

# **Improving Social Security Disability Programs for Adults Experiencing Long-Term Homelessness**

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## EXECUTIVE SUMMARY

People who are homeless are among our most vulnerable citizens and have great difficulty navigating the process for applying for the Social Security Administration's (SSA) disability benefits: Supplemental Security income (SSI) and Social Security Disability Insurance (SSDI). The correlation between homelessness and disabilities is high, and a significant proportion of adults who are homeless have serious mental illness, co-occurring substance use and long-term physical health problems. The difficulties inherent in navigating the SSI/SSDI application process are both individual and systemic. Individual challenges arise from the nature of homelessness itself with its impact on keeping appointments, having transportation, and being able to meet other basic needs. The inability to meet these needs makes it more difficult for these individuals to get to SSA offices and/or to obtain required documentation. Systemic obstacles include not being able to access needed medical care or the documentation required for the disability review in the application process; the fact that SSA communicates by mail; the need for a lengthy appeals process before being approved, and a lack of information about how to address this process among community providers who assist persons who are homeless.

In response to these individual and system-level challenges, the authors propose three strategies that would improve the processing of applications and potentially avoid the need for lengthy appeals. These include: (1) expanding the list of acceptable medical sources; (2) adding a presumptive disability category for SSI for people with schizophrenia and who are homeless for at least 6 months, and (3) refining or modifying processes to more effectively address the unique needs of adults who are homeless.

Expanding the list of acceptable medical sources to include certified nurse practitioners, certified physician assistants, and licensed clinical social workers would enhance homeless individuals' ability to obtain the diagnostic information required for applications. These practitioners are generally more readily accessible in the publicly funded health and mental health care systems. Research has shown that the number of physicians available to treat individuals who are uninsured is inadequate, particularly in rural areas (New Freedom Commission Subcommittee on Rural Health 2003, Perlino 2006). Each of these professions have requirements comparable to SSA's currently acceptable medical sources and, thus, should meet SSA's criteria for standardization of practice.

Creating a new category of presumptive disability (PD) for people who have schizophrenia and who have been homeless for at least six months, with its inherent provision of benefits much more quickly than through the usual process, would assist significantly individuals who have schizophrenia and who have been homeless for extended periods of time. The professional clinical and research literature finds that schizophrenia is a significantly debilitating illness that puts individuals at greater risk for homelessness (Caton, Wilkins, and Anderson 2007; Caton, et al. 2005; North et. al 1998). Currently, the SSA offices cannot approve presumptive disability for such individuals. Although the DDS can approve such individuals, these individuals rarely have the extensive medical documentation needed for the DDS to take such action. Unlike other psychiatric diagnoses, schizophrenia includes a durational component. Long-term homelessness, in and of itself, is indicative of functional impairment. Together, a diagnosis of schizophrenia and long-term homelessness meet the disability criteria of a diagnosed impairment of that has lasted at least 12 months along with functional limitations on the ability to perform substantial gainful activity (SGA).

Lastly, process strategies such as tracking residential status of SSI/SSDI applicants, flagging applications from applicants who are homeless, assigning these applicants to SSA and DDS staff who specialize in homelessness, and training SSA and DDS staffs on the impact of homelessness and mental illness would enhance the service SSA provides to this vulnerable population. These recommendations are also consistent with the SSA Homeless Plan developed in 2002, which recognizes that this is a unique population that deserves special consideration and assistance.

In summary, these policy changes would make it possible for applicants who are homeless to access benefits more quickly and to begin their recovery from homelessness and illness. Long-term homelessness is debilitating, traumatic, and all-consuming. Without intervention, it leads to hopelessness, poor health, and death. Implementing strategies to address these impacts are essential to save lives and reduce unnecessary suffering.

## Background

Since the early 1980s, homelessness has become an increasingly significant social problem demanding local, state, and federal attention and resources. The major cause of homelessness is the lack of affordable housing (National Alliance to End Homelessness (NAEH) 2007), but the situation for many people is more complex. Federal funding for public and low-income housing was cut significantly during the Reagan years. In addition, state psychiatric hospitals closed or reduced their censuses at greater rates. Funds for community-based treatment and housing for people leaving these facilities were not forthcoming, and many persons with serious mental illnesses became homeless as a result.

Estimating the number of people who are homeless is difficult as definitions of homelessness across federal agencies are inconsistent, and finding everyone who is homeless for an accurate count is challenging. According to the Third Annual Homelessness Assessment Report to Congress, an estimated 2.5 to 3.5 million people were homeless in 2007 (US Department of Housing and Urban Development 2008). As shown in Figure 1, many people who are homeless are unsheltered -- sleeping on ventilation grates, under bridges, in cars, abandoned buildings and other places not meant for human habitation.

**Figure 1: Sheltered vs. Unsheltered**  
(From 2007 Point-In-Time Count)

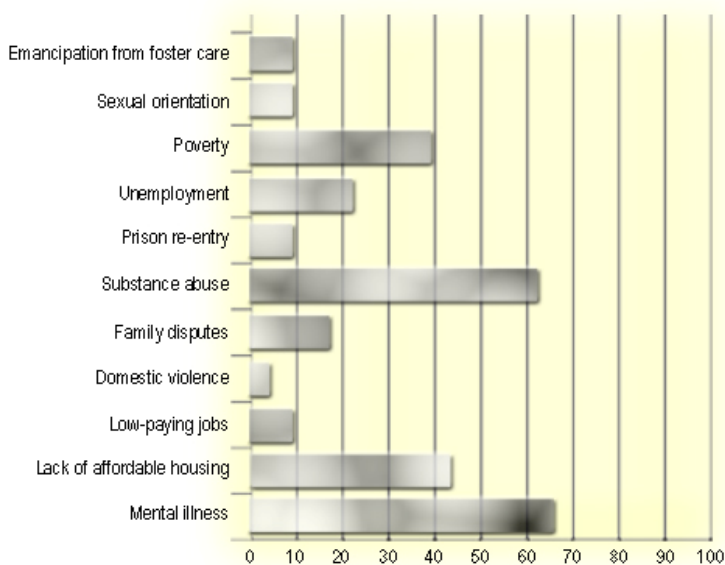


Source: U.S. Department of Housing and Urban Development.  
(2008) The Third Annual Homeless Assessment Report to Congress

The correlation between disabilities and homelessness is extremely high (SAMHSA 2003b; Culhane, Avery, and Hadley 1998; Dennis, Locke, and Khadduri 2007). Although other

factors contribute to homelessness, disabilities resulting from on-going physical and mental health problems are significant issues. In addition, the reasons for homelessness given by people who have no home are instructive. Figure 2 shows self-reported causes of homelessness (U.S Department of Housing and Urban Development 2008). Two-thirds of those interviewed reported that the reason they were homeless was related to a mental illness and/or a substance use problem.

