ramifications for the beneficiaries involved. On January 3, 1983, we issued instructions restating our policy that the full sequential evaluation process must be followed in every case. We also issued several social security rulings in January clarifying further the sequential evaluation process and the evaluation of mental impairments. In March, we issued another reminder to make sure all adjudicators have a clear understanding of the rules for the evaluation of mental impairments.

Question 5. What assurance does SSA have that the States are complying with the criteria for purchasing consultative exams?

Response. To make sure that consultative examinations (CE's) are not obtained in lieu of medical evidence of record, operating instructions require State agencies to try to obtain medical evidence of record prior to purchasing a CE. In addition, we require State agency physicians to review all requests for CE's to be certain they are necessary. To assure that this policy is being followed, we are sending a memorandum to all regional commissioners requiring them to montor State agency performance in this area.

Question 6. In determining the severity of a mental impairment, do you feel a psychiatrist or psychologist is required? How does SSA justify nontechnically qualified individuals making such determinations?

Response. We think it is preferable to have the assistance of a psychiatrist or a psychologist in determining the severity of a mental impairment and have encouraged State agencies to hire and use psychiatrists. All but three States have other staff psychiatrists available. Even these three have other staff physicians who were trained in psychiatry as part of their medical education and are well-versed in the adjudicative criteria for evaluating the severity of mental impairments. They are available for consultation with the lay disability examiners and must approve every disability determination.

We know adequate psychiatric resources in each State agency are very important and have been assisting State agencies to recruit psychiatrists and increase the number of psychiatric review hours. Since March 1982, psychiatric review hours have been increased by 510 hours. The problem of getting more psychiatric review hours, however, is not simply a lack of money; instead, in many States it involves a shortage of qualified psychiatrists. Also, some psychiatrists do not want to participate in the social security program.

SSA is working with the American Psychiatric Association (APA), at both the national and local levels, to gain its help in obtaining more psychiatrists for State agency staffs. The APA has made a mass mailing to its members encouraging them to participate in the social security disability program, and local branches of the APA are assisting State agencies in locating psychiatrists who might be interested in working for the State agency.

In addition, SSA will sponsor an exhibit booth at this year's national APA convention for the purpose of disseminating information about the disability program and recruiting psychiatrists for State agency staffs. The State agencies have also been participating in recruitment activities, and many have placed recruitment advertisements in medical publications.

Question 7. If the States claim their physicians' fees for psychiatrists are not competitive with private practitioners' rates, why doesn't SSA require the States to pay competitive rates?

Response. Under SSA regulations, the State agencies follow the applicable State-approved standards in compensating people, including psychiatrists, employed in the social security disability program. As a result, the States set salaries based on their laws and regulations and in line with their budgetary and funding limitations. Overall, this system has worked successfully and State salaries are generally adequate to insure employment of sufficient competent professional personnel to administer the disability program.

We do not think it would be appropriate for SSA to set salaries for psychiatrists or other State agency employees or to tell the States to increase their salary levels. Most States have to keep down the costs of operating human services programs due to budget constraints. Although State agency costs for administration of the social security disability program are fully federally funded, an increase in salary levels for the disability program would be likely to force an across-the-board increase in salaries for other State programs to maintain parity.

Further, imposing a Federal salary structure would be likely to be regarded by the States as an invasion of their authority for program administration and an infringement on their prerogative to determine the pay of State employees. Some States might consider withdrawing from social security disability program as a result. Moreover, applying a Federal pay scale to State agency salaries would substantially increase the cost of administering the disability program and salaries still might not be adequate in States with higher rates of compensation.

Question 8. Where CE's have to be purchased, can they be used in mental disability cases to augment limited psychiatric resources?

Response. No. A psychiatrist who performs a consultative examination (CE) does not have the training and experience necessary to perform the job of a State agency physician in determining whether a claimant is disabled under social security law. A CE is designed to obtain medical evidence, more detailed medical findings, or technical or specialized medical information, or to resolve conflicts in medical evidence. The role of a State agency physician is quite different; he must consider all the medical evidence in the file and determine whether the evidence shows that the impairment is severe, and, if it is, whether it meets or equals the level of medical severity in the listing of impairments. If the impairment does not meet or equal the listing, he must then determine the claimant's residual functional capacity (remaining physical and mental ability to do work-related activities). To perform this role, the State agency physicians are trained in disability evaluation under the social security program.

Question 9. Do you know the disposition of the claimants whose benefits are denied or terminated?

Response. No. We generally do not track the history of claimants who are determined not to be disabled.

Question 10. What is the basis for determining how many psychiatric review hours are required for each DDS?

Response. To assure that each DDS has at least the minimum needed psychiatric review hours, last fall we set up goals for each DDS. Our medical consultant staff estimated that, on the average, a mental impairment case requires about 30 minutes of psychiatric review time. This review time was multiplied by the approximate number of mental impairment cases expected to be processed during the year in each DDS to determine the minimum number of psychiatric review hours a DDS should have available.

Question 11. Examiners told the GAO that they have time and production goals which often cause them to adjudicate cases before all the medical evidence is acquired. Does SSA establish such goals—directly or indirectly—for the DDS'? If not, why do the DDS' have these goals?

Response. The 1980 disability amendments required us to publish regulations specifying performance standards for both processing time and accuracy that the State agencies are expected to meet in making disability determinations. In May 1981, SSA published the required regulations with respect to initial decision cases (but regulations have not yet been published with regard to continuing disability investigation cases). The processing time standards in the regulations are generally based on average State agency processing times.

While there are no federally established time and production goals for individual State agency personnel, some State agencies set such goals. We think it is appropriate for the States to have the flexibility to set individual time and production goals because of the importance of making prompt decisions on people's claims for benefits, and because the State is responsible to SSA for meeting the performance standards in the regulations. It is important to note, though, that Federal regulations also require the State agencies to meet accuracy standards so that the States cannot sacrifice accuracy in order to meet performance goals.

Question 12. The General Accounting Office made the following specific recommendations to this committee on what the Social Security Administration can do to improve the evaluation of mental disabilities. Please provide the committee with your evaluation of these recommendations; what actions, if any, you plan to take to implement the GAO recommendations; and within what time frame?

Response. SSA generally agrees with the thrust of the GAO recommendations. In a number of areas cited, we have already taken action. We have the following comments on the various parts of the GAO recommendations: [GAO recommendations are in italics.]

Part A—Overly Restrictive Interpretation of SSA's Medical Criteria

A qualified physician should make the assessment of both parts A and B of the medical listings.

We agree; this is already required.

When a claimant does not meet the listings because he or she does not meet part B, the quality of those activities that keep him or her from meeting part B must be determined and documented—in other words, one positive activity should not be the basis for deciding that the person: (1) Does not have a marked restriction of daily activities; (2) does not have a constriction of interest; (3) does not have a serious impairment in relating to others; and (4) does not have a serious deterioration of personal habits.

We agree. to assure that State agencies are adequately assessing these functional limitations, we have clarified our operating instructions and have issued a social security ruling on the evaluation of chronic mental impairments. These instructions are spelled out in detail in the response to question 3. Moreover, we are testing the use of multiple consultative examinations in psychiatric cases to see whether this will give us a better picture of the claimant's condition over time and avoid a snapshot of the claimant that may not be typical.

Because the mental disability criteria have not been revised substantially in many years (1968), we believe SSA should undertake a comprehensive study of the criteria and where study results indicate changes are needed, make them.

We are now considering revisions to the criteria for mental impairments in the listing of impairments. Some examples of the revisions we are considering are: (1) Clarifying that the criteria necessary to find that a mental impairment meets or equals the listing need not be present at the time the case is adjudicated so long as the criteria have persistently been present throughout the history of the claimant's mental illness; (2) expanding the discussion of how to evaluate daily activities by emphasizing that the adjudicator must consider the quality of the person's activities and determine whether the activities depend on the motivation and direction of other people; and (3) updating the psychiatric nomenclature in the listing.

Part B—Residual Functional Capacity and Vocational Characteristics Are Not Appropriately Considered

SSA's new instructions reinforce criteria that we believe are necessary for making accurate mental disability decisions. However, we believe that SSA needs to: (1) Closely monitor the implementation of the new instructions and enforce compliance through the existing quality assurance reviews and reporting systems; (2) prepare, periodically, reports on the extent to which evaluation tools called for—i.e., workshop evaluations, etc.—are actually used in reaching a disability decision.

We agree. SSA has initiated a study to monitor compliance with the recently issued instructions relating the evaluation of mental impairments, the assessment of residual functional capacity (RFC) and the evaluation of vocational factors. As discussed in the reply to question 3, we are doing a study to identify the types of mental conditions for which a workshop evaluation would be most likely to yield evidence useful for disability adjudication.

In addition, we believe that SSA needs to evaluate the vocational characteristics currently used to assess mentally disabled claimant's ability to work, especially the claimant's age. In mental disability cases, age has little direct relationship to a person's ability to realistically function in the "real world of work."

Residual functional capacity (RFC) is a medical assessment made in terms of what a person with a medically determinable physical or mental impairment can or cannot do. When we assess the RFC of a person who has a mental impairment, we consider factors which may affect work activities—such as the ability of the person to understand, to carry out and remember instructions, and to respond appropriately to supervisors, coworkers, and customary work pressures.

Age is considered, along with education and work experience, only at the last step of the sequential evaluation process when we determine whether a person can make a vocational adjustment to work different from that which he did in the past. We take age into account because it is recognized that even for unimpaired individuals increasing age is a negative factor for vocational adjustment.

Part C—Inadequate Development and Use of Existing Medical Evidence

Adequate development of medical information on mental disability cases is not occurring prior to ordering CE's; in fact, CE's are being used in lieu of developing the full medical history on cases.

SSA needs to enforce its existing policies that require: (1) A full longitudinal medical history be developed on each case prior to ordering a CE; and (2) a CE be ordered when needed to clarify medical evidence, obtain necessary data not otherwise available, or resolve conflicts or inconsistencies in the evidence obtained.

In addition, when a CE is ordered, the full medical history information should be given to the CE physician to improve the CE physician's ability to accurately evaluate the claimant's condition. Further, when a CE report conflicts with a recent treating physician's report, the CE report should be sent to the treating physician for comment and resolution of the conflict.

Our current policy is to require that State agencies make full use of existing medical evidence before requesting a CE and that the State agencies provide CE physicians with the medical history of the person to be examined. To enforce this existing policy, we are sending a memorandum to all regional commissioners stating that they must develop a plan to monitor State agency performance in this area. The memorandum will also require the regional commissioners to periodically survey CE physicians to assure that the State agencies are supplying them with medical histories for review prior to the CE examination.

By law, responsibility for resolving conflicting medical evidence rests with the Secretary of HHS, not with the treating physician. This responsibility has been delegated to the State agency review physician. However, the claimant has the right to request to have CE reports sent to his treating physician for review and comment, and to have such comments considered, along with all other evidence in file, in arriving at a decision. Also, pursuant to the Minnesota Mental Health court decision, we are routinely sending CE evidence to the treating source for comment in the Chicago region in cases where the CE evidence conflicts with the treating source evidence. The results of using this procedure in the Chicago region will help us to decide whether we should implement the procedure nationally.

Part D—State Psychiatric Resources Are Severely Limited

Because the mental disability decision process encompasses a medical (psychiatric) evaluation that is highly complex, a qualified psychiatrist or psychologist must be involved. However, neither the DDS nor SSA have adequate psychiatric resources to meet this need.

SSA needs to work with the States to develop a competitive fee structure for hiring psychiatrists and psychologists or hire the needed psychiatric resources directly. In addition, SSA should determine to what extent it can augment limited DDS resources through greater use of treating and CE physicians.

We think it is preferable to have a psychologist or psychiatrist involved in the decision, and we agree that we need to do more work with the States to achieve adequate psychiatric resources in each State agency. Part of the reason for inadequate State agency psychiatric resources is that in some States there are shortages of qualified psychiatrists. The steps we are taking to deal with this problem are discussed in the reply to question 6. Finally, our response to question 8 explains why we cannot use CE physicians to augment State agency staff physicians.

QUESTIONS FROM SENATOR BILL BRADLEY

Question 1. This country has significantly changed its methods for caring for the mentally ill. We no longer warehouse most patients; hundreds of thousands of patients have been released to residential settings and to the community at large. We may be witnessing a collision between the DI program and the deinstitutionalization movement, and we may need to make changes in DI to account for these changes.

Many of the patients who have been released are still incapable of working or of supporting themselves. Some of these people have been denied disability coverage, but most who have appealed had their benefits restored at the ALJ level. Does the problem stem from the interpretation of the law and/or regulations by the reviewers?

Response. Some reversals have occurred because ALJ's were not bound until recently by operating policies applicable to State agency decisionmakers. There are other factors which sometimes result in a reversal at the ALJ hearing level: The subjectivity of the decisionmaking process, the face-to-face contact between the beneficiary and the decisionmaker that first occurs at the hearing level, the possibility of progressive worsening of the beneficiary's medical condition during the course of the appeals process, and the fact that additional evidence may become available at the hearing level for the first time.

SSA has several initiatives well underway that should result in more uniform and accurate decisions at all levels of adjudication. These initiatives reflect our commitment to make reasonable and equitable disability determinations and our special concerns with regard to cases involving mental impairments. They are:

(1) The issuance of social security rulings, which are binding on all levels of adjudication, has been expanded to address policy and adjudicatory areas which are the most troublesome in terms of consistent application.

(2) We have expanded training for new ALJ's, instituted refresher training for current ALJ's, and are providing additional training for ALJ's support staff. We are also in the process of emphasizing the need for continued training of State agency adjudicators.

(3) We are experimenting to determine whether participation of Government employees representing SSA at ALJ hearings (at which claimants are also represented) will improve the quality and timeliness of hearing decisions.

(4) A face-to-face evidentiary hearing at the reconsideration level—to be implemented nationwide later this year—should result in better documentation of the person's impairment.

Question 2. Are changes needed in the DI law or regulations to account for the changes in treatment of the mentally ill? Are the "medical listings" still appropriate, given the changes in recent years in treating the mentally ill?

Response. We do not think changes in the definition of disability in the law are necessary. However, we are considering some changes in the listing of impairments that relate to mental impairments, and are discussing some of these possibilities with the American Psychiatric Association and other interested groups. The kinds of changes in the medical listings that we are considering include: (1) Clarifying that the criteria necessary to find that a mental impairment meets or equals the listing need not be present at the time the case is adjudicated so long as the criteria have persistently been present throughout the history of the claimant's mental illness; (2) expanding the discussion of how to evaluate daily activities by emphasizing that the adjudicator must consider the quality of the person's activities and determine whether the activities depend on the motivation and direction of other people; and (3) updating the psychiatric nomenclature in the listing.

Question 3. My understanding is that SSA's new policy requires a retroactive review of all recently terminated DI recipients with mental disabilities who live in the Chicago region. This doesn't help people cut off the rolls in New Jersey. Why did you restrict the reviews to the Chicago region? Why not a nationwide review?

Response. The U.S. District Court for Minnesota in *Minnesota Mental Health Association* v. *Schweiker* found that in the Chicago region the disability decisionmakers applied a presumption that workers age 18 to 49 with a severe mental impairment that did not meet or equal the level of severity in the listing of impairments were not disabled. The court based its decision in part on its findings that Chicago regional instructions did not require that we determine residual functional capacity and consider vocational factors in these cases. This was a mistaken interpretation of national policy which requires a full vocational evaluation in such cases.

A nationwide review of all terminated beneficiaries with mental impairments would require an enormous expenditure of personnel resources which would seriously impair our ability to make prompt and accurate disability decisions in our regular workloads. Further, we do not believe that the specific problem which arose in the Chicago region has occurred nationwide. Nevertheless, to assure that mentally impaired persons are not disadvantaged, SSA instructed all local offices to consider reopening cases of people who believe that their claims for benefits on the basis of mental impairments were improperly handled.

Chairman HEINZ. The hearing is adjourned.

[Whereupon, at 10:55 a.m., the hearing was adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

BACKGROUND INFORMATION ON SOCIAL SECURITY REVIEWS OF THE MENTALLY DISABLED, PREPARED BY THE STAFF OF THE SPECIAL COMMITTEE ON AGING

REGULATORY CRITERIA FOR DETERMINING MENTAL DISABILITY

The medical criteria (listing of impairments) most commonly relied on for determining mental disability is section 12.03, the listing for functional psychotic disorders. Section 12.03 requires that persons suffering from mood disorders, schizophrenias or paranoid states (functional psychotic disorders) evidence both A and B:

A. Manifested persistence of one or more of the following clinical signs: (a) Depression (or elation); or (2) agitation; or (3) psychomotor disturbances; or (4) hallucinations or delusions; or (5) autistic or other regressive behavior; or (6) inappropriateness of affect; or (7) illogical association of ideas.

B. Resulting persistence of marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people.

Section 12.04 of the mental impairments listing is similarly divided into two sections, with the A section listing conditions, symptoms and signs and B, the restrictions in daily functions. The wording of part B is similar for sections 12.03 and 12.04.

In order for a condition to meet the listing of mental impairments—thus qualifying the individual for disability benefits—the claimant must evidence at least one of the clinical signs, such as hallucinations or agitation or delusions, and all three of the restrictions noted in B. If any one of these requirements is missing, the claimant's condition will be found to fall short of meeting or equaling the listing.

If an individual does not meet or equal the listing, that does not mean the individual is not disabled within the meaning of the law. The sequential evaluation process under Federal regulations requires that if the individual's impairment is severe, but not as severe as the listing of impairments, then an assessment must be made of the individual's remaining functional capacity. Based on that remaining functional capacity and a person's age, education and work experience, an individual can be found disabled if he can't perform his past relevant work or any work in the national economy.

For individuals with mental disabilities which do not meet or equal the listing, the assessment of residual functional capacity is often the most important aspect of the sequential evaluation. The residual functional capacity (RFC) is a practical evaluation of what an individual can do in terms of work despite the individual's mental limitations.

GENERAL DESCRIPTION OF THE DISABILITY DETERMINATION PROCESS AND PROCEDURES

A. THE DEFINITION OF DISABILITY

The Social Security Act contains a strict definition of disability that is based on not only the severity of the disabling condition, but also its impact on the individual's ability to work. "Disability" is defined in the act as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted, or is expected to last, at least 12 months, or is expected to result in death. The determination must be made on the basis of medically acceptable clinical and laboratory diagnostic techniques.

The 1972 amendments, which established the SSI program, provided for the use of this same definition. (Some small changes were made for SSI by the 1980 amendments as to what constitutes "substantial gainful activity".) Thus, persons applying for disability benefits must generally meet the same definition of disability under both the social security DI program and the SSI program.

The definition of disability, in title II of the Social Security Act, reads as follows:

Sec. 223 * * *

(d)(1) The term "disability" means—

"(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

"(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of 'blindness' as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity, requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time."

(2) For purposes of paragraph (1)(A)—

"(A) an individual (except a widow, surviving divorced wife, or widower for purposes of section 202 (e) or (f) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of sustantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

"(B) a widow, surviving divorced wife, or widower shall not be determined to be under a disability (for purposes of section 202 (e) or (f), unless his or her physical or mental impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity."

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled.

(5) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

The State agencies, administrative law judges, and others involved in disability decisionmaking are directed how to apply the definition of disability by detailed Federal regulations, rulings, and administrative policy guidelines.

B. THE DISABILITY DECISION: A FIVE-STEP SEQUENTIAL EVALUATION

The Secretary of Health and Human Services has promulgated regulations governing determination of eligibility for social security disability insurance (DI) and for supplemental security insurance (SSI) disability payments. The standards for disability determinations under both programs are substantially identical.

The regulations require that a five-part sequential evaluation process be used to evaluate all disability claims.

Step 1

Is the individual currently working at a substantial gainful activity (SGA)? If the answer is "yes" he is not eligible for payments. If the answer is "no," he goes on to the second step of evaluation.

Step 2

Does the individual have a severe impairment? If the individual does have a severe impairment, he goes on to step 3; if not, he is deemed ineligible.

Step 3

Does the impairment meet or equal the severity level described in the listing of impairments? This determination is made on the basis of the listing of impairments (the listing), a list of conditions, signs and symptoms which are deemed by HHS to be so severe that their presence alone, without further evidence of inability to work, justifies a finding that the individual is entitled to disability benefits.

NOTE: None of these first three steps of the sequential evaluation process involves an assessment of residual functional capacity (RFC) or consideration of the vocational factors of age, education, and work experience.

Step 4

The fourth step involves two sub steps: A determination of the claimant's residual functional capacity (RFC) and a determination of whether the claimant has sufficient RFC to return to the physical or mental demands of his past relevant work. The determination of RFC requires a practical examination of what the individual can do despite the limitations resulting from his impairment. For individuals whose disability is based on a mental impairment, the evaluation of RFC must include consideration of "ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers and work pressures in a work setting." For claimants whose impairments do not meet or equal the severity level of the listing, the assessment of RFC is often the most important aspect of the sequential evaluation process.

Step 5

If the individual cannot do his past work, five factors are assessed in step five: The individual's RFC, age, education, and work experience, and the demands of other jobs in the national economy. If the individual cannot do other work which exists in substantial numbers in the economy, a finding of disability is made.

STAGES OF DISABILITY DECISIONMAKING

FEDERAL COURT REVIEW

Administered by: Federal court system.
Time allowed to request next stage: Not applicable.
Average time from request to decision: [1] Not available.

APPEALS COUNCIL

Administered by: SSA's Appeals Council.
Time allowed to request next stage: 60 days.
Average time from request to decision: [1] 66 days.[2]

HEARING

Administered by: SSA's administrative law judges.
Time allowed to request next stage: 60 days.
Average time from request to decision: [1] 168 days.

RECONSIDERATION

Administered by: State agency (DDS).
Time allowed to request next stage: 60 days.
Average time from request to decision: [1] 40 days.

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[1] For DI cases including the DI portion of a concurrent case.

[2] Includes DI, OASI, SSI, and black lung cases in fiscal year 1981.

INITIAL CLAIM OR CONTINUING DISABILITY INVESTIGATION (CDI)

Administered by: SSA district office takes applications and explains CDI process face-to-face; State agency (disability determination service—DDS) makes medical determination.

Time allowed to request next stage: 60 days.

Average time from request to decision:[3] 65 days.[4]

CDI REVIEWS: CURRENT ESTIMATED SAVINGS

In fiscal year 1983,[5] the Social Security Administration plans to review the disability status of 466,000 social security disability beneficiaries and achieve savings of $650 million as a result of individuals removed from the rolls. In addition, the administration is planning to review the disability status of 174,000 SSI recipients for estimated savings of $15 million in fiscal year 1983.

Fiscal year 1983 total estimated CDI's are 640,000 with estimated savings of $665 million.

In fiscal year 1984, SSA plans to review 453,000 social security disability beneficiaries for trust fund savings of $1 billion. Another 174,000 individuals will be reviewed under SSI, producing savings of $115 million.

Fiscal year 1984 total estimated CDI's are 627,000 with estimated savings of $1.15 billion.

CDI REVIEWS: 1980 ESTIMATED SAVINGS

In comparison, the Social Security Subcommittee of the House Ways and Means Committee published in March 1981, the savings and administrative expenses from CDI's as estimated at the time of the conference report on the 1980 amendments. Following is an excerpt from the subcommittee's report:

"The 1980 law provision calling for a review of the nonpermanently disabled once every 3 years would be effective in fiscal 1982. It was estimated at the time of the conference report to have had no net savings until after 1984. It takes time and an assured budget for the States to beef up their staffs to take on this additional function. The breakdown of all administrative costs and savings for the 1980 amendment provision were as follows:"

[In millions of dollars]

	1982	1983	1984	1985
Periodic review of continuing eligibility for disability benefits, effective Jan. 1982:				
Benefit savings(−)	−$2	−$28	−$70	−$118
Administrative costs (+)	+43	+53	+55	+57
Projected net savings (−) or costs (+)	+41	+25	−15	−61

SOCIAL SECURITY DISABILITY: SOME STATISTICS

As of January 1983, there were 3.9 million disabled workers, spouses and children collecting $1.3 billion in social security disability benefits per month. This breaks down to an average of $440 per month for the 2.6 million disabled workers, $129 per month for 361,000 wives and husbands of disabled workers and $128 per month for 993,000 children of disabled workers.

As of December 1982, there were 2.2 million disabled individuals getting SSI (although 434,000 of these are age 65 and over and could qualify on that basis). The average monthly Federal SSI payment is $204 for a disabled individual.

How many people getting social security or SSI disability have mental impairments?

A precise number is not available. For an estimate, about 11 percent of social security disabled worker awards have been made to individuals whose primary disability is a mental impairment. The corresponding number for SSI is about 18 per-

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[3] For DI cases including the DI portion of a concurrent case.

[4] For initial claims only. CDI processing time not available.

[5] Prepared for the Senate Special Committee on Aging hearing on Social Security Reviews of the Mentally Disabled, Apr. 7 and 8, 1983.

cent (not counting mental retardation, which has made up 13 percent of SSI disability awards).

Applying these percentages to the current beneficiary population yields approximately 700,000 individuals receiving social security or SSI because of mental illness. This estimate does not include the mentally retarded receiving SSI (another 286,000), nor does it include individuals who have severe mental disabilities along with other severe medical problems.

STATISTICS ON CDI TERMINATIONS—JANUARY 1, 1981 THROUGH AUGUST 1982

Total CDI[6] reviews: 665,165 (included diaried cases and accelerated). Terminations, 335,871 (50.6 percent); continuances, 327,294 (49.4 percent).

Reviews of mentally disabled: 182,893. Terminations, 86,438 (47.2 percent); continuances, 96,455 (52.8 percent).

Reviews of mentally disabled as a percent of total CDI's, 27.5 percent; terminations of mentally disabled as a percent of total CDI's, 25.7 percent; continuances of mentally disabled as a percent of total CDI's, 29.4 percent.

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[6] Statistics on initial decisions supplied to the Special Committee on Aging by the U.S. General Accounting Office, January 1983.

SOCIAL SECURITY ADMINISTRATION RESPONSES TO REQUESTS FROM SENATOR JOHN HEINZ FOR BACKGROUND INFORMATION

1. <u>What are SSA's estimates of savings from CDI's using the Trustees' intermediate II-B assumptions for FY's 1982-1988?</u>

The estimates are shown on the attached chart.

ESTIMATED OASDI AND SSI SAVINGS DUE TO PERIODIC REVIEW 1/ OF CONTINUING ELIGIBILITY FOR DISABILITY BENEFITS

(Pluses indicate costs, minuses indicate savings)

	Estimated effect on OASDI and SSI expenditures in fiscal years 1982-88 (in millions)						
	1982	1983	1984	1985	1986	1987	1988
Benefit Payments 2/......	$-250	-575	-985	-1,435	-1,665	-1,785	-1,890
Administrative Costs 3/...	+135	+215	+227	4/	4/	4/	4/
Total 5/...........	$-115	-360	-758	*	*	*	*

1/ Does not include other CDI cases, such as medical diaries.

2/ Based on the 1983 Trustees Report assumptions, alternative II-B.

3/ Based on the President's FY 1984 budget.

4/ Administrative cost estimates for periodic review are not available for FY 1985-88.

5/ Since the benefit payments and administrative costs estimates are based on different economic assumptions, the totals are only approximate.

2. What categories of individuals with severe mental impairments are classified as permanently disabled?

Two categories of disability beneficiaries with mental impairments are considered permanently disabled and are therefore excluded from the 3-year periodic review.

- Those with an IQ of 59 or less or individuals with severe mental retardation or very low intelligence level. These conditions must be established after the individual attains age 16.
- Those with psychiatric impairments which have required institutionalization in a licensed mental hospital for the past 2 years without releases that would indicate improvement.

3. What percentage of new applications for title II and title XVI disability benefits came from individuals with mental impairments in 1981 and 1982? How many of these were awarded benefits, denied benefits, and at what stage of the appeals process were they awarded benefits?

We cannot provide all the data you requested because we generally do not keep records of all claims activity broken out by type of impairment. For title II, about 13.4 percent of workers who applied for disability insurance benefits in 1978 had a primary diagnosis of mental disorder. Of disability awards to workers in 1978, 11.7 percent were to individuals with mental disorders.

For title XVI, 24 percent of blind or disabled adult applicants in 1977 were individuals with mental disorders. For blind or disabled children, the figure was about 47 percent. Of awards to adults who were either blind or disabled in 1977, about 31 percent were to individuals with mental disorders. For children, the figure was 59 percent.

4. What is the current rate of favorable ALJ determinations for both new disability applications and CDI's?

The current rates of favorable ALJ determinations are 59.2 percent for CDI decisions and 47 percent for all other decisions (this includes old-age and survivors claims as well, although they are a small proportion of the total). These figures are based on decisions for January 1983.

5. What are the QA results and error rates on a State-by-State basis for CDI's and new applications in general and mental impairments in particular?

Deficiency rates on initial and CDI decisions for all cases and for mental impairment cases alone are shown on the attached chart. The deficiency rates cited represent the percentage of cases in which the QA reviewer disagreed with the State agency with respect to either the adequacy of documentation or the correctness of the decision. However, experience has shown that after complete development only about 50 percent of those cases result in revised decisions.

Attachment

Fiscal Year 1982 Quality Assurance Review Deficiency Rates for All Initial Determinations and All CDI Determinations

	Initial Determinations		CDI Determinations	
	Mental Cases	All Body Systems	Mental Cases	All Body Systems
United States				
BOSTON				
Connecticut	7.6	6.8	11.3	10.1
Maine	8.7	6.6	5.5	8.0
Massachusetts	3.6	4.8	8.9	7.2
New Hampshire	12.6	5.5	11.2	10.7
Rhode Island	7.3	7.4	10.7	8.0
Vermont	6.4	2.5	4.7	8.5
NEW YORK				
New Jersey	8.3	6.7	11.7	10.5
New York	4.1	4.8	4.3	4.8
Puerto Rico	4.6	5.1	5.0	5.8
PHILADELPHIA				
Delaware	4.2	3.9	3.4	4.0
District of Columbia	9.0	4.9	8.3	6.5
Maryland	10.6	8.9	5.7	10.5
Pennsylvania	8.2	7.4	6.0	7.7
Virginia	8.3	6.6	6.1	8.6
West Virginia	4.5	6.3	3.6	6.6
ATLANTA				
Alabama	11.3	5.6	10.0	8.3
Florida	7.3	4.9	5.7	7.3
Georgia	8.5	5.1	4.6	3.3
Kentucky	1.6	4.5	9.3	7.9
Mississippi	6.9	4.0	6.4	5.8
North Carolina	9.8	5.7	6.7	5.6
South Carolina	3.3	4.2	9.7	6.2
Tennessee	11.2	6.6	7.7	8.3
CHICAGO				
Illinois	15.0	6.1	20.1	11.1
Indiana	9.6	6.0	16.7	10.9
Michigan	10.4	6.3	8.3	7.2
Minnesota	8.3	4.1	9.9	7.1
Ohio	12.3	7.0	18.9	9.7
Wisconsin	12.0	9.0	12.1	7.3
DALLAS				
Arkansas	2.7	3.0	5.9	5.9
Louisiana	4.0	4.7	10.2	8.7
New Mexico	1.3	2.5	5.4	4.6
Oklahoma	5.8	3.4	4.8	6.0
Texas	2.5	4.2	6.2	5.2
KANSAS CITY				
Iowa	5.3	8.7	8.7	7.7
Kansas	4.4	4.5	5.2	5.7
Missouri	2.7	5.2	7.7	6.5
Nebraska	3.7	4.3	3.8	4.5
DENVER				
Colorado	6.6	4.1	6.0	6.3
Montana	4.5	3.0	3.0	6.4
North Dakota	8.4	4.4	5.3	3.8
South Dakota	6.0	4.3	6.1	8.6
Utah	3.6	5.0	7.8	8.1
Wyoming	4.4	3.9	4.7	4.3
SAN FRANCISCO				
Arizona	14.6	7.0	8.8	7.8
California	12.9	7.0	8.9	7.7
Hawaii	8.6	4.4	5.6	4.6
Nevada	9.1	7.3	16.0	10.3
SEATTLE				
Alaska	4.1	8.2	11.3	8.5
Idaho	11.3	7.4	7.8	6.9
Oregon	7.3	6.7	4.6	6.5
Washington	9.9	7.0	11.4	9.8

6. Provide a brief description of the QA system used by SSA and an organization chart showing where the various QA units are situated administratively within SSA.

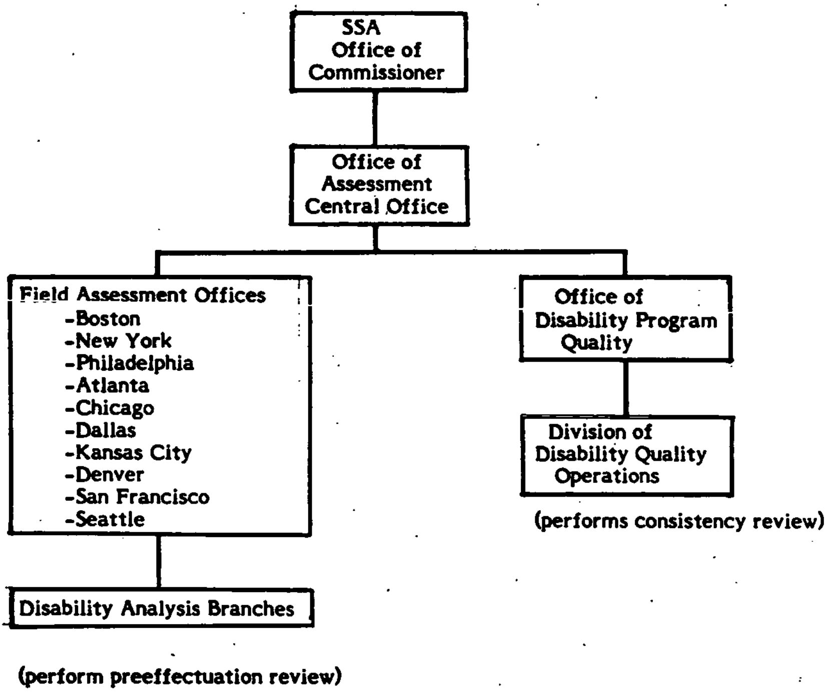
A random sample of initial and CDI disability determinations made by the State agencies is selected for quality assurance review. These reviews are conducted by disability analysis branches (DAB's), which are located in the 10 Field Assessment Offices of the Office of Assessment, prior to the effectuation of the decision. The review process begins with a review by a member of the Regional Medical Consultant Staff and includes participation by a disability examiner. If complex medical/vocational issues are involved, a vocational consultant also participates in the review. If the State agency decision is found to be in error or there is insufficient medical or vocational documentation in the file, the case is returned to the State agencies for corrective action.

In addition to the quality assurance reviews, a consistency review is performed by the Office of Assessment in central office. The purpose of this review is to measure and assure the consistency of quality assurance reviews that are performed in the 10 DAB's.

An organization chart is attached.

Attachment

QUALITY REVIEW--DISABILITY INSURANCE PROGRAM



7. What guidelines are given to DO's regarding curtailing CDI's at the initial face-to-face interviews for individuals with mental impairments?

The CDI may be curtailed in a mental impairment case when the beneficiary exhibits gross aberrations in appearance, thought, mood, and behavior. This is a far more difficult judgment for DO personnel to make than when physical impairments are involved, of course. The DO's are authorized to refer cases to the regional medical staff if there is doubt as to whether a curtailment would be appropriate. In all mental impairment cases, the regional office must approve the curtailment.

8. What rulings have been issued in the area of mental impairments in 1982 and 1983 and which are contemplated with projected release dates?

Six Social Security Rulings relating to mental impairments listed below were issued in 1982 and in 1983 to date. No additional rulings are scheduled at this time relating to mental impairments.

Mental Deficiency--Intelligence Testing (SSR No. 82-54)

Capability to Do Other Work--The Medical-Vocational Rules As a Framework for Evaluating Solely Nonexertional Impairments (83-13)

Capability to Do Other Work--The Medical-Vocational Rules As a Framework for Evaluating a Combination of Exertional and Nonexertional Factors (83-14)

How to Evaluate Long-Term Chronic Mental Impairments (83-15)

Residual Functional Capacity for Mental Impairments (83-16)

How to Evaluate Symptoms in Mental Disorders (83-17)

9. How many Title II and Title XVI disability beneficiaries had mental impairments at the end of 1980, 1981, and 1982?

We have not been keeping records on the number of beneficiaries on the rolls by type of impairment, but such information will be available in the next several years. Beginning in February 1983 all States were required to record the type of impairment for all CDI continuances and new allowances.

