



DEPARTMENT OF VETERANS AFFAIRS  
VA Chicago Health Care System

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BALTIMORE, MARYLAND

Social Security Administration  
Re: Rules for Evaluating Mental Disorders

May 5, 2003

To Whom It May Concern:

This is being written in response to the Social Security Administration's request for input and feedback regarding its current rules and procedures for evaluating psychiatric disorders. We are a team of clinicians working in a short-term partial hospitalization program at this VA medical center, where our focus is typically on severe mental illness and psychiatric crises. Treating our patients requires that we simultaneously address the multitude of psychosocial problems that typically precede and are worsened by these crises. Most of the veterans referred to this program present with severe psychiatric illness that significantly impairs their ability to either work or to function socially. Many have followed a steadily deteriorating course for many months before "landing" in treatment, and for some of these patients this is their first-ever psychiatric treatment. Consequently, our clients frequently present for treatment having already lost jobs or homes due to the impact of their mental illness, or else they are on the verge of losing homes or services. In such appropriate cases, we view it as part of our job to assist them wherever possible in obtaining disability benefits as expeditiously as possible, and we have consequently supported many applications for Social Security benefits.

For the most part, we are satisfied with our interactions with the Social Security system (in Illinois, the Bureau of Disability Determination Services), and with how our patients' cases are processed and reviewed. Our local office (in particular the local liaison assigned to this hospital) has been consistently responsive and reliable when it comes to assisting veterans with initiating claims. Once the claim has been started, we have repeatedly found it useful to contact the adjudicator assigned, and we have been able to expedite the process by forwarding relevant records and summary statements to the adjudicator. In many cases we have agreed to complete the mental status examinations that are part of the review process. We find that this level of involvement on the part of the treating clinicians is advantageous to the claimant on several levels. First, from our daily contacts we have a greater knowledge of the claimant's deficits and symptoms, including paranoia and hypervigilance (that in some cases cause claimants to withdraw from the claims process rather than meet with an examiner whom they do not know). Second, we can assist the claimant with organizing and completing their portion of the paperwork in an accurate yet expeditious manner. Finally, the whole process proceeds much more quickly without the necessity of the claimant's scheduling a separate evaluation with a non-treating clinician, and the resulting time required for that evaluation to be completed, typed and transmitted to the adjudicator.

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While the claims process is undoubtedly expedited by the inclusion of treating clinicians in the data-gathering, the process can still be problematically lengthy for our patients, sometimes with significantly negative results. Reducing the need for duplicated paperwork would be very useful, in particularly the employment history provided by the claimant at the time the claim is first filed and then provided again while the claim is in process. For severely mentally ill patients, completing these forms can be a time-consuming and stressful endeavor, and many are not able to recall the data being asked for. Another delay in the process of securing benefits occurs when claims are initially approved but then selected for review at a higher administrative level; we have found that this process can add an additional month to the total time that a person in personal and financial crisis has to wait.

Why are these delays important? Few if any of the disabled, inner-city clients we serve have any savings or financial reserves to speak of. By the time they acknowledge the severity of their illness and they file a claim for disability benefits, many are already "in trouble" financially: they are facing eviction, are behind in mortgage payments or utility bills, or are facing repossession of cars or disconnection of utilities. Even a relatively brief interruption of income can render many of our patients homeless or can precipitate financial crises that are extremely difficult to surmount; once they have fallen behind, it is very hard to "catch up" again. We have worked with clients who had become too severely depressed, psychotic, or dangerously angry to maintain employment and who had lost their homes or apartments while waiting for a claim to be reviewed. Some have ended up in homeless shelters. Some have incurred debts and balances that they are unlikely to be able to pay, even once benefits are awarded; this means that they cannot afford to have telephone or electricity accounts "turned on" again due to the outstanding balance needing to be paid in full. Others have moved in with relatives where the home environment is so chaotic or unsafe that the patient cannot attain or maintain any psychological stability (for example, (1) the addicted schizophrenic who is forced to move in with his cocaine-abusing brother, or (2) the anxious, hypervigilant combat veteran who must sleep on a couch in a high-traffic living room, or (3) the sexually abused woman who returns to her parents' home, where she first suffered the abuse). We have also noted that some patients are forced to withdraw from treatment or can attend only sporadically due to lack of funds for transportation; resources for this (even for the disabled) in Chicago are extremely limited, and so the patients who most need daily, intensive treatment are sometimes unable to access it. In sum, a wait of even several months for approval of a disability claim and the initial receipt of benefits can have destructive and even dangerous effects on a mentally disabled person and their family.