**Figure 2: Self-Identified Causes of Homelessness**



Source: U.S. Department of Housing and Urban Development. (2008)  
The Third Annual Homeless Assessment Report to Congress

Lacking income and health insurance, many homeless persons with mental illnesses and/or co-occurring substance use disorders are unable to exit homelessness on their own. About 25 percent of people who are homeless have serious mental illnesses, including diagnoses of chronic depression, bipolar disorder, schizophrenia, schizoaffective disorders, and severe personality disorders (NAEH 2008). It is difficult to determine the proportion of people in specific diagnostic categories because people who are homeless often receive treatment only in acute or emergency situations, making accurate and consistent diagnoses a challenge. People with mental illness are estimated to comprise 10 percent of the population that has been homeless a year or longer and consume approximately 50 percent of all homeless emergency services (Culhane et al. 2007; McNeil and Binder 2005; Metraux et al. 2001; Burt et al. 2001).

A landmark study in New York City found that each long-term homeless individual costs \$40,000 annually in publicly funded services. The cost per person was reduced to \$23,000 when

access to housing was provided (Culhane, Metraux, and Hadley 2002). Another report estimates that the approximately 150,000 long-term or chronically homeless individuals cost about \$11 billion per year in public funds. Permanently housing these individuals, with access to Social Security Administration (SSA) benefits as a critical component, would lower this cost to \$7.9 billion (Oxford Analytica, 2008).

To access housing, however, income is essential. For people who are disabled due to a serious mental illness, SSA disability benefits are the primary sources for a stable income (Schoeni and Koegel 1998). People recovering from long-term homelessness also typically need supportive services and physical and behavioral health care. The two SSA disability programs, Social Security Disability Insurance (SSDI), which provides Medicare after two years, and Supplemental Security Income (SSI), which makes Medicaid available to SSI recipients in most states, provide the health insurance needed to pay for treatment and other supports (Burt and Sharkey 2002; Rosenheck et al. 2000; Fawcett 2002). Yet, access to these benefits for people who are homeless is fraught with such difficulty that many eligible people do not apply, are denied for technical reasons, or wait years for resolution of their cases.

### **The Problem and the Target Population**

The target population for the policies proposed in this paper is adults who are homeless with mental illnesses and/or co-occurring substance use disorders. Despite the high levels of disability estimated among people who are homeless, many potentially eligible persons never apply for SSA disability benefits (GAO 2000). Among those who do apply, approval rates are very low. With few exceptions, most states and localities do not know what their approval rate is for homeless SSI and SSDI applicants, as these data are not maintained separately by SSA. Although SSA's data are rich in many ways, SSA does not track approval of benefits by housing status. Where local programs collect these data, approvals on initial application for homeless applicants range between 10 and 15 percent (Dennis et al. 2006). This compares with a national aggregate approval rate on initial application of 35 percent (SSA 2008a).

If a SSA disability application is denied, an appeal that involves waiting for a hearing before an administrative law judge (ALJ) takes an average of 500 days nationally (SSA 2008a). This compares with a wait of 415 days at the close of fiscal year 2005 (Social Security Advisory Board, 2007). Thus, the wait for hearings is increasing rather than declining. Further appeals are

possible through the Appeals Council level and federal court. Although appeals take a long time, they are often successful at the hearing level (Social Security Advisory Board 2007). However, most applicants do not appeal for a variety of reasons including a decline in health and feeling discouraged about the process.<sup>2</sup>

Prior policy analysis related to SSA disability benefits for people who are homeless has focused on either the effect of reforms to the drug abuse and alcoholism (DA&A) disability category or on the potential of representative payees to help manage a person's benefits (see, for example, Watkins and Podus 2000; Rosenheck, Lam, and Randolph 1997; Luchins, Robert, and Hanrahan 2003). Much less attention has been paid to policies or practices designed to increase initial access to benefits (Rosenheck, Frisman, and Kasproff 1999; Nuttbrock et al. 2002; Jacobs, Newman, and Burns 2001).

Concern over access to SSA disability benefits for those experiencing homelessness prompted Congress to appropriate \$24 million to develop demonstration projects to assist people who are homeless and other underserved populations. SSA used these funds to develop and implement the Homeless Outreach Projects and Evaluation (HOPE) initiative, which ended in 2007. The HOPE demonstration was intended to pilot strategies to increase the efficiency of the disability application process for people who had been homeless for more than one year. It was also expected that the 41 HOPE programs, funded for three years, would reduce case processing time at SSA and denials for initial claims. Overall, the HOPE initiative reported a 41 percent allowance rate on initial application, with a 4.8 month average time to determination (McCoy et al 2007).

In 2001, the U.S. Department of Health and Human Services and the U.S. Department of Housing and Urban Development addressed their concern about access to SSA disability benefits for people who were long-term homeless by jointly funding the SSI/SSDI Outreach, Access and Recovery (SOAR) Technical Assistance Initiative. The authors of this paper developed and continue to provide assistance and training through SOAR. To date, 34 states have participated in forums to plan local SSI outreach projects in collaboration with local SSA offices and state Disability Determination Service (DDS) offices, which contract with SSA to make disability determinations. With 19 states reporting, SOAR has an allowance rate of 70 percent and

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<sup>2</sup> The issue of the wait for a hearing is one of the critical components addressed in SSA's current strategic plan (Social Security Administration 2008b).

decisions are taking 93 days on average for initial claims (Dennis, Perret and Lassiter, submitted). This compares to a national approval rate through the usual process of 35 percent on initial application (SSA 2008a) and an average processing time of 4-6 months (Allsup 2008). The policy recommendations in this paper stem from the authors' experience with SOAR and similar work related to SSI and SSDI that the first author began in the early 1990s (Perret and Dennis 2008; Post et al. 2007; Dennis et al. 2006; Rosen and Perret 2005).

**Challenges to accessing benefits.** When applying for benefits, people who are homeless face many challenges (Rosen, Hoey, and Steed 2001). These challenges generally are of two types: those related to the situation of homelessness and those related to systemic issues.

