



# **SSI/SSDI for Homeless Adults with Co-occurring Disorders A PATH National Teleconference**

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## Welcome and Introduction

### *Lynn Aronson*

Good afternoon everyone and welcome to our call. Our topic today is SSI/SSDI for Homeless Adults with Co-occurring Disorders. And our presenter for today is Yvonne Perret.

My name is Lynn Aronson and I'm with Advocates for Human Potential in Albany, New York. Along with our colleagues at Policy Research Associates, we provide technical assistance for the PATH program, the program that's funding this call. And I will be your moderator for today's presentation.

I would also like to acknowledge the very special role of HUD's Office of Special Needs Program and HRSA (Health Resources and Services Administration) in the interagency SOAR (SSI/SSDI Outreach, Access, Recovery) initiative. That initiative has contributed much to the development of successful strategies to address SSI eligibility of homeless individuals.

So we want to give some very special thanks to Lynnette Araki (HRSA) and Velma Simpson (HUD) and the offices that they represent. We also want to thank our own Michael Hutner for the work that he has done on this project.

CSAT has joined SAMHSA in sponsoring this audio presentation as part of CSAT's continuing commitment to addressing homelessness among persons who have substance abuse disorders. It's a very special treat to introduce Charlene LaFauve, chief of the CSAT Co-occurring and Homeless Branch. Dr. LaFauve leads CSAT's large program of grants for the benefit of homeless individuals who have substance use disorders. She has spoken forcibly for their needs and has been a strong supporter of finding new ways to ensure that they get the benefits to which they are entitled. And it's my pleasure to introduce Dr. LaFauve.

### *Charlene LaFauve*

Thank you very much, Lynn. And I want to also thank Yvonne Perret and Michael Hutner and my

associate, Ruth Hurtado, who's been partnering here with Michael and our SAMHSA colleagues on this important initiative. It's a pleasure to introduce this afternoon's teleconference on Co-occurring Disorders and SSI/SSDI Benefits. Now, this topic is especially important to CSAT and SAMHSA for several reasons. Income and health insurance are critical to recovery. And often the benefits are only available through Federal programs of the Social Security Administration.

We know that substance use by itself does not qualify a person for such benefits. The practical problem, however, is that we do hear reports that people with substance use disorders are frequently denied benefits despite the fact that they have a co-occurring mental health problems that have resulted in impairment. And we understand that the standard set by Congress in 1996 makes it difficult to determine clinically. But at the same time, we know that best practice and clinical sense would mean eligibility for many of the individuals who are homeless and who have those co-occurring disorders.

So the issue for CSAT and Dr. H. Westley Clark, the director of the Center for Substance Abuse Treatment, is that the current standard must be applied accurately and consistently and without disadvantage or differential treatment to people with substance use disorders. Now, we know that case managers assisting applicants are probably the most important partners for people with these co-occurring disorders and for SSA to meet their goals of accuracy, consistency, and more expeditious processing.

And the focus today is on co-occurring disorders—mental illness with substance use. The prevalence rates are much higher than one would think, and they are of great concern to all of those of us who are in the service profession. Future sessions will focus on other co-occurring disorders which may accompany substance use disorders. And it is a privilege for CSAT to partner with SAMHSA and co-sponsor this presentation.

On behalf of Dr. H. Westley Clark, our Center director, and my team and all of the staff at CSAT, I want to thank you all for this opportunity.

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## **Lynn Aronson**

Thank you very much, Charlene. We are very fortunate to have as our presenter today the leading expert on the issue of SSI/SSDI for adults with co-occurring disorders, Yvonne Perret.

Yvonne is a psychiatric social worker who was the program director of the SSI Outreach Project in the Community Psychiatry Division of the University of Maryland Medical System from 1993 to 2002. She managed the intensive case management program as well. This innovative program helped homeless adults who had serious and persistent mental illness with accessing SSI, other benefits, and services. In 2001, the SSI Program was named Best Practice Program by the National Alliance to End Homelessness and an exemplary program by SAMHSA at the October 2005 homeless conference.

Currently, she is the executive director of the Advocacy and Training Center in Cumberland, Maryland, and focuses on advocacy and training on public benefits, mental health services, and co-occurring disorders.

## **Yvonne Perret**

Thank you, Lynn. Hi everyone. I'm going to walk everyone on the call through slides that you have. And as Lynn mentioned, we will have two opportunities for you all to ask questions.

## **Co-occurring Disorders and SSI/SSDI**

We're going to focus today on the co-occurring disorders of substance use and mental illness. I think it's interesting that we talk about substance use and mental illnesses as if we don't consider a substance use disorder in that way. But we all know that it's listed in the category of mental disorders. So, I will say substance use and another mental illness.

We also know that people who have co-occurring disorders often have serious physical health problems, especially folks who are homeless. Those will be

touched on but our focus will be primarily on the substance use and mental health problems.