10. How many psychiatrists and psychologists are employed by DDS's on a State-by-State basis and how many are employed by SSA in Baltimore?

The attached chart shows the number of full- and part-time psychiatrists employed by each DDS as of the end of December 1982. (The District of Columbia and Arkansas have each added one psychiatrist since that time.) We do not have data on the number of psychologists employed by each DDS.

SSA central office employs two full-time psychiatrists and one full-time psychologist plus 29 contract psychiatrists and one contract psychologist. SSA regional offices employ 36 contract psychiatrists and 8 contract psychologists.

Attachment

Number of DDS Psychiatrists as of December 1982

Boston

Connecticut	5
Maine	1
Massachusetts	15
New Hampshire	3
Rhode Island	3
Vermont	2

New York

New Jersey	7
New York	13
Puerto Rico	9

Philadelphia

Delaware	0
District of Columbia	0
Maryland	2
Pennsylvania	0
Virginia	2
West Virginia	1

Atlanta

Alabama	2
Florida	3
Georgia	5
Kentucky	2
Mississippi	2
North Carolina	1
South Carolina	1
Tennessee	2

Chicago

Illinois	1
Indiana	1
Michigan	4
Minnesota	3
Ohio	12
Wisconsin	1

Dallas

Arkansas	0
Louisiana	3
New Mexico	0
Oklahoma	1
Texas	6

Kansas City

Iowa	1
Kansas	6
Missouri	4
Nebraska	2

Denver

Colorado	3
Montana	1
North Dakota	1
South Dakota	1
Utah	2
Wyoming	1

San Francisco

Arizona	6
California	8
Hawaii	2
Nevada	2

Seattle

Alaska	1
Idaho	1
Oregon	2
Washington	1

11. What changes in the listings regarding mental impairments were made in the 1970's and 1980's?

Several changes in the Listing of Impairments relating to mental impairments were made in 1979.

- Part B of Listing 12.05 (the listing for mental deficiency) gives the IQ rating at which disability from mental deficiency is presumed without consideration of limitations from other impairments. This was changed from an IQ of 49 or less to an IQ of 59 or less.

- Part C of this listing 12.05 gives an IQ range at which disability is established when the person has limitations in additon to those imposed by low intellectual function. Prior to 1979, part C had two criteria: (1) inability to perform routine repetitive tasks; and (2) a physical or other mental impairment resulting in restriction of function. Only one of the two had to be met.

    - The criterion on routine tasks was deleted and the IQ range was changed--from 50-69 to 60-69.

    - There were also changes in the wording of the second statement conerning an impairment in addition to low intellectual function. The word "additional" was added to emphasize that the limitations from the other mental impairment must be separate from the limitations resulting from the lowered IQ. The term "signficant work-related limitations" was added to emphasize that the limitation resulting from an additional physical or mental impairment must be in areas relevant to work activity.

- An identical format change was made in each of the following listings: 12.02, Chronic Brain Syndromes; 12.03, Functional Psychotic Disorders, and 12.04, Functional Nonpsychotic Disorders. This change had no substantive effect.

- In listing 12.02, Functional Nonpsychotic Disorders, a description under subsection G was deleted that related to antisocial and amoral behavior.

On May 6, 1982, a proposed revision of the Listing of Impairments was published in the Federal Register for public comment. It did not include any substantive changes related to mental impairments, although it did cite a revised version of an IQ test.

12. How many CDI's were conducted in 1981 and 1982? What was the rate of cessation/continuance? Of these, how many involved mental impairment cases and how many were ceased/continued at the State agency level?

The following chart shows the information on State agency decisions on CDI's conducted in the last 2 fiscal years.

CDI's	Decisions	Continuance	Cessations
Fiscal Year 1981			
Total CDI's	208,934	110,134 (52.7%)	98,800 (47.3%)
Mental Impairment cases	62,680	34,050 (54.3%)	28,630 (45.7%)
Fiscal Year 1982			
Total CDI's	435,262	239,788 (55.1%)	195,474 (44.9%
Mental Impairment cases	108,800	56,600 (52.0%)	52,200 (48.0%

JOHN HEINZ, PA., CHAIRMAN
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E. BENTLEY LIPSCOMB, MINORITY STAFF DIRECTOR

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 18, 1982

The Honorable Charles A. Bowsher
Comptroller General
U.S. General Accounting Office
441 G Street N.W.
Washington, D.C. 20548

Dear Mr. Bowsher:

As Chairman of the Special Committee on Aging, I am deeply concerned about the process followed by the Social Security Administration and the State agencies in determining whether individuals suffering from mental impairments are eligible for Social Security and Supplemental Security Income benefits.

I am therefore requesting the GAO to thoroughly evaluate SSA's regulations, policies and procedures for determining disability of those who are suffering from mental illness or mental retardation. In particular, I would like the GAO to evaluate any potential conflicts between these procedures and the substance of the law, and I would like the GAO to make specific recommendations that will ensure that the spirit of the law is accurately reflected in the procedures observed by SSA.

You are probably aware that several suicides have occurred in connection with the termination of disability benefits. In reviewing the circumstances surrounding one alleged suicide — the case of Kathleen McGovern — I noted serious deficiencies in the procedures for dealing with claimants with diagnoses of mental illnesses, and, in particular, the possible failure on the part of agency officials to evaluate the seriousness of suicidal tendencies. I pointed out these deficiencies in a letter to Secretary Schweiker, which is attached for your information. In particular, you should note the apparent discrepancies between the findings of the psychiatric consultative examiner and the physician employed by the State agency. According to the also-enclosed letter from Dr. Lebovitz, State agency physicians consistently disregard the reports of treating and consulting psychiatrists.

Various mental health organizations have also stated that many individuals with severe mental impairments are being denied disability because of the following reasons: 1) SSA's medical criteria do not reflect current professional standards and nomenclature; 2) the methods for evaluating the individual's capacity to work fail to reflect good professional practices; and 3) decisions are often based on insufficient medical documentation, often, on one brief consultative examination.

Mental health organizations also state that because the Social Security medical listings are not current, persons who are mentally disabled within the meaning of the law do not meet SSA's medical criteria. Further, those individuals who do not meet the medical listings are not afforded a realistic evaluation of their so-called "residual functional capacity". Therefore, the medical listings become the final arbiter of whether or not one is disabled.

Psychiatric consultants have publicly complained that the brief time allotted to them to evaluate the patient's condition is altogether insufficient to reach a valid conclusion about the individual's mental health, and the American Psychiatric Association (APA) has pointed out that the consultations are too cursory and too brief to be of value. I enclose a copy of the letter Dr. James Folsom sent to Commissioner Svahn, which spells out some of the concerns of the APA.

Because of the large numbers of mentally disabled individuals who receive Social Security and SSI disability benefits, and because large numbers of those diagnosed as mentally ill are being denied benefits or losing previously granted benefits, it is important that the Special Committee on Aging, with your assistance, make a thorough examination of the decisionmaking process and the criteria used to decide disability cases.

Because of the urgency surrounding the high rates of termination of disabled individuals, I am also asking the GAO to expedite this investigation and make a preliminary report to me as soon as possible. The GAO has been of considerable assistance to this Committee in the past, and I thank you, in advance, for your prompt attention to this request.

Sincerely,

John Heinz

JOHN HEINZ
Chairman

JH/fmh

United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, D.C. 20510

August 3, 1982

The Honorable Richard S. Schweiker
Secretary of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

I am writing to you about Kathleen McGovern, a former social security and SSI beneficiary, who received notification that her disability benefits were to be terminated. Kathleen McGovern was found dead in her apartment and the allegation was initially made that she committed suicide as a result of depression caused by the threatened loss of her benefits. Whatever the final findings of the investigation of that issue, serious broader questions remain to be answered.

As Chairman of the Senate Special Committee on Aging, I immediately asked the General Accounting Office to undertake a review of the McGovern case. In addition, the Social Security Administration provided the Committee with the file on Kathleen McGovern. Our review of the case generated the following questions, which we would like answered at the earliest possible date.

Although the questions directly relate to Kathleen McGovern, the answers have a bearing upon the entire program of continuing disability investigations and, in particular, the processes employed in reevaluating the disability status of beneficiaries suffering from mental illness.

The first question is: Why does the file indicate contradictory statements by SSA and State agency personnel regarding the date of onset of Kathleen McGovern's disability? The Summary Fact Sheet states the onset date was established as June 30, 1975, when the claimant "began regular treatment at Einstein Day Hospital". Yet the Office of Disability Operations Medical Consultant's case analysis dated 6/17/82 begins: "This 40-year old woman began receiving title II DIB with an onset date of 6-78." Form SSA 2417 indicates date of onset was June 30, 1975. SSA Form 833 dated 3/17/82 indicates date of onset of 6/78, while SSA Form 833 dated 7/27/81 indicates date of onset of 6/30/75. Both 833s, with contradictory dates of onset, were signed by the same reviewing physician, [redacted].

Question 2: Why was the Senate Special Committee on Aging not supplied all the files on Kathleen McGovern upon request? Although SSA did supply the Title II Social Security file, the SSI file was not received. On the contrary, it was shipped to the Federal Storage Facility in Wilkes Barre, where it arrived on June 25, 1982, one week after the Committee's request. I ask that you recall this SSI file and make it available to the Committee staff.

Question 3: Why was the SSI file not associated with the Title II file at the time this concurrent Title II/SSI disability investigation was undertaken? We have learned that Kathleen McGovern's receipt of SSI benefits was not continuous, and that she filed a new SSI disability application in June 1978. Without the SSI file, we cannot determine whether new medical evidence was supplied upon reapplication.

Question 4: Why were normal procedures not used in processing Kathleen McGovern's disability termination appeal? This was a concurrent Title II/Title XVI case. An informational report of contact in the file, dated 3/16/82 and signed [redacted], reads:

> "Please note: a CDI reconsideration may only be filed on a Title II claim — concurrent and Title XVI only claims must file for a hearing."

The reconsideration filed September 8, 1981, and filled out by SSA personnel, as well as the reconsideration decision dated February 5, 1982, should not have been rendered. The case should have been immediately elevated to the Administrative Law Judge level.

Compounding this original error, a [redacted] from Philadelphia Downtown Social Security Office sent a memo to the DDS which reads:

> "We need to have a CDI decision made for the SSI benefits she (Kathleen McGovern) also receives.
>
> Since she receives SSA/SSI you should have made 2 decisions. SSA benefits stopped in 9/81. Also notify claimant was due process (sic)."

On the basis of this erroneous handling of the case, and the recommendations by SSA personnel, a second SSA-833 was completed and signed by two disability examiners and two reviewing physicians, and a notice of planned action (and reconsideration denial of benefits) was sent to Kathleen McGovern in March 1982.

It appears, therefore, that in the 7 months between the initial termination letter dated August 18, 1981, and the hearing application filed March 22, 1982, Kathleen McGovern went through a lengthy, stressful, and unnecessary reconsideration decision process.

SSA should have been aware that the CDI process itself generated considerable stress for Kathleen McGovern. Her signed statement dated July 14, 1981, indicated: "I suffered a nervous breakdown several years ago and after receiving this letter (notice of CDI investigation) my nerves are really bad, I don't want to go back to Bayberry State Hospital."

The summary medical report from Albert Einstein Medical Center, Daroff Division, for the hospitalization during 8/24/81 through 9/11/81, further documents the stress related to the CDI:

> "Mrs. McGovern was admitted 9/24/81 complaining of depression and suicidal thoughts. The depression was precipitated by the fact that on August 21 the patient found out that her social security check was being stopped. It made her extremely depressed and disoriented. She suddenly felt that she had nothing to live for and all her plans had collapsed. Consequently she was thinking of taking an overdose, however, she was able to realize that she needed help and went to the emergency room and subsequently was admitted to the unit."

Question 5: Why was there no documented effort by SSA or State agency personnel to evaluate Kathleen McGovern's suicidal tendencies? In addition to the suicidal expressions noted above, the report by the consultative physician, [redacted], dated 12/17/81, states at the very outset: "Patient to be admitted for suicidal ideation." This failure by SSA and State agency personnel to respond to serious suicide threats leads me to believe that either no — or very inadequate — procedural guidelines exist for such cases.

Question 6: Why were Kathleen McGovern's contradictory statements not evaluated and resolved? In an untitled questionnaire with the claims representative Holland's name at the top, dated 4/15/81, Kathleen McGovern responded that she attends "ball games, movies, and plays cards". An earlier response on the same form says she spends her days "cleaning, cooking, visiting friends and relatives, watching TV". All of these social activities conflict with her statement of 9/8/81 on the Report of Continuing Disability Interview. Under "Daily Activities", the box "engaging in social activities" was indicated as an area in which she had difficulty or needed assistance. Her explanation: "I do not socialize because I get very nervous in a crowd and I cannot function well." It appears that the response on 4/15/81 copied the precise words used in the question. Further, the consultative report of 12/17/81 clearly indicated that she was not doing the things indicated on 4/15/81. Yet there is no documented effort to resolve these contradictions.

Question 7: Why are there contradictions between the findings of the State agency and the consultative report by [redacted] date 12/17/81? For example, Dr. [redacted] describes Kathleen McGovern as "inadequate — Totally dependent on institutions, agencies and boyfriend to make all decisions. No interests. Unmotivated. Cannot shop for self. Cannot prepare meals except very rudimentary items." Yet the reconsideration decision dated 1/7/82, which was allegedly based in part on Dr. [redacted]'s report, states: "Although she depends on others and has structured her living to such, there is no marked restrictive qualities to her day to day living or her ability to interact with others". These two findings are in obvious conflict.

The reconsideration decision found her memory was "good". Yet Dr. [redacted] reported that her memory was "subjectively poor" and had deteriorated. Further, the reconsideration decision states: "She can adequately relate to people in a work setting." How did the examiner and the reviewing physician reach that conclusion, when the CE report describes her as "withdrawn, seclusive, stoic, isolated. Has no friends outside of a single boyfriend who is inadequate himself"? Yet the examiners, who never saw this woman, found she would have no problem relating to people in a work setting.

Question 8: What vocational evidence was used to reach the conclusion in the reconsideration that "Her relevant work history is that of a waitress, a semi-skilled light occupation which would require superfisual (sic) contacts and routine repetitive movements"? The vocational report which disability adjudicator [redacted] sent to Kathleen McGovern on April 13, 1981, and which was returned to SSA (date stamped April 27, 1981) is completely blank.

Yet the reconsideration decision was that she could perform her past relevant work as a waitress. She had not worked since 1972. On her hearing application she indicated that she tried volunteer work "and I was a nervous wreck after 4 days. I couldn't keep working." There was no development by SSA or the State agency of this volunteer work experience.

On her original application for disability benefits, she stated she had only worked 4 to 5 months as a waitress and that, moreover, she did not believe she had social security insured status. She later was the subject of an SSA investigation because of scrambled earnings. Kathleen McGovern indicated she had not worked for the employers listed on the earnings record background. In fact, a claims representative has a memo in file indicating that if her denial of employment is correct, she does not have insured status for disability. In short, there is a major question about the inadequate vocational development of this case.

Question 9: Why was [redacted] the reviewing physician who signed both the initial termination of benefits and the reconsideration decision of 1/13/82? Is it customary for the same physician to review the original decision and the appeal?

In closing, my review of this individual case raises two major concerns about the entire program of accelerated continuing disability investigations.

First, there is a real question as to how adequate SSA's procedures are for dealing with beneficiaries who are mentally ill. I am concerned that such beneficiaries have serious problems responding to the bureaucratic questionnaires sent out by the agency, and I question how well they can present their case while they are simultaneously suffering from symptoms like thought disorder, chronic depression, or social withdrawal. I think it is imperative that SSA take steps to advise SSA and State agency personnel of the need for a special effort on their part to make sure that beneficiaries and applicants who are mentally ill are capable of understanding the CDI process and are capable of complying with all aspects of it. If they require assistance, SSA should provide it.

Second, my review of this case indicates that this continuing disability investigation was characterized by incorrect procedures and an apparent failure to resolve contradictory evidence in the file. I am concerned that the sheer volume of CDIs, and the workload deadlines associated with them, contribute to hasty processing of cases. I would like to see SSA issue guidelines that will result in a more complete development of decisions. In particular, the rationale used by State agency personnel in support of their decision should be more elaborate and more specific in stating how the decision was reached on these matters where conflicting medical and vocational evidence is involved.

I would greatly appreciate that you make the SSI file on Kathleen McGovern available to the Senate Special Committee on Aging at the earliest opportunity. Your prompt response to the specific questions raised in this letter would also be appreciated.

Sincerely,

JOHN HEINZ
Chairman

JH/fmt

DOCTORS LEBOVITZ AND GUEHL
ASSOCIATES, P. C.
WEBSTER HALL APRATMENTS
4415 FIFTH AVENUE
PITTSBURGH, PENNSYLVANIA 15213
TELEPHONE 681-9177

JUN 23 1982

June 22, 1982

Senator John Heinz
2031 Federal Building
Pittsburgh, PA 15222

Dear Senator Heinz:

I am in the private practice of psychiatry. In my work I am seeing injustice brought on by the Social Security Disability program that should not be permitted. Many of my patients, who are barely surviving because of their mental health conditions, are being systematically harassed with terminations and appeals, which are aggravating their illnesses, and causing great suffering.

I have had personal experience where my reports, and those of the psychiatrists consulting for Social Security, have been totally ignored, and disability payments were unjustifiably terminated by bureaucrats whose only interest seems to be to save money. In the majority of the appeal cases that I have been involved in, these decisions to terminate disability were reversed once I presented the evidence to the administrative law judges.

Before me, as I write this letter, I have a review form for the case of a patient for whom I had to give testimony last August to help her receive disability. At the time of the appeal I testified that she was totally and permanently disabled by her mental illness. The review being requested now, after such a short time, is nothing more than harassment, which will end up causing this patient mental anguish, and, for the second time in a year, loss of money for lawyers fees, etc..

I do not take issue with the government's right to dispense or not dispense disability payments under social security. I do take issue with the unfairness of the bureaucratic harassment of a segment of the population that is most vulnerable and impotent, the mentally ill.

If you have concern for your constituents, and wish to pursue this further, I can supply many names, dates, cases, etc..

Sincerely yours,

Allen E. Lebovitz

Allen E. Lebovitz, M.D.

AEL/sbs

American Psychiatric Association
1700 Eighteenth Street, N.W., Washington, D.C. 20009 • Telephone: (202) 797-4900

June 29, 1982

John Svahn
Commissioner
Social Security Administration
Department of Health & Human Services
P.O. Box 1585
Baltimore, MD 21203

Dear Commissioner Svahn:

On behalf of the American Psychiatric Association, a medical specialty society representing over 27,000 psychiatrists nationwide, I am pleased to respond to your call for comments on proposed regulations amending and revising the medical evaluation criteria for both the Social Security Disability Insurance and Supplemental Security Income disability programs, (Federal Old-Age, Survivors, and Disability Insurance; Revised Medical Criteria for the Determination of Disability, 20 CFR Part 404) published in the Thursday May 6, 1982 Federal Register (Vol 47, No 88).

As you are aware, the APA has been deeply concerned about the current conduct of the SSDI program, based in large part on the growing body of evidence attesting to an adverse impact upon mentally ill persons either now under investigation for continuing disability and retention of the SSDI rolls, or first applying for disability benefits. We well recognize that many of the apparent difficulties facing such individuals are based in statute, not regulation. For example, the statutory requirement that a person be deemed ineligible for SSDI if he or she has the residual functioning capacity to perform any work available in the national economy has certain unique perverse repercussions for the mentally ill. The availability of employment which, it would appear, but without regard to such person's disabling psychiatric illness, a mentally ill person may be able to perform, does not, mean for such individuals, that such employment is possible. I am sure that you understand, for example, that often it is impossible for a mentally ill person to negotiate a ten-block but ride to a place of employment by virtue of the illness itself.

Other difficulties are based in practice -- operating procedures which, due to the tremendous volume of casework now thrust upon the separate state claims examiners may not be consistent with SSA regulation. We know, for example, that SSA has urged special attention be taken in notification and evaluation of the mentally ill -- whether applying for SSDI for the first time, or undergoing a CDI. Such "going the extra mile," as SSA staff has described this effort, has simply not occurred, to the ultimate detriment of many of the mentally disabled. We further know that there are insufficient staff psychiatrists at the state level to provide the special technical expertise necessary to assure appropriate interpretation and review of disability case files. Sufficient numbers of properly and clinically trained claims examiners are simply not available to either keep pace with the increased workload of CDI reviews (approximately 31,000 per month this year) or to make the kinds of clinical judgments appropriate based upon a clear medical record. Further, we are concerned that insufficient attention is being paid at that initial review level to thorough evaluation of vocational as well as the medical factors in the disability determination process. The SSA's own five-step disability determination process is not followed completely, again, particularly adversely impacting upon the mentally ill.

In fact, however, some of the difficulties, particularly for the mentally ill, are based on the so-called "Medical Listings," the subject of the proposed rulemaking and upon which we are now pleased to provide our clinical expertise and comment. It should be noted at the outset, that APA rehabilitation experts have recently completed a chapter on "Mental and Behavioral Disorders" which will appear in the new AMA publication, Guides to the Evaluation of Permanent Impairment, and which provides invaluable advice and sets forth principles which may well be appropriate guides upon which claims examiners should rely when interpreting the listings.

Our substantive recommendations are specifically addressed to Sections 12.03 and 12.04 (Functional Psychotic Disorders and Functional Nonpsychotic Disorders). As well, we are concerned about the nomenclature utilized in these sections of the regulations. Each will be discussed in turn.

Section 12.03 - Functional Psychotic Disorders

Current regulations require that patients suffering from mood disorders, schizophrenias or paranoid states evidence both A and B:

A. Manifested persistence of one or more of the following clinical signs:

1. Depression (or elation); or
2. Agitation; or
3. Psychomotor disturbances; or
4. Hallucinations or delusions; or
5. Autistic or other regressive behavior; or
6. Inappropriateness of affect; or

7. Illogical association of ideas;

B. Resulting presistence of marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people.

Our suggested change in "A" would eliminate the current requirement that patients manifest active psychotic symptoms upon examination. Instead, our language recognizes and adopts the accepted professional practice in psychiatry to take into account evaluating the nature and severity of a patient's illness, medically documented persistence of psychotic symptoms and signs, even if those signs are not continuously present, and thus may not be evident at the moment of the examination.

Requiring that acute clinical signs be manifest at the time of the examination fails to assess fairly and adequately mental illnesses characterized by an intermittent pattern of symptoms and signs or mental illnesses where overt symptoms and signs are controlled by medication. Experience has shown that where a patient demonstrates at least two of the "B" criteria (marked restriction of daily activities, constriction of interest or impaired ability to relate to other people) in the presence of documented intermittent clinical signs or signs and symptoms controlled by medication, the illness is disabling. Moreover, these disabling effects are not limited only to those periods where acute symptoms and signs are evident.

Our proposed change in "B" would modify the requirements that an individual demonstrate three major impairments in combination with the clinical signs to be designated per se disabled. Good clinical practice indicates that "marked restriction of daily activities" or "seriously impaired ability to relate to other people" alone might be sufficient to establish presumptive disability, and certainly, coupled with "constriction of interests", either should establish per se disability.

Further, we recommend that any evaluation of the impairments set forth in "B" should consider such issues as frequency, appropriateness, autonomy and comprehension. For example, if, to ascertain potential resriction of daily activities, it were asked whether the patient cooked, it would be important to further learn whether that was once a year, or three times a day, and whether the patient were cooking food or using the stove inappropriately. Only if such issues are considered can a verifiable determination for or against disability be made.

Consistent with these recommendations, we propose that Section 12.03 of these regulations be modified to read as follows:

A. Medically documented persistence, either continuous or intermittent (even if medication may have reduced in some measure the intensity) of any one of the following clinical signs:

1. Depression (or elation); or
2. Agitation; or
3. Psychomotor disturbances; or
4. Hallucinations or delusions; or
5. Autistic or other regressive behavior; or
6. Inappropriateness of affect; or
7. Illogical association of ideas;

B. Resulting persistence documented as to frequency, appropriateness, autonomy and comprehension of at least two of the following impairments:

1. marked restriction of daily activities
2. constriction of interests
3. seriously impaired ability to relate to other people.

Section 12.04 Functional Nonpsychotic Disorders

The current regulations parallel Section 12.03 requiring "manifested persistence of one or more" of a list of 7 clinical signs (Part A) and "resulting persistence of marked restriction of daily activities and constriction of interests and deterioration in personal habits and seriously impaired ability to relate to other people" (Part B).

The changes we propose in Section 12.04 relect similar concerns as articulated above in reference to Section 12.03. As above "A's" medically documented clinical signs, even though not evident at the moment of the examination should, if 3 of the 4 impairments ("B") are also met, constitute a suffcient predicate for a finding of per se disability. Further, the descriptors "demonstrable" "persistent" and "recurrent" are deleted from the list of clinical signs since they are redundant.

Thus, we propose that Section 12.04 of the regulations be modified as follows:

A. Medically documented persistence, either continuous or intermittent, (even if medication may have reduced in some measure the intensity) of any one of the following clinical signs:

1. Structural changes mediated through psychophysiological channels (e.g., duodenal ulcer); or

2. Periods of anxiety, with tension, apprehension, and interference with concentration and memory; or
3. Depressive affect with insomnia, loss of weight, and suicidal preoccupation; or
4. Phobic or obsessive ruminations with inappropriate, bizarre or disruptive behavior; or
5. Compulsive, ritualistic behavior; or
6. Functional disturbance of vision, speech, hearing, or use of a limb with demonstrable structural or trophic changes; or
7. Deeply ingrained, maladaptive patterns of behavior manifested by either:
    a. Seclusiveness or autistic thinking; or
    b. Pathologically inappropriate suspiciousness or hostility;

B. Resultant persistence, documented as to frequency, appropriateness, autonomy and comprehension of at least three of the following impairments:
    a. marked restriction of daily activities;
    b. constriction of interests
    c. deterioration in personal habits
    d. seriously impaired ability to related to other people

Nomenclature

The current regulations use outdated nominclature inconsistent with that employed by practicing professionals. This lack of consistency creates confusion not only for the treating psychiatrist submitting information to the Social Security Administration about his or her patient, but also makes SSA evaluation of such disability unnecessarily difficult. Reports prepared by psychiatrists using current diagnostic categories and descriptive terms will, in effect, have to be first "translated" by SSA claims examiners. Not only is this costly and time-consuming, but it introduces the potential for errors in decision-making due to simple misunderstandings based on differing terminology.

We note, for example, that in Section 12.04, one of the disorders referred to is "neurotic disorders." Such terminology no longer is utilized in psychiatric clinical diagnosis and practice. Hence, its utility is severely limited.

For these reasons, then, we suggest that the descriptions of symptoms, clinical signs and diagnostic categories be made consistent with the Diagnostic and Statistical Manual of Mental Disorders III -- the current manual.

We are cognizant that much of the disability determination process is based on judgment of the levels of the intensity of signs, symptoms and impairments. However, we strongly believe that such judgements should be based on the skillfully developed, medically appropriate clinical evaluations conducted by psychiatrists (and psychological testing where appropriate). We would hope, therefore, that as claims examiners utilize these listings, that the latter reflect accurately the state of the art and that the former are appropriately trained to utilize the care materials provided by attending psychiatrists and other physicians.

The APA hopes that you will act favorably upon our recommended changes in the Medical Listings, but also hopes to work directly with you and your Disability Office in our mutual efforts to assure that statutory, procedural as well as regulatory roadblocks are lifted to assure that those individuals deserving and in need of disability insurance are not frustrated in their legitimate claims.

Sincerely,

James Folsom, M.D.
APA Committee on Rehabilitation

JF/TP:aw

APR 4 1983

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

FM: SSA OFFICE OF OPERATIONAL POLICY AND PROCEDURES

TO: ALL SSARCS

TO: ALL SSAARCPSPGS/ARCSFOS

TO: ALL SSADDS—ALL EXCEPT MINNESOTA, OHIO, INDIANA, ILLINOIS, WISCONSIN AND MICHIGAN

TO: ALL SSAPSCS/SSA ODO/SSADIO/PSCTAS

TO: SSAOA

TO: ALL SSAFAOS/DABS—ALL EXCEPT CHICAGO

TO: ALL SSADPEQS/DPEQSOS

TO: ALL SSADOS/SSABOS/SSATSCS—ALL EXCEPT THOSE IN MINNESOTA, OHIO, INDIANA, ILLINOIS, WISCONSIN AND MICHIGAN

TO: ALL SSAALJ—ALL EXCEPT MINNESOTA, OHIO, INDIANA, ILLINOIS, WISCONSIN AND MICHIGAN

IT 86-83 SJH-53 ODP-83-100 (971)

SUBJECT: PROCESSING OF CASES OF INDIVIDUALS IDENTIFYING THEMSELVES AS POTENTIALLY AFFECTED BY MINNESOTA MENTAL HEALTH COURT ORDERS

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
1	5	

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : 1976 O-207-835

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

THE U.S. DISTRICT COURT FOR MINNESOTA RECENTLY RULED THAT SSA MUST REEXAMINE THE CASES OF YOUNGER WORKERS WITH MENTAL IMPAIRMENTS WHICH WERE DENIED OR CEASED ON A MEDICAL-VOCATIONAL BASIS. OTHER SIMILAR SUITS HAVE BEEN FILED.

BECAUSE OF THE NATIONWIDE INTEREST IN THIS MATTER DO'S MAY RECEIVE INQUIRIES FROM PERSONS NOT COVERED BY THE COURT ORDER BUT WHO HAVE MENTAL IMPAIRMENTS WHO HAVE BEEN DENIED OR CEASED AND FEEL THEIR CASES WERE NOT PROPERLY HANDLED. SHOULD YOU GET AN INQUIRY OF THIS KIND, HANDLE IT UNDER THE RULES OF ADMINISTRATIVE FINALITY. BECAUSE WE CAN REOPEN FOR ANY REASON WITHIN ONE YEAR OF THE NOTICE OF THE INITIAL CESSATION OR DENIAL, IF THE INQUIRY IS WITHIN ONE YEAR OF THE DENIAL OR CESSATION NOTICE ROUTE THE CLAIMS FOLDER TO THE DDS FOR REOPENING CONSIDERATION IF IT IS IN THE DO, OR LOCATE

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
2	5	

U.S. GOVERNMENT PRINTING OFFICE : 1976 O—307-325

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION INFO	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

THE FOLDER AND ASK THAT IT BE ROUTED TO THE DDS IF IT IS IN ANOTHER LOCATION. IF MORE THAN ONE YEAR HAS GONE BY BUT THE PERSON BELIEVES AN ERROR WAS MADE IN THE DETERMINATION, HE/SHE MAY REQUEST REOPENING ON THE BASIS OF ERROR ON THE FACE OF THE RECORD (WITHIN 4 YEARS (TITLE II; 2 YEARS (TITLE XVI)). IN SUCH CASES, LOCATE THE FOLDER AND ROUTE IT (OR ASK THAT IT BE ROUTED) TO THE DDS FOR REOPENING CONSIDERATION.

DDS'S SHOULD HANDLE ANY CASES REFERRED IN THIS MANNER AS REGULAR ADMINISTRATIVE FINALITY CASES. IF THERE IS A BASIS FOR REOPENING, DO SO, AND PROVIDE A REVISED DETERMINATION AND NOTICE WITH HEARING RIGHT ATTACHED. IF THERE IS NO BASIS FOR A REOPENING, DECLINE TO REOPEN AND USE THE FOLLOWING :

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TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

WE HAVE RECEIVED THE ADDITIONAL MEDICAL EVIDENCE (OR YOUR LETTER, ETC.) CONCERNING YOUR APPLICATION UNDER THE DISABILITY PROVISIONS OF THE SOCIAL SECURITY ACT.

WE HAVE AGAIN REVIEWED THE EVIDENCE IN YOUR CASE TO BE SURE THAT A CORRECT DETERMINATION WAS MADE. AFTER CAREFULLY STUDYING THE EVIDENCE, WE STILL FIND THAT THE DETERMINATION IN YOUR CASE IS PROPER AND IN ACCORDANCE WITH THE LAW. THEREFORE, THE DENIAL OF YOUR APPLICATION REMAINS UNCHANGED.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM YOU MAY GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE TAKE THIS LETTER WITH YOU.

NOTE: IF THE TIME FOR REQUESTING A HEARING HAS NOT EXPIRED, ADVISE THE CLAIMANT OF THAT FACT (SEE GN 03102.245).

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
4	5	

STANDARD FORM 14
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U.S. GOVERNMENT PRINTING OFFICE: 1974-535-402

14-306

TELEGRAPHIC MESSAGE

NAME OF AGENCY

PRECEDENCE

ACTION:

INFO:

SECURITY CLASSIFICATION

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE

☐ SINGLE

☐ BOOK

☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME

PHONE NUMBER

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

IF THE DDS DOES REOPEN AND REVISE A CESSATION BUT IT REMAINS A CESSATION, THE NOTICE GIVING THE RIGHT TO HEARING MUST INCLUDE THE RIGHT TO REQUEST BENEFIT RESUMPTION IF THE HEARING IS REQUESTED WITHIN THE FIRST 10 DAYS (SEE POMS DI A00505.022).

IF A PERSON LIVING OUTSIDE THE CHICAGO REGION ALLEGES HE IS A MEMBER OF THE CLASS (I.E., LIVED IN A CHICAGO REGION STATE DURING 3/1/81-1/3/83, WAS AGE 18-49 AND WAS DENIED OR CEASED ON THE BASIS OF A MENTAL IMPAIRMENT (OTHER THAN RETARDATION)) SECURE THE FOLDER, VERIFY THESE FACTS AND, IF TRUE, SEND THE CASE TO THE APPROPRIATE DDS IN CHICAGO REGION "FOR REOPENING CONSIDERATION PER THE MINNESOTA COURT CASE." IF FOR WHATEVER REASON THIS PRESENTS PROBLEMS IN A GIVEN CASE, HAVE YOUR REGIONAL OFFICE COORDINATE WITH THE CHICAGO ARC PROGRAMS FOR RESOLUTION AND ADVICE.

DESTRUCTION DATE: APRIL 4, 1985 FILE CODE: DI-9

ASSOCIATE COMMISSIONER, OOPP

DESTRUCTION DATE:

FILE CODE:

PAGE NO.	NO. OF PGS.
5	5

SECURITY CLASSIFICATION

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

* U.S. GOVERNMENT PRINTING OFFICE : 1980 O - 311-153 (6032)

14-102

TELEGRAPHIC MESSAGE

APR 4 1983

NAME OF AGENCY

PRECEDENCE
ACTION
INFO.

SECURITY CLASSIFICATION

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE
☐ SINGLE
☐ BOOK
☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME

PHONE NUMBER

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:
FM: SSA OFFICE OF OPERATIONAL POLICY AND PROCEDURES
TO: RC CHICAGO
TO: ARC FO CHICAGO
TO: ARCPGS CHICAGO
TO: ALL DDSS CHICAGO REGION
TO: ALL PSCS/DIO/ODO
TO: SSA OCO/OFO
TO: ALL ADS CHICAGO REGION
TO: FAO/DAB CHICAGO REGION
TO: SSA OA
TO: ALL SSADOS/SSABOS/SSACOS CHICAGO REGION
TO: SSA OHA

IT 85-83 SJH-53 ODP-83-099 (970)

SUBJECT: PROCESSING OF CASES OF INDIVIDUALS IDENTIFYING THEMSELVES AS AFFECTED BY THE MINNESOTA MENTAL HEALTH COURT ORDER

A U.S. DISTRICT COURT IN MINNESOTA HAS RULED AGAINST SSA IN A CLASS ACTION SUIT WHICH INVOLVES PERSONS IN THE SIX STATES IN THE CHICAGO REGION.