The SSA disability application process requires two main components that are distinct and complex. First, the applicant is required to provide documentation to meet the non-medical or non-disability criteria. For SSI, this includes documentation of resources, living arrangement, and income, as access to SSI is based on need. For SSDI, this generally means documentation of work history and onset of disability. Once an individual meets the SSA non-medical criteria, the medical portion of his or her application is forwarded to the DDS to make the disability determination using SSA's rules. To make disability determinations, the DDS attempts to obtain all the medical information identified in the application. If that information is inadequate or information is not received, the DDS must then schedule a consultative examination (CE) for the applicant with a physician or psychologist who contracts with the DDS to do such exams. The CE then typically becomes the determining factor in whether the benefit is allowed or not.

When people who are homeless attempt to navigate this complex process, they face many challenges. They have great difficulty meeting the non-medical criteria as they typically do not have the necessary documentation and have no way to get it. They do not have transportation and, thus, miss appointments at SSA and may be denied on technical grounds for not completing their applications in the allotted time period (60 days for SSI and six months for SSDI).

In filling out their applications, people who are homeless with serious mental illnesses often do not mention these illnesses. This may be because they do not recognize them as such, deny them, or feel embarrassed or ashamed at having one or more of them. (This is also true of individuals with serious mental illness who are not homeless). Lack of access to needed medical evaluations, treatment, and other services causes people who are homeless to receive inconsistent treatment and to have inaccurate or changing diagnoses. Diagnosing a mental illness accurately



occurs when an individual is known over time; this is rarely true for people who are homeless. Cognitive impairment associated with these illnesses impedes an individual's ability to recall and provide a comprehensive treatment history and other relevant information. Further, as these individuals may move from place to place, documentation of treatment is difficult to gather. Often, then, medical information is not known or submitted, as it is not noted on the application. Thus, access to benefits is inhibited not only by the difficulty in navigating a complex approval process, but also difficulty in consistently accessing medical providers who must provide diagnostic and other necessary information.

Because of all these impeding factors, most people who are homeless and who have disabilities need assistance to apply for SSA benefits. Denials for people who are homeless are typically the result of SSA's inability to contact the individual for additional information as well as missed appointments. When CEs are scheduled, applicants often do not attend because they do not know about the appointment, have no transportation, or do not realize the significance of these evaluations. When applicants do attend, they often deny that they have a mental illness. Thus, CE evaluators are seldom able to learn about and report on the difficulties an applicant experiences and why. Also, the brief nature of these evaluations makes it difficult for individuals to convey effectively their history and struggles, especially in an encounter with an unknown evaluator.

In addition, many people with co-occurring disorders involving substance use do not apply because they believe incorrectly that if they have a substance use problem they are not eligible for SSA disability programs. While it is true that persons disabled solely on the basis of substance use are not eligible for SSA disability programs, many homeless persons with substance use disorders have co-occurring conditions that qualify them for benefits (Post et al. 2007).

Beyond these individual-level challenges, system-level barriers exist, both within the system of care and in the application and the disability determination processes. Case managers and clinicians are seldom able to assist homeless people with SSI and SSDI applications, because they have neither the time nor understanding of how to assist applicants effectively. Case managers who try to help applicants are frustrated by a lack of contact with SSA and a poor understanding of the eligibility criteria. Medical records, typically the source of information that

the DDS uses to determine disability, rarely contain information about functional impairment that is so vital to accurate determinations.

In addition, within the SSA application process, current policies do not match the reality of the treatment world, especially in publicly funded programs. The requirement of a diagnosis from a physician or licensed psychologist, in most instances, means that valuable diagnostic information provided from other health professionals is not granted the same level of credibility. In addition, people with mental illnesses have greater difficulty accessing presumptive disability under SSI. The granting of presumptive disability means quicker access to SSI benefits, as benefits are provided before a final determination is made at DDS. For people who are homeless, presumptive payments can be critical to accessing housing and services quickly.

### **Policy Approach and How the Proposed Changes Address the Problem**

To address these obstacles, we have identified three areas where policy changes would result in significant improvements in accessing SSA disability benefits for this vulnerable population. For each proposed policy change, we describe the current policy, the proposed change, how this change addresses the problem, who would be affected, and the estimated cost (to the extent that we are able to assess this). The three policy changes addressed in this paper are:

- Increasing the number of acceptable medical sources to include certified nurse practitioners, certified physician assistants, and licensed clinical social workers;
- Adding schizophrenia for people who are long-term homeless as a category for presumptive disability; and
- Modifying specific SSA processes for adults who are homeless, including (1) routinely collecting information and entering it into the SSA data system on housing status at the time of application; (2) flagging applications from applicants who are homeless; (3) assigning homeless applicants to designated SSA claims representatives and DDS disability examiners; (4) expediting claims from applicants who are homeless; and (5) including information in SSA and DDS staff training on homelessness and its effect on a person's ability to respond to questions and to function.

## **Increasing the Number of Acceptable Medical Sources**

Allegations of mental impairment in SSI and SSDI applications are increasing. Between 1987 and 2005, according to data from SSA, the share of SSI disability awards due to a mental disorder for people aged 18 to 64 rose from 24 to 36 percent (Danziger, Frank, and Meara 2008). For SSDI, awards for mental illness rose from less than 2 percent in 1978 to 30 percent of all beneficiaries and 39 percent for those under age 50 (Danziger, Frank, and Meara 2008).

In many communities, access to physicians and/or licensed psychologists is very difficult. Studies show that the current supply of medical and dental students will not be enough to meet the country's future primary health care needs (New Freedom Commission Subcommittee on Rural Health 2003). Physicians are currently in short supply (Perlino 2006). In publicly funded clinics, many, if not the majority, of health care services are provided by professionals other than physicians. For example, in Health Care for the Homeless programs, nurse practitioners and physician assistants account for 39 percent of the service encounters provided compared to 23 percent provided by family and general physicians (Health Resources and Services Administration 2006).

In behavioral health, especially, developing a workforce to meet the needs of persons with serious mental illnesses has been challenging. To begin with, much of the care for this population is delivered in publicly funded settings. Compared to privately funded settings, compensation in programs funded with public dollars makes it even more difficult to recruit and retain clinicians. Within many of the professional disciplines, the care of this population has not been of major interest to educators or trainees. Few academic training programs provide in-depth specialty training on the treatment of individuals with severe mental illness and, not surprisingly, a small proportion of graduates pursue this area of work (Hoge et al. 2007).