To begin, I'd like to make sure that everyone on the call has the same understanding of what these disability programs mean. So, if you go to the third slide, you will see that Social Security oversees two disability programs: Supplemental Security Income, known as SSI, and Social Security Disability Insurance, which you will hear called Social Security Disability or simply "disability" or SSDI. Those are kind of used interchangeably.

SSI is an income benefit for people with disabilities, those who are 65 and over, and people who are blind. If you are assisting somebody who is 65 or over, you have to simply show the age and that the person meets the resource and income limitations—they don't have to prove disability. In most States, SSI carries with it Medicaid eligibility. To be eligible a person must have limited income, assets, and resources, and there is a maximum (schedule) benefit rate of \$603 a month this year; some States supplement, most do not. And it's important that SSI has an equally important insurance benefit in terms of people with co-occurring disorders.

The income limitations this year require a person to earn less than \$860 a month. For both SSI and SSDI, if an individual is working and making \$860 a month—that's the gross earnings—they will not be eligible for either program. Part-time workers, however, might be eligible.

SSDI, unlike SSI, is based on the contribution that we all put into the Social Security System from what we get paid. And the benefit depends on how much we put into the system and how old we are. And there is a formula Social Security uses to determine benefits. Medicare usually comes with SSDI, but it's after 2 years of eligibility. So for a lot of folks that means that they may go that period of time without much in the way of health insurance. It's really a curious policy question that we should all be thinking and advocating about.

The two programs have similarities and then a great [many] differences. The similarities are that both have certain non-medical and medical criteria. The

medical criteria are exactly the same for both; the non-medical (criteria) differ. And it's more complicated for SSI because SSI is based on need—on income and resources. The process of eligibility determination is similar for both programs. A person must meet the non-medical criteria before having a disability decision made.

The medical criteria, as I mentioned, are the same for both programs. The individual must have what's called a medically determinable physical or mental impairment. Generally that means a diagnosis of a serious and ongoing disorder. And one that affects the person's ability to work. That's the impairment part.

Social Security looks at the impairment's duration. It must have lasted or be expected to result in death within 12 months [for a person] to be eligible. And that can be retrospectively or prospectively although prospective predictions are harder to make.

In addition, looking at eligibility based on disability related to a mental health and/or co-occurring problem, a person must show functional limitations that keep the person from being able to earn the \$860 a month gross that I mentioned. And that's labeled substantial gainful activity by Social Security—the \$860 a month—and it changes every January 1st. It goes up about \$20 to \$30 each year. So you'll see different numbers as you go along.

## Severity of Illness and Ability to Work

This is not a program that's simply about severity of illness. This is a program about severity of illness vis-à-vis a person's ability to do significant work, and that's absolutely critical because, typically, that's not information that we provide.

The functional areas are on page 3 if you have them printed out of your slides. The first functional area is called the *activities of daily living*. So when we think about activities of daily living, what do all of us have to do to be able to work?

We have to be able to get up on time—we have to do that consistently. We have to get to work, pretty much mostly on time. We have to be able to wash; we have to dress and make sure that when we go out we've got covered what's supposed to be. We need to be able to either drive or use transportation or walk and get there on time. We typically need to be able to prepare food, maintain a place to live, be able to use a phone, etc. If you broke down your day in terms of the tasks you had to do to work consistently, you can see where these things come in to play.

The second area is called *social functioning*. And it has to do with the person's ability to communicate clearly with other people and to be able to be with other people, tolerate other people, and interact. So, if you have a person who's very withdrawn around other folks and much too anxious to tolerate being around other people, it's going to be hard for that individual to work.

Third functional area is ability to *maintain pace and persistence* in the completion of tasks. That is a specific phrase in the Social Security regulations. It has to do with the cognitive functions that we all must do to work. So, things like completing tasks on time, concentrating, not being too distractible, being able to follow directions, being able to remember directions, and repeatedly being able to do these things.

The last area has to do with something called *periods of decompensation of extended duration*. This one is a little tricky. This has to do with a person having had three episodes over the past year of decompensation and inability to function that's related to their illness and that had lasted at least two weeks or more each.

Here's an example: I'm going along and I'm doing okay. I have a bipolar disorder and I have an alcohol problem. And I'm managing okay. I'm in treatment, and I have a major stressor such as the loss of parent or someone I love. And I wind up becoming much more symptomatic, maybe relapsing in my alcohol use, and I'm hospitalized for three weeks. That would be considered one episode. So a hospitalization isn't required, but it's that kind of decompensation.

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## Disability Determination

As I mentioned, I must meet the non-medical criteria, which have to do with income resources for SSI, [or] earnings history for SSDI, before I move on to the State agency called Disability Determination Services (DDS). The DDS follows a process called the sequential evaluation. And I want to emphasize that this is not about making every person with co-occurring disorders eligible. It's to ensure that every person with those disorders is approved. That's our advocacy.