SECURITY CLASSIFICATION

PAGE NO. 1
NO. OF PGS. 12

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. GOVERNMENT PRINTING OFFICE : 1980 O - 311-153 (8032)

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

MEMBERS OF THE CLASS ARE: ALL PERSONS WHOSE DISABILITY BENEFITS WERE DENIED OR CEASED BETWEEN MARCH 1, 1981 AND JANUARY 3, 1983, WHILE THEY WERE RESIDING IN THE CHICAGO REGION, ON THE BASIS OF A MENTAL IMPAIRMENT (EXCLUDING MENTAL RETARDATION) WHICH WAS SEVERE BUT DID NOT MEET OR EQUAL THE LISTINGS, AND WHO WERE BETWEEN THE AGES OF 18 AND 49 (UNDER 50) AT THE TIME THE DECISION WAS MADE.

NOTE: ALL DISABLED WIDOW/WIDOWER, STATUTORY BLINDNESS CASES, AND SSI CHILDREN UNDER AGE 18 ARE EXCLUDED.

DO'S IN THE CHICAGO REGION HAVE BEEN INSTRUCTED TO TAKE THE NAMES, ADDRESSES, SSN'S ETC. OF PERSONS CONTACTING THEM REGARDING THIS COURT RULING. THIS TELETYPE PROVIDES INSTRUCTIONS ON THE HANDLING OF THE PENDING INQUIRIES AND ANY FUTURE INQUIRIES. (WE ARE REQUIRED TO NOTIFY THE MEDIA AND MENTAL HEALTH GROUPS SO INQUIRIES WILL INCREASE IN NUMBER.)

DISTRICT OFFICES

1. LOCATE AND REQUEST THE CLAIMS FOLDER FOR ALL INQUIRIES

PAGE NO.	NO. OF PGS.	SECURITY CLASSIFICATION
2	12	

STANDARD FORM 14
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14-306

TELEGRAPHIC MESSAGE

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ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

2. CHECK THE FOLDER TO BE SURE THERE IS A DENIAL OR CESSATION BETWEEN THE DATES GIVEN ABOVE, THAT THE PERSON WAS UNDER AGE 50 AT THE TIME THE DECISION WAS MADE AND THAT THE DECISION WAS BASED ON A MENTAL IMPAIRMENT (OTHER THAN RETARDATION.)

   IN THE CASE OF A DENIAL CHECK THE REG-BASIS CODE IN BLOCK 22 OF THE SSA-831. IF IT IS NOT G1, G2, H1, H2, J1, OR J2 IN TITLE II CASES, OR N31 OR N32 IN TITLE XVI CASES, PROCEED AS IN 5. BELOW.

   IN THE CASE OF A CESSATION, CHECK ITEM 11 ON THE SSA-833. IF ITEM 11A IS NOT CHECKED, PROCEED AS IN 5. BELOW.

3. ROUTE ALL CASES MEETING THESE CRITERIA TO THE DDS "FOR REOPENING PER THE MINNESOTA COURT CASE." FOR CESSATION CASES ALSO ANNOTATE ROUTE SLIP "MEDICAL-VOCATIONAL SCREENING REQUIRED."

4. IF YOU ARE NOT SURE WHETHER A MENTAL IMPAIRMENT (OTHER THAN RETARDATION) IS INVOLVED, ROUTE THE CASE TO THE DDS WITH A FURTHER NOTE RE: YOUR LACK OF CERTAINTY ABOUT THE IMPAIRMENT.

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3	12	

☆U.S. Government Printing Office: 1979—655-848

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

5. IF YOU ARE SURE THERE IS NOT A MENTAL IMPAIRMENT INVOLVED, OR THERE IS A MENTAL IMPAIRMENT BUT THE REG BASIS CODE FOR DENIAL WAS OTHER THAN THOSE LISTED ABOVE OR FOR CESSATIONS AN ITEM OTHER THAN ITEM 11A IS CHECKED, OR THE PERSON WAS OVER 50 AT THE TIME OF THE DECISION, OR NO DECISION WAS MADE DURING THE TIME FRAME IN QUESTION--ADVISE THE INQUIRER THAT HIS CASE IS NOT BEING LOOKED AT AGAIN BECAUSE HE IS NOT A MEMBER OF THE CLASS, USING THE FOLLOWING GUIDE LANGUAGE:

THE U.S. DISTRICT COURT FOR THE DISTRICT OF MINNESOTA HAS REQUIRED SSA TO REVIEW DENIED OR TERMINATED DISABILITY CLAIMS FOR CERTAIN INDIVIDUALS. TO HAVE YOUR CLAIM LOOKED AT UNDER THIS COURT ORDER, YOU MUST:

- HAVE HAD DISABILITY BENEFITS DENIED OR CEASED BETWEEN MARCH 1, 1981, AND JANUARY 3, 1983, WHILE YOU WERE A RESIDENT OF ILLINOIS, INDIANA, MICHIGAN, MINNESOTA, OHIO, OR WISCONSIN;

PAGE NO. 4	NO. OF PGS. 12	SECURITY CLASSIFICATION

TELEGRAPHIC MESSAGE

NAME OF AGENCY

PRECEDENCE
ACTION:
INFO:

SECURITY CLASSIFICATION

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE
☐ SINGLE
☐ BOOK
☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME

PHONE NUMBER

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

- o HAVE HAD DISABILITY BENEFITS DENIED OR CEASED ON THE BASIS OF A MENTAL IMPAIRMENT (EXCLUDING MENTAL RETARDATION) WHICH WAS SEVERE, BUT WHICH WAS NOT AT THE LEVEL OF SEVERITY IN SSA'S LISTING OF IMPAIRMENTS; AND
- o HAVE BEEN UNDER THE AGE OF 50 WHEN ANY DDS DECISION WAS MADE ON YOUR CLAIM.

BECAUSE YOUR CASE DOES NOT MEET ALL OF THESE REQUIREMENTS, WE HAVE NOT LOOKED AT YOUR CASE AGAIN.

IF THE CLAIMANT OR HIS ATTORNEY INSISTS ON THE CLAIM BEING REVIEWED AGAIN, FORWARD THE FILE TO THE DDS FOR THEIR REVIEW. ANNOTATE THE TRANSMITTAL THAT THE FOLDER IS BEING FORWARDED BECAUSE THE CLAIMANT OR HIS REPRESENTATIVE INSISTS ON A REVIEW.

AFTER SCREENING THE CESSATION CASES TO DETERMINE WHETHER BASIS FOR CESSATION WAS MEDICAL-VOCATIONAL, THE DDS WILL RETURN TO THE DO FOR FACE-TO-FACE INTERVIEW AND INTERIM PAYMENTS CESSATION CASES OF CLASS MEMBERS.

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SECURITY CLASSIFICATION

STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

U.S. Government Printing Office: 1979—[illegible]

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DISABILITY DETERMINATION SERVICES

1. VERIFY THAT THE CASES YOU RECEIVE FROM THE DO'S AS EXPLAINED ABOVE ARE PROPERLY CLASS CASES. (FOR CESSATIONS THIS INCLUDES DETERMINING WHETHER THE BASIS WAS MEDICAL-VOCATIONAL.) IF NOT, ADVISE THE INQUIRER IN WRITING THAT THE INDIVIDUAL DOES NOT MEET THE CRITERIA, USING THE GUIDE LANGUAGE IN DISTRICT OFFICES #5., ABOVE.

2. FOR CLASS MEMBER CASES, DETERMINE WHETHER THE CASE IS A DENIAL OR CESSATION. RETURN CLASS MEMBER CESSATION CASES TO THE DO FOR FACE-TO-FACE INTERVIEW, COMPLETION OF THE SSA-454, NEW CONSENT STATEMENTS AND PAYMENT OF BENEFITS EFFECTIVE DECEMBER 1982.

3. FOR ALL CLASS MEMBERS, THE DETERMINATION MUST BE REOPENED PER POMS DI 3300ff.

4. TO THOSE WHO WERE DENIED A NOTICE MUST BE SENT AS FOLLOWS:

> IN ACCORDANCE WITH YOUR REQUEST AND THE ORDER OF THE COURT, WE ARE REOPENING THE DETERMINATION IN YOUR CASE. WE WILL CAREFULLY REEXAMINE ALL THE EVIDENCE WE HAVE AND MAY NEED YOUR HELP TO OBTAIN ANY NECESSARY ADDITIONAL EVIDENCE.

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STANDARD FORM 14
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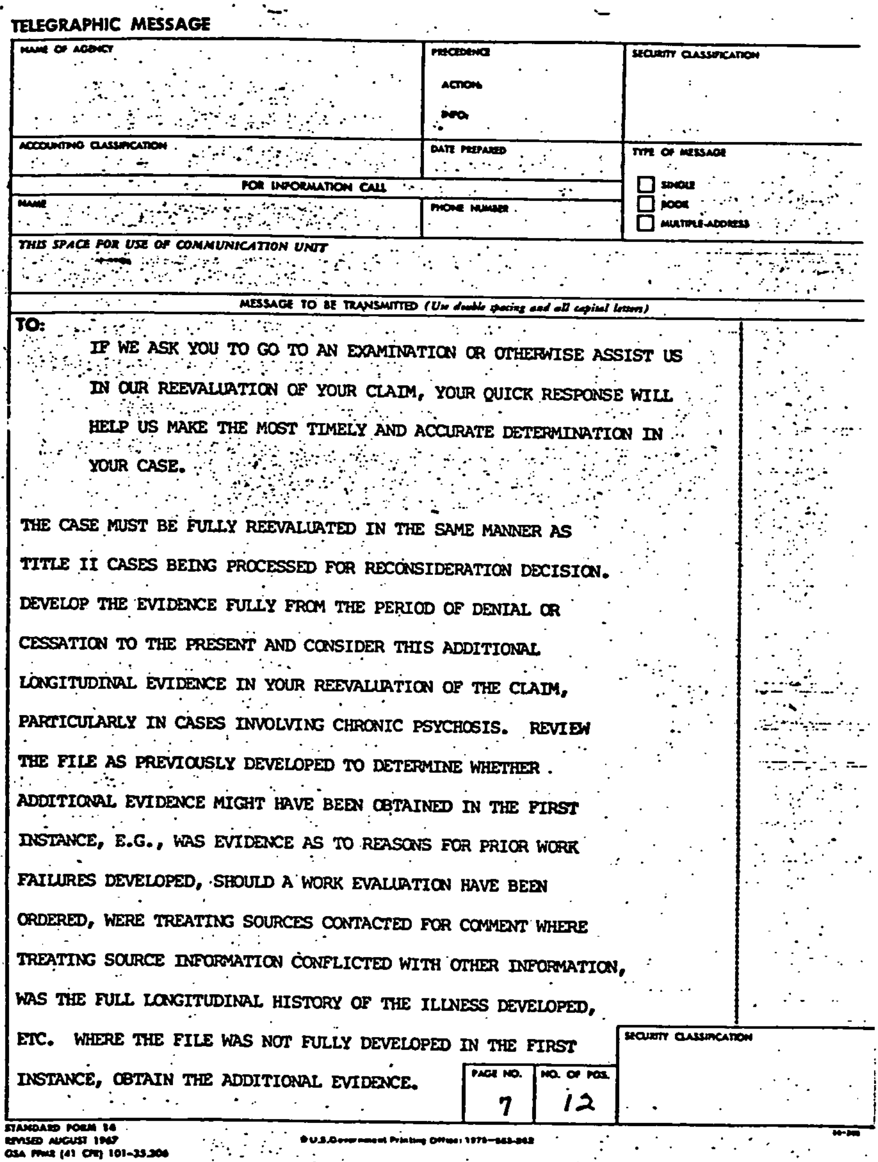
GSA FPMR (41 CFR) 101-35.306

☆U.S. Government Printing Office: 1975—065-343

14-306



TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

IF WE ASK YOU TO GO TO AN EXAMINATION OR OTHERWISE ASSIST US IN OUR REEVALUATION OF YOUR CLAIM, YOUR QUICK RESPONSE WILL HELP US MAKE THE MOST TIMELY AND ACCURATE DETERMINATION IN YOUR CASE.

THE CASE MUST BE FULLY REEVALUATED IN THE SAME MANNER AS TITLE II CASES BEING PROCESSED FOR RECONSIDERATION DECISION. DEVELOP THE EVIDENCE FULLY FROM THE PERIOD OF DENIAL OR CESSATION TO THE PRESENT AND CONSIDER THIS ADDITIONAL LONGITUDINAL EVIDENCE IN YOUR REEVALUATION OF THE CLAIM, PARTICULARLY IN CASES INVOLVING CHRONIC PSYCHOSIS. REVIEW THE FILE AS PREVIOUSLY DEVELOPED TO DETERMINE WHETHER ADDITIONAL EVIDENCE MIGHT HAVE BEEN OBTAINED IN THE FIRST INSTANCE, E.G., WAS EVIDENCE AS TO REASONS FOR PRIOR WORK FAILURES DEVELOPED, SHOULD A WORK EVALUATION HAVE BEEN ORDERED, WERE TREATING SOURCES CONTACTED FOR COMMENT WHERE TREATING SOURCE INFORMATION CONFLICTED WITH OTHER INFORMATION, WAS THE FULL LONGITUDINAL HISTORY OF THE ILLNESS DEVELOPED, ETC. WHERE THE FILE WAS NOT FULLY DEVELOPED IN THE FIRST INSTANCE, OBTAIN THE ADDITIONAL EVIDENCE.

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U.S. Government Printing Office: [illegible]

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

THE SEQUENTIAL EVALUATION PROCESS MUST BE FOLLOWED (INCLUDING AN RFC ASSESSMENT DETERMINATION WHERE REQUIRED), AND A NEW DETERMINATION MUST BE PREPARED (SSA-831/SSA-833), AS WELL AS A NOTICE OF REVISED DETERMINATION FOR THOSE DETERMINATIONS WHICH REMAIN UNFAVORABLE.

THE NOTICE IN CESSATION CASES WHICH REMAIN CESSATIONS SHOULD INCLUDE THE RIGHT TO REQUEST BENEFIT CONTINUANCE PENDING HEARING IF THE PERSON REQUESTS IT IN THE FIRST 10 DAYS. USE THE APPROPRIATE APPEALS AND BENEFIT CONTINUATION LANGUAGE FOR THIS PURPOSE AND SEND THE CASES TO THE APPROPRIATE DO. FOR FAVORABLE DETERMINATIONS, FORWARD THE CASE TO THE APPROPRIATE OFFICE FOR EFFECTUATION.

IF A PRIOR DENIAL OR CESSATION IS AFFIRMED BUT THE PERSON IS NOW DISABLED, REQUEST THE DO TO OBTAIN A NEW APPLICATION.

DDS'S MUST MAINTAIN A LIST BY NAME AND SSN OF ALL CASES PROCESSED UNDER THIS INSTRUCTION BROKEN DOWN AS FOLLOWS:

1) NOT CLASS MEMBER
2) CLASS MEMBER, REOPENED BUT NOT REVISED
3) CLASS MEMBER, REOPENED AND REVISED TO FAVORABLE DECISION

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STANDARD FORM 14
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14-102

☆ U.S. GOVERNMENT PRINTING OFFICE : 1980 O - 311-153 (6030)

TELEGRAPHIC MESSAGE

NAME OF AGENCY

PRECEDENCE
ACTION:
INFO:

SECURITY CLASSIFICATION

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE
☐ SINGLE
☐ BOOK
☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME

PHONE NUMBER

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

DISTRICT OFFICES—WHEN A CESSATION CASE OF A CLASS MEMBER IS RETURNED TO THE DO IMMEDIATELY CONDUCT A FACE-TO-FACE INTERVIEW, SECURE AN SSA-454 AND NEW CONSENT STATEMENTS AND IMPACC/FORCE PAY ONGOING BENEFITS EFFECTIVE DECEMBER 1982 (TO WE ONLY - NO MEDICARE).

USE SPECIAL PROCESSING CODE C12 FOR IMPACC.

SEND ALL PERSONS REINSTATED THE FOLLOWING NOTICE:

DUE TO A RECENT COURT DECISION THE SOCIAL SECURITY ADMINISTRATION IS REQUIRED TO IDENTIFY ALL PEOPLE RESIDING IN THE STATES OF MINNESOTA, MICHIGAN, OHIO, ILLINOIS, INDIANA, AND MICHIGAN:

- WHOSE DISABILITY CLAIMS WERE OF A MEDICAL OR VOCATIONAL NATURE AND BASED ON A MENTAL IMPAIRMENT (OTHER THAN RETARDATION); AND
- WHOSE CLAIMS WERE DENIED OR CEASED BETWEEN MARCH 1, 1981 AND JANUARY 3, 1983; AND
- WHO WERE BETWEEN THE AGES OF 18 AND 49 AT THE TIME ANY DDS DECISION WAS MADE.

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U.S. GOVERNMENT PRINTING OFFICE : 1976 O-207-325

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY	PRECEDENCE ACTION: INFO:	SECURITY CLASSIFICATION
ACCOUNTING CLASSIFICATION	DATE PREPARED	TYPE OF MESSAGE ☐ SINGLE ☐ BOOK ☐ MULTIPLE-ADDRESS
FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

THE COURT HAS REQUIRED US TO REEXAMINE OUR DETERMINATIONS AND DECIDE IF THEY WERE CORRECT.

SINCE YOUR CLAIM MEETS THE ABOVE REQUIREMENTS, WE WILL MAKE PAYMENTS TO YOU WHILE WE COMPLETE OUR REEXAMINATION OF OUR DECISION. WE WILL PAY YOU FOR DECEMBER 1982 ON.

THESE INTERIM PAYMENTS WILL CONTINUE, UNLESS YOU ELECT OTHERWISE, UNTIL AFTER A DECISION IS MADE FOLLOWING THE REOPENING OF YOUR CASE.

IF YOU RECEIVE A FAVORABLE DECISION, YOUR PAYMENTS WILL BE CONVERTED FROM INTERIM PAYMENTS TO REGULAR <u>SOCIAL SECURITY DISABILITY BENEFITS/SUPPLEMENTAL SECURITY BENEFITS</u>. IF WE DISCOVER THAT THE INTERIM PAYMENTS WERE HIGHER THAN YOUR REGULAR BENEFITS THIS AMOUNT WILL BE SUBJECT TO RECOVERY FROM YOUR FUTURE <u>SOCIAL SECURITY/SUPPLEMENTAL SECURITY</u> BENEFIT CHECKS. YOU WILL BE NOTIFIED OF THE AMOUNT OF THE OVERPAYMENT AND GIVEN THE OPPORTUNITY TO APPEAL. IF WE DISCOVER THAT YOUR REGULAR BENEFIT AMOUNT IS HIGHER THAN THE INTERIM PAYMENTS, WE WILL PAY THE DIFFERENCE.

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U.S. GOVERNMENT PRINTING OFFICE : 1976 O-207-325

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TELEGRAPHIC MESSAGE

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FOR INFORMATION CALL		
NAME	PHONE NUMBER	

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

IF YOU RECEIVE AN UNFAVORABLE DECISION, INTERIM PAYMENTS WILL STOP, AND THE INTERIM PAYMENTS YOU HAVE RECEIVED WILL CONSTITUTE AN OVERPAYMENT. YOU WILL BE NOTIFIED OF THE AMOUNT OF THE OVERPAYMENT AND GIVEN THE OPPORTUNITY TO APPEAL.

IF YOU DO NOT BEGIN TO RECEIVE THE SPECIAL INTERIM PAYMENTS WITHIN ____ WEEKS OF THE DATE OF THIS LETTER, YOU SHOULD CONTACT ANY SOCIAL SECURITY OFFICE. YOU SHOULD ALSO CONTACT ANY SOCIAL SECURITY OFFICE IF YOU DO NOT WISH TO RECEIVE THESE SPECIAL INTERIM PAYMENTS WHILE YOU ARE AWAITING A DECISION IN YOUR CASE.

PARAGRAPH MG20 (END OF NOTICE)

MAINTAIN A LIST BY NAME AND SSN OF ANYONE YOU IMPACC/FORCE PAY PURSUANT TO THIS INSTRUCTION.

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U.S. GOVERNMENT PRINTING OFFICE : 1976 O—207-325

14-102

TELEGRAPHIC MESSAGE

NAME OF AGENCY

PRECEDENCE
ACTION
INFO.

SECURITY CLASSIFICATION

ACCOUNTING CLASSIFICATION

DATE PREPARED

TYPE OF MESSAGE
☐ SINGLE
☐ BOOK
☐ MULTIPLE-ADDRESS

FOR INFORMATION CALL

NAME

PHONE NUMBER

THIS SPACE FOR USE OF COMMUNICATION UNIT

MESSAGE TO BE TRANSMITTED *(Use double spacing and all capital letters)*

TO:

IF THE DDS'S REVISED DETERMINATION IN A CESSATION CASE REMAINS ONE OF CESSATION, THE BENEFICIARY WILL RECEIVE A NOTICE INCLUDING THE RIGHT TO REQUEST BENEFIT CONTINUATION PENDING A HEARING, IF THE PERSON REQUESTS IT IN THE FIRST 10 DAYS. FOLLOW CURRENT INSTRUCTIONS FOR PROCESSING THESE REQUESTS.

FURTHER INSTRUCTIONS WILL BE FORTHCOMING SHORTLY. THESE WILL INCLUDE A CHECKSHEET TO AID IN THE CLASS IDENTIFICATION PROCESS. THESE WILL ALSO INCLUDE INSTRUCTIONS FOR HANDLING THE CASES IDENTIFIED BY COMPUTER WHICH WILL BE RECEIVED DURING APRIL AND MAY.

DESTRUCTION DATE: APRIL 4, 1985 FILE CODE: DI-9

ASSOCIATE COMMISSIONER, OOPP

DESTRUCTION DATE:

FILE CODE: CL-10

SECURITY CLASSIFICATION

PAGE NO. 12

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STANDARD FORM 14
REVISED AUGUST 1967
GSA FPMR (41 CFR) 101-35.306

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14-108

Chicago Regional Instruction

SUBJECT: Sharing Consultative Examination Reports With Treating Physicians in Cases of Younger Workers With Mental Impairments

The order of the court in Minnesota Mental Health Association, et al vs. Schweiker requires us to afford the treating physician an opportunity to comment on any psychiatric consultative examination (CE) report obtained by SSA in the case of a younger worker alleging a mental impairment (other than retardation). The instruction is as follows:

> When the decision takes into account information generated by a CE which is contrary to the information provided by any current treating source (someone who has treated the person within 12 months), the treating source should be given a copy of the CE report and requested to write or call in any comment or additional information to the disability determination service (DDS) which he believes will provide a better understanding of the individual's condition. It is important to expedite these actions. Consideration must be given, therefore, to use of telephone contact with the treating physician, where it is clear that this will (suffice) instead of requiring a written response.

As an alternative, the DDS may arrange for the CE physician to simultaneously send his report to the DDS and a copy directly to the treating physician so that the treating source may call/send in reactions to the DDS as quickly as possible. One followup with the treating source for response is required.

The claimant must consent to the sharing of the CE report with the treating physician. To avoid delay, the DDS may want to secure claimant consent at the time the CE is ordered.

Please keep the regional office informed as to how this is going, including any suggestions for improvement in the process. SSA has recommended appeal on this issue; this recommendation is under consideration. In the meantime, we must comply with the court order.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Social Security Administration

Under a recent court order the Social Security Administration will review certain disability claims in Illinois, Indiana, Ohio, Michigan, Minnesota and Wisconsin, where individuals with mental impairments were either denied disability benefits or terminated from the disability rolls.

Certain individuals who were either denied Social Security disability benefits or Supplemental Security Income disability payments or whose disability benefits were terminated on or after March 1, 1981 and before January 4, 1983, who alleged a mental impairment (other than mental retardation) and who were between the ages of 18 and 49 will have their eligibility considered for review.

If you believe you meet these requirements, you should either visit your local Social Security office at ____________________ or phone ________________ to obtain further information.

radio ____________ ____________________ ______________

PUBLIC SERVICE ANNOUNCEMENT

From: (Name) ____________________

(title) ____________________

(Address) ____________________ For use ____________, ____________
day date

(Phone) ____________________ through ____________, ____________
day date

DISABILITY REVIEW

Time : 20 Seconds

Words: 69

ANCR: Here's an important message from the Social Security Administration: Due to a recent court ruling, certain people between the ages of 18 and 49 in (State) who were denied disability benefits based on a mental impairment (other than retardation) or whose benefits were terminated . . . under the Social Security or supplemental security income programs . . . on or after March 1, 1981 and before January 4, 1983, may now have their claims considered for review. For more information call your local Social Security office at (phone number).

radio

PUBLIC SERVICE ANNOUNCEMENT

From: (Name) ____________________

(title) ____________________

(Address) ____________________ For use __________, __________
day date

(Phone) ____________________ through __________, __________
day date

DISABILITY REVIEW

Time : 30 Seconds

Words: 95

ANNCR: Here's an important message from the Social Security Administration: Due to a recent court ruling, certain people between the ages of 18 and 49 who were denied disability benefits or terminated from the disability rolls based on a mental impairment (other than retardation) . . . under the Social Security or supplemental security income programs . . . on or after March 1, 1981 and before January 4, 1983 . . . can now have their claims considered for review.

A Federal judge has ruled that Social Security must review certain disability claims made by the mentally impaired under age 50 in (State) that were either denied or terminated on or after March 1, 1981 and before January 4, 1983.

For more information call your local Social Security office at (phone number).

Radio ______ ______ ______

PUBLIC SERVICE ANNOUNCEMENT

From: (Name) ______

(title) ______

(Address) ______ For use ______ (day), ______ (date)

(Phone) ______ through ______ (day), ______ (date)

DISABILITY REVIEW

Time : 60 Seconds

Words: 134

ANNCR: Here's an important message from the Social Security Administration: Due to a recent court ruling, Social Security will review certain disability claims. People aged 18 through 49 with mental impairments (other than retardation) who were either denied disability benefits or terminated from the disability rolls under the Social Security or supplemental security income programs may now have their claims considered for review.

Under a recent court order . . . the Social Security Administration will review certain disability claims made by the mentally impaired in (State) . . . between the ages of 18 and 49 . . . that were turned down on or after March 1, 1981 and before January 4, 1983. If you believe that this recent ruling may affect you and you meet these requirements call the (locality) Social Security office at (phone number) . . . or visit the office at (address). Someone there will be glad to help you.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Social Security Administration
Refer to
Baltimore MD 21235

Under a recent court order the Social Security Administration will review certain disability claims in Illinois, Indiana, Ohio, Michigan, Minnesota and Wisconsin, where individuals with mental impairments were either denied disability benefits or terminated from the disability rolls.

Certain individuals who were either denied social security disability benefits or supplemental security income disability benefits or whose disability benefits were terminated on or after March 1, 1981, and before January 4, 1983, who alleged a mental impairment (other than mental retardation) and who were between the ages of 18 and 49 may have their eligibility reviewed.

If because of your special concerns for the mentally impaired you know of anyone who meets these requirements, we ask that you advise that person to either visit or telephone the local social security office to obtain further information. If you are representing such a person, you may contact a social security office on behalf of that person.

SSA PROGRAM CIRCULAR

Disability Insurance

No.

Date:

Office of Disability Programs, Office of Operational Policy and Procedures

Evaluating Mental Impairments in Younger Workers

This circular is being issued to assure that all Social Security and Disability Determination Services adjudicators have a clear understanding of the rules for the evaluation of mental impairments in younger worker cases.

1. What the basic rule is.

When a disability claim involving a mental impairment cannot be allowed on medical grounds alone, i.e., when the impairment falls short of the severity described by the listings, yet there is a limitation in the ability to perform basic work-related functions, a finding of ability to engage in substantial gainful activity (SGA) cannot be justified solely on the basis that the impairment does not meet or equal the level of severity depicted by the listings.

The sequential evaluation process must continue in the claim with consideration of vocational factors in light of the claimant's residual functional capacity (RFC). RFC assessments in mental disorders include consideration of such factors as the ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers and customary pressures in a routine work setting (see sections 404.1545 and 416.945 of SSA's regulations and POMS DI 2105). Current procedures call for such assessments to be recorded on the RFC form (POMS DI 3004).

2. What the rule is not.

Any understanding on the part of any adjudicator that SSA's standard is that a younger worker (age 18-49) who suffers from a severe mental impairment which does not meet or equal the listings can automatically be assumed to be able to do at least unskilled work is erroneous; no such rule is in effect. Conclusions as to the extent of a person's RFC are drawn from the medical and other evidence in the file and not from the fact that the impairment fails to meet or equal the listings.

List 244
Retention Date:

Social Security Administration
Office of Operational Policy and Procedures
SSA Pub. No. 64-044

Any such statement in any memorandum, letter, Informational Digest item, POMS section, return comment or oral statement which implies, states or implements such a policy has been and is rescinded.

3. <u>What is to be taken into consideration in reaching a decision as to RFC?</u>

The RFC evaluation must be based on a realistic assessment of the individual's remaining capacity to function in the conditions of the real world of work. The RFC must measure the ability to meet the minimum standards of a normal, competitive work setting on a sustained basis. The conclusion as to RFC would include consideration of available medical and other evidence such as: a workshop evaluation; work adjustment evaluation; past work successes and/or failures; other relevant reliable information that may be available from third parties; and, of course, the medical evidence.

4. <u>What is the role of the treating physician in the evaluation of mental impairments in younger individuals?</u>

Since generally the treating physician is the physician most knowledgeable about the claimant/beneficiary, the information he or she provides must be given appropriate consideration in the adjudicative decision making process. When a consultative examination (CE) has been purchased, undue weight must not be given to such a one-visit report. In mental impairment evaluation longitudinal history is critical and cannot be replaced by one CE. See SSR 83-15 and POMS DI T2213.

5. <u>Are there cases in which a younger worker with a mental impairment has such a limited RFC that he should be allowed even though he does not have adverse vocational factors?</u>

Yes. There are younger workers who do not meet or equal the listings who cannot perform SGA. Vocational factors, by definition, will generally not be adverse for these younger workers. For individuals who do not meet or equal the listings but have a severe mental impairment, the evaluation of RFC may show that the claimant's ability to engage in work-related activities is significantly limited. In such cases an allowance may be appropriate even though vocational factors are not adverse.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Refer to: SGP-2

Memorandu

Date:

From: Chief Administrative Law Judge

Subject: Identification and Processing of Cases Covered by the Order of the United States District Court for the District of Minnesota in the Case of Mental Health Association of Minnesota et al., v. Schweiker

To: See Below

General

On December 22, 1982, the United States District Court for the District of Minnesota issued an order in the above-entitled class action. One of the provisions of the Court order requires that certain individuals residing in the States of Minnesota, Michigan, Ohio, Illinois, Indiana, and Wisconsin be given the opportunity of proceeding with a requested hearing or having their case returned for a revised reconsideration determination.

Although the vast majority of cases will be in these States, there may be some cases covered by the order in other States, particularly border State HO's and HO's with cases of travelling ALJ's. This memorandum is being directed to all affected HO's. All such HO's must screen all pending cases to ascertain whether any case falls into the class. Pending requests for hearing of individuals between the ages of 18 and 49 whose alleged disability was based on a mental impairment (excluding mental retardation as defined in listing 12.05 of Appendix 1) and whose initial applications for benefits were denied on or before March 1, 1981, and prior to January 4, 1983, or whose disabilities were ceased on medical/vocational bases, on or after March 1, 1981, and prior to January 4, 1983, must be identified so that the claimant may be given the option of proceeding with his or her hearing or having the case reviewed again by the DDS. Cases pending in HO's as a result of Appeals Council (AC) or court remand are not covered. Where a claimant exercises the option of having the claim returned to the DDS, the pending request for hearing will be dismissed. After the DDS reviews the case it will issue a revised determination. If the claimant disagrees with the revised determination he or she may file a new hearing request.

This memorandum provides instructions for identifying and processing cases pending at the hearing level covered by the Court order.

Addressees:
Regional Chief Administrative Law Judges
Administrative Law Judges in Charge, Region V
Administrative Law Judges, Region V
Administrative Law Judges on the Attached List

I. Criteria to Determine if Case Covered by Court Order

In order for a case to fall within the class, there are certain specifications which must be met. These are as follows:

A. The case must be title II, title XVI, or concurrent disability initial entitlement or cessation case; and

NOTE: All disabled widow/widower, statutory blindness cases, and SSI children under age 18 are excluded.

B. The claimant resides in one of the following States: Minnesota, Michigan, Ohio, Illinois, Indiana, Wisconsin; and

C. The claimant be between the ages of 18 and 49 at the time any denial or cessation determination was made; and

D. Any SSA-831 or SSA-833 or notice of determination in file must identify a mental impairment other than mental retardation either alone or in combination with other impairments; and

E. The most recent SSA-831 or SSA-833 must show that the claim was denied prior to January 4, 1983, on other than (1) a lack of insured status, (2) engaging in SGA, or (3) a not severe impairment.

II. Instructions to Hearing Offices For Identifying Cases Pending at the Hearing Level Which Are Covered by the Court Order

All HO's having jurisdiction over cases of claimants residing in States specified above must screen all pending requests for hearing to determine whether a case falls under the court order in accordance with the criteria set forth in I above. In screening cases, the most recent SSA-831 or SSA-833, and notice of such determination, and the RFC assessment form (if any) must be reviewed. The following would not fall within the class:

- The case is before the ALJ based on an AC or court remand.
- The SSA-831 or SSA-833 was issued on or after January 4, 1983.
- Neither the SSA-831 or SSA-833 nor the notice of such determination indicates that the claimant had any mental impairment(s).
- The SSA-831 or SSA-833 and the notice of such determination indicates that the claimant had a mental impairment but indicates that the denial or cessation was due to a lack of insured status or was based on engaging in SGA or a not severe impairment.

III. Required Action On Cases Identified by HO's as Falling Within the Class

All individuals whose cases have been identified as falling within the class and are awaiting a hearing or a decision by an ALJ must be given the option of either (1) proceeding with the hearing request, or (2) having the claim reviewed again by the DDS. Therefore, once a claim is identified as falling within the class, a notice (attachment 1) must be sent to the claimant (with a copy for the claim file) so that he or she can exercise this option. Where a claimant is represented, the original of the notice will be sent to the representative with a copy to the claimant in accordance with existing instructions. A copy of the notice should be reproduced locally. A self-addressed franked envelope for return of the option form should be enclosed with the notice. The notice will give the claimant 10 days to reply. Allow an additional 5 days for mailing.

If the claimant indicates that he or she wishes to proceed with the hearing request, the ALJ should include a copy of the claimant's option in the claim file and proceed. If the claimant exercise the option of having the claim reviewed again by the DDS, the request for hearing should be dismissed. The regulatory authority for dismissing the hearing request under these circumstances is contained in 20 CFR 404.957(a) and 20 CFR 416.1457(a). Pursuant to OHA Handbook sections 1-470 and 2-470, use the HA-515-U9, the blank order for dismissal. Include the following language:

> "In accordance with an order of the United States District Court for the District of Minnesota in the case of Mental Health Association of Minnesota et al., v. Schweiker you have chosen the option of having your case reviewed by the Disability Determination Service in your State. Therefore in accordance with 20 CFR 404.957(a) or 20 CFR 416.1457(a) (as appropriate), your request for a hearing is dismissed."

Use the preprinted HA-L5021-U8 (Notice of Dismissal) to transmit the order of dismissal to the claimant. Where the ALJ dismisses the hearing request, the file, including any additional evidence submitted in connection with the hearing requst, should be sent to the appropriate DDS. A transmittal slip should be attached to the file, including the following remark:

> "Minnesota Mental Health Association Case"—At the claimant's request, the request for hearing has been dismissed. Please review the case under the terms of the court order and issue a revised determination advising the claimant of the right to request a hearing if he or she disagrees.

For case control purposes, two actions need to be entered. For the 330 action, hearing dispostion issued, enter WDDI as the dispostion code (DSP) on both the coding sheet (HA-672) and case control card (HA-670). For the 335 action, enter the destination code for the appropriate DDS in the "claims file transferred out" block (CTT) on both the HA-672 and HA-670. The DDS location codes are shown on attachment 2.

IV. Caution

(1) Scheduling and holding hearings should continue while identification of cases and mailing of required notices is undertaken. However, where a case is identified as being in the class subject to the court order, a denial decision or dismissal for cause as appropriate should not be issued until the claimant is given the opportunity to exercise the option. If the claimant chooses the option to have the DDS review the case, then the hearing request should be dismissed and the case returned to the DDS even if a hearing has been held.

(2) If the claimant appears at a scheduled hearing and is part of the class but has not yet exercised the option, he or she should be asked to exercise the option in writing (use the notice attached) before the start of the hearing.