In rural areas, the shortage of physicians and other professionals is even more pronounced in both primary and behavioral health care. More than 85 percent of the 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, and Hartley 2001; Hoge et al. 2007). Obtaining medical evaluations and medical evidence to support SSI and SSDI claims and scheduling and traveling to CEs are extremely difficult in rural areas. For example, in Montana, applicants often drive 70 miles or more for CE appointments, certainly difficult for people who are homeless (Downing, personal communication 2007).

Although resources are more plentiful in urban areas, people who are homeless still have difficulty accessing physicians. In both urban and rural areas, services are often provided by other professionals, especially for behavioral health care. For example, clinical social workers comprise the largest specialty in social work and provide intensive services to individuals with mental illness and substance use disorders (Whitaker et al. 2006). In the majority of states, clinical social workers are specifically licensed by their state to be able to diagnose (Association of Social Work Boards website 2008).

For purposes of disability determination, the Code of Federal Regulations that mandates SSA policy requires that evidence of one's impairment must come from an "acceptable medical source." Impairment is considered to be the impact of one's diagnosis on ability to function in critical areas that are related to being able to perform substantial gainful activity (SGA) SSA regulations state: "Acceptable medical sources are (1) licensed physicians (medical or osteopathic doctors); (2) licensed or certified psychologists ... (3) licensed optometrists, for the measurement of visual acuity and visual fields ... (4) licensed podiatrists, for purposes of establishing impairments of the foot, or foot and ankle only, depending on whether the State in which the podiatrist practices permits the practice of podiatry on the foot only, or the foot and ankle; and (5) qualified speech-language pathologists, for purposes of establishing speech of language impairments only. For this source, 'qualified' means that the speech-language pathologist must be licensed by the State professional licensing agency, or be fully certified by the State education agency in the State in which he or she practices, or hold a Certificate of Clinical Competence from the American-Speech-Language-Hearing Association" (Code of Federal Regulations 2007).

For SSA to add a profession to the list of acceptable medical source, that profession must show that it "adhere[s] to consistent educational training requirements; [has] national standardization of licensing or certification requirements in these jurisdictions, and show[s] consistency in the scope of practice and degree of supervision required" in all 50 states, the District of Columbia, and the U.S. Territories (Karman, personal communication 2008).

We recommend expanding the list of acceptable medical sources for applicants to include certified nurse practitioners, certified physician assistants, and licensed clinical social workers. This policy change would help address the inherent difficulties that currently exist in obtaining diagnostic information for much of the population applying for SSI and SSDI, but especially for

people who are homeless. It would also be more consistent with the reality of who is providing most of the primary and behavioral health care in the United States, particularly in the publicly funded health and behavioral health systems.

*Nurse practitioners.* In 2000, researchers found that the outcomes of individuals treated by nurse practitioners were comparable to the outcomes of those treated by physicians (Mundinger et al. 2000). Clearly, the care given by nurse practitioners is appropriate and meets acceptable medical standards.

The Dictionary of Occupational Titles (a publication that SSA uses to determine an applicant's ability to do certain work as part of the disability determination process) defines nurse practitioner as someone who can provide general medical care and treatment to patients in a medical facility, such as a clinic, health center, or public health agency, under *direction of physician*" [emphasis added]. It is noteworthy that this definition does not specify on-site supervision or sign-off by a physician. The definition also notes that nurse practitioners may "prescribe or recommend drugs or other forms of treatment and may, where state law permits, engage in independent practice" (National Academy of Sciences 1971).

Certification as a nurse practitioner can occur through the American Nurses Credentialing Center (ANCC), which certifies the greater proportion of nurse practitioners, or the American Association of Nurse Practitioners (AANP). Our recommendation is that, for the purpose of this proposed policy change, certification be through the ANCC. Such certification requires: (1) a current, active RN license in a state or territory of the United States or the professional, legally recognized equivalent in another country; (2) a master's, post-graduate, or doctorate degree from a nurse practitioner program accredited by the Commission on the Collegiate of Nursing Education (CCNE) or the National League for Nursing Accrediting Commission (NLNAC) plus 500 faculty-supervised clinical hours in the area of accreditation, and (3) passage of a national exam to be board certified in the area of certification. Certified nurse practitioners are also licensed in accordance with state criteria, which are becoming increasingly uniform.

We believe that the passage of a national exam along with certification by the ANCC meets SSA's criteria for a profession to qualify as an acceptable medical source. Thus, nurse practitioners should be considered acceptable medical sources in the area in which they are certified.

*Physician assistants.* Physician assistants (PAs) are “health care professionals licensed or, in the case of those employed by the federal government, credentialed, to practice medicine with physician supervision . . . PAs deliver a broad range of medical and surgical services to diverse populations in rural and urban settings” (American Association of Physician Assistants (AAPA) 2007). In certain communities, especially some rural ones, a PA may be the only health care provider (AAPA 2007). Physician assistants’ scope of practice usually includes physical exams, diagnosis and treatment of illnesses, ordering and interpreting medical tests and evaluations, assisting with surgery, and writing prescriptions. All 50 states, the District of Columbia, and Guam allow PAs to write prescriptions (AAPA 2008).

To be certified as a physician assistant, one must have met the defined course of study and passed the Physician Assistant National Certifying Exam, given by the National Commission on Certification of Physician Assistants (NCCPA) (AAPA 2008). This exam is developed by the NCCPA working in conjunction with the National Board of Medical Examiners. The defined course of study means one in which an individual receives intensive medical training in a program accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). These programs usually run for 26 months and all PAs must graduate from one of these accredited programs and meet the standards of these programs (AAPA 2008).

PAs work very closely with physicians and are trained in the medical model. They learn how to diagnose and treat medical problems. For initial licensure to practice, all 50 states, the District of Columbia, and the major US territories require national certification (Pace, AAPA, personal communication 2008). In addition, to maintain their certified credential, PA-Cs must take 100 hours of continuing medical education every two years and must pass a recertification exam every six years. While there are licensing requirements that differ somewhat from state to state, most states require current NCCPA certification (Pace, AAPA, personal communication 2008). In all states, according to the NCCPA, certified physician assistants are trained and authorized to take medical histories, conduct physical exams, diagnose and treat illnesses, order and interpret medical tests, work with individuals on preventative health care, assist in surgery, write prescriptions, and perform a variety of medical procedures (NCCPA Foundation and National Commission on Certification of Physician Assistants 2006). The certification and exam requirements for physician assistants should meet the criteria for acceptable medical sources as required by SSA.