So the first step is, is the person working? If so, that's substantial gainful activity, and they're denied. The next step is, does the person have a severe impairment? Does the person there have significant functional difficulty related to their illness? If the answer to that is yes, they go on to Step 3; if the answer to that is no, the person is denied at Step 2.

Step 3 is the first step at which a person can be found eligible. And the question there is, does the impairment that the person has meet or equal the "listing" requirement? And the "listing" is something that DDS uses; you might hear it called the "Blue Book" or the "listing." It's on the Social Security Website. The Web site address is: <http://www.ssa.gov/disability/professionals/bluebook/>.

In that book is a listing of all the different body systems that we all have, like cardiac, respiratory, endocrine, and there's one called mental disorders. And under each section there are criteria for different diagnoses. If we're working with folks that we feel are eligible, we should be able to articulate this clearly enough to have them meet the "listing" and be approved at Step 3.

What happens at Steps 4 and 5 is that the process becomes more subjective. And I'll tell you why. Say I don't have an impairment that's considered to meet or equal the "listing," and as you look at that book, it was last printed in January '05. It's not going to be printed any longer because when they change a minor part of it, they have to reprint the whole thing. So you're only going to be finding it online as time goes on.

I go on to Step 4, and the question there is, is the individual able to do work that he or she was able to do in the past? So, suppose I'm a construction worker and I have a significant back injury. Well, at Step 4 I'm going to say no, I probably can't do that. If the answer at Step 4 is yes, I can do that work I used to do, then I'm denied. If the answer at Step 4 is no, I can't do that work, I go on to Step 5, which is the other step at which I can be approved.

And there the question is, given the person's age, education, and work history, can this individual do any work that exists in the national economy or regional economy? So this is not a question about, can the person get a job in your community? Does that job exist in your community? They're really looking at the regional and national economy.

And to deny someone at that step, the DDS staff has to find three jobs that they feel a person can do. And to look for these jobs, they turn to the Dictionary of Occupational Titles. It's this huge two volume book that hasn't been updated for about 15 years or more. And in there are jobs—my favorite one is mattress tester because I really would love to put my jammies on and go to bed. Anyway, mattress tester, garment bagger, toy stuffer are three of my favorite jobs.

So you can see where at Steps 4 to 5 it becomes more subjective. And so I think we should be able to give information that can address the problems at Step 3, although certainly people can be approved at Step 5. Okay, so that's the set-up, and that's the process for all applicants for SSI or SSDI.

When we look at substance use, it's important just to look at how the standard has evolved. And also, what affects the policy on substance use. In 1961, substance use disorders were considered under the category of personality disorders. I know that there are still folks who would say that applies to some extent.

In '72 when SSI began, Social Security started the Drug Addiction and Alcoholism Program, and you'll still hear references to the DA&A program. What happened under the DA&A program is anyone receiving SSI would be required to have a representative payee and to be in substance use

treatment. Time went on and what was noted was more and more people who had substance use disorders contributory to their disability were getting approved. Keep in mind that you could never get these benefits based solely on substance use.

The increase in people getting benefits that had substance use disorders went up significantly in the early '90s. And in '94, to curb the growth, Social Security added SSDI to the SSI requirements, and they limited the receipt of SSI to a lifetime limit of 36 months. In '96, in the major welfare reform law there were also a couple of things that affected SSI, but the big one is they changed the way that substance use was considered material to somebody's disability.

What it means today is, if a person has a substance use disorder, the question is, if he or she were clean and sober, would the individual still be disabled by another illness or impairment? If you can answer yes, the person would more likely be approved. If the answer is no, they will likely be denied. So it is a tough one conceptually. Those of us who care about this field, and about these folks affected with these disorders, need to think what the heck is this policy all about. It certainly doesn't fit clinical best practice. It's clinically difficult to answer. It reflects the bias about substance use disorders that exists in our culture in many ways. Keep in mind that these standards are congressionally set; these are not set by Social Security.

So to decide materiality, we need to have comprehensive evaluations that are longitudinal, that address all the relevant information, that are done with the use of as many open-ended question as we can ask. And that we really have to understand much more about the early and ongoing context of substance use. Right now, we'll break for questions.

## Questions and Discussion

### Caller

It's difficult to find representative payees. I have a client right now who cannot get his fund, because I'm trying to find one, and they would not release his money until such time. Is there a directory or a way of finding out who is available? I'm in New Jersey.

### Yvonne Perret

Actually, there is no directory that I know of, and I think this is a national question. And one bizarre outcome on this change in the standard is as I mentioned, prior to '96, if somebody had a substance use disorder, they were required to have a representative. Now, because if you have substance use disorder it's in a sense not considered because it can't be material for you to get benefits, that requirement is no longer so. Representatives are a tough question all over. I can give you some ideas.