Any questions regarding these procedures should be directed through the OHA Hotline.

Philip T. Brown

Attachments

Attachment

SOCIAL SECURITY
NOTICE

From: Department of Health and Human Services
Social Security Administration

Date:
Claim Number:

As a result of an order issued by the United States District Court for the District of Minnesota in the case of Minnesota Mental Health Association et al., v. Schweiker, we are required to review the cases of certain persons whose claims for disability benefits were denied or whose disability was ceased as a result of a determination by the Disability Determination Service.

Your case is now in a hearing office of the Office of Hearings and Appeals because you have requested a hearing before an Administrative Law Judge. (You may have already had your hearing.) Under the terms of the court order you have the option of either going forward with your hearing request before an Administrative Law Judge of the Office of Hearings and Appeals or having your case returned to the Disability Determination Service, for a new determination.

If you wish to have your case returned to the Disability Determination Service, your request for a hearing will be dismissed. However, the Disability Determination Service will, after its review, send you a notice of its new determination. If you disagree with that determination you may file a new request for hearing.

After you choose the option you prefer, please mail the option form enclosed in the self-addressed envelope which is provided. No postage is required. If we do not hear from you within 10 days, we will assume that you wish to proceed with your hearing request.

If you have any questions about this notice, you may get in touch with any social security office. Most questions can be handled by telephone or mail. If you visit an office, please take this notice with you.

Enclosures

Attachment

OPTION FORM

________________________________ ____________________
Claimant's Name   Claim Number

(SIGN ONLY FOR THE OPTION YOU CHOOSE. DO NOT SIGN FOR BOTH OPTIONS.)

(1) I wish to continue having my hearing request processed by an Administrative Law Judge of the Office of Hearings and Appeals.

________________________________ ____________________
Signature   Date

(2) I wish to have my case reviewed by the Disability Determination Service. I understand that my request for hearing will be dismissed. I also understand I will be notified by the Disability Determination Service of its new determination and of my further appeal rights.

________________________________ ____________________
Signature   Date

Attachment

List of Administrative Law Judges to whom memo sent

Region II

Albany, New York
Buffalo, New York
Camden, New Jersey
Hato Rey, Puerto Rico
Jamaica, New York
New York, New York
Syracuse, New York

Region III

Charleston, West Virginia
Philadelphia Regional Hearing Office
Johnstown, Pennsylvania
Roanoke, Virginia

Region IV

Charleston, South Carolina
Lexington, Kentucky
Nashville, Tennessee
Paducah, Kentucky
Charlotte, North Carolina
Louisville, Kentucky
Tampa, Florida

Region VI

Albuquerque, New Mexico
Dallas (North), Texas
Little Rock, Arkansas
Oklahoma City, Oklahoma
San Antonio, Texas
Dallas (Downtown), Texas
Fort Worth, Texas
McAllister, Oklahoma
Shreveport, Louisiana

Region VII

Brentwood, Missouri
Kansas City Regional Hearing Office
St. Louis, Missouri
West Des Moines, Iowa

Region VIII

Denver, Colorado

Region IX

San Diego, California

Clmnt's State of Residence	DDS Address	DO's/BO's Serviced by DDS	DDS CCS Location Code
Illinois	Bureau of Adjudication Services P.O. Box 3842 Springfield, Illinois 62706	ALL	1140
Indiana	Disability Determination Division P.O. Box 7069 Indianapolis, Indiana 46207	ALL	1150
Michigan	Disability Determination Service Divison of Vocational Rehabilitation Services P.O. Box 30011 Lansing, Michigan 48906	Adrian Ann Arbor Battle Creek Benton Harbor Dearborn Detroit (Livernois St.) Flint Flint, North Grand Rapids Hamtramck Highland Park Holland Jackson Kalamazoo Lansing Monroe Mt. Pleasant (Gartiet County) Muskegon Owosso Wyandotta Elkhart, Ind. T. Wayne, Ind. Michigan City, Ind. Toledo, Ohio Toledo, Ohio, West	1230
Michigan	Disability Determination Service P.O. Box 37730 Oak Park, Michigan 48237	Detroit: Downtown East Grand River Conner Ave. Northwest Southwest Farmington Livonia Mt. Clemens Pontiac Roseville Royal Oaks Warren	1231
Michigan	Disability Determination Service P.O. Box 1200 Traverse City, Michigan 49685	Alpena Bay City Escanaba Ironwood Marquette Mt. Pleasant Patoskey Port Huron Saginaw (Saginaw County) Traverse City	1232
Minnesota	Disability Determinations Unit Metro Square Building P.O. Box 34709 Suite 460, Seventh and Roberts Streets St. Paul, Minnesota 55101	ALL	1240

Ohio

Bureau of Disability Determination
Rehabilitation Services Commission
P.O. Box 29700
4574 Heaton Road
Columbus, OH 43229

1360

Services these DO/BO's in Ohio:

- Akron:
  - (Downtown)
  - (Akron West)
- Ashtabula
- Athens
- Bowling Green
- Cambridge
- Canton
- Chillicothe
- Cleveland:
  - (Downtown)
  - (Cleveland Hgts)
  - (Midtown)
  - (Northeast)
- Cleveland:
  - (Northwest)
  - (Southeast)
  - (Southwest)
  - (University Circle)
  - (West)
- Columbus:
  - (Downtown)
  - (E. Columbus)
  - (W. Columbus)
- Dayton:
  - (Dayton)
- Defiance
- E. Liverpool
- Euclid
- Findlay
- Fremont
- Gallipolis
- Ironton
- Lancaster
- Lima
- Lorain
- Mansfield
- Marietta
- Marion
- Medina
- New Philadelphia
- Newark
- Painsville
- Piqua
- Portsmouth
- Ravenna
- Sandusky
- Springfield
- Steubenville
- Toledo:
  - (Toledo)
  - (West)
- Warren
- Wooster
- Youngstown
- Zanesville

Ohio

Bureau of Disability Determination
9403 Kenwood Road
Cincinnati, OH 45242

1361

Services these DO/BO's in Ohio:

- Batavia
- Cincinnati:
  - (Downtown)
  - (North)
  - (Kemper Lane)
- Dayton:
  - (W. Dayton)
- Hamilton
- Middleton
- Xenia

Wisconsin

Bureau of Social Security
Disability Insurance
P.O. Box 7623
Madison, WI 53707

1521

Glossary of Mental Impairment Diagnoses

Abuse, alcohol
  drug (various drugs)
  substance (various substances)
Adjustment disorder (reaction)
Affective disorders (syndrome)
Aggressive personality
Agoraphobia
Alcohol abuse (dependence) (intoxication)
Alzheimer's disease
Amnesia
Amnestic disorders
Anorexia nervosa
Antisocial behavior
Anxiety disorders (states)
Asocial behavior
Asthenic disorders
Atypical eating disorder
Autism
Bipolar disorders
Borderline personality disorder
Bulimia
Catatonic (catatonia)
Cerebral dysfunction
Chronic brain syndrome
Conduct disorder
Conversion disorder
Cycloid personality
Cyclothymic disorder
Delirium
Delusions
Dementia
Depersonalization disorders
Depression
Derealization
Dissociative disorders
Drug abuse (dependence)
Dysthymic disorders
Ego-dysthymic disorders
Emotional instability
Explosive disorder (personality)
Factitious disorder with psychological symptoms
Frontal lobe syndrome
Ganser's syndrome
Generalized anxiety disorder
Hallucinations
Hebephrenia
Histrionic personality
Hypochondriasis
Hypomanic disorders
Hysteria, hysterical
Introverted personality
Involutional melancholia
Korsakoff's disease
Melancholia
Mental disorder
Monopolar disorders
Munchausen syndrome
Neurasthenia
Neurotic disorder
Obsessive compulsive
Organic brain syndrome
Organic delusional syndrome
Organic personality syndrome
Panic disorder
Paranoia (paranoid)
Paraphrenia
Passive-aggressive
Personality disorders
Phobia (phobic)
Pick's disease
Postencephalitic syndrome
Post-traumatic stress disorder
Presenile dementia
Psychogenic
Psychological
Psychopathic
Psychophysiologic
Psychosexual
Psychosomatic
Psychosis (psychotic)
Schizoaffective
Schizoid
Schizophrenia
Schizophrenia, paranoid
Schizophrenia, residual
Schizophrenia,
  undifferentiated
Schizophrenoform
Schizotypal
Senile dementia
Senility
Sociopathic
Somatization
Somatoform
Stress disorder
Substance use (abuse)
  (dependence)
Wernicke's encephalopathy

HEDWIG HOUSE, INC.

Main Office: 904 DeKalb Street, Norristown, PA 19401 Phone: 279-4400
Pottstown Satellite: 946 High Street, Pottstown, PA 19464 Phone: 326-9112
Lansdale Satellite: 703 West Main Street, Lansdale, PA 19446 Phone: 362-2887
Lower Merion Satellite: 1111 Lancaster Avenue, Rosemont, PA 19010 Phone: 525-6874

H. John Heinz III
443 Russell Senate Bldg.
Wash., D.C. 20510

HERE IS WHAT MY HOME TOWN NEWS PAPPER HAD TO SAY. I LIKE IT. I WOULD LIKE IY BETTER IF ALL DISABLED PEOPLE GOT WHAT THEY ARE ENTITLED TO I WOULD LOVE TO GET BACK MY DISABILITY. I TRULY WOULD FEEL LIKE A DEAD MAN WHO CAME BACK TO LIFE, IF I GOT BACK MY DISABILITY. DURING THE PAST 14 MONTHS I KIND OF HAVE BEEN LIVING A SLOW DEATH. IF I DO GET BACK MY DISABILITY. I WOULD NOT BE HAPPY. I AM TO SEVERLY DEPRESSED TO BE HAPPY. BUT I SURE WOULD BE THANK FUL. FIRST OF ALL , I WOULD BE VERY THANK FUL FOR JUSTICE. AND I WOULD ALSO LIKE TO THANK YOU AND ALL OTHERS THAT ARE TRYING TO HELP. AND MAY BE I COULD FIND A REASON TO THANK MY SELF

THANK FOR TRYING

MERRITT F. REISH
437, CHERRY STREET
POTTSTOWN, PA.
19464

Local man says Social Security unfair to mentally disabled

By MIKE CONTOS
Mercury Staff Writer

Merritt Reish doesn't fit the role of a man of courage. The 37-year-old Pottstown resident chain smokes, wears bifocals, and admits to a nervous anxiety when placed under pressure.

But Reish opened his life for America to see, detailing on network news the severe depression, paranoia and schizophrenia that has forced him into hospital after hospital over the past 10 years. When he testified in Washington, D.C., Thursday, he said, he stood for the thousands nationwide who have fallen through the safety net established by President Reagan to insure the truly needy were not hurt by cuts in federal health and welfare benefits.

U.S. Senator John Heinz publicly apologized to the Pottstown man and claimed that Reish was indeed among the many deserving mentally ill who have been dropped from the Social Security disability program because of revised government standards.

"I apologize to you for the callousness and insensitivity of your government," Heinz told Reish Thursday at a hearing for the Senate Aging Committee. "We have pursued a harsh, unfair and cruel policy."

Reish, who had worked at odd jobs after dropping out of Spring-Ford High School some 20 years ago, spent three years in Norristown State Hospital. Prior to that, he underwent treatment at the Eagleville Drug and Rehabilitation Center, where he suffered a nervous breakdown because of increased job pressures.

In 1975 his parents helped to quailify Reish for the disability program and he began to receive monthly checks from Social Security. He was released from the state hospital in part because of financial security with the checks.

Reish lived a normal life style over the next several years, acquiring his own apartment, and was responsible for all bills he created. He continued to receive counseling and medication during the period, working with therapists out of the Hedwig House in Pottstown. Striving to be self-sufficient became part of that therapy.

But in February, 1982, Social Security officials said Reish was not eligible for payments. They stopped the $400-a-month checks based largely on the recommendation of a Norristown psychiatrist who observed Reish for 10 minutes, asking him a total of 10 questions, according to Reish.

"I felt they (Social Security officials) planned to wipe out a whole lot of disabled people in a hurry," Reisch told The Mercury Friday. "When this happened, I felt rejected, that I had nothing to look forward to. What's the use of trying anymore, I thought...What's the use of living..."

Reish said the same words during the Senate committee hearing which opened this week in Washington, D.C. (See related story page 5.) Pennsylvania Senator Heinz heads the committee and is expected to pay close attention to the Reish case.

"If I could get back the disability, it would be like a dead man coming back to life," Reish said Friday.

He noted that government agencies lack the psychiatric expertise to deal with thousands of mentally ill throughout the nation.

"How can you understand mental disability if you haven't experienced it?" Reish said. "A mental disability can be just as bad as a physical disability. The mind controls the body, but the body does not control the mind."

Reish said he had to move into his parent's home on Cherry Street when his income was slashed by more than half last year. He said he applied for state welfare funds and began receiving $180 a month when the $400 Social Security checks ended. Twice the state cut him from the welfare roles because of bureucratic mistakes, he added.

Reish says he is a worker. Having a slight learning disability, he said, he left school in the 10th grade and starting earning $1.40 an hour at the Valley Forge Flag Co., Spring City. He then became a laborer at the former Kinsey Distillery in Linfield where he worked for about four years.

He suffered a nervous breakdown while on a work program at Eagleville Hospital. While living at the drug and alcohol center, Reish worked there as a janitor. His progress improved to the point where he was made foreman of others in the hospital. But Reish said the pressure of the extra responsibility simply got to him, forcing a breakdown and the subsequent transfer to the state hospital for the mentally ill.

"I was nervous when I went to Washington," Reish said of his testimony in the nation's capitol Thursday. "I told the Senator that I was going to talk and talk and talk.

"I told the Senator my being wiped off the disability list was like me and him being on a ship, and me throwing him overboard, yelling down to him to sink or swim. If you swim, okay; if you don't, tough luck."

Critics of the cuts in Social Security claim that many were denied benefits based on wrong or inadequate information. Maryland Attorney General Stephen Sacks accused Social Security of "doing delicate surgery with a chainsaw." The hearings are expected to continue next week.

MERRITT REISCH

RESOLUTION ON REFORM OF THE SSDI & SSI PROGRAMS

WHEREAS, NACo supports provision of assistance to disabled people unable to work, under Title II (SSDI) and Title XVI (SSI) of the Social Security program; and

WHEREAS, certain provisions to methods of implementation of some aspects of the program have resulted in some inappropriate loss of benefits to disabled people, both adults and children, when their cases are reviewed, and

WHEREAS, similar problems with the present system have prevented some disabled people unable to work from initial enrollment as beneficiaries, and

WHEREAS, disabled people who are inappropriately denied SSDI & SSI benefits frequently must fall back on already over-burdened county assistance programs, as well as experience considerable anxiety and trauma at the loss of legitimate benefits:

NOW THEREFORE BE IT RESOLVED THAT NACo supports reforms of the SSDI and SSI programs that incorporate the following principles:

- Individuals may not be terminated from disability programs unless there is clear and convincing evidence of significant improvement, employability, or total failure to cooperate in the review process
- Disability reviews should consider all available vocational information as well as medical information
- People with mental impairments should be provided with fair and impartial assistance outside the Social Security review system in completing the review process if necessary and should have a vocational assessment based on realistic experience of competitive employment
- Provisions of PL 97-455 relating to a reasonable pace of reviews, continuation of Medicare eligibility through the hearing, scheduled to expire in October, 1983, should be made permanent
- Reviews and hearings should be in buildings and at locations and conducted in a manner that makes the proceedings accessible to the client.

Approved by Human Services Steering Committee February 27, 1983
Passed by NACo Board of Directors March 1, 1983.

PASSING THE BUCK:
FEDERAL EFFORTS TO ABANDON THE MENTALLY DISABLED

I. Introduction

Over 160,000 people receive Social Security Disability (SSD) and Supplemental Security Income (SSI) benefits each month in New York State as a result of being mentally disabled and unable to work. Many of these people are state psychiatric hospital dischargees, living in single room occupancy hotels, adult homes and community residences. They are dependent on federal disability benefits to buy food and pay the rent.

Thousands of these chronically ill, mentally disturbed men and women will lose these benefits due to a federal initiative to re-examine the eligibility of all disabled Social Security beneficiaries. While the publicly-stated intent of this action is to eliminate improper payments to employable people, the harsh reality is that many "truly" mentally disabled are being terminated as well. The fact that they still suffer from recurring and debilitating mental illness is apparently being routinely ignored.

An estimated 5,500 mentally disabled beneficiaries in New York State (including 2,300 in New York City) will lose benefits in federal fiscal year 1982 alone. (See Appendix I-A) This federal initiative is yet another way in which the Reagan Administration is removing the federal safety net for helpless people dependent on government benefits for survival.

The outcome of this process is all too predictable. After losing federal disability benefits, some people will apply for the public assistance program of last resort, Home Relief, further increasing state and local welfare costs.

The less fortunate will end up destitute on the streets, causing yet another surge in the number of homeless people in New York City.

II. Federal Social Security Programs for the Mental Disabled

To qualify for SSD and SSI disability benefits, applicants must establish their "inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."[1] Three major factors are taken into consideration: current work activity, the severity and duration of the impairment(s), and current capacity for employment.[2]

For many mentally ill New Yorkers, federal disability benefits -- which average $413 a month -- are the mainstay in their lives.[3] SSD and SSI are the only sources of income for thousands of chronic, mentally disabled patients discharged from State psychiatric institutions during the past two decades of deinstitutionalization. Of the 463,000 State residents receiving SSD and SSI benefits, 160,700 are mentally disabled. More than half of the mentally disabled -- 83,900 -- live in New York City.[3a]

Table 1

Number of Mentally Disabled Federal Disability Recipients in New York State and City (rounded to nearest hundred)

	New York State	New York City	Percentage of State Total
SSD	78,300	32,800	42%
SSI	82,400	51,100	62%
Total	160,700	83,900	52%

Source: New York State Department of Social Services

The SSD and SSI Programs are both administered by the Social Security Administration (SSA).* Rules and regulations governing eligibility, procedures for evaluating applicants, and reviewing the status of current beneficiaries are promulgated by the SSA. The federal government contracts with the states, however, to actually perform the initial eligibility determinations and status reviews. In New York State, the Department of Social Services (DSS) performs these functions.

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*SSD benefits are paid to disabled individuals who have contributed to the Social Security System for the required number of quarters. SSI benefits, on the other hand, are not based on contributions to the Social Security fund but are paid from general tax revenues to the financially destitute.

III. Federal Disability Benefits Are Being Terminated for Thousands of Mentally Ill Beneficiaries in New York

The Social Security Act was amended by Congress in 1980 to require periodic reviews of all SSD beneficiaries at least once every three years.[4] Previously, eligibility reviews were conducted only when a mental disability was expected to improve, not for chronic psychiatric conditions. As a result of the 1980 amendment, the number of SSD reviews is expected to rise dramatically from 160,000 nationwide in 1981 to 360,000 in 1982.[5]

SSI recipients are now being reviewed in cases where mental illness is considered temporary. However, the Social Security Administration has the authority to institute periodic reviews for all mentally disabled SSI recipients as well, and is expected to do so beginning late 1983 or 1984.[6]

The accelerated review process is well underway in New York State. In the last six months of 1981, reviews of SSD cases increased by 39 percent over the same period in 1980.[7] And the Social Security Administration has an ambitious schedule for the future: reviews are expected to soar by more than 500 percent from 1980 to 1984 -- from 16,000 to 88,000 annually.[8]

At the same time, denial rates are going up as more and more disabled beneficiaries are losing benefits after their case review. In 1981, the proportion of SSD case closings after review rose by nineteen percent over 1980.[9] Similarly, the rate of SSI case closings increased by 22 percent from 1980 to 1981.[10]

Table 3

Five Year Schedule for SSD reviews in New York State

Year	Number of Reviews
FY 1980	16,000
FY 1981	20,000
FY 1982	38,000
FY 1983	63,000
FY 1984	88,000

Source: New York State Department of Social Services

Table 4

SSI Reviews In New York State, 1980-1981

	Period		Percent
	5/2/80-12/26/80	5/1/81-12/4/81	Increase
Number of Cases Reviewed	6,049	5,545	(-11%)
Number of Denials	2,690	3,017	12%
Percentage of Denials	44%	54%	22.7%

Source: New York Regional Office of the Social Security Administration

IV. In Many Cases, Reviewers are Abusing Their Authority and Terminating the "Truly" Mentally Disabled

At a time when the Social Security system is experiencing major financial difficulties and public funds for social programs are in short supply, no one can argue with the need to maintain strict procedures to insure that disability benefits are not provided to mentally competent people who are able to work. However, it appears that many clearly eligible, mentally disabled beneficiaries are being terminated after case reviews.

In assessing whether someone has the mental capacity to work, reviewers are legally required to "consider factors such as [the] ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting."[12] After a series of interviews with mental health professionals and legal services lawyers, it appears these factors are routinely being ignored.* For the mentally ill, the consequences can be devastating.

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*Mental health professionals in seven agencies serving the chronically mentally ill were surveyed -- Transitional Services, The Bridge, the St. Francis Residence, the Washington Heights-Inwood Community Mental Health Center, the Soundview Throgs Neck Community Mental Health Center, South Beach Psychiatric Center and Kings County Hospital. Attorneys representing the mentally disabled from Lawyers for the Public Interest and Legal Services for the Elderly Poor were interviewed as well. Together, these professionals provided information on dozens of disability recipients whose eligibility status was recently reviewed. In the opinion of the health professionals surveyed for the report, none of the individuals terminated from the federal disability rolls were "employable" in any realistic sense. (See Appendix II for the names and titles of mental health professionals and legal services lawyers interviewed for this report.)

Harry Baird* of the St. Francis Residence[13]

Forty year old Harry Baird is both mentally and physically disabled. Prior to 1973, he had been hospitalized at least once a year for two to three week periods. He has been known to the St. Francis priests since 1973, when he was released from the Manhattan State Psychiatric Hospital. Mr. Baird is diagnosed as suffering from chronic schizophrenia.

Since he became affiliated with the St. Francis program, his mental condition has somewhat stabilized. He has been hospitalized only three times since 1973, the most recent in November, 1980. With the aid of the St. Francis escort service, he regularly attends a state psychiatric clinic, and he receives medication daily at the residence.

In the summer of 1981, Mr. Baird was hospitalized at Bellevue with chest pains and high blood pressure. Doctors found that his heart was enlarged to the size of a football; his prognosis was described as very poor.

In August, 1981, Mr. Baird received notification that his SSD eligibility was being reevaluated, and that he had to appear on two separate occasions for physical and psychiatric examinations. Despite his appearances, Mr. Baird received in September a letter of termination, which he appealed with the help of the St. Francis staff.

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*All names of disability recipients used in this report are pseudonyms.

Questioning the reasonableness of the decision that Mr. Baird was "employable", St. Francis social worker John Gaines described his client's limited capacity to perform even simple tasks:

> "When you speak to this man, he simply doesn't understand what you are talking about. He often doesn't respond. We have to watch him take his medication to make sure he doesn't take the wrong thing at the wrong time. He could not even get to an appointment at the Social Security office on his own. He must always have an escort."[14]

Dr. Charles Rosenbloom, his treating psychiatrist, also questioned the decision.

> "[Mr. Baird] suffers from chronic auditory and visual hallucinations, including command hallucinations of a suicidal nature; the patient has acted on these command hallucinations on more than one occasion in the past. These symptoms do not disappear with the psychotropic drugs which he receives at the clinic.
>
> "[He] has the fragile ego structure of a chronic schizophrenic. He is unable to cope with the stress of everyday life without the constant support of the on-site staff at his residence and the interventions of this clinic. He is a fearful, isolated individual who is totally dependent upon the social structure provided by the residence. He has been referred to Day Programs on several occasions in the past, but these experiences have proved to be so threatening that his symptoms increased to an alarming degree (particularly in view of his suicidal attempts,) and the programs were discontinued.
>
> "Since [Mr. Baird] is unable to relate in the relatively safe environment provided by a therapeutic day program it is impossible to consider him as a candidate for employment. His prognosis remains extremely guarded and his ability to assume competitive employment, even at a most basic level, is non-existent. There is no time in the foreseeable future that this prognosis will improve based on our observations of his capacity to cope since he began treatment with us in 1973.
>
> "We hope that you understand the seriousness and indeed life threatening nature of [Mr. Baird's] disability and will reinstate him on the disability rolls."[15]

In November, Mr. Baird received a final notice that benefits were being terminated. The letter stated that, while he might not be able to resume his previous occupation (he had been a cart-pusher in the garment district), he could perform some kind of work.

With the assistance of the St. Francis staff, Mr. Baird filed a final appeal and is now waiting for a hearing to be scheduled.

The church has deferred Mr. Baird's rent and is loaning him money for food and other expenses. Priests at St. Francis state that if he were on his own he would never be able to pursue the appeal. He cannot read and hands his correspondence unopened to the St. Francis workers. They believe he is not really aware of his situation.

Alan Palmer of South Beach State Psychiatric Hospital[16]

After his SSI benefits were terminated, Alan Palmer threatened to assassinate President Reagan and was admitted to South Beach State Psychiatric Hospital as a result. Thus, just days after being notified by the Department of Social Services that he was "employable", psychiatrists were hospitalizing Mr. Palmer as delusional and a danger to others.

Linda Breslin, Deputy Director of South Beach, emphasized that he "could maintain himself out of the hospital but could never work. The stress of having his livelihood cut off led to the last hospitalization and rather drastic threat."[17]

Jane Rollen of Washington Heights CMHC[18]

Jane Rollen is a 46 year old woman, living at the Washington Heights-Inwood residence since January 1981. Previously, she was homeless and slept on the streets of Manhattan.

In 1967, Ms. Rollen began receiving SSD and SSI disability benefits (after she became delusional and was diagnosed as suffering from chronic schizophrenia). Since then, she has undergone several psychiatric hospitalizations, the most recent in the spring of 1980. Ms. Rollen also suffers from severe back pain as a result of a previous injury. She attributes the back pain to possession by demons.

In November 1981, Ms. Rollen was notified that her disability benefits would be terminated because she was determined to be "employable". With the help of her counselors, she is now appealing that decision.

John Gables of The Bridge[19]

Mr. Gables is 46 years old and has a ten year history of manic-depressive psychosis. He has experienced twelve manic episodes requiring hospitalization, the most recent in August, 1981. Divorced when he became ill, Mr. Gables has lost all contact with his former wife and two children. With the support of the Bridge Social Rehabilitation Program, which he has attended daily for the past two years, he is able to live on his own. He is also seen regularly at St. Luke's Psychiatric Outpatient Clinic and takes lithium to control his symptoms.

His last full-time job was in 1973. In 1977, Mr. Gables enrolled in an Office of Vocation Rehabilitation training program but was forced to drop out after a month because it was too stressful. In 1980 he tried to work as a census taker, but again work proved too stressful and he was rehospitalized.

In September, 1981, Mr. Gables was asked to submit evidence to support his claim of psychiatric disability. Despite the fact that all professional staff members at the Bridge sent letters stating that Mr. Gables was unemployable, his claim was turned down.

Jane Michele, Director of the Bridge's Day Program commented on the DSS decision. "Mr. Gables is motivated to work as indicated by his history and he has attempted to return to work, but he manifests severe depression which makes it very difficult for him to function. He also has periods when he is really manic. He has difficulty sleeping then and often becomes delusional. He is also very hyperactive. His case is really sad because he would really like to work, but his illness prevents him."

Mr. Gables had his hearing on January 19, 1982. Ms. Michele says that the stress was too much for him and he will probably need to be rehospitalized.

Sadly, Harry Baird, Alan Palmer, Jane Rollen and John Gables do not seem to be isolated and atypical examples of mentally disabled people now being terminated from the Social Security Disability rolls.

Many psychiatrists and social workers interviewed for this report expressed anger at the termination of benefits for vulnerable men and women under their care. Dr. Itamar Salaman, Director of the Soundview-Throgs Neck Community Mental Health Center, echoed the feelings of many of his colleagues in his criticism:

> "The disallowance of disability coverage appears to be an arbitrary, unfeeling and unthinking procedure causing great distress to large numbers of very chronically and seriously ill psychiatric patients and their families. It is only with great effort and much support that these people are able to remain outside of hospitals. The ultimate outcome of this inhumane policy will be to add to the numbers of homeless and to increase the psychiatric readmission rate to hospitals, thus shifting the financial burden for caring for these helpless people to the cities and states. The cost of hospitalization is far greater than keeping them in community-based programs."[20]

Ms. Margaret Murphy, Human Resources Coordinator for Transitional Services, a mental health program for the chronically ill located in Queens, said that the number of terminations of seriously ill program participants had increased dramatically. Between August and December, 1981, she accompanied 18 clients to disability hearings after their benefits were terminated, compared to one hearing every three months previously. She reported that all 18 clients were chronically disabled with long-term, serious and extensive psychiatric problems:

> "I have been with clients on occasions when they were experiencing psychotic episodes at the hearings, and the hearing officer still upheld the denial of benefits.
>
> "The slightest progress evidenced by our clients was used as the justification to terminate benefits at a time when these men and women were clearly not ready for completely independent living. Loss of income at that stage wiped out years of progress by triggering a relapse or causing the client to leave the program prematurely."[21]

Dr. Ginny Gerbino, attending psychiatrist at Kings County Hospital, has treated many patients after SSD benefits were terminated:

> "Despite the fact that mentally disabled patients are out of the hospital, they are often not employable. These people, who are most in need of what public assistance benefits have to offer, are rendered helpless when benefits are cut off precipitously. It is tantamount to punishing these patients for the progress they have made in staying out of the hospital.
>
> "One of the great misunderstandings of this particular problem is that progress made in remaining out of the institution and adjusting to living in the community is the same as employability. It is not."[22]

When questioned about the impact of the eligibility reviews on his patients, Dr. Roger Brunswick, Medical Director of the Bridge, said:

> "Chronic psychiatry patients live in a very precarious state of mental health. Predictability in their lives leads to the least amount of stress and results in a dramatic decrease in psychotic episodes and hospitalizations. Most of them have tried to work in the past and have not been able to tolerate even the stress of the easiest jobs.
>
> "Cutting off the disability benefits of chronic mental patients is to cut off one of the only constant things in their lives and, as it would be for anyone, it is a major stress. We have seen at the Bridge, a number of psychotic decompensations and hospitalizations as a result of the discontinuation of benefits. In people who have already shown their difficulty in competing in the world of work, cutting off their only financial support is a catastrophe."[23]

The federal disability recipients discussed here are all involved in mental health programs which have provided support and advocacy for their patients undergoing review. They have also given financial support when benefits were terminated. Yet, due to New York City's inadequate community mental health system, only a fraction of the chronically mentally disturbed population have access to such services.*

Mentally disabled SSD and SSI beneficiaries not receiving services from a mental health or social service agency are even more likely to lose benefits; not because they are more "employable", but because they are unable to effectively cope with the bureaucratic process.

Mr. Robert Hayes, the attorney for homeless plaintiffs in <u>Callahan</u> v. <u>Carey</u>,[24] is alarmed by the threat to the economic stability of SRO and adult home residents:

> "Many of these poor disabled people simply cannot negotiate the bureaucratic maze by themselves. With recent cutbacks in legal services programs, they'll go unrepresented. When their checks stop, they lose their place to live. That is how people become homeless."[25]

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*In New York City, only six percent of the chronically mentally ill are receiving case management social services, and 22 percent are receiving needed clinical treatment. (Source: New York State Office of Mental Health 1981 Five Year Plan.)

V. Complying With Complex Review Procedures Is Often Difficult For Confused Mentally Ill Beneficiaries.*

Federal disability benefits can, and often are, terminated even before a formal case review on the merits takes place. Under federal law, the responsibility to submit all evidence required for review rests with the beneficiary. Failure to supply this information is ground for termination.

Placing this responsibility on mentally ill men and women is obviously problematic. A three page questionnaire is attached to the notice of review which must be completed and returned. (See Appendix IV). Medical evidence is required to document the beneficiary's claim of mental disability. Even if the questionnaire is returned and medical evidence provided, the Department of Social Services may require the beneficiary to show up and submit to a medical and/or psychiatric examination.[26]

This process is difficult enough to negotiate when the mentally ill have social workers advocating on their behalf. For sick people without any direct contact with a mental health program, it can be impossible. The Department of Social Services purports to deal with this problem by referring all cases (where the mentally disabled do not respond to two notices) to SSA district offices for a home visit.

In fact, it does not appear that Social Security offices are personally assisting all mentally disabled beneficiaries

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*Appendix III describes the various stages of the review process.

who need help, although the dimensions of the problem are unclear. Ms. May Blatt, Director of the New York City Regional Office of the DSS Office of Disability Determinations, could not provide any figures on the numbers of cases already referred for home visits. In another attempt to understand the actual availability of home visits, we directly contacted intake workers at the Social Security Administration and Department of Social Services.

Three workers at the central information number for Social Security were telephoned; each stated that mentally disabled beneficiaries receiving checks directly were considered to be "competent" and were automatically terminated if they didn't reply to the review notices. Local Social Security offices in Brooklyn, Queens and Manhattan were also contacted. Intake workers in these offices stated that the DSS Office of Disability Determinations did forward requests for home visits for some mentally disabled beneficiaries under review, but could not say whether this occurred in all cases. When the Division of Disability Determination was telephoned again, we were told that home visits could be requested but that the decision was discretionary and not done in every case.

Even with proper assistance, the mentally ill often have trouble representing themselves during the review process. A social worker at Transitional Services, Joseph Berkman, says that patients generally approach the hearings with "intense feelings of anxiety. In some cases, they become emotionally paralyzed when confronted with it."[27].

Problems were also found with the psychiatric examinations conducted by DSS for beneficiaries that did manage to complete and return the initial questionnaire. DSS requires that a thorough mental status examination and complete medical history be done.[28] The reality, however, can be quite different.

One chronic patient at the Soundview-Throgs Neck Community Mental Health Center was recently taken off thorazine because of her adverse reaction to the medication and given valium to minimize her disruptive behavior. According to the patient, who is considered reliable by her social worker, the examination consisted of the following:

M.D.: "Hello."

Patient: "Hello."

M.D.: "What kind of medication are you on?"

Patient: "I'm on Valium."

M.D.: "Oh...you are on Valium. You are not sick!"[29]

The father of a South Beach Psychiatric Center Outpatient timed the length of his son's examination -- it lasted four minutes. Ms. May Blatt admitted that it is impossible to do the kind of work-up required by the agency in that limited time period.

Formal appeals are available after an unfavorable review decision, but effective representation is even more important at this stage. Unfortunately, many mentally disabled beneficiaries lack this assistance as well. According to Linda Breslin, the Deputy Director at South Beach State Psychiatric Hospital:

> "It appears to us that many more patients are categorically being denied SSD and SSI benefits and are not being recertified. We are often able, however, to reverse the final denial of benefits for our patients during the appeals stage. It is State Office of Mental Health policy to appeal all of these cases.
>
> "This requires an enormous amount of time and work. Our clients do not have the resources to hire or locate attorneys, nor can they understand the complications and intricacies of the appeals process.
>
> "It is highly unlikely that confused and disorganized individuals who do not have the support of a skilled professional working on their behalf could negotiate the appeals system."[30]

The large numbers of the mentally disabled forced to confront this process on their own may, because of their inability to comply with the review requirements, lose their benefits without ever having a fair review of the merits of their claim. Without personal assistance by DSS and SSA at every stage of the process, many "truly" disabled men and women will lose their only source of support and be forced into the shelters and onto the streets.

DSS officials concede that they have not been given the financial resources to provide effective personal assistance to the mentally disabled who need it.[31] The SSA has raised the number of eligibility reviews for New York State, but it has not increased DSS's budget accordingly, making it difficult for DSS to adequately review each case. From 1981 to 1982, the number of scheduled reviews is projected to increase by 53 percent while DSS's budget has been raised by only about 2.5 percent in real dollars.[32]

With all these apparent difficulties, the burden is on the Social Security Administration and Department of Social Services to demonstrate that the review process is procedurally fair to the mentally disabled. Requests for more detailed information have been sent to SSA and DSS to enable more comprehensive analysis by the City Council President's Office. (See Appendix V).