*Licensed clinical social workers.* Licensed clinical social workers are the majority profession providing outpatient mental health services. In a recent study of licensed social workers conducted by the National Association of Social Workers (NASW), 40 percent of social workers report working in behavioral health and 98 percent report providing direct service (Whitaker, et. al. 2006).

As is true of all health professions, licensing for social workers is handled at the state level. Even so, in all 50 states, the District of Columbia, and the U.S. Virgin Islands clinical social workers are licensed for independent practice (Association of Social Work Boards (ASWB), personal communication 2008). In all of these jurisdictions except California, states “use the ASWB clinical social work licensing examination to determine whether applicants for clinical licensure have the minimum social work knowledge necessary to practice safely...” (ASWB, personal communication 2008). The ASWB licensing examinations are developed “according to the guidelines of the American Psychological Association, the Joint Commission on Standards for Educational and Psychological Testing, the American Educational Research Association, the National Council on Measurement in Education, and the Equal Employment Opportunity Commission, with psychometric guidance from ACT, a national testing company” (ASWB, personal communication 2008). Licensure at the clinical level means that social workers can practice independently. In all states, to be licensed at this level, social workers must have a minimum of 100 hours of supervised clinical practice post-Master’s degree.

*In summary.* The addition of certified nurse practitioners, certified physician assistants, and licensed clinical social workers to the list of acceptable medical sources would greatly facilitate obtaining the diagnostic information that DDS must have to process SSI and SSDI applications. This is particularly true for people who are homeless, who have inconsistent treatment, increased risk for cognitive impairments, great difficulty providing medical information, and even greater difficulty accessing consistent care from currently authorized acceptable medical sources. The addition of these professions would facilitate the disability determination process tremendously.

Adding these professions is also consistent with current SSA-approved medical sources. Even physicians, who are generally considered to be the most acceptable medical source, have variability regarding their certification and licensing from state to state. This is especially true of foreign-trained physicians (Immigration Law Portal 2008). Speech therapists, too, have

variability in their licensing standards across the country. The American Speech-Language Hearing Association (ASHA) acknowledges that “complete uniformity among state licensure programs, although desirable, is unrealistic” (ASHA 2004). There is variability as well in the licensing requirements of optometrists where, for example, the U.S. Virgin Islands does not allow the same scope of practice as do the states (Garrett 2007).

Expanding the list of acceptable medical sources might raise concerns within SSA that the number of applications will increase along with the cost and number of CEs. The authors’ experience with SOAR suggests that expanding the list of acceptable medical sources is not likely to cause more people to apply. Applying for these benefits is an arduous process and, typically, only people who believe they qualify apply. However, people who are homeless do not often follow through with the process for many reasons that include the complexity of the process, the lack of resources and ability to provide ongoing information, and the ability to keep appointments. They are often technically or medically denied for lack of information and/or missing scheduled CEs. While hard data do not exist on this phenomenon, anecdotal evidence from across the county confirms that this is frequently the experience of applicants who are homeless.

In addition, applicants often apply more than once, with inherent costs to SSA and DDS. Though not reporting on repeat applications per se, data from SSA suggest that this is a common occurrence. In 2007, for example, there were 1,945,464 applications for SSI for adults aged 18 to 64 but only 1,100,954 applicants. Thus, for every applicant there were 1.8 applications (SSA 2007a). This does not mean that nearly all applications were initially unsuccessful; some may have been approved and then terminated for some reason. Even so, it is reasonable to assume that adults who are homeless are more likely to have difficulty following through and more likely to have repeat applications than people who are housed. This is true in part because SSA communicates by mail; not having a home compounds the difficulties already mentioned.

In FY 1998, the average national CE cost per disability claim was \$181 (SSA OIG, 2001). A review of five DDSs found that 66,220 CEs were purchased in calendar year 1998 at a cost of more than \$2.4 million (SSA OIG, 2001). There are no available data on the percentage of applications that require a CE. However, it is reasonable to assume, given the sporadic treatment history and limited access to continuous care that people who are homeless experience, that many (if not most) of them are referred for CEs. Were the list of acceptable medical sources



expanded in keeping with this policy recommendation, it is also reasonable to assume that the ratio of CEs to applicants could decline as these practitioners are generally more readily available to homeless applicants. Adding nurse practitioners, physician assistants, and license clinical social workers to the list of acceptable medical sources would facilitate diagnostic information sharing and processing rather than add to costs.

Finally, it is clear that the Commissioner of SSA has the power to make this change to the list of acceptable medical sources. Regulations note that the Commissioner has broad authority “to make rules and regulations and to establish procedures...which are necessary or appropriate to carry out” the provisions of the Social Security Act (42 U.S.C. § 405(a)). In addition, by excluding language that expressly defines “medically acceptable,” Congress has given the Commissioner the authority to determine what evidence will establish the evidence for a disability (42 U.S.C. § 423(d)).

### **Adding Schizophrenia Combined with a Duration of Homelessness as a Presumptive Disability Category**

Currently, presumptive disability (PD) is possible under the SSI, but not the SSDI, program. It can be authorized at the local SSA office for a limited list of categories of disabilities. It can also be authorized at a DDS, when there is a preponderance of medical evidence that supports the claim. According to the SSA Program Operations Manual System (POMS), an award of PD can be allowed at the local SSA office for the following categories of medical conditions without obtaining medical evidence:

- Amputation of a leg at the hip;
- Allegation of total deafness;
- Allegation of total blindness;
- Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, allegedly due to a longstanding condition, excluding recent accident and recent surgery;
- Allegation of a stroke (cerebral vascular accident) more than 3 months in the past with continued marked difficulty in walking or using a hand or arm;
- Allegation of cerebral palsy, muscular dystrophy or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking, or coordination of the hands or arms;
- Allegation of Down Syndrome;

- Allegation of severe mental deficiency made by another individual filing on behalf of a claimant who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities; and
- Allegation of Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig's disease)

The following impairment categories require some medical evidence or confirming contact before PD payments can be initiated:

- Low birth weight (1200 grams or less/2 pounds and 10 ounces) – applies to children under age 1;
- Low birth weight (at least 1200 grams, or about 2 lb. 10 oz., but less than 2000 grams, or about 4 lb. 6 oz. at birth, and small for gestational age);
- Human immunodeficiency virus (HIV) infection;
- A physician or knowledgeable hospice official confirms that an individual is receiving hospice services because of a terminal illness;
- Allegation of a spinal cord injury producing an inability to ambulate without the use of a walker or bilateral hand-held assistive devices for more than two weeks, with confirmation of such status from an appropriate medical professional; and
- End stage renal disease (ESRD) with report of ongoing dialysis in file.