We did do representative payees in a project that I worked on. Sometimes, you can approach a foundation to actually set up a program. Sometimes, there are churches that would be willing to work with folks on having what are called anonymous payees, which means that the church has folks who volunteer to be the payee of record but the individual doesn't really know who it is. And so you still need somebody like a case manager working with a person on negotiating a budget and transferring funds and that kind of thing, but there is somebody then who will do the bookkeeping in some places.

Some advocacy groups have been on this. You could talk with them in your community about starting one or having a coalition bring this issue up. I'm sorry I don't have any magic for this. We did it. We found it wasn't as, you know, horrendous as everybody thinks it will be. But it is some significant work. So I think it's important to let folks know that they need a payee, and that you'd like to work with them to eventually become their own.

### Caller

What are your thoughts about clients applying for Social Security? What information would be best gathered?

### Yvonne Perret

I'm going to go into that in the next part of the call.

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**Caller**

What percentage of clients who do have substance abuse disorder would have also a co-occurring disorder?

**Yvonne Perret**

The percentage is probably somewhere in the 40 percent to 60 percent neighborhood, maybe higher, especially for homeless folks.

**Lynn Aronson**

And in the meantime, I do have an Internet question that I'll read for you, "Many of my clients wait several months after applying for SSI to start receiving these checks. When their checks start to come, they get back payments from the date they applied. Does this apply to the effective dates of their Medicaid as well?"

**Yvonne Perret**

People's Medicaid should begin the same day as their eligibility for SSI benefits. Now, keep in mind that some States have additional criteria. Generally, their eligibility for Medicaid should come with their original eligibility date for their SSI benefits. That's why we advocate that you get people's information submitted well and accurately because it will expedite the process.

The recent Deficit Reduction Act of 2005 changed something about back checks. Instead of getting checks in 12-month amounts, which had been the rule up until now, people will get back checks in 3-month amounts and they will get them every 6 months and it will last no longer than 2 years.

So they'll look at the amount of money. It's going to be interesting because there is a limit on how long this will go on for. So they're going to have to add more than 3 months if it's a long-standing retro payment. But essentially, the amounts of money are going to be smaller.

**Lynn Aronson**

Thank you. Are there any more questions?

**Caller**

The question I have is regarding how to help someone be able to answer the right question when they go for an interview for SSDI. I have this client who is almost 26 years old, and he has bipolar 1, and when he goes for an interview, he presents so well. He's not able to land a job, and when he gets a job he has social limitations, and he's not able to perform in a work environment.

**Yvonne Perret**

I'll tell you. If we can go ahead in a few minutes, I will address some of that, but one of the things to keep in mind is, as I mentioned, there are two parts of this, the non-medical and the medical. We need to assist people in providing all of the health information that might be relevant, and we don't want to rule out anything. So, I always find out everything that a person has been treated for and make sure we include that kind of information.

The second thing is, as you look at the sequential evaluation and they don't have enough medical information to decide whether or not a person's disorder meets the "listing," they will schedule what's called a consultative exam, which is an evaluation by one of their doctors or psychologists that is often cursory. These are often problematic for people with mental health problems, because people go in and say, "I'm fine. I'm great. I can work and I'm terrific and I don't have any mental health problems, and the people who sent me here are the ones with the problem."

Again, I'm talking about homeless folks with co-occurring disorders who wind up often getting poorly served by those evaluations, and I feel that what we need to really address the information that's needed. So if I may proceed, is that okay?

**Lynn Aronson**

Yes. Go ahead right now.

## Personal History and Current Functioning

### *Yvonne Perret*

This is the critical part that we all have to address. One other thing—as I mentioned before the break—what we need to understand and articulate for Social Security is the longitudinal history of a person’s life; the person’s experiences, both positive and negative; and the impact of those experiences and current functioning.

We need to do that in regular language. This is not about impressing them with the wonderful mental health terms we know. This is about being clear and keeping in mind that the people who make disability determinations never meet your client. The DDS folks never meet your client. So you are writing the description of the person you see for people who won’t ever see that person. Typically what’s relied on for that are medical records, which are not really designed to answer the questions that must be addressed.

Medical records are designed for symptom identification, done by person’s self report and clinical observation. They’re designed, then, to diagnose those symptoms and prescribe treatment. They do not address how that affects a person’s day-to-day life and ability and work. Most of us spend a lot of time with folks to see that more clearly and must articulate it.

So, if you break down these criteria that must be addressed, they are diagnostic criteria, they are durational—how long has this stuff been going on, essentially—and then there’s the functional information.

So I believe that to do this, remember two things. We need to let our practice drive our forms that we use rather than the forms drive our practice. I think questions get structured for us in a way that’s done by forms and requirements. It’s not so much about are we learning what we need to learn.

So, if we look at early history, we have to understand the possibility of early trauma, probably because it often sets up the context of somebody’s substance use.

To do that we cannot simply ask about, you know, “Were you sexually abused?” Yes, no. “Were you physically abused?” Yes, no. We have to ask things in a way that will elicit information and help the person be comfortable.

