

March 30, 2010

Submitted via www.regulations.gov

Commissioner Michael J. Astrue
Social Security Administration
6401 Security Boulevard
Baltimore, MD 21235-6401

Re: Request for Comments: Drug Addiction and Alcoholism, 75 Fed. Reg. 4900
(Jan. 29, 2010); Docket No. SSA-2009-0081

Dear Commissioner Astrue:

These comments are submitted on behalf of the National Council for Community Behavioral Healthcare (National Council) and NAMI (the National Alliance on Mental Illness).

The National Council represents America's community behavioral health organizations. Together with our 1,700 member organizations, we serve our nation's most vulnerable citizens — more than 6 million adults and children with mental illnesses and addiction disorders. We are committed to providing comprehensive, quality care that affords every opportunity for recovery and inclusion in all aspects of community life. The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services. And we offer state-of-the-science education and practice improvement resources so that services are efficient and effective.

NAMI (National Alliance on Mental Illness) is the nation's largest grassroots mental health organization dedicated to improving the lives of individuals and families affected by mental illness. NAMI has over 1100 state and local affiliates that engage in research, education, support and advocacy. NAMI has a long history of advocacy to improve treatment and services for youth and adults with serious mental illnesses, including individuals with co-occurring mental illnesses and substance use disorders. A critical component of this advocacy is to ensure fair eligibility standards and access to vital income supports and medical benefits.

We appreciate the opportunity to comment on current policies and practices regarding SSA disability determinations and drug addiction and alcoholism (DAA). Our primary concern is for persons living with serious mental illnesses like schizophrenia, bipolar and other disabling illnesses that involve psychosis. It was recognized in 1996, and even more well recognized now (SAMHSA Report to Congress, 2002) that persons with these serious mental illnesses have rates of co-occurring substance use of at least 50%. The 1996 law that removed substance use disorders from the listing of disabling

conditions had an inordinate impact on people with co-occurring disorders, and subsequent guidance has not clarified this issue sufficiently.

SSA's sub-regulatory policy statements (e.g., POMS, HALLEX, EM-96200) provide guidance in making disability determinations involving DAA. In many cases, adjudicators ignore or misapply these policies, and claimants are unfairly denied benefits or must face protracted appeals to obtain a just decision. As a result, many individuals with disability have lost their benefits, and some have never applied, both of these situations result in devastating consequences to the individual, their family, and society.

We appreciate the opportunity to comment and recommend that SSA update the regulations to reflect the 1996 statutory change and issue formal substantive policy guidance for all adjudicators in Social Security Rulings (SSRs) that reflects and reinforces the various sub-regulatory instructions and policies.

SSI IS A CRITICAL INCOME AND INSURANCE SOURCE FOR PEOPLE DISABLED BY MENTAL ILLNESSES, ESPECIALLY THOSE WITH CO-OCCURRING DISORDERS

The 1996 change had serious consequences. People with drug or alcohol use who were found ineligible to receive SSI benefits after the law changed lost Medicaid coverage, even those who had prior hospitalizations due to mental illnesses. Within 18 months after the law was changed, more than one in four of recipients who had both a history of prior hospitalization and a diagnosis of schizophrenia were without Medicaid; almost half of those with both a history of prior hospitalization and diagnoses of psychotic disorders had no Medicaid coverage.¹ Research has long shown that people with mental illness and co-occurring substance use have difficulty documenting their disability.² In Los Angeles, for example, benefits were terminated for half of SSI recipients who had a high level of severity of psychiatric symptoms, including all those who did not appeal: "[t]wenty percent of individuals with high psychiatric severity scores did not appeal, and 40 percent of those who did appeal were denied."³

The challenges faced by eligible claimants are significant because SSI is critically important for obtaining both housing and health care. SSA's own data shows that people who are homeless are much more likely to find and maintain housing, and thereby end their homelessness, if they are receiving SSI.⁴ SSI recipients also gain

¹ Hanrahan, Patricia, et. al. Medicaid Eligibility of Former Supplemental Security Income Recipients With Drug Abuse or Alcoholism Disability. *American Journal of Public Health* | January 2004, Vol 94, No. 1. At 46.