VI. Conclusion and Recommendations

Beginning in 1980, Congress required periodic case reviews of all mentally disabled social security beneficaries. The legislative purpose was laudatory: to assure that all federal disability beneficiaries are, in fact, unemployable due to their mental or physical impairment. Unfortunately, this laudatory purpose is being undermined by improper implementation. Placing the burden of proof on mentally disabled beneficiaries is a serious injustice to the many beneficiaries too ill to represent themselves. Without adequate assistance, confused and disturbed people are being terminated for failure to cooperate before a review on the merits even takes place. In other instances, beneficiaries with severe impairments are deemed "employable" despite strong psychiatric evidence to the contrary.

The State Department of Social Services has already agreed to cooperate with the Council President's ongoing investigation of this problem. Further analysis will be developed in the coming months as additional information is provided. In the meantime, it is clear that a number of steps must be taken immediately:

1. Social Security Disability benefits for mentally disabled beneficiaries should not be terminated prior to a case review on the merits. Failure to respond to written notices, complete the questionnaire, provide medical documentation, or show up for a psychiatric consultation cannot be

the basis for automatic termination of benefits to chronically mentally ill people.

2. Mentally disabled beneficiaries must be provided with personal assistance (and home visits if necessary) throughout the review process. Legal representation should be provided for appeals after the initial case review. The Department of Social Services should consider contracting with the private bar or legal services attorneys with experience in social security disability hearings to provide the necessary legal assistance to beneficiaries.

3. Psychiatric social workers and psychiatrists working in community mental health programs should be given training in what type of information is required by the Social Security Administration to verify mental disability.

4. The Department of Social Services should begin a study of the impact of terminating federal disability benefits on rehospitalization rates, the mental health of beneficiaries, home relief rolls, and City shelters for the homeless.

5. The Congress should schedule hearings on the implementation of the 1980 amendment, its fiscal impact on state and local government, and the appropriateness of placing the burden of proving continued disability on mentally impaired beneficiaries.

FOOTNOTES

1) Social Security Administration Rules and Regulations, 20 CFR Subpart P, §404.1505

2) Ibid., Subpart P

3) Social Security Disability Bulletin, (Social Security Administration, December 1981)

3a) Telephone Interview with Lloyd Moses, Associate Commissioner, NYS Office of Disability Determination, December 31, 1981

4) PL 96-265 (June 9, 1980)

5) Wall Street Journal (December 1981)

6) Telephone Interview with Lloyd Moses, Associate Commissioner, NYS Office of Disability Determination

7) Telephone Interview with Helene Ebenstein, Coordinator, New York Regional Office of the Social Security Administration, on December 23, 29, 30, 1981. Also See Table 2.

8) Telephone Interview with Lloyd Moses. See Footnote 6.

9) Telephone Interview with Helene Ebenstein. See Table 2.

10) Ibid., Also see Table 4.

11) Telephone Interview with Robert Trobe, Deputy Administrator for Family and Adult Services of the Human Resources Administration, on January 19, 1982.

12) Social Security Administration Rules and Regulations, 20 CFR, Subpart P, §416.945(c)

13) Telephone Interview with Al Pettis, Program Director, St. Francis Residence, on December 29, 1981, January 5 and 6, 1982.

14) Telephone Interview with John Gaines, Social Worker, St. Francis Residence, on January 15, 1982.

15) Letter from Dr. Charles Rosenbloom, to the Office of Disability Determination, dated October 14, 1981.

16) Telephone Interview with Linda Breslin, Deputy Director of Treatment Services, South Beach Psychiatric Center on January 18, 1982.

17) Ibid.

18) Telephone Interview with Pam Pannell, Senior Residence Counselor, Washington Heights-West Harlem Inwood Mental Health Council, on December 22, 1981 and January 5, 1982.

19) Telephone Interview with Jane Michele, Director of Day Program, The Bridge, Inc., on December 29, 1981 and January 13, 1982.

20) Telephone Interview with Dr. Itamar Salaman, Director, Soundview-Throgs Neck Community Mental Health Center, on January 6, 1982.

21) Telephone Interview with Margaret Murphy, Human Resources Coordinator, Transitional Services, on December 29 & 30, 1981 and January 5 & 6, 1982.

22) Telephone Interview with Ginny Gerbino, M.D., Attending Psychiatrist, Kings County Hospital, on January 7, 1982.

23) Telephone Interview with Roger Brunswick, M.D., Medical Director, The Bridge, Inc., on January 8. 1982.

24) Supreme Ct., N.Y. County, Index No. 42582-79.

25) Telephone Interview with Robert Hayes, Staff Attorney for the Coalition for the Homeless, on January 12, 1982.

26) Interview with May Blatt, Director of the New York City Regional Office of the Office of Disability Determination.

27) Telephone Interview with Joseph Berkman, Social Worker, Transitional Services, on January 12, 1982.

28) Telephone Interview with May Blatt. See Footnote 26.

29) Telephone Interview with Catherine Meany, Clinical Coordinator, Adult Outpatient Clinic, Soundview-Throgs Neck Community Mental Health Center, on January 13, 1982.

30) Telephone Interview with Linda Breslin. See Footnote 16.

31) Telephone Interview with Lloyd Moses and May Blatt. See Footnotes 6 & 26.

32) Telephone Interview with Lloyd Moses. See Footnote 6.

FINANCIAL IMPACT ON PENNSYLVANIA AND PHILADELPHIA ON TERMINATIONS AND DENIALS OF BENEFITS TO SSI/SSDI APPLICANTS AND RECIPIENTS,

PREPARED BY THE MENTAL HEALTH ASSN. OF SOUTHEASTERN PENNSYLVANIA

BACKGROUND

In March, 1981, the Social Security Administration (SSA) began an accelerated review of disabled people who were receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI). SSDI is a disability program for former workers who had paid sufficient contributions into a Disability Trust Fund. SSI is a disability program with the same disability standards but for poor, disabled people without a sufficient prior work record to qualify for SSDI. Both physically and mentally disabled people have been adversely affected by these reviews and by the highest rates of denials for initial applications. During this period, SSA also changed its policies in evaluating disability claims by instituting changes which were not published nor approved by Congress or the courts.

The mentally disabled have suffered a proportionately higher rate of denials and terminations than other groups of disabled people. Advocacy organizations, family members, legal service attorneys and human resource professionals have been pushing for reforms to stop this termination of disabled from their statutory entitlements, and there has been excellent media coverage of the tragic impact of this shift in Federal policy on individuals who have lost their income. However, there has been less attention given to the financial impact or cost to state and local governments when individuals lose their income from Social Security. State and local governments, often unaware of these costs, have not pursued their own interests in reforms in this area.

There are four main areas in which costs are being transferred from the Federal government to Pennsylvania and Philadelphia through the SSI/SSDI review process. They are:

1) increases in State funded General Assistance (GA);

2) increases in State funded Medical Assistance (MA);

3) increases in State Mental Health funds for operation of the Community Residential Rehabilitation Program (CRR) or a reduction in the size of the CRR Program;

4) loss of eligibility for the Domiciliary Care Program and transfer of residents to CRR, personal care boarding homes, local emergency shelters or decompensation and hospitalization.

1. General Assistance

General Assistance (GA) in Pennsylvania is a 100% state funded, cash grant program for individuals who have no source of income. Based on Act 75, or the Welfare Law passed in 1982, there are two categories of assistance: the chronically needy who receive permanent cash assistance and Medical Assistance coverage and the transitionally needy who may receive a cash grant for up to three months per year and are eligible for some Medical Assistance and Food Stamps throughout the year.

Almost all the people who are reviewed and who lose their SSI/SSDI benefits will then apply for and receive General Assistance. From March, 1981 - August, 1982, the State Disability Unit, through the continuing disability investigation, reviewed and denied benefits to 13,205 SSDI beneficiaries for a denial rate of 42%. A total of 16,494 SSI beneficiaries were also reviewed and denied for a denial rate of 77% at the initial periodic review decision level. National statistics indicate that 50% of persons who are reviewed do appeal and 67% are successful on appeal at the Administrative Law Judge level. Therefore, we estimated that, of the total SSDI and SSI terminations, 14,849 would not appeal and 4900 would lose their appeal so that a total of 19,749 individuals would turn to Pennsylvania for General Assistance. The cost to Pennsylvania if all beneficiaries applied for and received GA as chronically needy would be an additional $40,761,936 each year. If they were all classified as only transitionally needy, the cost would be $10,190,484.

The costs escalate rapidly if one also considers the denials of new applications for SSI/SSDI. While not part of the accelerated review process, these denials of new applicants have a significant impact in terms of the General Assistance costs for Pennsylvania. From March, 1981 - August, 1982, the Social Security Administration denied 33,980 initial applications for SSI in Pennsylvania for a denial rate of 58%. If one assumes that 75% of these individuals then applied for and received GA for the chronically needy, it would cost Pennsylvania $52,601,040 each year for the cash grant of these beneficiaries. If all these individuals were transitionally needy and only received three months of GA, the cost would still be $13,150,260.

In the same 18 month period, SSA denied SSDI benefits for medical reasons to 43,314 applicants for a denial rate of 44%. Because this group includes some individuals with assets and income above the GA level, we assumed that only half of them would apply for GA. If 50% received GA for the chronically needy, the cost to Pennsylvania would be $44,700,048. If these same individuals were transitionally needy and only received three months of GA, the cost each year would still be $11,175,012.

In summary, the estimated increase to Pennsylvania in GA costs alone is in the range of $34,515,756 to $138,063,024 each year for the group of beneficiaries who have been denied or lost their SSI/SSDI benefits.

2. Medical Assistance

Medical Assistance (MA) is a publicly funded health care program for low income people. All individuals on SSI are automatically eligible for MA and the federal government matches Pennsylvania's costs at a rate of approximately 55% federal to 45% state funds.

By contrast, transitionally and chronically needy individuals on GA receive MA but it is 100% state funded. Thus, Pennsylvania must pay the 55% which was formally covered by the Federal government for those on SSI and SSDI. In Pennsylvania, the average costs per year to the State for Medical Assistance per eligible person in 1981 was $1,158.

Using the same assumption described above, there were a total of 66,891 individuals who were denied SSI/SSDI or terminated from SSI/SSDI who might apply for and receive MA. The cost to Pennsylvania would be an additional $42,609,567 each year for these beneficiaries which is the equivalent of the Federal share if the same individuals were on SSI or SSDI.

HOUSING SERVICES FOR THE MENTALLY ILL

BACKGROUND

In Pennsylvania, there are two state funded and administered housing programs that serve the mentally ill. These programs rely, in part, on the resident's income to offset part of the cost of the program. If the resident is determined to be ineligible for SSI or SSDI and subsequently applies for and receives General Assistance, he/she will either be ineligible for the housing program, if the person is in Domiciliary Care, or the Office of Mental Health will pay a larger share of the costs for housing from mental health funds, if the person is in the Community Residential Rehabilitation Program.

3. Community Residential Rehabilitation Program (CRR)

This is a community living arrangement program for mentally ill people who need some daily help and supervision. It is primarily funded by State mental health money but the resident's income offsets part of the cost of the program. A person does not have to be on SSI to be accepted into the program. However, SSI recipients receive $145.00 more per month than General Assistance recipients, of which $112.60 is Federal funds. Since SSI payments are almost entirely Federal money, the program is subsidized by the federal dollars coming to SSI recipients living in the CRR program.

As of June 30, 1982, there were 1,937 beds available statewide and the average occupancy rate was 83%. Therefore, there were an estimated 1,608 people in CRR programs. The Office of Mental Health does not keep statistics on the number of people in the program who are on SSI. Therefore, it is assumed that only persons in full care are on SSI. There are 827 full care beds statewide. Assuming an 83% occupancy rate, there are 686 residents in full care on the average day. Residents pay approximately 72% of their income for room and board. This is $228.24 for SSI recipients but only $123.84 for GA recipients.

As noted earlier, the denial rate at the initial decision level for SSI recipients in Pennsylvania has been 77%. Assuming 50% appeal and 67% of these are successful, the final denial rate is estimated to be 51%. If 51% of the full care residents are reviewed and lose their SSI benefits, the additional cost to the Office of Mental Health would be $472,920 per year assuming all apply for and are approved as chronically needy GA recipients. In order to keep the individuals in the program, the Office of Mental Health would have to:

1) request an increase in state funds to cover the cost or;

2) cut the size of the program so fewer mentally ill people would be served or;

3) reduce the funding for other mental health services to cover the cost for this service.

In Philadelphia, there are approximately 250 people in the CRR program and program staff estimate that 50%, at a minimum, are on SSI. If 51% are reviewed and terminated, the additional cost to the county program to retain these individuals would be $86,477 per year assuming all individuals apply for and are approved as chronically needy GA recipients.

4. <u>Domiciliary Care</u>

Domiciliary Care is a community living arrangements program for people who are disabled. The program serves people who are mentally ill, mentally retarded or physically handicapped. Older people, without disabilities, are also eligible for the program. In order to be accepted a person must be receiving or be eligible for SSI. The program is funded through a combination of SSI and a state supplement in the following amounts:

Federal SSI Payments	$284.60
State SSI Supplement	32.40
State Domiciliary Care Supplement	114.90
Total Available Money	$431.90

As of 12/31/82, there were 1,533 people in placement in Pennsylvania. The Department of Aging does not collect information about the primary disability of the residents. However, at least 24% were referred by mental health agencies and can be assumed to be mentally ill.

Assuming a denial rate of 51%, 187 people might be reviewed and denied continuing benefits. These individuals would also lose their eligibility for the Domiciliary Care program and either move to a personal care boarding home, a CRR program, the local emergency shelter, live on the streets or decompensate and require hospitalization. If 187 people required psychiatric hospitalization in a state hospital for one year, the cost to Pennsylvania would be $10,238,250.

In Philadelphia, there are 265 people in the Domiciliary Care program of which 67% have a primary disability of mental illness. If 51% of them were reviewed and denied continuing benefits, 91 people would again have to try to move into a boarding home, a CRR program, the local emergency shelter or live on the street. They might also decompensate and require psychiatric hospitalization. The cost of a year of care in a state hospital for these 91 people would be $4,982,250.

Unfortunately, data is unavailable to estimate the other costs to Pennsylvania and Philadelphia for this shift in Federal policy. But it is likely that this policy is increasing the need for local emergency shelters, additional outpatient mental health services and an increase in psychiatric hospitalization for people who lost their income and cannot continue to cope in the community.

(717) 823-2155

LUZERNE-WYOMING COUNTY
MENTAL HEALTH CENTER No. 1
103 SOUTH MAIN STREET
WILKES-BARRE, PA. 18701

March 14, 1983

Senator John Heinz
443 Russell Senate Office Building
Washington, DC 20510

Dear Senator Heinz:

I am writing to you on behalf of many of our clients at the Luzerne-Wyoming County Mental Health Center who are or have been receiving Social Security and Supplemental Security Income. With the recent changes in SSI regulations, we are finding more and more of our clients decompensating due to being adjudicated ineligible to receive these benefits. Many of these mentally ill and mentally retarded persons have chronic disabling illnesses and have been receiving these benefits for many years. Their lives over these years have come to depend on this fixed income since they cannot, realistically, find gainful employment nor can they function adequately enough to keep a job if they could find one.

The problem is twofold. First, these people are now being told that they are "able" to work, thus ineligible to receive benefits. Once this determination is made, their benefits cease. Second, the appeals' process is so lengthy and complex as to continue for several months before any determination is final on the appeal. Even though my staff are involved in helping these people through the appeals' process, these people have very few coping skills and often become more ill during the process. Financially, this is critical because many of these people become so ill that they have to be hospitalized either in our inpatient unit or in a state hospital which is far more expensive than maintaining them in their homes.

Procedurally, we have learned that our clients are interviewed by a Social Security adjudicator but do not necessarily talk with a physician or psychologist. Additional evidence from our records is not usually requested despite the fact that these clients have a long history of treatment at our Center. The Social Security adjudicators who interview these clients have little or no knowledge of their psychiatric illness, and due to the large numbers of people being interviewed, we believe short-cuts in the evaluation process occur.

The impact that we see is that these reviews and rejections place our clients under a great deal of emotional and financial stress. Clients who once received $317 per month now find themselves trying to survive on $172 per month. Clients whose illness has been stable in the past are now decompensating and having to be hospitalized. Ultimately, the Commonwealth has to pay for these hospitalizations because these people have no other financial means. Isn't $317 per month in benefits more cost-effective than $300 per day in a hospital? I have enclosed a typical case history of one client.

I am aware that you will be holding hearings soon on this subject and would hope that you would consider the plight of these people who are less able to speak for themselves. If I can be of any further assistance, please call me.

Respectfully yours,

John A. Creek

John A. Creek
Executive Director

JAC/mms

cc: A. Brown
file

CASE HISTORY
of
JOHN DOE

Joe Doe is a 43 year old single male. He has been a patient of the Luzerne-Wyoming County MH/MR Center since 1977. Since John's involvement with the Mental Health Center beginning in 1977, he has been psychiatrically admitted to area hospitals four times. Through this period John has been attending the Mental Health Center's Partial Hospitalization Program in an attempt to stabilize his condition. For the past year, John has been followed by the Mental Health Out-Patient Department, Partial Hospitalization, and the Mental Retardation Units on a monthly or as needed basis. His diagnosis is Schizophrenia Undifferentiated Chronic and is functioning in the Borderline Range of Mental Retardation. John is also a client of Pan Am Inc., Adult Minimal Supervision Program assisting with budgeting, shopping, and refinement of other daily living skills. The following information is an account of John's involvement with the Mental Health Center from the time he had been notified of his Social Security Benefits being terminated. Increased anxiety and preoccupation with finances was noted.

In September, 1981, John began experiencing auditory and visual hallucinations. He was not sleeping and was found wandering the streets aimlessly in the early morning hours. He appeared extremely anxious over his disability benefits being terminated which was his primary focus. Medication prescribed was Prolixin 1cc every 2 weeks and Prolixin tablets 5 mg., TID. September 9, 1981, John came into the Center for out-patient therapy sessions expressing suicidal ideations, stating that he tried to kill himself the prior evening by ingesting pain pills and alcohol. Precipitating factor noted was his preoccupation with the termination of his disability benefits. Continuous reassurance and support of all involved parties and the appealing of the decision stabilized his condition for a short time. Increased anxiety was noted towards the end of the month.

October 6, 1981, John stated that he was "getting the shakes" and experienced nausea. He denied auditory and visual hallucinations. His medication was increased. Continuing anxieties were noted relating to finances.

John continued to have bi-weekly contacts through November 1981. It is noted that John continued to experience facial twitching and increased stuttering. Occasional incidents of incoherence were noted by AMS worker, however, John continued to deny audio/visual hallucinations.

Following receipt of his appeal for Social Security Benefits being denied in January, 1982, John began to actively hallucinate admitting to both audio and visual hallucinations. Another appeal was filed with the Social Security Office to challenge the decision.

In February, 1982, John was again denied benefits following the appeal. The denial was based on reports from Social Security staff psychiatrist and the Mental Health report. John, knowing of the reasons for the denial, became hostile to the Mental Health Center, placing responsibility on the Center.

In March 1982, Jim continued to be hostile towards services and again began to decompensate. He admitted to ingesting rat poison and alcohol. He was medically hospitalized at the Nesbitt Hospital, Kingston, PA. There was no concrete medical evidence verifying his rat poison intake. Further decompensation was noted throughout March.

On April 5, 1983, John was found wandering in Scranton, PA. He had walked from his apartment in Edwardsville to Scranton. He was disoriented and was responding to audio and visual hallucinations. John believed that he was being evicted from his apartment due to his inability to pay for his rent or buy food. John was evaluated and hospitalized on a voluntary commitment to Clarks Summit from April 5th to July 10, 1982. During his hospitalization his medication was Mellaril. No change was noted by hospital as far as stabilization. John submitted a written notice of his intention to leave the hospital against medical advice, however, on July 29, 1982, one day prior to his discharge, John was given 2cc of Prolixin. His reaction to the medical was very positive.

Upon discharge John agreed to continue with services through the Mental Health Center and support services through Pan Am. A hearing was scheduled at Social Security to determine grounds for reinstatement in August 1982. A favorable decision was released following a review of the information from the time since John's last appeal.

John continues with MR case management services and with outpatient medication groups at the Mental Health Center. He also remains involved with the Adult Minimal Supervision Program, Pan Am Inc. To date there has been a notable stabilization of John's behavior and overall condition.

MENTAL HEALTH ASSOCIATION FOR GREATER BATON ROUGE
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April 5, 1983

Senator John Heinz
Special Committee on Aging
Room SD-G37
Dirksen Senate Office Bldg.
Washington, D.C. 20510

Attention: Mr. Frank McArdle

Dear Mr. McArdle:

Pursuant to our telephone conversation submitted herewith is Case Example of Earl Garrett, Jr., beneficiary whose eligibility was reviewed under SSA's policies and resulted in termination of benefits.

Constraints of time and heavy work schedule made the trip to D.C. impossible at this time. At a later date, however, time permitting, Fran Bussie would like to address the problems regarding SSA's policies in the area of mentally ill assessments.

I trust this Case Example will be useful in the April 7th hearings before the Senate Aging Committee.

If I can be of further assistance, please contact me.

Sincerely,

Josephine G. McCarthy
Executive Director

JGM:ea

enclosure

cc: Chris Koyanagi
National Mental Health Association

Fran Bussie

A CHAPTER OF THE LOUISIANA DIVISION OF THE NATIONAL ASSOCIATION FOR MENTAL HEALTH

CASE EXAMPLE

OF

EARL GARRETT, JR.
(SSI *Beneficiary*)

SSA's Policies evaluating Mental Illness resulted in termination of disability benefits

Submitted by:

Earl Garrett, Jr. (Beneficiary)

Fran Bussie, Vice-President
Mental Health Assn. for Greater
Baton Rouge

Virginia Mazerat, Job Developer
Job Development Program
Mental Health Assn. for Greater
Baton Rouge

Josephine G. McCarthy, Ex. Director
Mental Health Assn. for Greater
Baton Rouge

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I. Copy of Earl Garrett, Jr.'s original letter to Editor of the Morning Advocate, Baton Rouge.

II. Copy of Earl Garrett, Jr.'s letter as published in Morning Advocate, Baton Rouge.

III. Statement from Virginia Mazerat, Job Developer Mental Health Assn. for Greater Baton Rouge.

"The Apparently Cast Aside"

I recently had the opportunity to read an interesting article which was written by Mr. Sherman Day of Port Allen. Mr. Day's article was relating to his social security being terminated. I too fall into the same category as Mr. Day; i.e., I have been dependent on social security for reasons of which I have no control, as a sole means of income, the difference being that my disability is mental in nature, whereas, his appears to be physical.

My initial disability began in approximately 1972 or 1973 and has continued to mushroom until the present time. I too have been treated by doctors whom I consider to be top in the field of psychiatry. Also, what remains a mystery to me is how an individual, a doctor, who has never treated me before, can in a short period of time, about forty-five minutes, make a determination which is completely adverse to specialists who have treated me for years.

Does a person, as a consequence of having connections with a state agency, really have the expertise and authority to play God, and be given a position to determine my destiny relative to my sole means of survival and support?

The method utilized to coerce me to go into see the social security doctor was achieved in a very devious manner from my viewpoint of the situation.

Every year, around May, June or July, I receive a piece of correspondence from social security via the disability determination department with the state. Each time that I have received correspondence relative to my condition it has caused me mental anguish as well as further depressing me. This past July was no different in this respect other than that it disturbed me more than usual. I spoke with my social worker about the situation. She in turn called the disability determination section of the state and informed them that the correspondence had me greatly disturbed. She was informed to tell me not to let it bother me, that it was nothing more than a formality to update their records. (I was there when the call was made).

This relieved my distress to a degree as I relied on this information and expected it to be the truth. After being reassured I made the appointment; approximately two weeks later a letter came through the mail stating that as a result of the social security doctor's report and also reports received from my doctor, my disability check would be terminated. The letter stated that if I had anymore information pertaining to my condition to sign the letter and return it. I talked to my social worker about the letter and was told to sign it and send it back. My doctor then sent in a report reiterating his diagnosis regarding my condition.

Shortly thereafter, a letter was sent to me verifying receipt of the report. Not long after this another letter was sent to me stating that the decision to terminate my check would not be reversed.

I have copies of the reports and letters sent in, and the situation is being treated as if there was never anything having been sent in.

To me it appears that persons responsible for having my benefits terminated not only want me totally disabled but entirely and completely incapacitated as well. "Decisions" - I am unable to make them and find myself dwelling on situations which the average person would not even have to give a second thought. This is an example of the way my mind is disarranged and in essence I can only hope to learn to cope with it. Being placed in a position of premature retirement at my age is something that has been very difficult for me to learn to cope with. Not only is it a task to learn to keep occupied all the time so as to keep myself from being put into the hospital again; my last hospitalization lasted a little less than two years. Not only do situations occur that keep me depressed, anxious, and exhausted all the time, but also causes me to be very paranoid. As a consequence of these problems and fears, I am forced to continue to live in a frame of mind that keeps me leery and suspicious of most new situations and persons, not only those I don't know, but also friends and relatives I have had for life.

They continue to attempt to console me. Essentially the life I am describing is really, to me, an unending, dismal, living and tormenting hell on earth from which I apparently will never have any lasting peace.

I would like to apologize for the length of this article. However, I had this much and more to say about the situation and I know of no shorter means to express myself. Thanks for reading this.

Earl

Earl Garrett, Jr.
5675 Guice Drive
Baton Rouge, LA 70811

II

"Will The Mental Lashings Ever Stop"

Back in October of 1982, I had the opportunity to read an article to you written by Mr. Sherman Day from Port Allen.

I too fall into the category of being disabled, as Mr. Day is; the difference being that my disability is mental instead of physical.

Hardly a day goes by without there being an article in the newspaper relative to either social security or one of the other social programs. A number of years back I became both frightened and confused as a result of articles in the newspapers. For a long time I would not read anything.

Now again, I am beginning to get the same feelings that I have strived so much to overcome and forget.

I endeavor, by doing volunteer work, at one of the local mental health centers to alleviate my guilt feelings of being on social security and also to help relieve the agony of feeling like I am a burden on society.

There are a number of people I know who are on disability social security who do not attempt to make any contribution whatsoever to society.

I, in turn have done everything in the past that I have felt capable of to make restitution to society and the community. Therefore, it infuriates me to no end everytime the situation crosses my mind. Here I am trying to do, what to me seems right, and in turn I am being chastised by having my disability check terminated. It has taken me years to become resigned to the fact that destiny of my life has been placed into such a precarious position. It is very disturbing that apparently one individual, or a very few, at the most, who really know nothing about a person can place an individual's whole means of support, and only means of survival, into such jeopardy. It is very distressing to know that such a situation can occur in which an individual really has no defense whatsoever.

Earl Garrett Jr.

Earl Garrett, Jr.

III.

re: Earl Garrett, Jr.
Age 42 - Married
Veteran
Dates Served: 8/63-7/65
Unemployed since 5/75
SSI Beneficiary

Earl Garrett, Jr. was referred to the Job Development Program by Karen Peyton, Social Worker at Margaret Dumas Mental Health Center, Baton Rouge, La.

He was interviewed September 8, 1982. During the first interview the applicant showed great signs of stress and anxiety to the point of tears and trembling. He had received notice that his Social Security would be terminated and had come to my office for job placement assistance.

He showed a great lack of ability to face the "world" and its job market.

It is my responsibility to help the mentally restored find suitable work. As for Earl Garrett, Jr., I did not find him "job ready". In all likelyhood, if Earl loses the security of his Social Security benefits, he will require institutionalization once again.

Submitted by

Virginia Mazerat

Virginia Mazerat, Job Developer
Job Development Program
Mental Health Assn. for Greater
Baton Rouge

MORNING ADVOCATE, Baton Rouge, La., Tues. March 8, 1983

Letters to the editor

Voluntary work apparently not enough

Editor, Morning Advocate:

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Hardly a day goes by without there being an article in the newspaper relative to either social security or one of the other social programs. A number of years back I became both frightened and confused as a result of articles in the newspapers. For a long time I would not read anything.

Now again, I am beginning to get the same feelings that I have strived so much to overcome and forget.

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I, in turn, have done everything in the past that I have felt ~~capable~~ of to make restitution to society and the community. Therefore, it infuriates me to no end every time the situation crosses my mind. Here I am trying to do what to me seems right and in turn I am being chastised by having my disability check terminated.

It has taken me years to become resigned to the fact that the destiny of my life has been placed into such a precarious position. It is very disturbing that apparently one individual, or a very few, at the most, who really know nothing about a person can place an individual's whole means of support, and only means of survival, into such jeapordy. It is very distressing to know that such a situation can occur in which an individual really has no defense whatsoever.

Earl Garrett Jr.
5675 Guice Drive
Baton Rouge

HOURS BY APPOINTMENT

BOARD CERTIFIED PSYCHIATRIST

Gene F. Haring, M.D.
841 WYOMING AVE.
KINGSTON, PA. 18704
(717) 288-8191

April 6, 1983

Senator John Heinz, Chairman
Special Committee on Aging
Room SD-G37
Dirkson Building
Washington, D.C. 20510

Dear Senator Heinz:

I am a board certified psychiatrist practicing in this geographical area since 1969. I have been under contract with the Social Security Administration for several years as a medical advisor available for expert testimony in cases of social security disabled evaluations on individuals with mental or emotional impairments. Involvement in this capacity has been more intense since 1979. For example, I am scheduled to appear as a medical advisor on fifteen separate cases in the month of April, 1983.

I do not have access to the cases once a hearing is held so that I am at a disadvantage in providing specific details. It is, however, my distinct impression that the claimed psychiatric disability is present as claimed in at least sixty to seventy-five percent of the cases where I have appeared as medical advisor. One specific case which I can recall involved a female who was residing in a supervised living setting with twenty-four hour staff supervision and was involved in a sheltered workshop in the daytime hours. Benefits were terminated with one comment made "since you can think" the decision was made that this individual could be and should be involved in gainful employment. Given the need for supervised living and a sheltered workshop setting, I would submit that common sense would dictate that this individual could not be gainfully employed. Other cases where disability benefits have been terminated, upon review, clearly indicate that

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Senator John Heinz

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the individual's status has not changed from the time that disability benefits had been granted at a prior time. Termination of disability benefits would appear, in my professional opinion, to often be an arbitrary process.

Thank you. Your review of this process is certainly indicated and I appreciate your giving time and effort in this matter.

Respectfully submitted,

Gene F. Haring, M.D.

GFH:cjk

STATMENT OF THE ASSOCIATION OF ADMINISTRATIVE LAW JUDGES, DHHS

submitted by Chester Shatz, Legislative Cochairman

Psychiatric cases have constituted a large part of the workload in hearings before administrative law judges, and in many instances the judges have noted that the state agencies have inadequately developed the evidence. In this regard state agencies have often failed to get complete and up-to-date psychiatric evidence. Thus, cases have been dumped into the laps of the administrative law judges because of faulty state-agency work. Moreover, state agencies have continually failed to evaluate psychiatric impairments based on an individual's entire psychiatric history. Too often state agencies deny a claim based on a person's psychiatric condition during a very narrow time-frame when psychiatric records covering a much larger span of time clearly indicate that the individual suffers from a severe psychiatric impairment. We have often noted state agency denials based upon a rationale that the claimant is not delusional or hallucinating. However, there is no statutory requirement that a person be delusional or hallucinating to be found psychiatrically disabled. We also have noted denials of claims despite reports in the record from impartial psychiatrists and psychologists specifically indicating that the claimant is unable to meet ordinary production quotas and is unable to respond appropriately to ordinary work pressures.

As a result of the above mentioned failings, state agencies have found claimants to be "not disabled" when in fact full development and proper evaluation of the evidence would have indicated that these claimants were unable to work because of severe psychiatric impairments. Another major deficiency in state-agency evaluations is that many state-agencies have denied claims because a claimant's impairment did not meet or equal the severity of a listed psychiatric impairment. Of course that is an incorrect application of the law since the Social Security Act does not require that disability be based on meeting the requirements of a listed psychiatric impairment. All that is required is that a person have a psychiatric impairment which has lasted or is expected to last 12 months, and which is of such severity to preclude substantial gainful work.

Some typical examples of state-agency denials are as follows:

> Claimant, who had not worked for about 10 years because of a long history of psychiatric illness and multiple hospitalizations and who was hospitalized at time of filing of his application for benefits because of a psychotic breakdown, was found not disabled because impairment not expected to last 12 months.
>
> Claimant, who believed he was God and who was found by an impartial psychiatrist to be unable to respond to customary work pressures and stresses and unable to relate to others, was found not disabled since the state agency thought he could perform simple repetitive work.
>
> Claimant, who was of borderline intelligence and who was determined to be suffering from a severe crippling, anxiety neurosis by an impartial psychologist, was found able to work by the state agency since he was not delusional or suffering from hallucinations.
>
> Claimant after psychometric testing by an impartial psychologist was determined to be of low intelligence with a severe psychiatric impairment precluding any type of gainful work except that in a sheltered workshop. Nonetheless the state agency denied the claim on a theory that claimant could perform simple repetitive work.
>
> Psychometric testing showed claimant, who heard voices, to be suffering from severe paranoid schizophrenia. Claimant was withdrawn and unable to relate to others and had been fired from several jobs because of bizarre behavior. The state-agency denied the claimant since it felt claimant's impairment did not meet or equal a listed impairment.

In closing, the Association points out that it appears that state agencies do not have a basic understanding of the definition of psychiatric disability as contemplated under the Social Security Act and the Secretary's <u>published</u> Regulations. It further appears to us that state agencies give "short shift" to psychiatric cases and usually will not find a person "disabled" unless he either is institutionalized or is a raving maniac. Corrective action certainly needs to be taken and the Association recommends the following:

1) More detailed <u>published</u> Regulations defining psychiatric disability

and

2) A comprehensive training program for state-agency staff psychiatrists who have the power to deny or allow claims.

nade

Mr. Chairman and Members of the Committee.

On behalf of the members of the National Association of Disability Examiners, I welcome the opportunity to offer our views on the Social Security reviews of the mentally disabled under the Periodic Review and Continuing Disability Investigation processes.

The National Association of Disability Examiners has a membership composed primarily of employees in the state Disability Determination Services who adjudicate Titles II and XVI disability claims for the Social Security Administration. These examiners are also responsible for evaluating the Continuing Disability Investigations (CDI) claims to determine current eligibility of beneficiaries in terms of medical and vocational severity.

The Social Security Regulations No. 4, Subpart P and Regulations No. 16, Subpart I are the medical criteria used by the states in initially establishing disability and then evaluating the beneficiaries' conditions as to continued eligibility. Social Security Disability Insurance Benefits and Supplemental Security Income are unlike other medical insurance programs in that as their primary tenet, they require the beneficiary to have a one-hundred percent impairment, which, under the law " defines disability as the inability to do any substantial gainful activity by reason of a physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." In order to determine the initial entitlement and to evaluate a continuing period of eligibility, it is necessary to establish by "medically acceptable clinical and laboratory diagnostic techniques" the presence of a physical or mental impairment. Many critics of the Social Security Disability Program suggest that, especially in mental impairment cases, objective medical evidence, similar to that which they readily agree is necessary in physical impairments, is not needed. The Regulations (Section 404.1513) specify that medical reports be obtained from acceptable sources, include medical history, clinical finding, laboratory studies, diagnosis, treatment and prognosis, and medical assessment. The "ability to do work related activities... and in cases of mental impairment, the ability to reason or make occupational, personal, or social adjustment" can then be derived from the reports.

Our Association agrees there have been "horror" stories of persons whose benefits have been terminated erroneously. There have, likewise, been horror stories of persons receiving benefits who currently are working or originally did not meet the definition of disability, based on either a physical or mental impairment. Social Security has been taking steps to rectify these situations. Unfortunately, the "acceleration" of the CDI process (by the 1980 Legislation, this would not have gone into effect until January, 1982) brought significant numbers of claims to the states for review, beginning in 1981. In fiscal year 1982, it was anticipated there would be 152,000 regularly scheduled CDIs and 415,000 additional CDIs nationwide. These increases in cases to review will naturally heighten the public's awareness of cessations of benefits and further add to the magnification of so-called "erroneous" decisions. What few people readily admit is that the "public" called on Congress to establish the means by which the disabled, collecting public funds, would be periodically reviewed. Congress, in turn, developed the periodic review process, which Social Security speeded-up in implementing. PL 96-265 required that beneficiaries with non-permanent impairments be re-examined every three years and that those with permanent impairments be re-evaluated every seven years. This legislation was considered necessary too, because GAO Studies showing that many scheduled medical re-examinations were not being done in a timely manner or often were not being done at all. Other GAO Studies and studies conducted by the Social Security Administration indicated that thousands of Social Security (and SSI) recipients did not meet SSA's eligibility criteria. PL 96-265 was designed to correct these problems by requiring that <u>all</u> disability claims be re-evaluated at least once every seven years. This then, resulted in the chagrin of the "public" who found their benefits being ceased. It becomes a question then of who should be ceased benefits. Depending upon any particular advocacy or lobbying group's special interests, it should only be those people with other impairments who should be taken off the rolls. This is only human nature.