If we’re not comfortable asking about early trauma such as physical or sexual abuse, we shouldn’t ask, but we need to ensure that this is learned about, and we set up the context in a way that will help the person feel safe and able to respond. We also, if we ask about early trauma, have to make sure that the person will be safe when we finish speaking with them. So handling the answers and ensuring safety are absolutely the driving forces behind this.

We have found that it’s very helpful to ask something instead of, “Were you physically abused?” If you ask, “So when you did something your parents or whoever raised you didn’t like or that was naughty, what would they do?” you will find out if a person then was hit with a stick or sent to their room or what happened.

So you will find out about physical abuse without necessarily asking the person to label it that way. Same thing with sexual abuse, “When you were growing up, did any grown-up”—or I’d say bigger person because sometimes sexual abuses are by adolescents—“touch you in a way that made you feel uncomfortable or just felt kind of private or strange? Can you tell me about that?”

And it’s important to explain to folks why you’re asking these questions. I usually say, “Social Security wants to understand what your life has been about. They want to know what’s been hard; they want to know what’s been not so hard. So the reason I’m going to ask you is to be able to explain to them what kinds of things you had that have made things tough for you now.”

Creating the safe setting and asking questions in that setting will elicit important information. I asked folks what it was like for them to be in their family. “You know, some families are happy, some are sad, some are angry, some are tense. What was yours like? How old were you when you left home? What made you

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decide to leave?” And then we start connecting those with substance use.

“How old were you when you started drinking?” You know, when I first started doing this thing, we asked, “Do you abuse drugs? Do you do that progressively?” Nobody did. So then I started saying, “How much do you drink? When did that start? What was going on with you when that started?” And you begin to then see if the current and past substance use is linked to prior trauma or prior difficulties.

As we’re looking at all of this, we want to understand people’s learning experiences. We typically ask what grade. We want to know what it was like to be in school for them. “Was school tough? Did they find that easy to do? What were their relationships like with other kids and with the teachers? How did they get along?”

I don’t ask people if they were in special education. I usually ask how many other kids were in their class. Most people react to special education by showing that they were stupid, and our job is certainly not to reinforce that feeling. I ask them if they ever found that they had to do a grade more than once just to make sure they learned it really well. So I’m not asking about failure, because I think most people with co-occurring disorders who are homeless don’t feel successful. Our main job is to provide hope to people. I try to ask things in a way that doesn’t reinforce any put-down feelings they already have.

So then I ask folks to read something for me. Typically, a newspaper is good because of the basic reading level. We want to know about literacy issues. I ask, “What subjects were tough? What weren’t?” Again, just try to understand any learning problems.

The goal and this [recovery] language have been around in substance use for a long time. We’re finally learning that recovery is for mental health too. So employment history is not only what was tough but what might you use and help the person use that are skills that apply if they want to return to work.

So I want to know when the person started working. Some people do employment histories more

comfortably, retrospectively. Some do when they started. For each job they mention, I ask them, “What did you do in that job? What did you like? What did you dislike? What did you find easy? What did you find tough? How did you get along? If you didn’t get along with folks, what was that about?”

Instead of asking fired, laid off, or resigned, I ask people what made them decide to leave. If you ask somebody if they were fired, resigned, or laid off, and they say they resigned, you miss learning about the jobs where maybe they were told if they didn’t resign, they would be fired. So if you just ask, “What made you decide to leave? they go, “Oh, well, they said if I didn’t resign, they’re going to let me go.” So then you have more information.

I also want to know about cognitive impairment either from injury or from ongoing substance use. While substance use cannot be a determinant for SSI and SSDI and cannot be material if there is substance use that has caused organic mental disorder, people can get benefits based on an organic mental disorder. What I call brain hurt or brain damage is absolutely missed in a huge number of people whom we see. So I want to know, not only about accidents or being hit, I want to know if somebody was in a fight or fell or anything happened that they were knocked down, and then I want to know about evaluation and treatment.

If I suspect that somebody has brain damage, I’m going to need objective proof. I can’t just submit information that says, “This person has brain damage, and we know because they don’t look so good.” So I’m going to need an abnormal EEG or CAT scan or psychological testing, something that’s going to show it. And I really need to think about the possibility of brain damage when I’m working with folks who have long-term substance use especially with something like alcohol or other drugs that we know can make you brain damaged.

As they ask more about substance use, we have to understand much more about its context. So I want to know, “When did you first start using? What was going on in your life then? What did it do for you? What did you not like about it?”

I want to know how the use progressed. And again, what was going on with the person's life. I think if we see any one who talks about substance use at ages 8, 9, 10, 11 and talks about consistent use from that time, we have got to think about trauma, because ongoing substance use beginning that age is not normative. It's just not.

I ask people, "If you could use any drug at all, what would it be and how come?" What you'll find is that people's use is purposeful; meaning that if I'm somebody who has a major depression, I know that if I use cocaine I will show more energy. I know that if I drink sometimes, I will show more energy. Even though contradictorily, alcohol is a depressant. I know if I then can use alcohol, I can be kind of mellowed out.