² See, e.g., Zlotnick C, Robertson MJ, Lahiff M. A longitudinal perspective on entitlement income among homeless adults. *Psychiatr Serv.* 1998;49:1043–1048.

³ Watkins KE, Wells KB, McClellan AT. Termination of Social Security benefits among Los Angeles recipients disabled by substance abuse. *Psychiatr Serv.* 1999;50:914–918.

⁴ Rosenheck, Robert, Frisman, Linda, and Kaspro, Wesley. "Improving Access to Disability Benefits Among Homeless Persons with Mental Illness: An Agency-Specific Approach to Services Integration." *Am. J. Public Health.* April 1999. 89(4): 524-28.

greater access to health care through Medicaid, often for the first time, which is critical to curtailing the risk of severe irreversible disease and mortality. Research has similarly shown a significant link between SSI receipt and decreasing homelessness, with resulting costs avoided at the local, state and federal level.

SSA SHOULD CODIFY CURRENT SSA POLICIES IN SOCIAL SECURITY RULINGS

Since 1996, the primary guidance providing substantive instructions for determining DAA available to the public include the following:

- Emergency Message EM-96200, issued on August 30, 1996: “Questions and Answers Concerning DAA from the 07/02/96 Teleconference—Medical Adjudicators—ACTION”
- POMS section DI 90070.050: “DAA Material Determinations” (issued in July 1996, updated July 1997)
- HALLEX I-5-3-14A: “Drug Addiction or Alcoholism” (issued November 14, 1997, revised August 24, 2000)

While these policy statements are similar, they are not identical and do not apply to adjudicators at all levels. In fact, the HALLEX provisions no longer appear on the SSA public website.⁵ As a result, we do not know if there are any policy statements that specifically apply to Administrative Law Judges (ALJs) and the Appeals Council. It is our understanding that some ALJs have stated that they are not required to follow EM-96200 because it does not apply to them.

*It is essential that all policies be consolidated and unified into one or more Social Security Rulings (SSRs) that must be binding on all SSA adjudicators and will provide guidance to the courts. SSRs are published in the Federal Register, are “binding on all components” of the SSA.*⁶

SSRs provide formal yet detailed adjudicative guidance for agency decision makers and the courts. For example, the nine SSRs issued in 1996 (SSR 96-1p through SSR 96-9p) offer more detailed guidance regarding the disability determination process. Over the years, these SSRs have been incorporated into decisions at both the administrative and judicial levels. Failure to follow the SSR instructions constitutes legal error by the adjudicator.

More recently, in February 2009, SSA issued a series of SSRs for evaluating SSI childhood disability claims.⁷ As we are recommending with DAA issues, the SSI childhood disability SSRs consolidated a variety of SSA policy statements—e.g., training materials, Questions and Answers—and provide much more detail for

⁵ Our comments will still refer to the prior version since the HALLEX sections provided guidance to ALJs and the Appeals Council

⁶ 20 C.F.R. §402.35(b)(1)(“These rulings represent precedent final opinions and orders and statements of policy and interpretations that we have adopted.”).

⁷See SSR 09-1p through SSR 09-8p.

evaluating these often difficult to decide claims than exist in the regulations. Since the policies are now stated in SSRs and published in the Federal Register, they must be followed at all administrative levels and will provide guidance to the courts.