The DDS uses the required criteria for SSI and SSDI but can award a PD when it has medical evidence to suggest eventual approval of a claim. In addition, the DDS is not limited to the above list of impairments.

Presumptive disability provides six months of SSI payments, virtually immediately after application, while the application is processed through the usual process at DDS. If a person is denied upon processing of the application, the paid benefits do not have to be reimbursed. For homeless applicants, presumptive disability can literally save lives. Yet, presumptive disability is rarely used for this population, or for anyone with a serious mental illness, because mental illness is not an allowable category at the local SSA office. It is also rarely used for homeless adults at

the DDS because they are seldom able to provide the medical evidence needed at that level for a presumptive award.

For a person to be eligible for SSI or SSDI, he or she must meet the SSA definition of disability. SSA regulations note that the “law defines disability as the 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.” To meet this definition, a person must have a severe impairment(s) that makes him or her unable to do past relevant work (see §416.960(b)) or any other substantial gainful work that exists in the national economy (CFR 20 §416.905). Thus, a person must have, in lay terms, a diagnosis of an illness that affects functioning and impairs a person’s ability to work (earning a specific amount) for at least 12 months or results in death.

We propose that the diagnosis of schizophrenia with a defined period of homelessness be added to the list of diagnoses that meet the criteria for presumptive disability. Since this disorder is one of the most disabling mental illnesses and one which is found disproportionately among persons who have been homeless for long periods of time, allowing people with this disorder to be presumptively eligible would greatly facilitate their recovery. Compared to other serious mental illnesses, schizophrenia is particularly debilitating. The DSM-IV-TR notes that, with schizophrenia, “complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder” (p. 309). To be accurately diagnosed, one must have at least two or more of the characteristic symptoms, including delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior and negative symptoms, such as flattened affect, lack of motivation, and limited speech (DSM-IV-TR, p.312). In addition, these symptoms must persist for at *least 6 months* (emphasis added). Finally, evidence of social and occupational dysfunction must be “markedly below the level achieved prior to the onset” (DSM-IV-TR, p. 312). Thus, the diagnosis of schizophrenia incorporates functional difficulty along with duration. Although no one in the mental health profession would argue that other mental disorders are not also extremely difficult and impairing, none of the other diagnoses incorporate the same degree of duration in their definitions that schizophrenia does.

For this presumptive category, we advocate combining schizophrenia with a duration of homelessness because we believe that longer-term homelessness is, in and of itself, indicative of

functional impairment. Most people who are functioning well do not become homeless, despite extreme poverty and other overwhelming life events. Among national homeless advocacy organizations, there is consensus that “homelessness itself is an indicator of functional impairment and often a marker of disability. The fact that people with disability constitute the ‘chronically homeless’ population in America is extremely troubling” (Joint Comments from Homeless Advocacy Organizations 2006).

In recent studies comparing those experiencing homelessness to those who are very poor but who remain housed, one of the most prevalent differences is mental illness, although it is not the only risk factor (Caton, Wilkins, and Anderson 2007; Caton, et al. 2005; North et. al 1998). The U.S. Conference of Mayors Report (2007) finds that the most common cause of homelessness in single adults is mental illness. Folsom and colleagues (2005) and McNiel and Binder (2005) show that, among the Axis I diagnoses of people experiencing homelessness, schizophrenia is the most prevalent. Folsom states that “patients with schizophrenia were more likely to be homeless than those with major depression.” Caton and colleagues (1994) found that people who are homeless with significant mental illnesses, such as schizophrenia, do not access services compared with those who are housed. They also report (Caton, Wilkins, and Anderson 2007) that those who are homeless with schizophrenia are less likely to be admitted to a hospital in the early stages of their disease, making treatment more difficult and homelessness more likely as a result.

We propose adding presumptive disability for individuals diagnosed with schizophrenia who have been homeless for at least six months. By suggesting the diagnosis of schizophrenia (which includes a durational component) along with a specific period of homelessness, which suggests functional impairment, this new PD category would meet the major criteria for disability, i.e., a medically determinable impairment that lasts at least 12 months or more or results in death and that affects functioning in terms of an individual’s ability to engage in SGA.

The following proposed language was developed by faculty and students at the Widener School of Law in conjunction with one of the authors (Yvonne Perret) of this paper (Arnold, Conroy, and Neary 1996). This proposal would create an additional category for presumptive disability and would amend the Supplemental Security Income for the Aged, Blind and Disabled 20 C.F. R. § 416.934. For the purposes of this regulation, an individual may be found presumptively eligible for SSI disability benefits if the following conditions are met:

1. The applicant has been homeless for at least six months immediately preceding application for benefits.
  - a. Homelessness must be proven by signed statements from at least two individuals with knowledge of the applicant's homelessness for the past six months or longer.
  - b. These two individuals may be taken from any of the following classes:
    - i. Social workers;
    - ii. Law enforcement officers;
    - iii. Homeless program employees;
    - iv. Mental health professionals;
    - v. Case managers;
    - vi. Social or human service caseworkers;
    - vii. Other health care workers; or
    - viii. Other individuals authorized by the Social Security Administration (SSA)
2. The applicant has been diagnosed as having schizophrenia.
  - a. For schizophrenia to be diagnosed, the illness must have lasted least six months and include at least one month of active phase symptoms (i.e., two [or more] of the following: delusions, hallucinations, disorganized or catatonic behavior, negative symptoms). (American Psychiatric Association, 1994, p. 273).
  - b. Severity, for the purposes of this regulation, is shown by the following:
    - i. The applicant is unable to engage in substantial gainful activity (SGA), as defined in 20 C.F. R. § 416.971 (1995) et seq.; and
    - ii. Two or more of the following functional limitations are present:
      1. Marked restriction of activities of daily living
      2. Marked difficulties in maintaining social function;
      3. Frequent deficiencies of concentration, persistence, or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere); and
      4. Repeated episodes of decompensation (each of extended duration).