So what you're trying to identify are the symptoms a person is experiencing, what the use of the substance does and vis-à-vis those symptoms.

If somebody's in treatment, I want to know how they feel if their use is reduced. I want to know what happened in any sort of past treatment, of course. And I want to know what likely starts them using again. One of the things to think about as we look at treatment is [this]: if people have past trauma and they engage in substance use treatment, and the trauma effects are not addressed, they'll actually feel worse unless the trauma is addressed.

And so when we tell people, "Gee, get treatment, and stop using, and you'll feel better," that's not always the case when people initially engage in treatment, because if they've been using substances to manage and suppress those symptoms that are so painful, they will come flooding back. So we need to understand that.

We also want to understand any physical problems that were induced by substance use. So what we have to do is, not look only at the substance use, but rather underneath and what it means for this individual. And that's what we need to articulate for SSI and DDS.

## Write a Letter

By the way, you can write a letter and not use any of those forms they send you to fill out about activities, the daily living, and all that stuff. In this letter, you can describe the person physically and what it's like to be with the individual in your own clear language. Write it for somebody who's not in mental health to read it and understand.

If you can put the history in terms of the person's life and trauma experiences and learning experiences and employment experiences and homelessness history, that's very helpful, and obviously any treatment history as well. And then articulate what you see in terms of functional difficulties and what they are caused by. I'll give you an example.

Suppose I'm a person who just hates to get up in the morning. I just hate it. And I am actually that person. That's not an impairment caused by a disorder. That's just me. But suppose I'm somebody who has significant depression, and in the morning I have such low energy that I can't drag myself out of bed. That's the kind of daily living impairment that I want to address.

And I would simply say it that way, "Yvonne says that she is so depressed each morning that she can't get out of bed. And some days she doesn't even bother to wash and dress. She never used to be like this before she was so depressed." Very clear language.

So with each of the functional areas, what is the person doing related to disorders other than substance use? And you're just going to write it out in a clear description. Extraordinary helpful because, most of the time, the disability determination agencies never get functional information. And they need you to be the contact person they can call with questions. It would be absolutely wonderful for you to be that person and to write a letter.

And lastly, if you're working in a healthcare setting where you have relationships, you can cultivate relationships with physicians or psychologists or psychiatrists, and have them co-sign your letter. It raises it to the standard of information that DDS

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considers as provided by the physician. Basically, we're looking at a report that captures what you've learned about trauma history, about past abuse, about learning problems, about employment problems, and looking at whether the ongoing disorder would continue to exist if the person were clean and sober.

So we can stop now for a couple of minutes, and then we'll have an example of a person just to give you an idea. And then we'll wrap up. And I will also give you a Web site where you can look at sample reports like the one I just described that I've written, but I've changed the names, of course, so people's privacy is protected. So I guess we can stop for some questions.

## Questions and Discussion

### *Lynn Aronson*

Okay. I'm going to start us with some Internet questions. And the first question is, "Does 'maintained pace and persistence' mean 35 or 40 hours per week, or could it be less? We have someone who is mentally ill or someone who has a heart disease and could probably work 20 hours a week, but not 35 or 40."

### *Yvonne Perret*

That's a wonderful question. I love that question.

Well, it has to do with what the person can earn. So if you're looking at a job that pays minimum wage, you're pretty much looking at 35 to 40 hours. But suppose I'm a computer programmer, and I can make \$40 an hour. I'm looking again at am I able to make \$860 a month. So it really depends on what are you looking at in terms of rate of pay and the amount of time that it would take to earn that. I hope that make sense.

### *Lynn Aronson*

Thank you. I have another one on the Internet. She wants to know, "How does one determine eligibility for SSDI? It was my understanding that the individual must have worked a specific amount of quarters to qualify. Now my co-worker was told by SSA that the individual she was working with had to have worked 5

years of the 10 years he was considered disabled. Can you please clarify for us?"

### *Yvonne Perret*

Sure. The way Social Security determines quarter of earnings is by a certain amount. They design a quarter by certain amount of earnings. And this does get a little complicated. People at different ages need different numbers of quarters. For instance, if I'm 25, I may only need 12 quarters versus if I'm 50 I probably will need 20 out of the last 40 quarters.

I would contact Social Security and say, "I'm working with somebody and they're this age? What would they need in terms of earnings?" And, if you can, get the person to sign a release to let Social Security tell you if they would be eligible for SSDI given their earnings history. Essentially it depends on how old I am, how many quarters I need, and that "quarter" is defined by a certain amount of earnings.

Typically right now, Social Security is suggesting to everyone that they apply for both SSI and SSDI at the same time, and then they'll find out more quickly if they're not meeting earnings requirement for SSDI, and then the process goes forward.