The importance of formally promulgating SSA's DAA policies was underscored in a federal court decision, *Parra v. Astrue*.⁸ In *Parra*, the claimant relied on the HALLEX and EM-96200 regarding the "materiality" determination in DAA cases. Without deciding whether they applied in this case or addressing that they reflected agency policy, the court stated that "internal agency documents such as these do not carry the force of law and are not binding upon the agency ... Therefore, they do not create judicially enforceable duties, and we will not review allegations of noncompliance with their provisions (citations omitted)."⁹

EVIDENCE SSI SHOULD CONSIDER TO BE MEDICAL EVIDENCE OF DAA

SSA's current policies provide strong statements about the role of medical evidence in DAA cases. These policies recognize that a finding of DAA can have serious implications for the applicant. Because the consequences can be severe, the standard of medical evidence should be high. These statements need to be codified as guidance for all adjudicators.

SSA sub-regulatory guidance cautions adjudicators to apply medical evidence "with care" because a finding that such evidence is "material" can result in a denial of benefits.¹⁰

The various SSA policy statements provide clear guidance about what is and is not considered medical evidence of DAA. For instance, the POMS defines medical evidence of DAA as evidence that is:

- (1) from an "acceptable medical source"; and
- (2) sufficient and appropriate to establish that the individual has a medically determinable "substance use disorder" as described in the "Diagnostic and Statistical Manual of Mental Disorder," Fourth Edition (DSM-IV).¹¹

When asked what constitutes "sufficient and appropriate evidence to establish the existence of a substance use disorder," SSA has emphasized that the medical evidence must meet the criteria outlined by the DSM-IV.¹²

⁸ 481 F.3d 742 (9th Cir. 2007).

⁹ 481 F.3d at 749.

¹⁰ POMS DI 90070.050 E. "If the evidence in file is sufficient and consistent to establish that the individual is disabled but it does not establish that the individual has DAA, do no additional development of the DAA. Make the favorable disability determination based on the evidence in file." Id. at E.1.

¹¹ Id. at C.1 and 2.

¹² EM-96200, Question 24.

Statements by the individual about his/her own condition, such as statements made to emergency room personnel, do not constitute medical evidence of DAA. To clarify this point, SSA has cited its own regulations— 20 C.F.R. §§ 404.1508 and 416.908—which require that an “impairment” be established by medical evidence “consisting of signs, symptoms, and laboratory findings, not just an individual’s statement of symptoms.”¹³

SSAs current policy statements stress the importance of obtaining truly medical evidence that meets DSM IV criteria for a substance use disorder to establish the existence of DAA. We respectfully recommend that these policy statements be incorporated into formal agency policy.

MATERIALITY: HOW SSA SHOULD EVALUATE THE CLAIMS OF PEOPLE WHO HAVE A COMBINATION OF DAA AND AT LEAST ONE OTHER MENTAL IMPAIRMENT¹⁴

The current law enacted in 1996 provides that an individual "shall not be considered to be disabled . . . if alcoholism or drug addiction would . . . be a contributing factor material to the Commissioner's determination that the individual is disabled."¹⁵ Congress intended that individuals with impairments caused by drug or alcohol use, but who have other impairments that are independently disabling, will continue to be found disabled, even if that other impairment was caused by drug or alcohol use: "Individuals with drug addiction and/or alcoholism who have another severe disabling condition (such as AIDS, cancer, cirrhosis) can qualify for benefits based on that disabling condition."¹⁶ The key question, after finding medical evidence to support a finding of DAA, is how to determine materiality.

Under the current regulations, DAA is "material" to the disability determination when the claimant would not be found disabled if use of drugs or alcohol stopped.¹⁷ The materiality determination is a three-step process:¹⁸

Step 1: Determine whether the claimant is disabled, using the general sequential evaluation of disability and considering the effects of DAA.

Step 2: If the claimant is disabled, determine whether there is medical evidence of DAA. (See discussion above re medical evidence of DAA.)

Step 3: If the claimant is disabled and medical evidence of DAA exists, determine whether DAA is "material" to the disability determination.

¹³ EM-96200, Question 23; see also POMS DI 90070.050C.1.b and HALLEX I-5-3-14A, § C.2.

¹⁴ Although SSA invited comment on DAA and both co-existing physical and mental impairments, our comments speak only to mental impairments because that is where our expertise lies.