Critics of the CDI process, suggest mental impairments not be reviewed under the same criteria of objectivity as those used to assess physical impairments. The law, in the form of the Regulations, as stated previously, is very clear on this point. To that end, mental impairments need to be assessed as to the severity of the condition in comparison to the Listings of Impairments to determine if there is present, an impairment to meet or equal those Listings. The Listings of Impairments describe the impairments, by body system, considered severe enough to meet the requirements for Social Security. It is true that the impairments noted in the mental Listings are not as quantifiable (except the mental retardation evaluations by psychometric test scores) as those for physical impairments (e.g. EKGs, PFS tracings, etc.). This necessitates a greater reliance on mental status examinations by psychiatrists, psychologists,etc. Unfortunately, psychiatry is still a new enough "science" that it lends itself to various therapies and analyses which often provide subjective overtones. This with the sensativity still associated with mental impairments, puts the evaluation in a grayer area than the "typical" physical impairment, which can be <u>seen</u>, measured and manipulated. The implication is there also, that when dealing in an area affecting the mind or psyche, different evaluations should be used or a different approach taken than with a physical impairment. Yet, periodic reviews of the mental impairments are necessary and NADE supports the concept of such reviews for all disabilities. The question now is how can these reviews be conducted in a way which protects the integrity of the disability rolls without causing undue hardship to those beneficiaries whose claims are being re-evaluated.

nade

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There are instances where a full continuing disability investigation is not warranted, presents a hardship to the beneficiary, and is not cost effective to SSA. These occur in mental impairment cases as well as those involving physical disabilities. The Social Security Administration is now curtailing development on many claims, even though the beneficiary is still contacted and being told of a review. If there has been no return to work or death has not occurred, and it is obvious that the beneficiary cannot work due to a permanent impairment, development stops. This is true of the person with an IQ of 59 or less established by appropriate tests after age 16. NADE supports this category of permanency. NADE also supports the curtailing of development in cases of Downs Syndrome because of the usual multitude of physical and related mental impairments. This is an impairment not currently curtailed by Social Security.

Critics often state that institutionalization constitutes a permanent condition. This may not always be the case, since the institutionalization may have resulted from incarceration or family inability to cope with the individual in the home setting. Social Security has compromised and establised a separate criteria for use by their District Offices, whereby, a hospitalized person, unable to complete the CDI interview, is temporarily curtailed, and benefits continue. NADE does not support placing such individuals in a permanent category. We do suggest that curtailed medical evaluations such as these be given to the states also. We also advocate the detailed documentation of the reasons for hospitalization in these cases. We cannot support the belief that any one category of impairments, psychiatric or physical be excluded from the CDI process altogether. Such an exclusion, particularly one mandated by Congress, does not take into account past and future medical and technical advances in treatment.

NADE strongly recommends the enforcement, by the Social Security Administration of sequential evaluation, in all states and regions. By this process, complete documentation is obtained and evaluated so as to determine if the Listings are met or equalled in severity. If either of those two decisions cannot be found, based on signs, symptoms, mental status examination and detailed daily activities (as set forth in the Regulations mentioned previously) along with evidence of remissions and exacerbations, then a medical-vocational allowance (continuance) should be considered. It should not be an automatic assumption that a person with a mental impairment, which does not meet or equal has the physical or resultant mental ability to perform unskilled work. NADE supports the guides outlined in the Social Security Disability Operational Policy and Procedure Information Digest (No. 79-32 d4.02a; No. 79-33 d4.02b; and No. 79-34 d4.02c) which further clarify this issue. NADE would like to go one step further and have Social Security add these guides to the Rulings for mandated use by all review levels. NADE wishes to go on record additionally to support the use of workshop evaluations so as to evaluate ability to function with others and in a job setting. While it is known that workshops are not always accessible to the individual state Disability Determination Services, without undue time involvement (a valid assessment through a workshop can take from one week' to a month) we encourage Social Security to supplement state budgets accordingly and to not penalize states for lost processing time in these cases. The recent court case of the Mental Health Association of Minnesota v Schweiker (No. 4-82-civ.83) has made it painfully obvious that sequential evaluation, with emphasis on vocational assessment, must be used in mental impairment CDIs as well as physical disability evaluation.

To further assist the truly disabled and those reliant on disability benefits, in keeping beneficiary status, NADE will go on record before this committee, as it has recently done before the Social Security Administration, with two proposals. These proposals, while not directed solely toward the mentally impaired, would, in fact, benefit many disabled beneficiaries.

1. Beneficiaries, aged 55 years and older, who have been on the disability rolls for five(5) years or longer, should be continued unless there is <u>specific</u> evidence of medical improvement.
2. Beneficiaries, aged 50 years and older, who have been on the disability rolls for ten(10) years or more, and who have not demonstrated the ability to perform past work, should be continued.

We believe these provisions are necessary to protect the older worker who has been out of the work force, who has become accustomed to and relies upon the income provided by the disability insurance and who may not have been advised that disability benefits were not necessarily lifetime benefits.

Summary

For several years NADE has gone on record on many issues pertaining to the disability process. Again, on the issue of the CDI review of mental impairment cases, we believe some changes to the current evaluation system are necessary. While, as stated previously, not all of our recommendations would benefit just the mentally impaired, we see the need to consider them for <u>all</u> beneficiaries (especially of older age, regardless of disability). In the same vein, NADE supports the refinement of assessments of mental impairments as opposed to the elimination of their review. The Social Security Disability and Supplemental Security Income Programs are to serve <u>all</u> citizens applying, who are found disabled. <u>All</u> disabled beneficiaries should then be reviewed equally. To that purpose, we look for changes in Social Security Rules and Regulations. NADE also encourages you to accept our proposals.

This concludes our statement for the record. Thank you, Mr. Chairman and Committee Members for permitting the National Association of Disability Examiners the opportunity to provide written comment.

THE SSI/SSDI DISABILITY CONTROVERSY:

How and Why the Social Security Administration Has Reduced the Number of SSI/SSDI Beneficiaries

Prepared by: State of Michigan
Interagency Task Force on Disability
Phil Michel (Author)

Released: April 1983

For further information contact:

L. Annette Abrams, Director, Office of
Intergovernmental Relations
Michigan Department of Mental Health
Cass Building, Sixth Floor
Lansing Michigan 48926 (517) 373-6900

ABSTRACT

This report is nonpartisan. It focuses on bureaucratic activities undertaken by the Social Security Administration (SSA) during the tenures of President Carter and President Reagan. It describes the effects of adjustments in the federal disability program which have exceeded apparent Congressional intentions. As such, this report is targeted at members of Congress: those who have the authority, through oversight, to maintain the nation's disability program on its expected course.

Specifically, the report discusses the abrupt decline in the total number of individuals benefitting from programs authorized under Titles II and XVI of the Social Security Act: the Social Security Disability Insurance program (SSDI) and the Supplemental Security Income program (SSI), respectively. It examines the years between 1976 and the present during which, after years of legislative stability and caseload growth, the numbers of approvals (referring to benefit awards to new applicants) and continuations (referring to continuation of payment to current recipients) have steadily declined.

Michigan asserts that these reductions are due to the more stringent procedures which the Social Security Administration (SSA) has required state Disability Determination Services (DDS's) to adopt. These more narrow disability examination procedures, in and of themselves, will be shown to have reduced the numbers and percentages of new approvals. Furthermore, as large numbers of current recipients undergo mandatory case reviews, the negative effects of revised procedures is passed onto an even larger portion of the disabled population, i.e., over 40% of those undergoing periodic reviews are declared ineligible for further benefits. Consequently, many incoming applicants and current recipients--all disability cases--are becoming part of a growing number of so-called "ineligibles."

Most striking is the estimated impact which increased cessations will exert on state and local budgets. Should narrower standards continue to reduce the total pool of eligibles by 40% and if (as some states have found) 30% of those denied eventually depend on state-financed programs, states can expect General Assistance (GA) and Aid to Families with Dependent Children (AFDC) caseloads to increase by about 730,000 persons nationwide.

In addition to the reductions described above, SSA is supporting new legislation and administrative changes which will deny benefits to even greater numbers of applicants and current recipients.

This paper reviews the history of, and the rationale underlying, recent administrative changes in the disability program. The paper also recommends that Congress undertake the following actions:

1. Direct the Social Security Administration (SSA) to set aside the majority of the more stringent case review practices adopted since 1976.

2. Continue legislative activity begun in the 97th Congress by enacting comprehensive statutory improvements in Continuing Disability Investigation (CDI) procedures. Procedural improvements which merit inclusion in statute are described on pages 13-14 of this report.

3. Recognizing that most SSI recipients have had only a tenuous connection with the labor market, direct SSA to adopt a definition of disability for the SSI program which is separate from the meaning of disability applied in the SSDI program. A new SSI definition should give weight to the fact that physical or mental impairments, coupled with negligible work experience, limit the employability of SSI-eligible individuals far more than their impairments alone may indicate.

4. Direct SSA to undertake a longitudinal comparison of persons approved and denied benefits. Such a study should seek information pertaining to the subsequent earnings, if any, of denied applicants.

EXECUTIVE SUMMARY

Downward Caseload Fluctuations

In 1976, the federal Social Security Administration (SSA) began removing flexibility from the disability review procedures imposed upon state Disability Determination Services (DDS's). The result of tighter procedures has been a continuing decline in the number of applications approved for benefits under both the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs. By 1982, the lower approval rates for both programs represented a halving in the number of approvals documented six years earlier in 1975.

Until SSA began largescale reviews of all current recipients in March of 1981, these gradual caseload reductions remained relatively obscure. Largescale increases in the number of reviews, termed "Continuing Disability Investigations (CDI's)" caused multiple thousands of clients to be reevaluated under more rigid procedures which had, by 1981, become standard. These periodic reviews using narrower standards caused nearly half of the beneficiaries examined to be declared ineligible for further benefits. Because many of the recipients terminated as a result of CDI's remained "disabled" under almost any definition of that word, these "erroneous cessations" came quickly to public and Congressional attention.

Current Legislation

A number of bills proposing revisions of CDI procedures were introduced in the 97th Congress; several others are now pending in the 98th Congress. Much of the legislation proposed in 1982 focused on periodic review procedures. The authors of this report applaud the 97th Congress, especially Senator Carl Levin and other supportive members of this state's delegation, for their determination in enacting H.R. 7093, a disability reform bill which addressed several obvious weaknesses in the periodic review process. This bill received Congressional approval near the end of the lame duck session, and became Public Law 97-455 subsequent to the President's signature in January 1983. P.L. 97-455, as emergency legislation, mandated one temporary and three permanent improvements in the periodic review process for Title II (SSDI) beneficiaries:

1. It allows beneficiaries who are appealing a termination decision to request that benefits be continued until the appeal has been completed, i.e., through the rendering of a decision by an Administrative Law Judge (ALJ). This provision expires in June 1984.
2. It grants discretion to the Secretary of HHS in determining how many CDI's each state can appropriately review.
3. It mandates that, by January 1, 1984, all initial appeals (reconsiderations) of negative decisions will be conducted face-to-face and will be evidentiary in nature. The bill further specifies that beneficiaries requesting reconsideration will be informed of opportunities to be represented by counsel and to introduce all available evidence at the reconsideration.
4. It ensures, for the first time, that Congressional Committees will receive semiannual reports on periodic reviews (the number carried out and the human impact of these reviews).

To date, bills introduced in the 98th Congress indicate an understanding of the need for deep and comprehensive refinements in the way disability is determined and cases are periodically reviewed. S. 476, a bill sponsored by Senator Carl Levin of Michigan, includes several provisions whose enactment into law would make periodic review processes more consistent with Congress' reasons for passing the Social Security Amendments of 1980.

Specifically, S. 476 would:

- prevent the termination of benefits unless SSA proves that the beneficiary, due to medical improvement, has become more capable of gainful employment. The bill requires that SSA's decisions be based on medical information which is gained from treating physicians and covers the previous 12-month period.

° permanently place in statute the opportunity for beneficiaries to request that benefits be paid until an appeals decision is rendered by an ALJ.

° require SSA to promulgate all disability review standards in the form of regulations, i.e., proposed modifications would be subject to public notice and comment.

H.R. 1766, sponsored by Congressman Robert Davis of Michigan, addresses similar problems in the case review process. Specifically, H.R. 1766 mandates that SSA provide evidence of medical improvement before SSA ceases benefits on the grounds that the individual in question is "gainfully employable." H.R. 1766 also requires that beneficiaries undergo periodic review within three years of gaining disability benefits; subsequent case reviews would be conducted at the discretion of HHS' Secretary, rather than in accordance with the rigid triannual schedule mandated in current law.

Regardless of legislative reforms affecting current beneficiaries, the number of new approvals will remain historically low. To illustrate the need for legislative action to ensure that benefits are awarded to eligible new applicants, this report reviews the history of recent disability laws and recommends legislative action designed to provide a "safety net" for the truly needy.

Stable Statutory Definition of Disability

Legislatively, the definition of disability is the same for the Title II (Social Security Disability Insurance) and Title XVI (Supplemental Security Income) programs. The basic definition of disability in the Social Security Act reads:

> The term "disability" means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months...
>
> ...an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applies for work...

The original disability definition was drafted in 1954, and was revised twice in the mid-1960's. Prior to 1965, the statutory definition required disabilities to be of "long, continued and indefinite duration." In 1965, the "12 month duration" requirement was substituted for the previous, more ambiguous criterion. In 1967, the phrases defining work "available in the national economy" were added. The current definition, with minor variations, is used in the SSDI, SSI and Medicaid programs.

The statutory definition of disability is considered to be a strict definition which only the most severely disabled can meet. It is designed to distinguish between: (1) those who are out of work because of their medical impairment; and (2) those who could work even through impaired to some extent.

Although the definition of disability has not changed in fifteen years, the percentages of applicants approved under this stable definition has decreased substantially. For example:

- ° The percentage of applicants approved at the initial point of application (without challenging a denial through reconsideration appeal) dropped from 46% in 1968 to 22% in 1980.

Stated in other terms:

- In 1968, 568 of every 100,000 insured workers were awarded benefits. By 1981, this ratio had dropped to 357 awards for every 100,000 insured workers, making the 1981 rate the lowest in the history of the SSDI program.

Reasons suggested to explain downward caseload fluctuations have included: changes in the composition of the insured population, improvements in the general health of the population, increasing denials based on non-medical factors and a tighter "adjudicative climate." While all of these factors may have affected caseload fluctuations, only a much tighter "adjudicative climate" can explain the drop from 40% to 22% in initial approvals which occurred between 1976 and 1981.

The term "adjudicative climate" refers to the bases upon which disability cases are settled, i.e., the formal and informal procedures underlying decisions to grant or deny benefits. Over time, the prevalence of certain disability determination outcomes has substantially changed (from more awards prior to 1975 to more denials after 1975). This tighter adjudicative climate has often, been attributed to the mandates of Congress. For example, publications from both the General Accounting Office (GAO) and the SSA have suggested, respectively, that the adjudicative climate may have changed due to "a decade of prompting from the Congress" and due to "interest, on the part of Congress as well as the executive branch in the effect of program administration on costs...." Although Congress has been concerned with caseload growth, little information exists to support a conclusion that Congress expected SSA to implement its legislation in a manner which would cut in half the number of new disability beneficiaries.

SSA Restrictions Exceed Congressional Intent

Congress enacted two major legislative acts pertaining to disability during the period in question: Public Law 95-216, the "Social Security Amendments of 1977" and Public Law 96-265, the "Social Security Disability Amendments of 1980." During hearings for both the 1977 and 1980 legislation, SSA presented testimony regarding its problems with the definition of disability. Congress, in both instances, declined to change the statutory meaning of disability, in spite of SSA's stated problems. SSA, ignoring Congress' reluctance to change existing provisions, implemented administrative changes which led to more severe applications of the disability definition.

The statutory definition of disablity does not describe how the definition is to be applied in individual cases. These criteria are spelled out in regulations and operating instructions promulgated by SSA. State Disability Determination Services (DDS's), under contract to SSA, apply regulations and instructions in making eligiblity determinations.

Although the negative administrative changes were implemented by state DDS's, the procedures followed were minutely specified by SSA. Specifically, the half-page statutory definition was transformed by SSA into 108 pages of federal regulations. These regulations have been further expanded into three large, looseleaf binders containing instructions for use by disability examiners in developing eligibility recommendations. The administrative modifications having the greatest impact on how the definition is applied can be summarized as follows:

- "Severe" Impairments Redefined as "Slight" Impairments. The minutely-detailed instructions described above were revised ("clarified" by SSA guidelines) so as to change impairments which were formerly classified as "severe" (hence, eligible for approved benefits) into impairments classified as "slight" (hence, ineligible for approved benefits).

- Fewer Non-Listed Impairments Classified as Disabling. State DDS's formerly exercised latitude in deciding whether an impairment (or group of impairments) not specifically listed in the regulations had a disabling effect equal to listed impairments. SSA restricted the ability of state examiners to exercise this discretion. As a result, the number of allowances classified as "equal to the listings" dropped from 44% in 1975 to 9% in 1982.
- Quality Assurance Reviews Ignore Wrongful Denials. Additional "de facto" policy was manufactured by SSA through changes in quality assurance procedures. Specifically, numerous state-approved cases were returned as erroneous to state agencies. Virtually all such quality assurance reviews were targeted at benefit approvals; few, if any, quality assurance efforts were focused on the prevention of wrongful denials.

Reversals by ALJ's

As the approval rate of initial determinations declined, more applicants began to request hearings before Administative Law Judges (ALJ's). These hearing officers frequently found that original denials were made in error; benefits were awarded accordingly.

This "reversal rate" (i.e., the frequency with which ALJ's overturn DDS denials), was addressed by Congress in Section 304(g) of the 1980 legislation which directed the Secretary of Health and Human Services to "implement a program of reviewing, on his own motion, decisions rendered by ALJ's as a result of hearings...and...report to Congress by January 1, 1982, on his progress." The Secretary subsequently reported that ongoing reviews were not implemented until October 1, 1981, and "because the ongoing review program was only recently implemented, significant data about the results are not yet available." In his response to Congress, the Secretary also reported that steps designed to reduce the reversal rate were either planned or already implemented. It is important to note that the overall direction of planned steps to lower the reversal rate focused on bringing ALJ decisions into agreement with initial DDS denials (rather than restoring discretion to DDS's so as to prevent erroneous decisions).

Today, approximately one out of every four new beneficiaries is forced to establish eligibility through a protracted, often expensive ALJ hearing process. When 25% of all new recipients must prevail at a hearing before benefits are rightfully awarded, it is clear that changes are needed. However, it is not at all clear that such change should emphasize application of more stringent criteria and rules by DDS's.

Social Security Advisors Address the Definition

In addition to Congress, the definition of disability has been addressed by two recent SSA advisory groups. The Advisory Council concluded in its 1979 report that:

> A majority of the council recommends that the definition of disability for benefits under Title II be liberalized for older workers...
>
> A majority of the council also recommends that a more liberal definition of disability be used for determining eligibility for SSI disability benefits under Title XVI than is used for determining eligiblity for social security disability benefits.

The National Commission established under President Carter wrote that:

> The Commission finds little evidence that the definition of disability in the law is too liberal or that it allows benefits to be paid to people who are able to support themselves.

Employment and Death Statistics of Denied Applicants

A close examination of the circumstances faced by applicants who are denied benefits starkly affirms the conclusions reached by the advisory groups quoted above. Four studies of the employment achieved by applicants subsequent to denial report that between half and two-thirds of the denied applicants have $0 earnings during the five years following rejection. Only 10% had earnings of more than $300 per month.

One of the studies indicates that 11% of the younger males denied at all levels through ALJ hearings died within the next five years. This death rate is approximately three times the mortality rate documented among members of the same age group in the general population. It is essential to point out that death rates for both denied applicants and approved SSDI recipients differ by only five percentage points, with the rate for approved beneficiaries equalling 16%.

Disability review procedures purport to identify individuals whose illnesses are expected to prevent gainful employment and/or to cause death. The studies described above show little difference between denied applicants and approved applicants on two factors indicative of severe disability: employability and potential for death. These data support the conclusion that many wrongfully denied applicants continue to sustain life-threatening conditions and are unable to work long after SSA's restrictive criteria have categorized them as "able-bodied."

Need for a Separate SSI Definition of Disability

Although more rigid disability determination processes have been applied to both the SSDI and SSI programs, the individual effect of additional denials is more cruelly felt by SSI applicants. Profiles of SSI applicants show they are unlikely to have other resources to fall back upon. As noted in the 1979 Report of Social Security Advisory Council:

> Since disability insurance benefits are paid without regard to need and can, in many circumstances, provide fairly adequate income support, it is appropriate to restrict eligibility to those whose medical impairments are quite severe. However, in the SSI program, where benefits are generally lower and are paid only to those with little

> or no other income and only limited assets, such strict standards for eligibility are neither necessary nor desirable. *The SSI program should be viewed as a safety net.* It now protects those whose impairments are severe enough to qualify for disability insurance, but whose social security benefits are insufficient to provide a decent level of income. It should also protect those in need whose impairments are not quite severe enough to qualify them for disability insurance, but are severe enough to prevent them from working when the impairments are combined with other personal and economic factors that cannot be measured with reasonable objectivity. (emphasis added)

In summary, applicants for, and recipients of, SSI differ from their SSDI counterparts in the immediacy of their needs, the amount of potential benefits, their age, their disabling conditions, and their employment history. In view of the multitude of differences, a single definition of disability for both programs is more of a bureaucratic convenience than a logical decision.

State Impact

Artificially low SSI and SSDI approval rates will exert a substantial impact on the budgets of state and local government. For example, in Michigan, about two and one-half percent (2.5%) of the total state population receives SSI disability or SSDI benefits. Payments received by Michigan recipients currently equal about $85.5 million per month--$1.026 billion per year. Estimates based on small samples indicate that about 30% of the applicants denied benefits will become dependent on General Assistance (GA) or Aid to Families with Dependent Childen (AFDC). Some will also end up in jails, prisons and mental hospitals.

Continued application of the current stringent procedures can be expected to reduce both SSI and SSDI caseloads and payments by about 40% (although CDI's are currently terminating benefits about 45% of the time). Should these estimates prove to be accurate, *Michigan will eventually be called upon to replace $123 million in benefit payments which should rightfully be paid from federal monies.*

Conclusions

Administrative steps taken by SSA since 1976 made an already strict definition of disability more rigid. These steps have cut the approval rate for initial applicants under both SSDI and SSI approximately in half. In addition, the 1980 Disability Amendments required periodic reviews for all active disability cases. SSA conducts these periodic reviews under the more severe procedures developed since 1976. Consequently, benefits are now terminated for individuals who were approved under the procedures in existence before 1976.

Studies show that the definition of disability, as restricted by SSA, fails to separate those able to obtain work from those who, because of their impairments, are unable to obtain gainful employment. Very few applicants, whether their benefit applications are approved or denied, ever work full-time or otherwise again.

SSA's efforts to reduce the number of denials reversed at the hearings level are ill-conceived at best. There is little evidence supporting a conclusion that ALJ's routinely allow benefits beyond the bounds of law and regulation.

The strict definition of disability developed for the SSDI program is inappropriate for the SSI disability program. The SSDI definition is predicated on the assumption that eligible individuals have a history of participation in the work force. This precondition is seldom, if ever, met by SSI applicants.

Recommendations

1. Congress should direct the Secretary of Health and Human Services to set aside the majority of the more stringent practices required of the Disability Determination Services since 1976. In particular, the practices restricting state agencies' use of "equal to the listing," and those modifying the distinction between severe and slight impairments, should be rescinded. New disability regulations should be developed by a panel including experts in the fields of vocational rehabilitation, and labor

markets, as well as medicine. These regulations should specify that the expertise of all three fields be considered in individual determinations of disability.

2. Congress should amend the Social Security Act so that the following improvements in both initial and periodic disability investigation procedures are permanently initiated.

    a. Permanently amend the Social Security Act to ensure that clients appealing CDI cessations can receive benefits through the ALJ hearing.

    b. Mandate consideration of all available medical evidence, especially information from treating physicians, and including information used for the initial approval of eligibility.

    c. Require that SSA promulgate all disability standards in the form of regulations subject to public notice and comment.

    d. Prohibit SSA from terminating benefits unless SSA can prove (based on evidence of significant medical improvement) that the beneficiary is capable of significant gainful employment.

3. Congress should adopt a separate definition of disability for the SSI program. This definition should recognize that physical or mental impairments occurring in conjunction with a history of tenuous or non-existent connection to the labor force preclude any reasonable expectation of gainful employment. While some such individuals may be physically able to work in an abstract sense, their lack of experience and adaption to the work place present a significant additional handicap that can seldom be overcome, given the present resources allocated to rehabilitation.

4. Congress should direct the Secretary of HHS to undertake longitudinal studies of persons denied SSI and SSDI benefits, seeking to identify those characteristics, diseases and impairments that are most directly correlated with continued unemployment. The findings of the study should be used to modify future disability evaluation procedures to more adequately distinguish between those applicants who will be able to find employment and those who will not.

ANALYTICAL PORTION OF REPORT

STATEMENT OF PROBLEM: UNAUTHORIZED SSA PROCEDURAL CHANGES

Benefits awarded to the disabled under Titles II and XVI have fallen steadily and dramatically since the mid-1970's. The following comparative statistics illustrate the extent of the caseload reduction documented in the years between 1975 and the present.

- SSDI: Approvals Drop by 202,800

  In 1975, the Social Security Administration (SSA) processed 1,237,000 applications for Social Security Disability Insurance (SSDI). In that same year, benefits were awarded to 592,000 applicants for an approval rate of 47.8%. In 1980, SSA processed 1,159,000 SSDI applications and awarded benefits to 389,200 individuals for an overall approval rate of 33.6% (1)

- SSI: Approvals Drop by 118,000

  During the same years in question, parallel changes were occurring in the disability portion of the Supplemental Security Income (SSI) program. In 1975, 436,490 disabled SSI recipients were granted benefits. By 1980, the number of new beneficiaries had decreased to 318,699.(2)

An examination of the period from 1975 to 1982 reveals that the decline in awards continued at least through the first quarter of last year. Specifically:

- SSDI awards for the first quarter of 1982 were 55% of the first quarter 1975 level.
- SSI disability awards for the first quarter of 1982 were 54% of the first quarter 1975 level. (3)

SSA spokesmen have proffered a number of reasons for these continuous declines, including a tentative suggestion "that state agencies and disability examiners have become more conservative in the way in which they interpret and apply the standards."(4)

Others, however, have been more direct in linking declining awards to stringent practices initiated by SSA. A recent GAO study states that SSA "...has made major changes in the criteria and guidance used in the disability determination process."(5) In a December 1981 letter to the Region V Assistant Regional

Commissioner, the Director of the Wisconsin's Disability Determination Bureau stated that "the current adjudicative climate involving mental impairments seems to be one of deny, deny, deny." *In summary, the most plausible explanation for this nearly 50% reduction in approved applications is a substantial tightening of the disability criteria implemented by SSA.*

In addition to influencing caseloads in a downward direction, the more rigid criteria have contributed directly to a number of other changes throughout the system. *First*, an increased number of beneficiaries who undergo periodic review are determined to be employable.(6) *Second*, states with state-financed relief programs have noted an increase in the number of applicants. Some such states have begun assisting SSI applicants through the appeals process.* *Third*, SSA has initiated attempts to constrain appeals decisions by issuing minutely-detailed instructions resembling those imposed upon state Disability Determination Services (DDS's).

Congress Retains Stable Definition

The definition of disability has virtually been a perennial topic for Congressional hearings. Nevertheless, the definition has not been changed since Congress, in 1967, tightened criteria to control the direction of judicial rulings emerging from appealed cases. Recent major pieces of Social Security

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*More than two years ago, Michigan recognized the potential impact on the SSI program of the more stringent definition. In response, a program was designed to assist SSI applicants through the appeals process. While this "advocacy" approach has shown itself to be cost-effective and to have a significant impact on individual cases, it is a temporary stopgap rather than a long-term solution.

legislation are PL 95-216, The Social Security Amendments of 1977 and PL 96-265, The Social Security Disability Amendments of 1980. Although the legislative history of both acts indicates that possible changes in the definition of disability were mentioned during hearings, no changes were approved.(8)(9) Following are summaries of the content and impact of the 1977 and 1980 bills.

In the 1977 Act, Congress increased the payroll tax deduction used to fund disability programs. It also revised the formula for cost-of-living adjustments (COLA's) to prevent newly eligible recipients from receiving a double benefit (once from COLA increases and a second time from the use of inflated average wages in calculating benefit payment levels).

The 1977 amendments have proven to be largely effective. Specifically, the allocation of increased payroll taxes to the disability trust fund served to rescue the fund from potential bankrupcy. The 1977 amendments reduced the average monthly awards for newly-eligible recipients to within $2 of the monthly payments received by ongoing beneficiaries.(10)

In the 1980 Act, Congress mandated several changes designed to prevent a permanent loss of benefits on the part of recipients who attempt a return to work and subsequently fail to find or hold a job. The Act also established ceilings on family benefits to assure that SSDI benefit payments to low wage disabled workers would not surpass the earnings they received as healthy members of the work force. Additionally, the Act strengthened federal control over state DDS's, the agencies that determine an individual's eligibility to receive disablity payments under the law. Finally, SSA was mandated by the Act to review the status of disability recipients every three years.

The 1980 amendments, with one exception, have not been in effect long enough for definite trends to become apparent. One exception is the three-year periodic review which the Act imposed on SSA. The implementation of this requirement, in conjunction with the impact of stringent disability criteria on the process, are well known, if not notorious.

The 1980 legislation was prompted, at least in part, by two General Accounting Office (GAO) reports. These reports asserted that the files of many SSI and SSDI recipients lacked proof of continued eligiblity under the revised review procedures.(12)(13) Once one realizes that the beneficiaries studied by GAO were subject to changing eligibility rules, the report findings offer a clearer perspective. What is startling, is the extent of the impact exerted by changed eligibility determination procedures. The magnitude of the impact is illustrated by the results of these periodic reviews: <u>nearly one-half of the active cases investigated were terminated after review under the current standards.</u>(14)

SSA argues its ability to rationally target in initial periodic reviews, those few cases most likely, upon re-exmination, to justifiably be found ineligible. Even granting this possibility, it is inarguable that the definition of disablity, as applied, has changed. <u>The startling results of one study indicate that impairments remained the same or even worsened in 35% of the cases denied after periodic review.</u>(15) A second study conducted by the Social Security Administration reported that 9.7% had shown no improvement. (16)

The Social Security study outlines "characteristics of claimants being removed from the rolls." In an accompanying memo it is suggested that the report "be used to rebut allegations appearing in the media as to the types of persons we are removing from the rolls" and "to respond to congressional concerns." Using aggregate statistics the report concludes that there is a "strong tendency for cessations to involve younger workers, with good educational competence and an advantageous occupational background." Yet the more detailed statistics in the body of the report show that:

(1) Of those age 55 and above at the time of review, 42% were found ineligible for further benefits. Of those age 60 and above, 60% were found ineligible.

(2) Of those who have been receiving benefits between 9 and 12 years, 80% were found ineligible at review.

(3) Sixty-four percent (64%) of those who have been receiving Social Security benefits for 14 or more years were found ineligible when reviewed.

(4) Thirty-nine (39) of the cases reviewed had never worked. These were originally found eligible for adult disabled children or disabled spouses benefits. Of these individuals with no history of work, there were 14 (36%) found able to work at review.

Advisory Panel Recommendations

Section 706 of the Social Security Act requires that an Advisory Council be appointed every four years to review, among other things, the status of the disability insurance portion of the Act. The most recently established Council submitted a report on December 7, 1979.(17) The 1977 Social Security Amendments established an advisory body known as the National Commission on Social Security, also charged with reviewing various aspects of the disability program. This latter Commission submitted its report in March of 1981.(18)

Neither the Council nor the Commission described above recommended tighter disability criteria. On the contrary, a majority of the Council members recommended, on page 148 of their full report, that "the definition of disability under Title II be liberalized for older workers" and "that a more liberal definition of disability be used for determining eligibility for SSI." The Commission noted, on page 198 of its full report, that award rates had been declining recently; however, they found "little evidence that the definition of disability in the law is too liberal or that it allows benefits to be paid to people who are able to support themselves."

It is interesting to note that SSA's response to other recommendations made by both the Council and the Commission have often been contrary to advisory intentions. For example:

- The Council supported, on page 157, a House Bill mandating increases in the volume of Continuing Disability Investigations (CDI's). Increased CDI's, it was projected by advisors, would reduce disability expenditures by .03% over the subsequent 25 years. This reduction could be achieved by paying benefits to 900 fewer disabled workers (of a total beneficiary population of 2.8 million people in 1979). Rather than 900 people, about 107,000 people were determined to be ineligible during the first year SSA increased the volume of redeterminations.(19)
- The Commission noted, on page 195, that "the determination of whether an impairment constitutes a disability is a matter of judgement based on the vocational as well as the medical evidence available." Nevertheless, SSA has proposed to greatly restrict the consideration of non-medical (vocational) factors.(20)
- The Commission recommended, on page 224, that "appeals council review (should) become a significant element in a quality control program" for ALJ hearings. This recommendation would largely have been satisfied had SSA acted expeditiously to implement section 304(g) of P.L. 96-265, the Bellmon Amendment. However, as SSA's January 1982 report stated, "The ongoing review program was only recently implemented, significant data are not yet available.(21)

In brief, neither Congress nor two federally authorized advisory panels, recommended substantial tightening of the disability criteria. In fact, more flexible criteria were recommended.

SSA's Presumption: An Increasing Caseload Means a Healthier Caseload

The initial impetus to tighten eligibility criteria appears to have been stimulated by the following perception within SSA: The case level was increasing because "progressively healthier individuals have been granted benefits, and...progressively healthier individuals have been allowed to stay on the rolls."(22) Based on this belief, and without any legislative change in the definition of disability, SSA tightened disability criteria and reduced the 1981 award rate to "the lowest rate in the history of the program."(23)

There is little evidence to support the assertion that a larger caseload means a healthier caseload, or that a "healthier" caseload contains significantly more who are able to work. The primary evidence provided by SSA in support of the "larger, hence healthier" argument is a decrease in mortality. Other causes of caseload growth suggested by SSA over the years include:(24)(25)(26)

- In 1967, the methods for developing evidence of disability and for assessing the vocational impact of an impairment became more effective; and knowledge regarding the protection and available benefits became more widespread;
- In 1974, the SSI program came into existence;
- In 1976, benefit payments increased;
- In 1976 and 1981, applicants experienced increasing success in reconsiderations and appeals; fewer recipients recovered; unemployment increased; and the social acceptance of receiving government benefits increased.

As this report will show, none of the factors causing caseload growth ceased their influence in 1976. In other words, one cannot attribute the post-1976 decline in both new approvals and continuations to the disappearance of these factors; their effects continued from 1976 to the present.

For its part, SSA has suggested that the decline in beneficiaries is due both to improved health status and an increase in denials based on non-medical factors.(27) Recent testimony before the National Commission on Social Security shows that SSA's "improved health" argument is insufficient to explain the ongoing drop in benefit awards. This testimony states "...rather than a decline in the prevalence of work disability, we appear to have been experiencing an increase (in disability)".(28) SSA argued that award rates shrank because more non-medical denials were processed. This argument is only partially explanatory. A recent article indicates that "much of the decrease...was due to factors other than an increase in ineligible applicants."(29)

SSA's logic, when stripped to its bare bones, presumes that if fewer people die, then more people must be able to work. To understand SSA's fallacious assumptions, certain specific correlations between eligibility and employability must be addressed. First, one must ask whether those applicants who are allowed benefits can actually work and are, therefore, abusers of the system. Since some argue that benefits, in and of themselves, remove the desire to work, this question may not be answerable in practice. Second, and conversely, one may ask whether those applicants who are denied benefits are actually unemployable and are, therefore, victims of unreliable disability criteria. An answer to this question is available, and is discussed below.