In light of the above, we strongly support the concept of line clinicians (who are actively treating the claimant) having the option of submitting an opinion of "presumptive disability" for persons with mental illnesses who have applied for Social Security benefits. We are aware that this process is already in place for persons with certain medical disabilities such as HIV/AIDS, and we believe that a similar mechanism in place for mental illnesses would go a long way towards reducing the delays in processing claims and the serious consequences of these delays that we have detailed above. Clinicians and claimants would of course need to be aware that benefits were awarded on a provisional basis, with formal review and approval pending, with the chance that continuing benefits would be denied. However, we earnestly believe that in the vast majority of cases in which we would support a finding of presumptive disability, this opinion will ultimately be upheld based on the severe and pervasive degree of disability in those claimants.

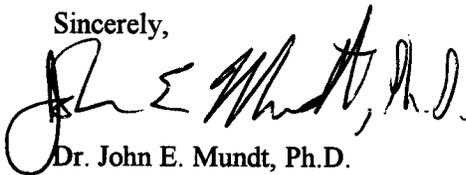
We encourage the Social Security Administration to make disability benefits available on a presumptive basis for all psychiatric disorders that can be considered to be of severe proportions. This would include psychotic disorders such as Schizophrenia, affective disorders such as Major Depression and Bipolar Disorder, and anxiety disorders where there is profound impairment. We

also believe, however, that presumptive disability benefits should be available for trauma-related conditions such as Post-Traumatic Stress Disorder, Dissociative Identity Disorder, and Borderline Personality Disorder. While many of these trauma patients will present with longterm impairments related to past traumas, they are very vulnerable to retraumatization and resultant rapid deterioration. We note as one of the most obvious examples of this the influx of Vietnam veterans seeking treatment for exacerbated PTSD since the onset of the war in Iraq: patients who have heretofore managed to maintain a job have abruptly experienced such marked aggravations of their underlying psychiatric condition that they can no longer work.

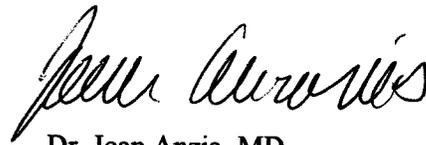
We believe that only qualified, licensed mental health professionals should be able to present findings of presumptive disability. Since not all psychiatric conditions are severely and pervasively disabling, and since some severely disabled patients can mask the underlying psychopathology, the expertise of clinicians trained in mental health should be a requirement. Similarly, we believe that any qualified, licensed mental health clinician, not just psychiatrists, should be able to offer evidence of their client's disability. Many psychiatric patients do not have a psychiatrist or physician involved in their care, and the therapist most involved and familiar with their disability will be a psychologist, social worker or nurse clinician. Non-physician mental health clinicians who are appropriately licensed in their disciplines are as qualified as psychiatrists to diagnose mental illness and to assess disability.

We are very grateful for the opportunity to provide input and opinions on this issue, and we hope that those charged with determining the Social Security Administration's guidelines for evaluating mental disorders will find our feedback useful. We are also available as needed for any questions or concerns, and we would welcome the opportunity for additional conversation or discussion regarding any of the above. We note that we are not speaking for or representing the Veterans Administration, but rather as "front line" clinicians who recognize the salience of the above psychosocial issues in the treatment of our clients. We can be reached at (312) 569-7130.

Sincerely,



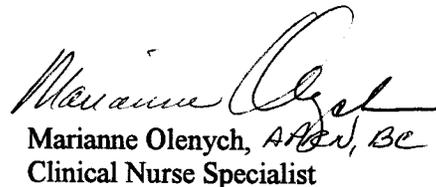
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