¹⁵ 42 U.S.C. §§ 423(d)(2)(C), 1382c(a)(3)(J).

¹⁶ H. Rep. No. 379, 104th Cong., 1st Sess. 16 (1995)(Committee Report for H.R. 2684), p. 16.

¹⁷ 20 C.F.R. §§ 404.1535(b)(1), 416.935(b)(1).

¹⁸ This process is set out not in the regulations but in sub-regulatory guidance. See POMS DI 90070.050B and HALLEX I-5-3-14A, § V.B.

The critical factor in the materiality determination is whether the claimant would be disabled if he or she stopped using drugs or alcohol. The adjudicator must determine whether (a) any of the claimant's mental and/or physical limitations upon which the Step 1 disability determination is based would remain if the claimant stopped using drugs or alcohol; and (b) any or all of the claimant's remaining limitations would be disabling.¹⁹ If the remaining limitations are disabling, then DAA is *not material* to the disability determination.²⁰ If the evidence in the file supports a finding of disability but no sufficient and appropriate evidence establishes the existence of a substance use disorder, a determination will be made based on the evidence in the file.²¹

Both the POMS and HALLEX provide examples of when DAA is material:

- The only impairment is a substance use disorder.
- The individual's other impairment(s) is by itself not disabling; e.g., a hearing impairment that is "not severe."
- The individual's other impairment(s) is exacerbated by DAA and the evidence documents that, after a drug-free period of 1 month, the other impairment(s) is by itself not disabling.²²

However, examples of when DAA is *not material* appear only in the HALLEX, not in the POMS or EM-96-200. The HALLEX provides that DAA is *not material* if:

- The individual has another non-DAA impairment(s) that meets or equals a listing, i.e., the other impairment(s) is by itself, disabling and none of the limitations resulting from it are caused or increased by drug or alcohol use.
- The individual is limited to sedentary work by an orthopaedic impairment and based on his/her age, education, and work history, the Medical-Vocational Guidelines in Appendix 2, Subpart P, of Regulations 4, direct a finding of "disabled."²³

When an individual has a physical or mental disability that is not directly the result of substance use, either on its own, or because of substance abuse exacerbating an otherwise non-disabling condition, that person is ELIGIBLE for disability, no matter how serious their co-occurring substance use might be. Disability determination should NEVER deny an individual benefits from a disabling condition, simply because of a co-occurring substance use condition that is non-material.

¹⁹ POMS DI 90070.050D.2.

²⁰ Current instructions state that a finding that DAA "will be made only when the evidence establishes that the individual would not be disabled if he/she stopped using drugs or alcohol." (emphasis added). POMS DI 90070.050D.1. See also EM-96200, Q. 27; HALLEX I-5-3-14A, § D ("Make a finding that DAA is material only when the evidence establishes that the individual would not be disabled if he/she stopped using drugs or alcohol.").

²¹ POMS DI 90070.050E.1.

²² POMS DI 90070.050D.3; HALLEX I-5-3-14A, § D.

²³ HALLEX I-5-3-14A, § V.D.

In sub-regulatory guidance, SSA has already determined what should happen in those cases where the adjudicator cannot disentangle the limitations caused by drugs or alcohol from those caused by the mental impairment(s):

Since a finding that DAA is material will be made only when the evidence establishes that the individual would not be disabled if he/she stopped using drugs/alcohol, the DE [Disability Examiner] will find that DAA is not a contributing factor material to the determination of disability.²⁴

To use a sports analogy, a “tie” (an inability to disentangle) goes to the individual. Considering the practical, clinical difficulty in separating out the influence of substance use and the high rate of comorbidity of mental and substance use disorders, the SSA sub-regulatory guidance should be codified in SSRs.