An SSA report of applicants denied benefits during the first year of the SSDI program stated: "It would be logical to expect that a significant number of (denied applicants) in the study...would resume employment." The report goes on to say that, "relatively few (denied applicants) earned anything at all and only a small group of those who did, earned enough to provide even a minimum standard of living."(30)

Every subsequent study located shows similar results. For example, a study by a staff member of the National Commission on Social Security Reform published in the September 1982 <u>Social Security Bulletin</u> matched unhealthy early retirees who received benefits with similarly unhealthy retirees who did not receive benefits. In summary, the study states that"...the (only) major difference between the groups is that one receives Social Security benefits and the other does not."(31) Those subjects who did not receive benefits, like their counterparts who were granted benefits, remained unhealthy and never returned to work.

Issues Underlying Efforts to Reduce Caseloads

As stated in a 1976 article, growth in the disability insurance caseload was the major program issue of concern to SSA.(32) The remainder of this report presents questions related to the SSA's decision to reduce caseload growth by narrowing the criteria. The additional questions discussed in the paper are listed below:

A. Why, in fact, was the caseload growing prior to 1976?
B. How was this growth reversed?
C. What happens to applicants whose benefit applications are denied?
D. How do the SSI disabled differ from the SSDI disabled?
E. What is the status of the SSDI Trust Fund?
F. How have modified eligibility criteria affected state relief programs?
G. Do ALJ's award benefits to applicants who are able to work?

A. Why, in fact, Was the Caseload Growing prior to 1976?

The number of disabled workers receiving SSDI benefits increased every year, from the program's enactment in 1958, through 1978; the number of recipients has currently dropped approximately to the 1976 level.(33)(34)

Relatedly, the SSI disability program grew beginning with its enactment in 1974, and appeared to continue this growth until January 1982. By taking into account the SSA practice of categorizing SSI recipients over age 65 as "disabled" rather than "elderly," it becomes clear that SSI disabled caseloads have dropped to their 1976 levels (i.e., the number of disabled SSI recipients under 65 years of age equalled 1.8 million in both 1976 and 1982).

For both programs, the decline in caseload was preceded by a decline in approvals which began in 1976 and has continued to the present.(35)(36) Comparatively, the current number of SSDI approvals is equal to approvals granted in 1968; approvals for SSI have reached the lowest level in the program's history.

Throughout this report, a distinction will be made between the term "caseload" (used in reference to eligible beneficiaries who receive benefits on an ongoing basis) and "approvals" (used in reference to newly-approved disabled applicants). The section which follows discusses those demographic and programmatic factors which served to increase both caseload size and new approvals during the years prior to 1976. As outlined, few of these factors can be held directly responsible for the decline which began in 1976.

Population At Risk of Disability

In discussing the population at greatest risk of becoming disabled, the age group between 50 and 65 years is predominant. Members of this age group, while making up only about 15% of the total population which is under 65 years, represent 66% of SSDI beneficiaries and 48% of SSI disabled beneficiaries under 65.(37)(38) This relationship between age and the prevalence of disability among members of this age group demonstrates that the total number of disabled can be expected to contain a high representation of individuals aged 50 to 65 years. The total numbers within this age group continued to grow after 1976.

National Growth in Income Support Programs

Generally, income support programs experienced a substantial growth from the late 1960's to the present. Nationally, during this period, recipients of Aid to Families with Dependent Children (AFDC) and state General Assistance (GA) doubled in number(40); unemployment insurance beneficiaries tripled in number (41); and food stamp recipients increased nine times over.

Factors which explain these increases in the overall dependent population include the following socioeconomic and attitudinal changes: (1) the visability of the "war on poverty" made people more aware of the benefits available; (2) subsequently, the stigma of receiving welfare declined; and (3) the national unemployment rate increased from 4.5% in 1965, to 8.5% in 1975, and finally to 10.4% in 1982.(42)

Increased Benefit Levels

Some argue that increased applications and caseloads were in large part, caused by an influx of employable applicants who were attracted to the programs' increasingly attractive benefits.(43)

This argument fails to stand up in light of information that those who are denied benefits do not return to work, as one would expect employable individuals to do. In fact, few applicants who are denied benefits ever earn substantial income again.

Improved Health Status

Furthermore, measures of overall health did not improve during this period of caseload growth. Unhealthy non-recipients, when measured in terms of mortality rates and the length of time during which disability limited their ability to work, appeared slightly less healthy than SSDI recipients.(44) This finding refutes the notion that overall improvements in the nation's health status produce more applicants who are healthy, long-lived and gainfully employable.

Increased Unemployment

Finally, some conclude that increased disability rates are a function of increases in the unemployment rate and the replacement rate (i.e., the amount of benefits received relative to an individual's past, predisability earnings). The inference drawn from this statistical relationship is that more non-disabled individuals choose to apply for SSDI benefits as jobs become more scarce, and as benefits more nearly replace potential earnings. Although this conclusion is not refuted, it is suggested that any correlation between the disability rate and unemployment is primarily related to the fact that additional competition in the labor force (caused by unemployment) increases the barriers to employment which the disabled face even in periods of plentiful employment.(45) It should, furthermore, be noted that SSDI applications have recently shown a slight decrease, regardless of increasing unemployment rates.

In summary, with the exception of a one-time surge of applicants due to implementation of the SSI program, all factors expected to increase program growth between the mid-1960's and 1976 were also present subsequent to 1976. The next section of this report discusses why, in light of contrary influences, caseload growth was reversed after 1976.

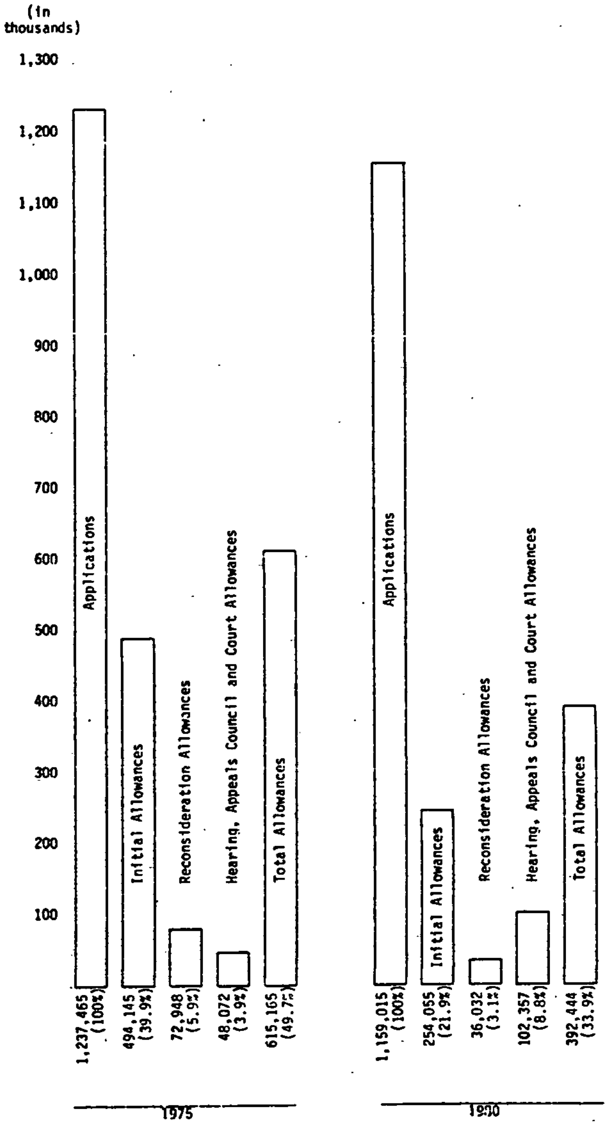
B. How Was Caseload Growth Reversed After 1976?

In 1976, the General Accounting Office (GAO) reported that disability determinations made by the separate states were not consistent across state lines.(46) For example, of 221 claims submitted to ten states, unanimous agreement was reached in only 48 cases. In responding to this criticism, SSA selected options which ultimately reduced approval rates, but which failed to produce consistent decisions. SSA's primary remedy for the problem was to reduce the latitude which states could exercise in allowing disability benefits on an "equal to the listing" basis.(47)

Subsequent to reduced latitude in this area, the percentage of approvals made on this "equal to the listing" basis declined from 44% in 1975 to 9% in 1981.(48) Thus, barring awards granted on other bases, restriction in state discretion accounted for a 35% reduction in allowances between 1975 and 1981.

This change was not the sole cause of reductions in allowances. Rather, it was the principle cause and its effects were exacerbated by two other changes: (1) promulgation of the vocational grid; and (2) revisions in the distinction between "severe" and "non-severe" impairments.

APPLICATIONS AND ALLOWANCES
(Percentages of Initial Applications)



As the preceding chart indicates, between 1975 and 1980, the percentage of total applications approved declined from 49.7% to 33.9%. The percentage of cases approved by state agencies also declined from 45.8% to 22%. Relatedly, as states lost discretion, more and more approvals occurred as a result of hearings. In 1975, approvals at the hearings, appeals council and court levels accounted for only 7.8% of all allowances, whereas by 1980, such approvals accounted for 26% of all awards.

Although the revised procedures were very effective in reducing the number of allowances and subsequently, the number of recipients, they did not produce the desired increase in consistency. Frequent instances of differing decisions based on the same information still exist. One 1981 report of a study conducted in 1978-79 concluded that differing decisions would be made in one of every six cases.(49) The Bellmon Report describes a study wherein third decisions were sought for 3,600 cases that had originally been decided at the ALJ level. These cases had all been denied by states at the initial and reconsideration levels. When these same cases were evaluated under state agency rules a third time, 13% were found eligible.(50)

A predominant conviction espoused by SSA is that disability decision making should be standardized and should produce uniform outcomes. SSA still aspires to make disability determinations more "objective" (as opposed to "subjective"). "Objective," in this case, apparently means "not requiring personal judgment." To this end, SSA has devised system lists, grids and formulae to remove the latitude of decision systems based on expert opinion and judgment. In short, they have attempted to mechanize the disability determination procedure.

A mechanistic system, however, is not necessarily appropriate for measuring the imponderables inherent in individual disabilities. As an expert on disability stated in Congressional testimony, "The underlying problem in providing and administering any plan of disability insurance is the extreme subjectivity of the state of disability."(51) Purely objective measures of a subjective state may well be equivalent to measuring miles with a thermometer, intelligence with a yardstick, or beauty with a clock. Furthermore, when a well-developed science does not exist, objective measures must be supplemented by expert judgment.

The need for such judgment is supported by the fact that the present effort to mechanize determinations still produces alarmingly inconsistent decisions. As the Bellmon Report states, 13% of cases that were once denied at both the initial and reconsideration levels were approved under the same procedures when examined a third time.

Earlier studies found similar results. Given these findings, Michigan does not believe that the determination of disability, as currently practiced, can be characterized as a science. Therefore, procedures must be issued which allow the latitude necessary for expert judgments to be formulated based upon the multiplicity of factors present in each individual case.

C. What Happens to Applicants Who are Denied Benefits?

SSDI and SSI disability programs were established to provide financial support for those unable to "engage in any...kind of substantial gainful work." As previously noted, very few of the applicants who are denied benefits ever again earn a substantial income; some denied applicants become eligible for retirement benefits; some die without ever receiving benefits; and others are eventually found to be disabled.

Four separate SSA studies offer insights on the economic status of various classes of SSDI applicants who were denied benefits. Following are brief summaries of the reports.

Subjects in the first two reports included individuals whose initial applications were denied. Both studies outline the percentages of subjects who had found jobs, had gained benefits at a later date or had died within a few years after initial denial.

The first report is a five-year follow-up study of the circumstances facing individuals whose benefits were denied in 1957.(52) The findings show that by 1962:

- 66% of the subjects had never secured work (page 29);
- 10% of the subjects were earning $3,000 or more (page 29). (Less than 2% of those subjects who were formerly employed in service occupations were earning more than $3,000 in the first year after their denial.) (page 51);
- 15% of the subjects had reapplied for disability benefits and were found eligible; and
- 7% of the subjects had died without receiving either retirement or disability benefits (page 18).

The second study reports the 1966 status of individuals whose initial applications were denied in 1963, 1964, or 1965.(53) Table 7 of the report indicates that, in 1966:

- 1% of the male subjects were working full-time; and
- Only 19% had worked subsequent to filing their SSDI application; and
- The working subjects had a median wage of $2,670.

The last two studies focus, for the most part, on individuals who appealed their initial denials. Both studies outline the percentages of subjects who had found jobs or had died within five years after denial or appeal.

The third report is a five-year follow-up of applicants denied benefits in 1967.(54) The study compares two groups of subjects: (1) those who appealed an initial denial; and (2) those who accepted the initial denial and did not pursue an appeal. Findings show that, in 1972:

- 63% of the non-appellant subjects, and 72% of the appellant subjects, were not working; and
- 15% of the total group of subjects were earning more than $3,000.

The study also compares subjects based on the level of their pre-disability income. Subjects are categorized as: (1) high wage earners (who earned more than $5,400 prior to application); and (2) low wage earners (who earned less than $1,800 prior to application). Findings show that, by 1972:

- 35% of the high wage earners were earning $3,600 or more; and
- 7% of the low wage earners had some earnings.

The report states that "almost none of the low earners had substantial earnings in 1972, whatever the result of their disability claims." (page 24). It is important for the reader to note that nearly every SSI applicant would fall into the low earner category.

The third study also reports on the death statistics linked to the subjects studied. In 1972, the report found death statistics distributed among subjects according to the following patterns:

- 28% of the subjects who had received initial approvals had died;
- 20% of the subjects approval at the reconsideration level had died (page 39);
- 7% of the subjects died without ever receiving federal benefits; and
- 23% of the subjects were receiving retirement benefits (page 40).

The fourth, and most recent, study followed-up on applicants whose benefits were initially denied between 1970 and 1975, but who subsequently requested an administrative hearing to appeal the denial.(55) The study reports that, in 1975, the following subjects were not working:

- 72.3% of the subjects denied at the initial application;
- 77.6% of the subjects denied both at initial application and at reconsideration; and
- 80.6% of the subjects who were denied by an ALJ.

The study also reports the following 1975 findings related to subjects with low earnings (less than $3,600 per year):

- 15.5% of low wage earning subjects had some current earnings;
- 5.7% were earning more than $3,600.

Finally, the study reports the proportion of subjects appealing through the ALJ level who died by 1976:

- 17.5% of those approved by an ALJ; and
- 12.9% of those denied by an ALJ.

The reports, as a group, indicate several important conclusions. First, researchers concur that, at least *67% of all denied applicants have no earnings whatever in subsequent years* and the likelihood of subsequent earnings is even less for those applicants who were low earners prior to seeking benefits. Second, the reports reach accord in reporting that those approved at initial application died more frequently than those approved at appeal. In addition, the studies show that *the death rate for those denied at all levels is substantially greater than that of the general population.*(56)

D. How Do the SSI Disabled Differ from the SSDI Disabled?

The same definition of disability is used for the SSDI program and the disability portion of the SSI program. Nevertheless, applicants and recipients of SSI differ from applicants and recipients of SSDI in numerous demographic and socioeconomic dimensions. Several of these differences are critical when evaluating an individual's potential for employment. Others are critical when evaluating the consequences of denial. The differences in both populations are summarized below.

Work Experience

SSI beneficiaries who have worked a sufficient number of quarters are eligible for SSDI benefits. However, the following statistics show that very few qualify. In December 1981, 2.3 million disabled individuals received SSI. Of these, only 275,000 (12%), received SSDI benefits based on their own work history.(57)

SSDI eigibility is dependent upon a recent connection with the labor force. In general, a worker must have had wages sufficient to establish insurance coverage in half of the quarters since age 21. Thus, except for the dependents of SSDI beneficiaries, all SSDI recipients have a history of work.

Former Occupation

Nearly 25% of all SSI recipients had not worked in the 15 years prior to receiving benefits. An additional 14% had no employment listed on their application.

Of SSI disability applicants, the most prevalent occupation rated was "service" (20.5%); the second most prevalent was "structural work" (6.7%).(58)

Service occupations accounted for 13.7% of the SSDI recipients; structural occupations accounted for 12.4% of SSDI recipients.

Sex

Forty percent of the SSI disabled are male and sixty percent female.(59) Seventy percent of the SSDI disabled are male and thirty percent female.(60)

Disabling Diagnosis

Diseases of the circulatory system account for about 20% of all SSI disability allowances.(61) Mental disorders account for about 30%. Nearly 50% of the mental disabilities are classified as mental retardation.(62)

Circulatory disorders account for 26.8% of the SSDI awards.(63) Mental disorders account for only 10%.

Age

An artifact of the SSI data system continues to count SSI recipients as "disabled" after their 65th birthday. Correcting for this miscount shows that 48% of the SSI disabled are ages 50 through 65 years.(64) The same age group accounts for 66.2% of SSDI recipients.(65)

Beyond the personal characteristics of the recipients, the SSI eligibility requirements select a very distinct subgroup, as described below.

Liquid Assets

The liquid assets of SSI recipients are limited to $1,500. Those with larger savings are ineligible.

A study of the assets of SSDI beneficiaries in 1972 indicated that 54.9% held liquid assets with an average value of $7,956.(66)

Benefit Amounts

In June 1982, the maximum federal SSI benefit for an individual recipient was $264.70. The average monthly payment was $215.75.(67)

There is no across-the-board maximum SSDI benefit. The average amount received in June by individual SSDI recipients was $442.85.(68)

Non-Liquid Assets

The non-liquid assets of SSI recipients are limited by program regulations. Stated briefly, any assets other than a home, limited personal property and a car of moderate value are counted toward a $1,500 resource limit.

There are no resource limits in the SSDI program.

Other Unearned Income

Social Security benefits averaging $214 per month are the most prevalent other income for SSI disability recipients.(69) These payments are made to 36.1% of the caseload. However, as noted under work history, only 12% earned the benefits based on their own employment. Of the 12%, one-sixth had worked so little that they were eligible for only minimum Social Security payments.(70)

When an SSI beneficiary has unearned income above $20 per month, the SSI payment is reduced dollar-for-dollar.

The unearned incomes of SSDI beneficiaries do not generally reduce their SSDI benefits until the combined income exceeds 80% of the indexed average predisability earnings. SSDI payments provide, on average, only about 40% of the predisability earnings. Therefore, on average, SSDI recipients can receive unearned income equal to their SSDI payments without seeking a reduction in SSDI benefits.(71)

Other Income of the Household

If the SSI beneficiary resides with others, SSA will try to determine if the others are providing any support. If so, the SSI payment is cut by one-third. SSA presumes that others do help; it is up to the beneficiary to prove otherwise. If the client is married, the income of the spouse will be deemed available after certain disregards. The end result is that if the spouse has more than a very minimal income, the SSI payment will be reduced.

Neither the living arrangments nor the income of others will reduce the benefits available to the SSDI recipient.

Profile of Recipients

If one were to select personal characteristics most likely to be possessed by a recipient of each program, the SSI profile would be a female with severe retardation in her early 50's who had never earned a wage. The SSDI profile would be a male in his late 50's who has worked the majority of his adult life and who suffers from heart disease.

As profiled, the SSI recipient could not keep more than $20 per month of any other unearned income she was able to obtain. She would be required to liquidate all but a home and a few limited assets, and spend the proceeds down to $1,500 prior to becoming eligible for SSI. If she lived with others, her SSI grant would be reduced to account for the value of any help received from them.

As profiled, the SSDI recipient could have other income that would nearly equal the Social Security benefit, and could retain any of the assets accumulated while working. Neither living arrangements nor the income of other family members would affect the SSDI benefit level.

Profile of Denied Applicants

A resource- and income-eligible SSI applicant determined "able to work" would have liquid and other non-homestead assets of less than $1,500, and an average income of less than $100 per month. The applicant's spouse, if any, would have few assets other than a homestead and income of less than $1,000 per month.

The denied SSDI applicant could have unlimited liquid assets and resources. The spouse, if any, could also have unlimited assets and income. The applicant could also continue to be eligible for private disability insurance provided by the former employer.

E. What is the Status of the SSDI Trust Fund?

The SSDI program is funded by allocating a portion of Federal Insurance Contribution Act (FICA) payments made by workers and employers to the Disability Insurance (DI) trust fund. The DI trust fund is separate from the Retirement, Hospitalization, and Supplemental Medical Insurance funds.

From 1966 through June 1974, the DI trust fund experienced growth; it increased from $1.7 billion to $8.3 billion.(72) An 11% increase in June 1974 benefits, subsequent cost of living increases, and a flawed formula for computing initial benefits contributed to reducing the trust fund from July 1974 through January 1978(73), when the fund contained only $3.2 billion.

The 1977 Social Security Amendments allocated additional funds to the SSDI program and corrected the benefit computation. Consequently, the SSDI fund began growing again. By September 1980, the fund had increased to $7.7 billion.(74) A $3 billion transfer of DI funds to the retirement trust fund occurred in October 1980. A portion of the FICA allocation for SSDI was temporarily reassigned to the Retirement Trust Fund. Additional interfund transfers from Disability to Retirement occurred in late 1982.

Had interfund transfers ceased, as mandated, in January 1983, and had the DI fund once again received its full portion of allocated FICA, the fund was expected to grow substantially.(75) It was the only program expected to be in the black in 1991--at which time it would have had a balance exceeding 400% of yearly expenditures.

The Social Security Reform Amendments of 1983 substantially modified the earlier SSDI trust fund projections by cutting nearly in half the funds allocated for the out years. The 1980 Disability Amendments had allotted the DI fund 1.9 cents out of every taxable dollar between 1985 and 1989. The 1983 amendments reduced the allocation to 1 cent per dollar for the same period. Barring unprecedented and ever steeper decreases in the DI caseload, this reduction in funding assures that the Disability fund will be in the red before the end of the decade.

In summary, the SSDI trust fund had been increasing. Except for past interfund transfers and a temporary realloction of its portion of the payroll tax, the fund would have the highest balance in the history of the program.

F. What is the Impact of Recent Changes on State Relief Programs?

Although it is difficult to gauge the impact that tighter disability criteria have had on state and locally administered programs, it is clear that many of those denied benefits under federally-administered programs have become recipients under the General Assistance (GA), Aid to Families with Dependent Children (AFDC) and Medically Needy programs. Others denied benefits enter or return to psychiatric hospitals, prisons and jails. Following are three findings suggesting that between 30% and 50% of those denied disability benefits will end up on state and/or local relief.

1. *A recent study of 160 SSI cases terminated in Michigan due to the CDI process found that 48% subsequently became eligible for GA, AFDC or Medicaid. An additional 7% entered psychiatric facilities, 4% entered prisons or jails, 5% are receiving outpatient mental health services and 2% died.*
2. *A report from the State of New York indicates that, of those SSDI cases losing benefits through the CDI process, about 30% end up on state or local welfare rolls.*
3. *States voluntarily assisting the medically needy disabled (under Group II Medicaid) have experienced startling caseload increases. These increases encompass the Medically Needy disabled who, in the absence of federal disability benefits, receive state relief. The history of this phenomenon is discussed below.*

In 1973, prior to the SSI program, states like Michigan, administered programs providing aid for two distinct groups of the disabled. These programs were: (1) Title XIV, Aid to the Disabled (AD), including Group I Medicaid coverage; and (2) the Title XIX Group II Medicaid program.

The AD program provided financial and medical assistance to the disabled with very limited income and resources. The Group II Medicaid program paid the medical costs for those disabled whose incomes were sufficient to meet their basic needs but were not adequate to cover their medical needs. States used identical disability criteria and procedures in both programs.

In 1974, the SSI program replaced the AD program and SSI disability determination procedures became those used in the Title II SSDI program. States continued to use their earlier procedures to make determinations for Group II Medicaid eligibility.

Although the legal definition of disability was the same in both 1974 programs, the procedures had become different. Under the separated procedures some indigent SSI applicants were found simultaneously: (1) able to work and ineligible for SSI; and (2) disabled and eligible for Medicaid Group II under state procedures. The effects of these procedural differences became increasingly evident as SSA procedures became more rigid.

In December 1973, when the state-administered AD program was in force, there were 9,906 <u>disabled</u> in the Michigan medically needy program. By December 1977, the number of recipients had more than doubled to 20,096. In December 1981, there were 22,622 disabled receiving Medicaid, but not SSI.

Of these 22,000 Medicaid recipients, more than 7,000 also qualify under the strict needs standards of the state GA program. It is important to point out that in December 1973, these 7,000+ individuals would have qualified for the state-administered AD program.

The preceding data clearly support the contention that at least 30% of those who are denied federal disability benefits due to the increasing rigidity of the definition of disability will eventually receive state-funded benefits. If this 30% rate occurs and if the federal caseload decreases by 40% (as the reduced approval rate and as the CDI cessation rate would indicate), states can expect caseload increase equal to 12% of the total unduplicated SSDI and SSI disabled caseloads, or 730,000 persons.

G. Do ALJ's Award Benefits to Applicants Who are Able to Work?

In the Bellmon Report, SSA observes that, "...if steps to significantly tighten administration at the DDS level result in a higher percentage of reconsideration denial," and "...if individual ALJ's continued to allow the same kinds of cases they previously had allowed--the overall ALJ allowance rate would increase. This is, in fact, what the data show."(76) The report goes on to outline a number of steps designed to bring ALJ decisions more in line with DDS decisions, i.e., to deny benefits more frequently. The steps are:

1. Publication of large portions of the POMS Disability procedure as Social Security Rulings. The effect of this change would require that ALJ's rigidly follow the same set of minutely specified procedures that SSA has imposed upon state DDS's.
2. Increase training programs for ALJ's, giving particular emphasis to adjucative differences between ALJ's and DDS's.
3. Require ALJ's to spell out, in more detail, the reasons individual denials were reversed. SSA expects this change to "eliminate the implicit incentive toward favorable decisions." In other words, to reduce the approval rate.
4. For selected offices, allow SSA representatives to present a case for denial as part of the hearings process.
5. Require the Appeals Council to conduct increasing numbers of own motion reviews concentrating on ALJ's and hearings offices with high reversal rates.

Except for the last action, none of these steps were requested or authorized by legislation. Congress simply asked that, "The Secretary of Health and Human Services...implement a program of reviewing on his own motion, decisions rendered by administrative law judges...and...report to the Congress by January 1, 1982, on his progress." The Secretary reported that the own motion review process had not been implemented until October 1, 1981 and that, "Because the ongoing review program was only recently implemented, significant data about the results are not yet available."(77)

The SSA decision to modify ALJ practices implicitly assumed that ALJ's have historically awarded benefits to significant numbers who were not eligible under the law, and that current DDS practices do not deny benefits to those who are truly eligible. Historically, the vast majority of evidence shows that DDS disability procedures tend to deny applicants who did not return to work even though "not disabled." Other evidence has shown that the health problems of these denied applicants are "severe" under the common meaning of the word.

If the ALJ's were, in a significant number of cases, allowing benefits to all but very weak or frivolous claims, one would expect a large portion of the applicants denied benefits by ALJ's to return to work. Those allowed benefits would include all except claimants who clearly had no disabling impairments. Available statistics show that precisely the opposite occurs.

The proportions of those denied at ALJ hearings level returning to work is substantially less than the proportion of those denied at the initial level. Of those denied at the initial level, 50.2% did not work at all in the next five years and 83.9% had average earnings of less than $300 per month. Of those denied at all levels through administrative hearings, 62.5% had no earnings at all over the next five years; and 90.6% had average earnings of less than $300 per month.(78) Apparently, those who are denied at hearings have very little chance of subsequently obtaining work.

In many legal and quasi-legal proceedings, the number and precentage of decisions reversed on appeal has been an accepted measure of the accuracy of the initial determinations. Using this measure to evaluate the determination of disability at various levels it is found that, until 1976, ALJ's were reversing DDS decisions between 40% and 50% of the time. During the late 1970's, the reversal rate grew to approximately 60%. Over the same period, the reversal rate of ALJ decisions at the Appeals Council level fell from 9% in 1970 to 6.8% in 1975, and to 4.6% in 1980. Looking solely at the outcomes of appeals, one would conclude that the accuracy of DDS decisions has been declining while ALJ accuracy has been increasing.(79) While this approach oversimplifies the situation, it does point out that ALJ decisions are much more in agreement with Appeals Council decisions than are decisions rendered under the procedures established for the state DDS's. In fact, after removing references to face-to-face contact from cases evaluated in a study referenced in the Bellmon Report, ALJ's approved 46%--nearly equal to the Appeals Council approval rate of 48%.(80) Only 13% of the same cases were approved under the procedures specified for state DDS use.

In essence, the Bellmon Report shows that the two higher levels of review--ALJ and Appeals Council--were in close agreement when working with equivalent information. Yet the report concludes that the procedures of the two higher level decisions should be changed to those of the "odd man out." This is equivalent to deciding that umpires should follow the rules the players made up between 1976 and 1980 as the game went along. Congress did not change the rules of the game.

Conclusions

Since 1976, SSA has significantly tightened the definition of disability by revising the directions provided to state Disability Determination Services. This conclusion is supported by testimony from SSA staff and state administrators. Nearly all the major demographic and programmatic variables have pointed toward an increasing caseload. Yet the caseload has declined. Only the most gullable would accept SSA's allegation that their changed disability rules are simply clarifications of existing policy.

The rising percentages of cessations since 1976 also reflect the increasingly stringent disability criteria. The controversy arising after the March 1981 implementation of periodic reviews is but a symptom of the more rigid criteria. Had the criteria remained static, significantly fewer benefits would have been ceased; the majority of questionable closures would have been avoided.

The definition of disability has always been very stringent. Although many applicants who are denied benefits have physical and mental capabilities that would allow them to work in some conceivable environments, these seldom occur in the real world. Only 10% are ever fully employed again--two-thirds never work at all. The outlook for those with low predisability wages is even more dismal.

The definition of disability used for SSDI is not appropriate for the SSI program. Only about 12% of SSI disability recipients have worked long enough to establish eligibility for regular Social Security disability benefits. All available statistics show that applicants with a low earning history are the least likely to ever work again. The SSI definition of disability should be revised to allow benefits more readily to those with very little or no work experience.

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March 18, 1983

Senator John Heinz
Chairman, Special Committee on Aging
Room SD-G37
Dirksen Building
Washington, DC 20510

Dear Senator Heinz:

As a follow-up to my phone call with Frank McArdle, I am sending you the enclosed article. This article was the basis for my testimony in Minnesota, and was presented at a conference at the National Institute of Mental Health on December 15, 1982.

Essentially, estimates of a psychiatrically disabled person's potential for employment cannot be made from knowledge about their psychiatric symptomatology. There is no relationship between a variety of assessments of psychiatric symptoms and future work performance. There appear to be no individual symptoms or symptom patterns which are routinely related to an individual's work performance.

Furthermore, there is little or no correlation between individuals' ability to function in their community setting (e.g., home, halfway house) and their ability to function in a job. Assessments of daily living activities show little relationship to vocational performance.

On the positive side, the best predictors of work performance seem to be ratings of a person's work adjustment skills made in a workshop setting or sheltered job site. Estimates of a person's ability to get along with co-workers and supervisors, and to be dependable (i.e., attendance, punctuality, completing tasks and beginning new ones) are most predictive of future vocational performance.

Still other points relevant to the evaluation of the psychiatrically disabled person's work potential are mentioned in the enclosed article. While much is known already, it is a topic area in which additional high quality research is sorely needed.

I hope you find the enclosed information helpful.

Sincerely,

William A. Anthony

William A. Anthony, Ph.D.
Director

WAA/jer

Enclosure

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Summary

The Vocational Functioning of the Severely Psychiatrically Disabled: A Research Review

William A. Anthony, Ph.D.

Research relevant to the vocational functioning of the severely psychiatrically disabled has been reviewed and summarized. Over the last two decades dozens of data based articles pertaining to this subject matter have been published. These articles have appeared in a variety of professional journals. Findings from each of these articles evidence near unanimous support for one or more of the following points:

(1) The best clinical predictors of future work performance are ratings of a person's work adjustment skills made in a workshop setting or a sheltered job site.

(2) The best demographic predictor of future work performance is the persons prior employment history.

(3) The best paper and pencil test predictor of future work performance are tests which measures a persons ego strength or self concept in the role of worker.

(4) A significant predictor of future work performance is a person's ability to "get along" or function socially with others.

(5) A poor predictor of future work performance is psychiatric symptomatology.

(6) A poor predictor of future work performance is diagnostic category.

(7) A poor predictor of future work performance are tests of intellegence, aptitudes and personality.

(8) There is little or no correlation between a person's ability to function in one particular environment (e.g., a community setting) and that same person's ability to function in a different type of environment (e.g., a work environment).

(9) There is little or no correlation between a person's symptomatology and functional skills.

(10) A person's vocational functioning can be improved by means of a rehabilitation skills training intervention.

First, information about groups of psychiatrically disabled persons' demographics, symptoms, behaviors, work ratings or test scores is collected. After a follow-up period, ranging from as short as one month to as long as seven years, these same persons' vocational functioning is determined. Data analyses are then carried out to find out which of the measures initially collected are related to vocational functioning at follow-up. The studies which used this pattern are presented in Table 1. These studies are summarized in tabular form to indicate the author and date of the study, subject characteristics, vocational outcome criteria used, length of follow-up period, percent employed at follow-up, variables significantly related to the vocational outcome criteria, variables not significantly related to the vocational outcome criteria, the study's data analysis procedures and data collection procedures. The table is organized by publication date.

The data analysis procedures were typically correlational or some variation of an analysis of variance between groups (employed vs. unemployed). Significance levels were .05 or less, except when noted otherwise. Information about the vocational outcome variable was obtained from agency records, follow-up interviews and phone calls or by mail. Data collection procedures for the predictor variables were a function of the specific variable under study, and included paper and pencil tests, ratings made by professionals after an interview with the subject or a relative, work behavior ratings made from observing work behavior, questionnaires and forms filled out by the patient or relative, a review of hospital records, or forms filled out by treating professionals.

Some of these studies (e.g., Ellsworth et al., 1968) were investigations of a number of variables, including employment. In such instances the information presented in this paper deals with that portion of the study which pertains to the vocational functioning of the psychiatrically disabled.

Results of Predictive Studies

The studies provide support for seven major findings with respect to the predictability of the vocational functioning of the severely psychiatrically disabled. Studies specifically relevant to each point are identified under each of the six major findings.

(1) *The best clinical predictors of future work performance are ratings of a person's work adjustment skills made in a workshop setting or sheltered job site.* In every study in which work adjustment skills were assessed they were found to be significantly related to future work performance (Cheadle, et.al., 1967; Cheadle and Morgan, 1972; Distefano and Pryer, 1970; Ethridge, 1968; Green et.al., 1968; Griffiths, 1973; Miskimins et.al., 1969; Watts, 1978; Wilson et.al., 1969). In every instance in which an overall measure of work adjustment skills was calculated, the total score was predictive of future vocational performance (Cheadle et.al., 1967; Cheadle and Morgan, 1972; Distefano and Pryer, 1970; Ethridge, 1968; Griffiths, 1973).

A majority of the individual scale items on each of the work adjustment rating scales correlated with outcome. Due to the manner in which the data is analyzed (i.e., statistical comparisons for each item are made between criterion groups rather than multiple regression analyses) it is difficult to say which individual work adjustment skill items appear most predictive of vocational performance.

Anthony, Howell, and Danley (1982) have categorized work adjustment skills into three fundamental kinds. These are the skills related to: (1) getting along, (2) doing the job, and (3) being dependable. Based on this classification scheme it would appear that estimates of the skills of getting along with co-workers and supervisors, and being dependable (i.e., attendance, punctuality, completing tasks and beginning new ones) are most relevant to future work behavior. It is possible to speculate that estimates of a person's ability to do the job (i.e., task competency as measured by work quantity and quality) is less strongly related to future vocational performance (Watts, 1978).

The ratings of work behavior in each of the studies were done by vocational counselors, occupational therapists or work supervisors. The settings in which these ratings occurred were various sheltered work environments.