This change would benefit a limited number of homeless adults. Preliminary data from the federal interagency Chronic Homelessness Initiative, which targeted people with mental

illnesses and co-occurring substance use disorders, show that 19 percent of the people in this program have schizophrenia (Mares and Rosenheck 2007). The cost to SSA of making this change is difficult to assess. Certainly, many of these individuals would apply for benefits anyhow so there would be no increased cost. For those who receive assistance in applying but who otherwise would not have, the cost would be their annual benefit amount. Because the person applying would have to show proof of diagnosis and duration of homelessness to qualify for a PD, the likelihood is that DDS would approve the individual for ongoing benefits. This upfront approval would save the cost of the lengthy appeals process that frequently occurs for homeless applicants. Having approval without going through this lengthy process would save money and offset the additional costs that might come from this regulatory change. In sum, although there would likely be some new costs to SSA, there would be cost offsets to SSA and cost savings to other systems (shelters, emergency rooms, jails and courts, etc.) when persons with schizophrenia who have been homeless for six months or more received benefits quickly.

### **Specific SSA Process Strategies for Adults Who Are Homeless**

Homelessness, in and of itself, impairs well-being and poses risks. People who are homeless for months or years tend to have disabilities associated with mental illness and/or substance use (SAMHSA 2003b). In addition, people who are homeless are generally the poorest among those in poverty. In 1996, the median monthly income for people who were homeless was \$300 or 44 percent of the Federal poverty level at the time (SAMHSA 2003b). People who are homeless with serious mental illness often also have untreated physical health problems, such as respiratory infections and disease, skin problems, tuberculosis, and other infectious diseases, such as HIV/AIDS. Compared to non-homeless individuals, people who are homeless have a much higher percentage of health problems—24 of 27 diagnostic categories in one study. These categories include injuries and digestive problems in addition to the disorders mentioned above (Vredevoe et al. 2007)

SSA recognizes that homelessness poses special difficulties for the people it serves as evidenced by the agency's development of a Homeless Plan to address some of these difficulties (SSA, 2002, 2008b). In this plan, SSA includes identifying barriers that people who are homeless face in accessing SSA programs, designing a "modest data collection method" to "aid the assessment of the homeless initiative," expediting "processing of homeless claims," and

providing training to SSA and DDS staff to “increase their ability to service the homeless.” The strategies suggested below serve to address some of the issues included in SSA’s plan as well as to serve people who are homeless more expeditiously.

Developing expertise and understanding the impact of homelessness (as it relates to processing disability claims), maintaining contact with applicants, and accurately tracking allowance rates for applicants who are homeless are challenges for SSA and DDS. To address these challenges, we propose several modifications to specific SSA processes that would be implemented as national policy by SSA. These changes, if adopted, would enhance SSA’s information about and work with applicants who are homeless. The proposed modifications are: (1) routinely collecting information and entering it into the SSA data system on residential status at the time of application; (2) flagging applications from applicants who are homeless for expeditious processing; (3) assigning homeless applicants to designated SSA claims representatives and DDS disability examiners; (4) expediting claims from applicants who are homeless, and; (5) including information in SSA and DDS staff training on homelessness and its effect on a person’s ability to respond to questions and to function. We examine the rationale for and potential costs of each of these proposals below.

*Collecting information on housing status.* Because SSA keeps no national data on housing status of applicants, it is impossible to know with any degree of certainty how many individuals who are homeless apply for SSI and/or SSDI and are approved or denied. Estimates of homeless individuals who apply are generally provided anecdotally at the SSA local office level, if at all.

In SSA’s Homeless Plan, there is a strategy that describes requesting data from the Office of Systems on the “transient” indicator in SSA’s system. This is an indicator that is already a part of the SSI application. For SSDI, such an indicator would need to be added. Adding information on housing status would enable SSA to report more accurately and systematically on, and to work with, applicants who are homeless. Such information is critical to recommending policy and procedural modifications for SSA and to assessing the impact of any changes that SSA makes to ensure “access and services to the homeless,” a strategic goal in SSA’s Homeless Plan.

To this end, we propose that SSA identify applications from homeless individuals and report allowance rates and other pertinent information. The definition of homelessness should include persons who are literally homeless at the time of application as well as those who are at

risk of homelessness (in prison or jail, in state psychiatric hospitals, facing eviction, in temporary or transitional housing, doubled up with others, etc.). While some additional work would be required to gather this information from SSDI applicants, starting with SSI would be a reasonable first step. Given the breadth of the SSA data collection currently, adding an element on housing status would provide critical information for policy assessment and service delivery that is now lacking.

*Flagging applications from people who are homeless.* In addition to getting an accurate count of applicants who are homeless, “flagging” or identifying applications from people who are homeless is key to efficient processing of these applications. Flagging allows the SSA claims representative to identify the claim as coming from a homeless applicant and, when turned over to the DDS, the flag triggers the assignment of the case to a designated disability examiner. Currently at SSA, there is an electronic “homeless” flag that can be used for applications from people who are homeless, but it is not universally or consistently applied. Implementing this flag in all jurisdictions and for all qualifying applicants is important for consistent processing of applicants and already exists as a mechanism.

*Assigning homeless applicants to designated SSA and DDS staff.* Once applications are flagged as homeless, they would be assigned to designated SSA claims representatives and DDS disability examiners. This accomplishes several important objectives. Staff becomes more experienced in working with people who are homeless and more effective interviewers. As they learn about and develop relationships with homeless service providers, SSA claims representatives and DDS examiners are also better able to locate applicants in the event that additional information is needed. Such relationship building would likely lead to greater efficiency in processing applications as well as fewer technical denials due to loss of contact or lack of information. Because these cases are assigned to staff anyway, there is no additional cost associated with making this change. In fact, it may result in some cost efficiencies as fewer individuals are lost to the process and more collaborative work is done with providers who serve people who are homeless.

*Expediting claims from applicants who are homeless.* People who are homeless and who have disabilities are the most vulnerable adults in the United States. As has been noted above, these individuals are at greater risk than people who are housed for multiple health problems, including mental illness and debilitating physical health problems. Given their vulnerability, the



processing of their applications should be a priority. Although SSA has initiated a Quick Disability Determination (QDD) process, its complex computer model does not identify people who are homeless with mental illness and/or co-occurring disorders as eligible for this process. Therefore, we recommend that SSA commit to expediting homeless applicants' claims as they have done for those "wounded warriors" returning from the war in Iraq and Afghanistan (SSA 2007b).