Examples of non-materiality include:

1. The SUD has nothing to do with the disability (the person is blind, and also has an alcohol problem)
2. The disabling condition is affected by the SUD, but exists independently of it. (Schizophrenia that is disabling at baseline with co-occurring substance use that may exacerbate it).
 - a. One type is that the condition was persistent and disabling prior to the onset of SUD
 - b. Another version is that the condition is persistent and disabling currently, whether or not the person is using substances, as determined by the assessment.
3. SUD may have contributed to the cause of the disability (as alcohol to cirrhosis, or methamphetamine to chronic psychosis), but the disability now exists independently of the substance use

SSA SHOULD NOT INCLUDE USING CIGARETTES AND OTHER TOBACCO PRODUCTS IN AGENCY INSTRUCTIONS

The Federal Register Request for Comments asks whether SSA should include using cigarettes and other tobacco products in the agency’s instructions. SSA should not include these products in its policy statements regarding DAA analysis. Such an inclusion would be inconsistent with Congressional intent and raises serious policy questions that go beyond the DAA analysis.

The intent of the 1996 changes was to eliminate cash benefits, such as SSI, to people who were considered “drug addicts and alcoholics.”²⁵ Congress was also concerned about fiscal oversight for those people who would qualify due to other

²⁴ EM-96200, Question 27.

²⁵ H. Rep. No. 379, 104th Cong., 1st Sess. 16 (1995), p. 17.

underlying disabilities but who also had substance use disorders, adding a requirement for representative payees.²⁶ In addition to fiscal concerns, Congress took action to ensure that SSI and SSDI beneficiaries had better access to treatment programs for substance use.²⁷ None of Congress' actions mentioned tobacco products nor would they appear to make any sense in the context of tobacco use. For example, there is no indication that a person under the influence of tobacco would have any need for a representative payee to manage their cash benefits.

Of great importance to our organizations and the people we represent is the disparate impact such a policy would have on people with mental impairments and co-occurring disorders. While about 20 percent of US adults are smokers, people with behavioral health disorders represent over 44 percent of the US tobacco market and consume one-third of all cigarettes smoked.²⁸ Studies estimate that 62-90 percent of adults with schizophrenia use tobacco; similarly disproportionate smoking rates have been found for adults with bipolar disorder (51-70 percent) and major depression (36-80 percent).²⁹ Recent research is finding that persons with mental illnesses have some biological predisposition toward smoking, such as "unique neurobiological features that:

- may increase their tendency to use nicotine,
- make it more difficult to quit, and
- complicate the withdrawal phase.³⁰

In addition, nicotine enhances concentration, information processing, learning and mood and may reduce side effects of psychotropic medications.³¹

Organizations like the National Council and NAMI are working to reduce tobacco use and promote healthy lifestyles among people with serious mental illnesses and co-occurring disorders. Including tobacco use as part of the DAA analysis would only punish many individuals who are clearly disabled and rely on SSI to obtain housing and treatment for myriad conditions. Indeed, the denial of SSI or SSDI benefits to individuals with mental illnesses who use cigarettes or other tobacco products would have the perverse effect of limiting access to programs with proven effectiveness in aiding smoking cessation and thereby enhancing the wellness of this population.

SSA SHOULD NOT REQUIRE A PERIOD OF ABSTINENCE OR NONUSE TO DETERMINE WHETHER DAA IS MATERIAL TO OUR DETERMINATION OF DISABILITY

SSA should retain and codify that its current policy does not require abstinence or nonuse in considering whether DAA is material to the disability determination. Such

²⁶ Id.

²⁷ Id.

²⁸ Lasser K et al: JAMA 284:2606-10, 2000.

²⁹ See Morris, C. & G. Smith. Tobacco Cessation within Behavioral Health: A Realistic Wellness Goal. Available at <http://www.thenationalcouncil.org/galleries/resources-services%20files/Morris%20and%20Smith%20National%20Council%20Final%20June%2023%202009.pdf>.

³⁰ Id. at 16.

³¹ Id.

policy is consistent with the statute, which does not require a period of abstinence, as well as the legislative history.