### *Lynn Aronson*

Thank you. I'm going to turn it over to the phones if we have any calls. And our question is in Washington.

### *Caller*

We work with people that are also in the jail system or have been incarcerated, and there's a provision for us to be able to take application for general assistance on Medicaid prior to a person being released. However, we're finding that it's not the same case with Social Security. They are not able to access the system, and it automatically gets denied, and they have to start all over again.

Is there any provision for people who are incarcerated that might be able to submit an application or return information while incarcerated when they're getting close to the release date so that we avoid this having to start all over?

**Yvonne Perret**

Yes, there is. Actually there are a couple of ways to go about it. You can begin an application for these benefits within 30 days of a person's release. Now, Social Security prefers an agreement with the facility that you all will be doing this. But it's not required that the criminal justice facility have such an agreement. The applications can be started again in the facility within 30 days of release.

And let me tell you that one thing that's very, very helpful. Typically what happens when somebody starts their application then is released is, it's very, very hard to get the treatment records from jail or prison once the person is gone because, you know, they start being sent to different places. One thing that you can do that's very helpful is to make sure that those records are sent prior to the person's release. We've done a lot of work with people in jail, in prison. And sometimes that's where folks have been identified and their treatments began. So, certainly, you want that diagnostic information.

**Caller**

Is there a place I can reference in the Social Security Law?

**Yvonne Perret**

The Social Security Web site is actually a very good one, and you go to [www.socialsecurity.gov](http://www.socialsecurity.gov) and you'll see in the upper right in the middle there's a section that says "Our Program Rules." And if you click on that you can look around [the laws and rules]. Of course, they have "Frequently Asked Questions" and those are often about what happens to benefits.

If you like, I have my email at the end of this presentation. If you want to email me, I can give you a more specific site.

**Caller**

Yeah, that would be great. But one problem I did have is I actually made arrangements for an inmate to make a phone call and the Social Security worker said, "I'm sorry, the person is in jail." And so, we cannot have this conversation at this time even though he is going

to be released within 30 days. So, basically, they're not able to access Social Security in any way or even return a form if incarcerated.

**Yvonne Perret**

Well, that's incorrect, what you were told. One other thing that's helpful to know is that, like any large organization, there is a hierarchy to it. If I were in your situation, I would contact the Social Security office that's closest to the jail and ask if you could meet with the manager and talk about how you work this out. If you don't get good success from that person, again, let me know, and I will give you contact information at the next step up.

**Caller**

Thank you so much. I appreciate it.

**Yvonne Perret**

I will give you a Web site where you can see some tools and some other SSI-related things that we keep updating. And the Web site address is [www.pathprogram.samhsa.gov/soar](http://www.pathprogram.samhsa.gov/soar). And if you look on that Web site, you'll see tools and resources, updates—there's a whole bunch of stuff in there that we keep adding to. And I'm going to be summarizing the changes in retro payments and there are some new identification changes.

**Caller**

I'll ask you a question that I don't know if you can even give me an answer to, but I did have a client—and I've had it happen to me more than once—that they've made it all the [way] through the third step and they are sent to Social Security's doctors. However, on both encounters they were in the office less than five minutes—they were asked maybe three to four questions, and that was it.

**Yvonne Perret**

Yeah, I'm not a fan of consultative evaluations, and I'll tell you what happens. The way that this process works is if a person had ten treatment sources and DDS gets records from three of them and they answer the questions, they lead to an approval, I'm good to

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go. Then, if they can approve someone from a subset of the medical records that might exist, they can go ahead and do that. Suppose that they get records from ten of them, and [the records] still don't address the criteria, that's when the consultative exams kick in.

When those records are solicited by the DDS, they send a release of information to the medical records department. Typically, the folks in that department don't know what the criteria are. So, they're pulling stuff from a chart that may not be helpful or relevant and they may not be pulling stuff from a record that could be very helpful because [the] medical records department is short staffed like the rest of us, and they don't know the criteria.

So, one other thing that can be very helpful is—if you have some major medical providers in your area—to call the medical records department director and say, “Hey, we're working to help folks. We'd like to talk with you about how important it is to get anything evaluative from the record.”

**Caller**

Okay.

**Yvonne Perret**

You've got this disconnect between what they need to send, what they wind up sending. What's not in the records anyway is all the functional information. So, for our population of folks with co-occurring disorders who are homeless, they're all over the place, and the treatment records are often not as good.

Our work is bridging these worlds so that we start to describe and do what we can to make sure that, at least in our part of the world, people work collaboratively and understand what they need to do. I hope that's helpful.

**Caller**

Yes, it was. Thank you.

**Lynn Aronson**

Yvonne, I'm going to give you one more question from the Internet, and then I think we need to go

back to finish your presentation. That question is from Virginia. She's had a client that is in treatment with substance abuse and is also bipolar. What is the first step in helping her get her SSI in looking at the duration and functional issue? The person had a very bad childhood that affects her ability to function normally in certain situations.