*Training SSA and DDS staff on the impact of homelessness.* Understanding the experience of homelessness requires particular expertise, sensitivity, and training. In addition, interviewing people who are homeless — and who have learned by their life experiences to be wary and cautious — requires additional skill. To collect appropriate data, to complete more comprehensive and thorough applications, and to develop the expertise needed to serve people who are homeless, we propose that SSA provide training to SSA and DDS staff on homelessness and its effect on a person's ability to respond to questions and to function. This recommendation is consistent with SSA's Homeless Plan. Homeless providers and advocates could develop and offer this training to local SSA office staff and to DDS examiners, and they would likely be willing to do so on a *pro bono* basis. Alternatively, the training could be provided using web-based technology, limiting the cost to initially producing the training and periodically updating it.

In sum, the proposed administrative strategies would assist SSA to provide more effective service to SSI and SSDI applicants who are homeless. The specific costs of these changes are difficult to assess, but they are expected to be largely one-time-only costs to cover the additional data element(s) on housing status and development of training on understanding homelessness and its impact more fully.

## **Conclusion**

The proposed policy changes — increasing the types of acceptable medical sources, adding schizophrenia for people who are long-term homeless as a category for presumptive disability, and modifying specific SSA processes for adults who are homeless -- would improve the disability determination process for eligible individuals and make demonstrable and vital contributions to ending and preventing long-term homelessness. In some cases, receiving

benefits means the difference between life and death. In all cases, access to these benefits is a major first step in the process of recovery for persons with disabilities who are homeless.

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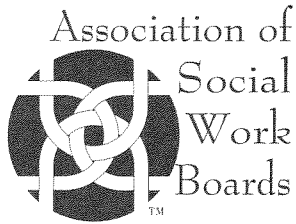
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February 28, 2008

Ms. Yvonne M. Perret, MA, MSW, LCSW-C  
Executive Director  
Advocacy and Training Center  
1116 Bedford Street  
Cumberland, Maryland 21502

Dear Ms. Perret:

I am writing to provide information on licensing for clinical social workers and the Association of Social Work Boards (ASWB) Clinical examination. Clinical social workers are licensed for independent practice in all 50 states, the District of Columbia, and the U.S. Virgin Islands. All of these jurisdictions, except California (which is currently considering it), use the ASWB Clinical social work licensing examination to determine whether applicants for clinical licensure have the minimum social work knowledge necessary to practice safely to ensure public protection. Eight of these states – California, Connecticut, Delaware, Montana, New Hampshire, Oregon, Tennessee, and Vermont – only license social workers at the independent clinical level.

The requirements for social work licensure exist to protect the public. The requirements set minimum standards for education, experience, supervision, and demonstrated knowledge. The social work licensure board must be assured that a candidate for licensure meets the requirements in all the areas specified by the jurisdiction's regulatory law. The purpose of the social work licensing examinations is to determine if social workers have the minimum knowledge necessary to practice in a competent and safe manner with little risk to the public they serve. In the case of the Clinical examination, the exam tests knowledge necessary to practice independently, diagnosing and treating emotional and behavioral problems, including the provision of psychotherapy, without supervision or accountability to anyone but clients. The Clinical examination content is focused on direct, clinical social work practice, including the supervision, research, policy, and management components. Enclosed is the content outline for the ASWB Clinical examination.

The ASWB licensing examinations are constructed according to the guidelines of the American Psychological Association, the Joint Commission on Standards for Educational and Psychological Testing, the American Educational Research Association, the National Council on Measurement in Education, and the Equal Employment Opportunity Commission, with psychometric guidance from ACT, a national testing company. First, the examination questions are based on knowledge statements developed through a nationwide practice analysis survey in

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*Executive Director*

Donna DeAngelis, LICSW, ACSW

Ms. Yvonne M. Perret, MA, MSW, LCSW-C  
February 28, 2008  
Page Two

which social workers were asked to identify and rank the tasks they must know how to perform on the first day of their job. The data from this survey are analyzed by social work subject matter experts, who then construct the content outline. The survey sample and respondents statistically reflect the make-up of the profession, as does the composition of the subject matter experts who analyze the data. The most recent survey was conducted in 2001 – 2003. The examinations that began being administered on May 17, 2004 test content determined by the results from the survey information. ASWB is planning to conduct another practice analysis beginning in 2008.

I hope that this information is helpful. Please let me know if you have any questions or need additional information.

Sincerely,

A handwritten signature in cursive script that reads "Donna DeAngelis".

Donna DeAngelis, LICSW, ACSW  
Executive Director

Enclosure

# Association of Social Work Boards

## Clinical Examination Content Outline

### **I. Human Development and Behavior in the Environment--22%**

- A. Theories of human development and behavior
- B. Human development in the life cycle
- C. Human behavior
- D. Impact of crises and changes
- E. Family functioning
- F. Addictions
- G. Abuse and neglect

### **II. Issues of Diversity--6%**

- A. Effects of culture, race, and/or ethnicity
- B. Effects of sexual orientation and/or gender
- C. Effects of age and/or disability

### **III. Diagnosis and Assessment--16%**

- A. Assessment
- B. Information gathering
- C. Diagnostic classifications
- D. Indicators of abuse and neglect
- E. Indicators of danger to self and others

### **IV. Psychotherapy and Clinical Practice--16%**

- A. Intervention theories and models
- B. The intervention process
- C. Treatment planning
- D. Intervention techniques
- E. Intervention with couples and families
- F. Intervention with groups

### **V. Communication--8%**

- A. Communication principles
- B. Communication techniques

**VI. The Therapeutic Relationship--7%**

- A. Relationship theories
- B. Relationship practice

**VII. Professional Values and Ethics--10%**

- A. Value issues
- B. Legal and ethical issues
- C. Confidentiality

**VIII. Clinical Supervision, Consultation and Staff Development--4%**

- A. Social work supervision
- B. Consultation and interdisciplinary collaboration
- C. Staff development

**IX. Practice Evaluation and the Utilization of Research--1%**

- A. Evaluation techniques
- B. Utilization of research

**X. Service Delivery--5%**

- A. Policies and procedures of service delivery
- B. Processes of service delivery

**XI. Clinical Practice and Management--5%**

- A. Advocacy
- B. Finance
- C. Management and human resource issues

Effective May 17, 2004