Although some adjudicators consistently rule otherwise, SSA's own sub-regulatory policies make it clear that there is no requirement for abstinence or non-use. The confusion may be caused by some references to nonuse, such as the following:

- POMS DI 90070.050 D.3 provides examples of "When DAA Is Material." Section D.3.c states: "The individual's other impairment(s) is exacerbated by DAA and the evidence documents that, after a drug-free period of 1 month, the other impairment(s) is by itself not disabling."
- HALLEX I-5-3-14A, § D provides the same examples except that it refers to a "drug-free period of at least 1 month"
- EM-96200 provides the most detailed guidance. Question 30 asks whether the example in the POMS (which, in the original instructions, used the "at least 1 month" language as the HALLEX) is just an example "or is it to be used as an adjudicative rule?" The Answer clarifies that:

It was intended only as an example. The time period of at least 1 month was not intended to imply that drug-free periods of less than 1 month should not be considered when determining whether DAA is material. To clarify this point, we deleted the words "at least" when we placed the example in [POMS] DI 90070.050D.3.

A recent SSA internal policy statement provides the clearest guidance on this issue. In the statement, dated April 30, 2009, the Office of Medical Listings Improvement is asked whether a materiality determination can be made even when there is no period of abstinence. The response was "Yes, in many, but not all, cases." This policy statement provides useful and instructive guidance to adjudicators, and we recommend that it be included in a Social Security Ruling regarding DAA analysis.

The 4/30/09 policy statement directly addresses the issue of "[t]he most difficult cases in which a person has an apparently disabling mental disorder co-occurring with DAA." Relying on EM-96200, it emphasizes that SSA's policy "provides that there must be evidence in the case record establishing whether the DAA is material." Some of the key statements regarding periods of nonuse include:

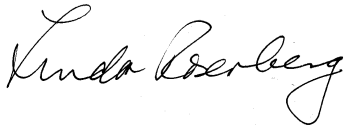
If there is no evidence from a period of nonuse, it is sometimes possible to determine whether the person would be disabled if the DAA were to stop; for example, based on medical evidence that shows a worsening of a co-occurring impairment(s) only during periods of acute intoxication, and evidence showing what impairment-related limitations remain after the acute effects of intoxication subside. However, note that in this case the determination is still based on evidence in the particular person's case record establishing that the DAA is material.

We also caution that adjudicators should be careful not to overlook the common situation in which an individual with a serious mental disorder (such as bipolar disorder or schizophrenia) is "self-medicating." Evidence showing worsening of a co-occurring mental disorder during periods of intoxication may not be demonstrating that DAA is material; rather, it may be demonstrating the frequency with which the person is experiencing exacerbations of the co-occurring mental disorder. There is no clearcut guidance we can give for making this determination.

It is most likely that you will need evidence from a period of nonuse in cases involving co-occurring mental disorders in which the separate effects of the mental disorders are not clear. *We do not prescribe or require a specific length of time for a period of abstinence because the periods will vary based on the type of substance and the particular effects on the person.* We intended the example of the 1-month period of abstinence in EM-96200 to illustrate the fact that, in some situations, it may not be possible to separate the effects of drug or alcohol use from the effects of the other impairment(s) until the individual has been abstinent for a length of time sufficient to allow the acute effects of intoxication and withdrawal to abate. *As we explained in Question 29 of EM-96200, we know of no research data upon which to reliably predict the expected improvement in a coexisting mental impairment(s) should drug or alcohol use stop.*³²

The National Council and NAMI would like to thank the Social Security Administration for allowing stakeholders the opportunity to comment on current policies and practices regarding SSA disability determinations and drug addiction and alcoholism (DAA). Please accept our comments on behalf of individuals with serious mental illness with co-occurring substance use and the community providers that serve them. We look forward to partnering with you to clarify SSA regulations to reflect the 1996 statutory change and the various sub-regulatory instructions and policies.

Sincerely,



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³² Id. (emphasis added).