(2) The best demographic predictor of future work performance is the person's prior employment history. Just as strikingly consistent as the data on work adjustment skills are the data on employment history. Every study that has investigated the relationship between previous employment history and future vocational performance has found a significant, positive association between these two variables (Anthony and Buell, 1974; Buell and Anthony, 1973; Green et.al., 1968; Hall et.al., 1966; Lipton & Kaden, 1965; Lorei, 1967; Lorei & Gurel, 1973; Möller et.al., 1982; Olshansky et.al., 1960; Strauss and Carpenter, 1974; Sturm and Lipton, 1966; Walker and McCourt, 1965; Watts, 1978). In each of these studies employment history was defined somewhat differently; yet the results are remarkably uniform. The strength of the relationship between this particular predictor variable and vocational outcome criterion is extremely strong. For example, in two separate

studies using multiple linear regression analyses (Anthony and Buell, 1974; Buell and Anthony, 1973) these investigators found 53% of the variance in post hospital employment outcome accounted for by demographic characteristics, and that the only demographic variable which accounted for a significant amount of this employment outcome variance was prior employment history.

(3) *The best paper and pencil test predictor of future vocational performance are tests which measure a person's ego strength or self concept in the role of worker*. While the studies pertaining to this conclusion are also consistent with one another, there has been neither a great deal of research nor very recent research relevant to this area. Three studies used the same sentence completion test to predict future vocational performance (Bidwell, 1969; Connors et.al., 1960; Stotsky and Weinberg, 1956). The Stotsky-Weinberg Sentence Completion Test, which is composed of work relevant sentence stems, provides an overall score of ego strength plus individual scale scores. The test used by Berry and Miskimins (1969) is a measure of the discrepancy between one's perceived self concept, ideal self concept, and how a person believes him/herself to be perceived by others. In all of these studies the tests showed a significantly positive relationship to employment outcome.

(4) *A significant predictor of future work performance is a person's ability to "get along" or function socially with others*. Data has already been presented which indicates a relationship between persons' abilities to get along in the workplace and their future vocational functioning. Similarly, ratings of more general social functioning have been found to

predict vocational performance (Green et.al., 1968; Griffiths, 1974; Gurel and Lorei, 1972; Miskimins et.al., 1969; Strauss and Carpenter, 1974; Sturm and Lipton, 1966).

Unfortunately one of the difficulties in reviewing these studies is that it is not always clear as to whether or not the raters of social functioning used information about a person's present work related social behavior as part of their overall estimate of social functioning. Nevertheless, the data is once again consistent in suggesting that knowledge of persons' social functioning can be used to make inferences about their future vocational performance.

The concept of social functioning is described differently in each study. For example, Sturm and Lipton (1966) assessed whether the person preferred activity in groups or only isolated recreation; Green et.al. (1968) rated the person's ability to initiate social contacts with other patients and staff; Miskimins et.al. (1969) rated social skills; Gurel and Lorei (1972) reported a significant relationship with the raters' estimate of restricted psychosocial functioning; Griffiths (1973) evaluated such items as - gets along well with other people, and communicates spontaneously; estimates in the Strauss and Carpenter (1974) study were of a person's personal-social relations, i.e., meets with friends or does things with social groups. Thus, in spite of the wide range of items used to tap social functioning, the studies were remarkably similar in finding a relationship between social ability and future vocational performance.

(5) A poor predictor of future work performance is psychiatric symptomatology. A number of studies have now been done which illustrate the lack of relationship between a variety of assessments of psychiatric symptomatology and future work performance (Ellsworth et.al., 1968; Green et.al., 1968; Gurel and Lorei, 1972; Lorei, 1967, Möller et.al., 1982; Schwartz et.al., 1975; Strauss and Carpenter, 1972, 1974; Wilson et.al., 1969). There appear to be no symptoms or symptom patterns which are routinely related to individual work performance. On occasion the studies have generated data contrary to what might be expected. For example, Wilson et.al. (1969) found future vocational performance to be related to higher levels of aggressiveness and depression.

Hall et.al. (1966) is the only study which reported a significant relationship. They reported a positive association between "degree of illness," an apparent measure of symptoms, and vocational performance. Unfortunately these authors did not report how ratings of degree of illness were obtained, nor of what it consisted.

Examples from studies indicating what did not correlate with vocational performance included assessments of: tension, distress/alienation, antisocial behavior (Lorei, 1967); depression, anxiety, paranoid hostility, deteriorated thought (Ellsworth et.al., 1968); alertness, orientation, use of defenses (Green et.al., 1968); anxiety, verbal hostility, depression (Gurel and Lorei, 1972); thought disorder, depression, flattened emotion (Strauss and Carpenter, 1974); confusion, mania, depression (Schwartz et.al., 1975); and global psychopathological state (Möller et. al., 1982). In a more general overview type of statement Strauss and

Carpenter (1972) commented that 30 of 32 measures of signs and symptoms were not significantly correlated with unemployment. Similarly, Wilson et.al. (1969) reported that "very few" of the psychiatric variables used in their investigation were able to differentiate vocational successes from failures, either in the validation or cross validation groups.

(6) A poor predictor of future work performance is diagnostic category. Based on the previous findings of no consistent relationship between symptoms and vocational performance, it would be expected that there would be no relationship between diagnosis and future vocational performance. An overwhelming number of studies have confirmed the absence of such a relationship (Distefano and Pryer, 1970; Douzinas and Carpenter, 1981; Ethridge, 1968; Goss and Pate, 1967; Hall et.al., 1966; Lorei, 1967; Möller, 1982; Sturm and Lipton, 1966; Taylor, 1962; Watts and Bennett, 1977). Of those few studies that have found a relationship, Buell and Anthony (1973) reported that a schizophrenic/non-schizophrenic dichotomy accounted for 2% of the variance in employment outcome as compared to 51% for other predictor variables. Olshansky et.al. (1960) reported less schizophrenics in the stably employed groups, although this perceived difference was not tested statistically. Wilson et.al. (1969) found more neurotics than psychotics to be employed at follow-up. While one might expect this neurotic-psychotic comparison to hold in other studies, neither Sturm and Lipton (1966) nor Watts and Bennett (1977) found a relationship between the psychotic/nonpsychotic classification and employment.

(7) A poor predictor of future work performance are tests of intelligence, aptitudes and personality. Scores on the traditional psychological tests

simply do not predict vocational performance (Bidwell, 1969; Goss and Pate, 1967; Griffiths, 1974; Lipton and Kaden, 1965; Lowe, 1967; Sturm and Lipton, 1966; Taylor, 1962). These include the General Aptitude Test Battery (Taylor, 1962), the Wechsler Adult Intelligence Scale (Griffiths, 1974; Goss, and Pate, 1967; Sturm and Lipton, 1966; Taylor, 1962), and routine psychological test batteries (Bidwell, 1969; Goss and Pate, 1967; Lowe, 1967) which include not only intelligence and aptitude tests but also measures of interest and personality.

Table 1

Research studies relevant to predicting the vocational functioning of the severely psychiatrically disabled

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Stotsky & Weinberg 1956	VA inpatients in a rehabilitation program; 99% were schizophrenic; (N=80)	Regular work assignment at the hospital or discharged from the hospital	6 months	50%
Connors, Wolkon, Haefner & Stotsky, 1960	VA male schizophrenic inpatients; (N=40)	Successful completion of a vocational program within a year plus maintaining regular employment during follow-up period	6 months	36%
Olshansky, Grob & Ekdahl 1960	State hospital patients; 22-45 years old; no other disabilities; (N=160)	Employed during follow-up period	3-7 years	62% either re-employed, stably employed, or marginally employed; 38% unemployed
Taylor 1962	VA inpatients (N=57)	Worked throughout the follow-up year	1 year	57%
Lipton & Kaden 1965	Married; male; schizophrenic inpatients; under 50; (N=36)	Level of employment earnings	1 year	(not provided)

Table 1

Research studies relevant to predicting the vocational functioning of the severely psychiatrically disabled

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures[1]
8 of 9 scores on a sentence completion test;	1 score: positive reaction to subordinates	Median test	PV-Stotsky-Weinberg Sentence Completion Test (sentence items are vocationally related); OV-(not provided)
4 of 8 scores on sentence completion test: self-reliance, reactions to situations of difficulty, interpersonal relationships, and overall score	4 of 8 scores on sentence completion test: reaction to failure, goal specificity, need achievement, and persistence	Mann Whitney U Test between employed and unemployed	PV-Stotsky-Weinberg Sentence Completion Test OV-VA records
More stably employed premorbidly; less restricted socially, married; less often schizophrenic, less hospitalization;		No statistical comparisons;	PV-hospital records OV-interviews with with patients
	Diagnosis; none of the nine General Aptitude Test Battery scale scores	t tests between employed and unemployed	PV-GATB scores administered in VA hospital OV-Hospital followed up released patients
Pre-hospital level of earnings during year prior to hospitalization	Educational level; WAIS Verbal IQ; number of admissions;	Correlational analyses	PV-Interviews with patient and wife during pre-release period and administration of tests OV-Bimonthly interviews with patient and wife

[1] PV=predictor variables
OV=outcome variables

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Walker & McCourt 1965	VA psychiatric inpatients; (N=225)	Two criteria: 1) employed for pay for 1 hour or more; 2) employed full time throughout the follow-up period	6 months	Criterion 1=47% Criterion 2=23%
Hall, Smith & Shimkunas 1966	Acute schizophrenic inpatients in nine hospitals (N=188)	Continuously employed during follow-up period	1 year	"Job difficulties" experienced by 72.3%
Sturm Lipton 1966	Functional psychotics in hospital; 4 or less admissions (N=87)	Employed full time	2-8 month range $\bar{x}$=11 months after admission to hospital	30% employed 31% not employed 39% unreachable
Cheadle, Cushing, Drew & Morgan 1967	Hospitalized psychotic patients; (N=171)	Obtaining a job within 4 weeks of discharge and working throughout follow-up period	6 months	103 successes 68 failures
Goss & Pate 1967	Inpatients on a vocational rehabilitation ward (N=135)	Discharged from hospital program to suitable employment	Discharge from hospital	

Table 1 - continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
	Engaged in work like activity in the hospital	Chi square between active and inactive patient groups	PV-Using hospital records a deter- mination was made as to work like activity level during 2 months preceding discharge OV-mailed survey
Age; sex; married; post-high school education; skilled occupation, work history of working at one job for a year or more; "degree of illness"	social class; race; diagnostic subcategory	Correlational analyses	PV-(It appears that information was obtained from ca records. No inf mation on how "degree of illne score was derive OV-Social workers classified patie into outcome categories
Voluntary social participation; less than 6 months unemployed during last 5 years	Psychotic versus non-psychotic; age; IQ; educational level	Analysis of variance between groups	PV-interview and case records, in cluding test dat OV-questionnaire handed or mailed to ex-patients or relative
Total score on work rating scale; individual scale items of initiative, persistence, finish the job, eager to work and punctuality; social withdrawal score; sex (female)	Work rating scale items of complicated tasks, communication with patients and staff, and work speed; socially embarrassing behavior score	Chi square or t test between the two groups	PV-Ratings of work performance in hospital immediately prior to discharge; ratings of socia withdrawal and behavior OV-Hospital records
Interest tests discriminated only when patients were classified into different symptom categories	Age; marital status; occupational level; diagnosis; IQ; psychological test battery	(Statistical technique not specifically identified)	PV-A biographical form and a battery of psychological tests completed at time of admission OV-Hospital records

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Lorei 1967	Male VA psychiatric inpatients; under 60 years old; 77% schizophrenic (N=215)	Employed full time for at least 6 months during 1 year period	1 year	24%
Lowe 1967	VA psychiatric inpatients (N=204 for Rorsach; 162 for WAIS; 138 for MMPI)	5 consecutive days of full time competitive employment	90 days	(not provided
Ellsworth, Foster, Childers, Arthur & Kroeker 1968	Hospitalized VA male schizophrenics; under 60 years of age (N=52)	2 scale items indicating full time employment and amount of earnings	3 weeks	(not provided
Ethridge 1968	Hospitalized psychiatric patients; mostly schizophrenic; average age = 32 (N=421)	Employed for at least 1 month after vocational rehabilitation services are closed	1 month	51% closed as rehabilitated

Table 1 - continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
Items that were cross validated were history of hospitalization; marital status; work history; uncritical optimism; factor scores of chronicity and simple mindedness (i.e., feeling of well being and optimism)	Items such as diagnosis; tension; interpersonal etiology; factor scores of distress/alienation; feeling of inadequacy; drinking/anti-social behavior	Scores were factor analyzed into 6 factors and multiple regression analyses computed	PV-VA recores; two questionnaires just before release; clinical ratings of social worker OV-Questionnaire and record search
Only 3 of 39 comparisons were significant and none were confirmed in a cross validation sample	36 of 39 test scores and all 39 test scores in cross validation sample	t tests between employed and unemployed	PV-WAIS, MMPI, and Rorschach protocols typically administered 1-3 months after hospital admission and placed in patients folder OV-Mailed questionnaire, hospital records, State DVR records
Ratings of patients' motivation (r=.52)	Symptom ratings; including depression, anxiety, paranoid hostility, deteriorated thought and cooperativeness; also measures of mood, communication and social contact	Correlational analyses	PV-Interviews conducted with patient and patients' relatives; rating scales completed by hospital staff OV-Interviews with patient and relatives
All 20 items on the work scale distinguished between the two groups; total score	Diagnostic category; age; sex	Chi square between groups	PV-4 point ratings on 20 items measuring work skills, work habits, tolerance socialization and personal characteristics while patient is in OT clinic or hospita based work assignment OV-State Division of Vocational Rehabilitation

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage of Number Achieving Outcome Criteria
Green, Miskimins & Keil 1968	Sample of psychiatric patients referred to a vocational counseling and placement program (N=106)	Placed on a job or in institutional training	6 months after referral to the program	54 successes 52 failures
Berry & Miskimins 1969	Sample of psychiatric patients referred to a vocational counseling and placement program (N=104)	Employed for 3 months or more versus no job or no job for over 3 months	Average follow-up of 5 months	(not provided
Bidwell 1969	VA psychiatric inpatients (N=51)	Discharged from hospital and working	1 year	16%
Miskimins, Wilson, Berry, Oetting & Cole 1969	Hospitalized psychiatric patients patients referred to a vocational counseling and placement program (N=159)	Employed for 3 months or more versus employed for less than 3 months	At least 3 months	(not provided

Table 1 - continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
Employment history; previous psychiatric help; rated intelligence; most social interaction variables rated at work setting and in hospital; work speed; judgment; cleanliness; more benefit from drugs	Age; sex; marital status; psychiatric variables such as alertness, orientation, use of defenses, diagnosis, and anticipated degree of improvement; OT ratings of iniative and acceptance of supervision	Chi square or t test between the two groups	PV-Hospital records; rating forms for symptoms, behavior ratings by various staff OV-Hospital records
Measures of self concept as measured by a paper and pencil test		Analysis of variance	PV-The Miskimins Self-Goal-Other paper and pencil test administered to vocational rehabilitation patients OV-Hospital records
Ego strength scores as measured by Stotsky-Weinberg Sentence Completion Test which uses work relevant sentence items	Appropriateness of vocational goal in terms of measured interests and aptitudes	(Statistical technique not specifically identified)	PV-GATB, Kuder, Stotsky-Weinberg SCT, and interview data about patients' vocational goals OV-(Method of obtaining information not identified)
11 of 13 items describing clients' needs and abilities (.001 level of significance); e.g., need for security, supervision, social skills, punctuality, etc.	Ability to learn physical skills	Analysis of variance	PV-7 point rating scale describing the fit between the patients' needs and abilities in relation to the working conditions and requirements of the job on which the client was placed OV-Hospital records

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Wilson, Berry & Miskimins 1969	Hospitalized adult psychiatric patients referred to a psychiatric rehabilitation program. (N=269)	Held job for 3 months after placement in it	3 months	Group 1: 39% successf 61% not successfu Group 2: 34% successfu 66% not successfu
Distefano & Pryer 1970	Hospitalized psychiatric patients referred to an 8 week vocational evaluation program (N=58)	Employed for at least 1 month after vocational rehabilitation services are closed	1 month	29 successes 29 failures
Cheadle & Morgan 1972	Hospitalized psychiatric patients (N=78)	Obtaining a job within 4 weeks after discharge and working throughout follow-up period	6 months	(not provided)
Gurel & Lorei 1972	VA hospitalized schizophrenics from 12 hospitals; males under age 60 (N=957)	Number of weeks of work over a 9 month period	9 months	53% had no work; average = 9.9 weeks worked out of 37 week period

Table 1 -- continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
Married; not welfare cases; neurotic as contrasted with psychotic; less prior treatment; 17 of 18 work therapy ratings, including ability to do job, get along and dependability; more depressed, more aggressive, better previous adjustment, and less impaired functioning	Age; sex; income; educational level; "most psychiatric variables" including hallucinations and anxiety	t tests between groups; used two groups-one as a cross validation group	PV-Admission form; interview checklist; work therapy rating form OV-Followed up by project
12 of 12 measures of work habits and skills; 4 of 6 measures of interpersonal relations while in work like setting; total score	Reading and math comprehension; appearance; verbal expression; group discussion participation; diagnosis	t test between groups	PV-5 point ratings of work habits and skills, interpersonal relations, and reading and math skills made in a vocational rehabilitation program OV-State Division of Vocational Rehabilitation records
Total score on work rating scale; individual scale items of persistence, eager to work, welcomes supervision, initiates and gets along well with others; ratings of embarrassing behavior	Work rating scale items of complicated jobs, grasps instructions quickly, work speed, manual dexterity, punctuality, and work standards; social withdrawal score	t tests between groups	PV-Ratings of work performance in hospital immediately prior to discharge; rating of social withdrawal and behavior OV-Hospital records and mail follow-u
For both inhospital and community ratings the greatest amount of variance was accounted for by 2 items: 1) more goal oriented and motivated; 2) restricted psychosocial functioning	Patient reports of anxiety, verbal hostility, depression	Regression analyses	PV-Interviews used to fill out 28 item symptom rating scale prior to hospital release and again 3 weeks later in community OV-VA records

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Strauss & Carpenter 1972	Inpatients; ages 15-45; 85% schizophrenic (N=111)	Percentage of time employed	2 years	(Not provid
Buell & Anthony 1973	Psychiatric inpatients discharged to community (N=78)	Working at the follow-up point or employed throughout the entire follow-up period	6 months	23%
Griffiths 1973	Hospitalized psychiatric patients in a rehabilitation unit (N=28)	Secured and kept job after discharge	(not provided)	13 successes. 15 failures
Lorei & Gurel 1973	VA hospitalized schizophrenics from 12 hospitals; males under age 60 (N=957)	Number of weeks of work over a 9 month period	9 months	53% had no work; average = 9.9 weeks out of 37 week period

Table 1 - continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
One symptom (somatic concerns) and one sign (retarded speech) correlated significantly	30 of 32 measures of sign and symptoms	Multiple regression analyses	PV-Standardized mental status, psychiatric testing and social data interview after admission OV-Outcome scale completed after personal interview or phone interview
Stable employment history which was defined as steady employment for at least 1 year in the same job prior to hospitalization accounted for most all of the variance in post-hospital employment; schizophrenic as opposed to non-schizophrenic category accounted for 2% of the variance on post hospital employment	Age; education; sex; number of hospitalizations; length of last hospitalization	Regression analyses	PV-Hospital records OV-Hospital records, phone follow-up
Total score on a 25 item scale of work behavior which measures five factors of task competence, response to supervision, social behavior, work enthusiasm, and initiative		t tests between groups	PV-Ratings of work performance in hospital made on the basis of 10 working days OV-Hospital records
Greater number of months of full time work in the last 5 years accounted for almost all of predictive variance; also less VA compensation, more trouble with law, younger, has driver's license	Work experience in hospital prior to release	Regression analysis to identify a non-redundant set of predictors	PV-VA records OV-VA records

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Anthony & Buell 1974	Psychiatric inpatients discharged to community (N=79)	Working at follow-up point or employed throughout the entire follow-up period	6 and 12 months	(not provid
Griffiths 1974	Outpatient unemployed psychiatric; 18-55 years old; less than 2 years of previous hospitalization (N=44)	Employed versus unemployed	11-21 months	7 successes 37 failures
Strauss & Carpenter 1974	Inpatients; ages 15-45; 85% schizophrenic; (N=111)	Percentage of time employed	2 years	(not provide
Schwartz, Myers & Astrachan 1975	Inpatient schizophrenics discharged from 6 inpatient units (N=132)	Overall measure of social adjustment and role performance, including work behavior	2 to 3 years	(not provide
Watts & Bennett 1977	Discharged from hospital to a vocational program; half were diagnosed psychotic (N=44)	Competitive employment or sheltered work paid at competitive rates throughout follow-up; also those who found work but did not stay in it	6 months	41% returned to work; 25% of total sample remained employed for 6 months

Table 1 - continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
Stable employment history defined as steady employment for at least 1 year in the same job prior to hospitalization		Regression analysis	PV-Hospital records OV-Hospital records, phone follow-up
Low ratings of patients' self confidence in ability to get a job, ratings of motivation to work, ratings of how disabled they believed themselves to be were all related to unemployment	Abbreviated WAIS; age; occupational level; rating of whether job choice or plan was realistic, or level of self confidence was justified	t tests between groups	PV-Standardized tests and ratings made from a structured interview done in a single outpatient session OV-Interview with patient
"Quantity of useful work in past year" (paid work, student, housewife); personal-social relations; Phillips Scale	Symptom ratings, including such symptoms as thought disorder, depression, flattened emotion, etc.; age of symptom onset	Correlational analyses	PV-A 14 item prognostic scale scored from interview data after admission OV-Outcome scale completed after interview with ex-patient
Sociodemographic variables accounted for 25% of variance in social adjustment and role performance	Measures of "natural history" (e.g., confusion, mania, depression) accounted for only 2% of variance (significance levels not provided)	Multiple regression analyses	PV-Data gathered from hospital records OV-A patient self report interview schedule assessing performance and feelings in 8 role areas, including work
Number of months of employment in previous 2 years was related to returning to work; staying on the job was related to 4 measures of prior occupational stability	Psychotic versus non-psychotic	Mann Whitney U Test	PV-Interview with patient at time of referral to program OV-Interview with patient and medical records

Table 1 - continued

Study	Subjects	Vocational Outcome Criteria	Follow-up Period	Percentage or Number Achieving Outcome Criteria
Watts 1978	Consecutive admissions to a vocational inpatient program; half were psychotics (N=39)	Employed at discharge and at follow-up	6 months	23%
Douzinas & Carpenter 1981	Psychiatric inpatients who completed a clerical training program at a state hospital (N=70)	Employed full time or actively engaged in a vocational training program	Up to 3 years for some clients	23%
Möller, von Zerssen, Eilert & Wuschner-Stockheim 1982	Psychiatric inpatients; 77% schizophrenic; 60% first admission; hospitalized for short term (N=81)	"Duration of occupational disintegration during follow-up period	5-6 years	(not provided)

Table 1 - continued

Variables Significantly Related to Outcome Criteria	Variables Not Significantly Related to Outcome Criteria	Data Analysis Procedures	Data Collection Procedures
The 2 week and 4 month ratings on the social relationships scale; the 4 month ratings on the response to supervision scale and enthusiasm scale for psychotic patients	Task competence scale at both 2 and 4 month period	Analysis of variance between employed and unemployed groups	PV-Griffiths (1973) work behavior rating scale; ratings made at 2 weeks and 4 months after admission OV-Hospital followed up released patients
Married or formerly married; black; living in any arrangement other than with parents; completion of rehabilitation program accounted for most of variance in regression analyses	Diagnosis; age; education	Correlation and regression analyses	PV-Hospital records OV-Questionnaire
Duration of occupational disintegration before admission to hospital correlated .47	Global psychopathological state at discharge	Correlation and regression analyses	PV-Administration of standardized instruments at admission and discharge; hospital records OV-Interview of patient or relatives

Relationships Between Different Areas of Functioning

In addition to the predictive studies described in Table 1, a number of researchers have examined the situational specificity of psychiatrically disabled persons' functioning. These studies have typically assessed the functioning of psychiatrically disabled persons in one environment and determined if there was any relationship between their ability to function in that environment and their ability to function in a totally different environment. Such studies provide information as to whether it is legitimate to make inferences about a person's ability to function in one area of functioning based on an assessment of that person's functioning in a totally different functional area. These studies are remarkably consistent in arriving at the following conclusion:

(8) There is little or no correlation between a person's ability to function on one particular environment (e.g., a community setting) and that same person's ability to function in a different type of environment (e.g., a work setting). Estimates of persons' functioning in their community environment have been varied. These include global ratings of social adjustment, ratings of community adjustment and measures of recidivism. On the basis of several decades of study, the conclusion of researchers is that functioning in one area shows little or no relationship to functioning in other areas. It is now standard practice in outcome research to assume little or no relationship between measures taken in two different areas of functioning (Anthony and Farkas, 1982; Schwartz et al., 1975).

The large scale research of Ellsworth et al. (1968) showed that the situation itself is a powerful determinant of a psychiatrically disabled persons ability to function. Their research found no relationship between hospital based ratings of adjustment and community based ratings of adjustment (Ellsworth et al., 1968). Forsyth and Fairweather (1961) had previously reported similar findings with respect to the independence of hospital and community adjustment measures.

Concerning employment outcome, a number of researchers have reported only a slight relationship (Forsyth and Fairweather, 1961; Freeman and Simmons, 1963; Gregorie and Downie, 1968; Lorei and Gurel, 1973) or no relationship (Arthur, Ellsworth, and Kroeker, 1968; Wessler and Iven, 1978) between recidivism and post-hospital employment. The lack of a strong relationship between recidivism and employment is somewhat surprising in that those individuals who are working throughout the follow-up period can by definition not be recidivists. There appears, however, to be a significant percentage of persons who find work and still recidivate, as well as a group who aren't able to work but still do not become recidivists.

Other researchers have noted the independence between measures of vocational functioning and other types of assessments. Summers (1981) found that while aftercare clients showed significant improvement in symptomatology and social functioning over a one year period, their vocational functioning did not similarly improve. In Tessler and Manderscheid's (1982) sample of over 1400 severely psychiatrically disabled clients they reported very low correlations between remunerative employment and social activity (.11) and basic living skills (.16). They concluded that the "...results supported the view that community adjustment involves relatively distinct yet independent dimensions." (Tessler and Menderscheid, 1982, p.206)

Interestingly, almost two decades earlier Hutt, Crocker, and Clancy (1964) arrived at a similar conclusion for inpatients; they found that changes in a patients' hospital based work environment had no appreciable effect on measures of hospital adjustment outside of the occupational sphere.

In several studies of state vocational rehabilitation clients (a portion of which were psychiatrically disabled) the independence of the vocational dimension from other measures of adjustment was once again confirmed. The results of Bolton (1974), replicated by Bolton (1978) and Growick (1979), showed that measures of vocational success are unrelated to self reported changes in psychological adjustment.

Strauss et al. (1972, 1974) examined predictors of outcome and focused specifically on four dimensions of outcome: work, symptoms, social relationships, and need for hospitalization. These investigators concluded that each of these areas must be considered separately in the evaluation of a psychiatrically disabled person's functioning.

Examining work specificity from still another perspective, several studies (Lorei and Gurel, 1973; Walker and McCourt, 1965) have found no correlation between work activity in the hospital and subsequent community employment. Walker and McCourt (1965) reported that only 26% of the patients active in hospital based work activity were employed after discharge; furthermore, 20% of the patients who did not participate in work activity in the hospital were employed at follow-up.

Correlations Between Assessments of Skill and Assessments of Symptomatology

It is sometimes assumed that if someone knows a person's symptoms they therefore have a good approximation of that person's functional skills and abilities. For example, Social Security's Section 2211 on Evaluation of Mental Disorders, which describes the Psychiatric Review Form states: "Although the functional restrictions found in the mental disorder listings, i.e., restriction of daily activities, construction of interests, and impaired ability to relate to other people, do not directly appear in any section of the review form, they are the consequences of the symptoms, signs, behaviors and findings incorporated in the 17 items." There are a number of studies which provide data relevant to the assumption of whether assessments of symptom and assessments of function are essentially redundant. In general the studies are uniformly similar in arriving at the following conclusion:

(9) There is little or no correlation between a person's symptomatology and functional skills. Measures of a psychiatrically disabled person's skills and measures of a psychiatrically disabled person's symptoms show little relationship to one another. This is most apparent in studies which have targeted either skills or symptoms as their treatment focus, but which have still taken measures of both. For example, it is well known that hospitalization and drug treatment effect symptomatology, yet have little impact on a person's vocational skills (Anthony, Cohen and Vitalo, 1978; Ellsworth et.al., 1968; Englehardt and Rosen, 1976). In particular, the research of Ellsworth et.al. (1968) has shown that hospital treatment results in significant symptom reduction but not instrumental performance changes. Examining this issue from a different perspective, Arthur et.al.

(1968) found that symptomatology, and not instrumental behavior, to be related to hospital readmission. Englehardt and Rosen (1976) concluded from their review of drug treatment that while chemotherapy impacts on symptomatology, ".. evidence for a direct effect of pharmacotherapy on the work performance of schizophrenic patients is so far lacking."

Similarly, researchers who have reported increases in skill performance have not found corresponding changes in symptoms. Vitalo (1971) found that a group of psychiatrically disabled persons who successfully learned interpersonal skills also increased in their level of symptomatology. Along the same lines Schooler and Spohn (1982) reported that an increase in social behavior was not related to increases in psychological functioning.

In summary, there seems to be little disagreement in the research data and among the conclusions of researchers. There is no rationale for making inferences about a person's functional skills based on measures of symptomatology. Knowledge of symptomatology does not duplicate knowledge of skills.

Improving Vocational Outcome

Significantly more difficult than assessing and predicting a psychiatrically disabled person's vocational functioning is improving that person's vocational functioning. A gradually accumulating body of literature exists which provides further support for the conclusion that it is skills, not symptoms, which are related to vocational outcome. Studies which have attempted to develop strategies to improve vocational functioning coalesce around this basic conclusion:

(10) A person's vocational functioning can be improved by means of a rehabilitation skills training intervention. The vocational rehabilitation intervention process is, in its most basic form simply a process of assisting persons in choosing, getting, and keeping a job (Anthony, Danley, and Howell, 1982). Individuals who are experiencing vocational difficulties typically have skill deficits in one or more of these vocational areas. Vocational rehabilitation interventions which have had a positive impact on outcome have attempted to correct skill deficits in one or more of the vocational areas of choosing, getting, and keeping a job. Table 2 provides an example of skill deficits categorized by vocational area.

Vocational interventions designed to overcome these skill deficits can be categorized into four types: career counseling, career placement, occupational skills training, and work adjustment skills training. Table 3 depicts the relationship between these four major vocational interventions and the three vocational areas of functioning. The classification scheme depicted in Table 3 allows for a clear conceptual understanding of typical work deficits and the corresponding vocational intervention.

Table 2

Typical Work Deficits Categorized by the

Three Vocational Rehabilitation Areas of Functioning

Choosing a Job	Getting a Job	Keeping a Job
Cannot identify own interests	Cannot identify job related assets	Cannot dress appropriately for work
Cannot identify own abilities	Cannot identify own employment sources	Cannot use public transportation
Does not know what occupations relate to interests	Does not use sources of employment information	Cannot be punctual
Does not know what occupations relate to abilities	Does not look for work frequently enough	Cannot control temper at work
Does not evaluate occupational alternatives based on own values (decision making skills)	Cannot write a resume	Cannot make friends at work
Cannot list more than one work alternative	Cannot fill out an application	Cannot accept criticism
Lacks career plan to achieve career objective	Cannot explain job skills	Cannot follow directions
Cannot identify deficits which are hindering career plan	Cannot use stigma reduction skills with interviewer	Cannot give directions
	Cannot attend and respond to interviewer	Cannot work for extended periods
	Cannot dress appropriately for interview	Cannot evaluate own work performance
	Cannot ask questions of interviewer	Cannot perform specific job skills (e.g., cooking, typing, programming)
	Cannot explain career plans to an interviewer	

Table 3

The Relationship Between The Vocational Rehabilitation Areas and the Major Vocational Interventions

		VOCATIONAL INTERVENTIONS
VOCATIONAL REHABILITATION AREAS OF FUNCTIONING	CHOOSE	CAREER COUNSELING
	GET	CAREER PLACEMENT
	KEEP	OCCUPATIONAL SKILLS TRAINING WORK ADJUSTMENT TRAINING

Results of Vocational Intervention Studies

Anthony, Howell, and Danley (1982) have recently reviewed the research relevant to vocational interventions with the psychiatrically disabled. These authors note that most vocational outcome studies that have investigated a single intervention have focused on career placement interventions. A body of literature now exists which indicates the impact on vocational outcome of a career placement intervention (e.g., Anderson, 1968; Azrin et al., 1975, 1979; Keith, 1979; McClure, 1972; Stude and Pauls, 1977; Ugland, 1977; Wesolowski, 1980). The technology of career placement, first promoted over 14 years ago by the Minnesota Rehabilitation Center (Anderson, 1968), and the subject of several research studies in the 1970's, seems to have become a credible intervention in both rehabilitation and mental health settings. Weslowski (1981) has presented an excellent comparative review of six current career placement packages.

Occupational skills training often occurs concurrently with some type of work adjustment training. There are few investigations of this intervention in the literature. Perhaps the most notable intervention of this kind occurred at the Vermont State Hospital (Brown, 1970). Rubin and Roessler (1978, p.72) summarized this project thusly:

> "Via utilization of existing hospital facilities, training programs for farm hands, maintenance men, cook helpers, and general maids were developed under the Manpower Development and Training Act of 1962. Program activities deviated from typical mental hospital patient work routines in that competitive work environment conditions such as quality standards and time deadlines were stressed. Work experiences were complemented by social development activities such as group therapy, gripe sessions, and field trips to restaurants. Program participants ranged in age from 16 to 57 years with an average hospitalization of 7½ years. Only patients who were considered good candidates for discharge were selected for the program. Thirty-seven of the 40 patients who entered the program completed it. At the time of the report of program results, 22 of the com-

> pleters were holding jobs, and 6 either were taking further training or were in school."

A later study by Ciardelli (1981) gives evidence that occupational skills training offered in many current sheltered workshop settings is often inappropriate for psychiatric clients. Many of the production work tasks involved in most sheltered workshop settings require the very skills in which psychiatric clients are consistently deficient. Most of the literature on work adjustment training is critical of the environment in which work adjustment training is carried out. Sheltered work adjustment training situations are criticized because they often prepare the client for a sheltered work placement and not competitive work placement. As noted by Anthony (1979, p. 135);

> "One of the greatest challenges facing work adjustment training programs is the blending of a therapeutic environment with a competitive working environment. That is, if the goal is to help the client function as independently as possible, and at the same time to teach appropriate work habits, a sensitive balance between treatment and work must be attained. This balance may be achieved by maintaining competitive employment expectations while at the same time providing opportunities for clients to explore with each other their deficits, strengths, difficulties, and how to function more effectively in the work environment. Although work adjustment programs attempt to approximate a working environment, practitioners must not lose sight of the fact that such settings are created in order to rehabilitate."

Career counseling interventions are rarely reported in the literature, even though the psychiatrically disabled are often deficient in career experience (Ciardelli and Bingham, 1982). The element of career choice for the severely psychiatrically disabled apparently seems foreign to many practitioners and researchers. Yet Rogan (1980) has presented a case study of the use of career decision making skills in the selection of a workshop program. This career counseling intervention eventually resulted in successful competitive employment. Rogan (1980) also describes another case study in which the use of career counseling resulted in a totally different yet more compatible occupational goal for a 36 year old psychiatrically disabled client.

In a small quasi-experimental study Kline and Heidington (1981) investigated the impact of a work values group which met for 1½ hours per week for 12 weeks. Over 50% of the work values group obtained employment whereas in the comparison group only 10% obtained employment. This study data hints at the potential impact of career counseling type interventions on vocational outcome.

In general there is a minimal body of research data with respect to the impact of vocational rehabilitation interventions for the severely psychiatrically disabled. Contributing to this lack of research has been the historical absence of a comprehensive vocational intervention technology at a level of detail that would facilitate the research effort. However, the research that does exist is consistent with the body of research literature which indicates that it is the psychiatrically disabled persons work related skills that relate to vocational outcome.

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