**Yvonne Perret**

Okay, well, the first step is to make sure that you really have a comprehensive application that mentions anyplace this person has been treated for anything. The second step is for you to describe what you know about this person's life and very, very difficult childhood history and what the person either describes or what you observe as the impact on this individual's current functioning.

To do that, we're looking at what do we understand about the substance use—what is the person telling us about what the use helps with. Obviously we're not advocates of substance use, but we need to understand the meaning of it to the individual. I mean [whether] symptoms get reduced or seem to subside when I use or it's overwhelming when I use. And that's what we need to be able to describe.

And I should mention that if you want to try writing something and want me to look at it, I'm very willing to that by email. I don't do as well with phone calls as I do email.

So, what do you think is really going on with this individual? What is the substance use about? What context do you put it in? Where does this person live emotionally and in terms of trying to manage his or her struggle? And then how do I describe that to somebody who's never gone to see the person? I'm trained to do that.

**Lynn Aronson**

Okay, I'm going to ask you to go ahead because we only have about ten minutes left.

## A Representative Example

### *Yvonne Perret*

The last part of this is really to try and give you an example of a fictional but representative individual. And so, I'm describing Fred Jones who's a 38-year old single man, has been living on the street for five years, was abused physically from ages 6 to 10 and was sexually abused by his Uncle Wally from ages 8 to 12. As a youngster, he was never able to tell anyone of this.

And I should add that this is somebody that I actually worked with and who told me that though he was in mental health treatment on and off for 15 years, no one had ever asked him about a history of sexual abuse in a way that he could answer.

So, Fred finished the eighth grade, was in special education, and repeated the sixth grade twice. This is a fairly representative experience in school. He worked for a while between ages 20 to 25 and was fired consistently for hitting his bosses. And I did mention to him that having been hit, I can understand why that didn't work out so well as a stress management tool.

So, Fred start drinking when he was 9 on a regular basis; his uncle who sexually abused him gave him beer. He started smoking marijuana and then added cocaine. Has had a history of six psychiatric hospitalizations, the most recent one being in January of this year. And, of course, what would be presenting is what led to these hospitalizations; we'd be trained to get information about what occurred vis-à-vis treatment and evaluation.

Fred has a history of bipolar disorder, major depression with psychotic features. So what happens to him experientially, his moods go up and down often with no feeling that he can either predict or control them. He finds these mood changes accompanied by bizarre thoughts. I would give a quote from Fred. For example, you know, "When I start thinking real fast, I start thinking about the water in my shower being poisoned by the people on the TV."

You don't have to label a statement like that psychotic, it says it for itself. Fred also hears people talking about his past abuse and that his substance use is consistent with his mood changes. So when he's depressed, he uses cocaine, and when he's manic, he uses alcohol and marijuana.

Now, I would say, "Fred says that when he has no energy and feels like hurting himself, he finds that if he uses cocaine, the thoughts go away and he doesn't feel so much like hurting himself." I would give more specific examples in regular language than I would in labels. "During episodes when Fred has not used substances, he finds that he can't sleep or do anything. He keeps thinking about what happened to him."

What you're capturing is Fred would be eligible based on his bipolar disorder, because that would be ongoing and would affect his functioning even if he were not using drugs or alcohol. The impairing symptoms would remain. So, we can make the argument that Fred's substance use would not be deemed material to his disability.

These are complicated things to address. But I think it's just important to keep in mind that we need to really understand who everyone is longitudinally and comprehensively. And we need to understand each individual substance use truly in the context of their life experience.

If you think about being a little child and experiencing trauma, whatever it is, we found in the homeless population we serve, 90 percent of women were sexually abused as kids and about half of the men—this is a very common phenomenon for our folks. You know, you don't have much choice as a little kid in terms of how you manage this. You typically disassociate, you live emotionally, or you figure out a way to suppress the symptoms. And that's what the substance use becomes often. And for people with co-occurring disorders, I would absolutely consider the expectation that past trauma is much more likely than it is less likely.

So I hope this has been useful. Thank you.

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## Conclusion

### *Lynn Aronson*

Thank you, Yvonne.

And I am sorry to say that we are just about out of time, and so we'll not be able to take any more questions right now. I'm assuming, Yvonne, if someone has a question, they can continue to email it.

### *Yvonne Perret*

Oh, absolutely. Yes, thank you. Sure.

### *Lynn Aronson*

And [Yvonne] has provided her email on the Web site. I'd like to remind everyone to please complete and return our evaluation form. Visit the Path Website at [www.pathprogram.samhsa.gov](http://www.pathprogram.samhsa.gov) for other resources that Yvonne has talked about today as well.

Finally, I just want to say thank you again to Yvonne—as always it's a wonderful presentation.

### *Yvonne Perret*

Thank you. Thank you. It's been great to be with you or even though I can't see you.

### *Lynn Aronson*

And with that, our call is concluded. And thank you all for participating. ▣