



Disability Determination Under Social Security: Increasing Rates of Approval

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Abstract

Supplemental security income (SSI), is the lifeline for our patients living in the community. Absent disability benefits most of our patients are homeless. Many will be hungry, poorly clothed, and have only rudimentary health care. The disability determination system will approve disability for < 30% of those adults making an initial application. The rate of actual disability is much higher. A large cohort (n = 251) of likely disability applicants had comprehensive diagnostic evaluations. These evaluations revealed extensive co-occurring psychiatric symptoms and features, particularly obsessive–compulsive features. Recognition and appreciation of the burden of co-occurring conditions leads to a robust increase in approval rates. Administrative or structural features of the disability determination system also depress allowance rates.

Keywords Social security disability · Psychiatric evaluation · Obsessive–compulsive

Introduction

McCauley and Samples (2017) recently reported on the barriers and the complexity faced by mentally ill offenders trying to navigate the disability determination process. They note a remarkably low rate of approval for all persons making an initial application for supplemental security income (SSI) under social security. Overall, the current approval rate for all adults making an initial application for SSI is 27.3% (SSI Annual Statistical Report 2016).

The report by McCauley and Samples is one of a series of reports describing favorable outcome from implementation of the SSI/SSDI Outreach, Access, and Recovery (SOAR) Program. The intensive case management employed by the SOAR program has resulted in disability approval rates exceeding 70% for homeless mentally ill disability applicants (Dennis et al. 2011).

Barriers and complexity are faced by *all* disability applicants. This report focuses on the disability determination process from a diagnostic standpoint. The population described are all community-dwelling out-patients. Attempts

to bring approval rates closer to *actual* rates of disability should also focus on comprehensive diagnosis and upon administrative features of the disability determination process that may disadvantage claimants.

Methods

Two hundred and fifty one consecutive psychiatric diagnostic evaluations were performed by the author on psychiatric outpatients who were *likely applicants* for disability benefits from June, 2012 through December, 2017. The evaluations all took place at a large psychiatric community treatment and rehabilitation facility in Chicago. A *likely applicant* was a person who was not currently receiving disability benefits and was being encouraged by casework staff to apply for disability benefits. All were adults. Most persons would be applying for SSI. Few were eligible for social security disability insurance (SSDI). Regardless, the medical criteria for SSI and SSDI are identical.

A retrospective review of the 251 diagnostic evaluations was conducted. The agency's Institutional Review Board found this study to be "exempt" because of the retrospective nature of the study. The review sought to discover clinical factors that might explain the high denial rate experienced nationwide by disability claimants making initial application. There is very little published in the clinical literature

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or by the social security administration (SSA) describing the clinical features of persons applying for disability.

The following information was abstracted from the 251 diagnostic evaluations: primary diagnosis; prevalence of co-occurring obsessive compulsive features, social phobia, cognitive impairment, presumptive intellectual disability, proxies for anosognosia, and socially stigmatizing features. The presence of collateral sources and the duration of each interview (in minutes) was noted. These interviews are described as “comprehensive” because of their broad diagnostic reach, their duration, and their inclusion of collateral sources. Additionally, outcome information was sought on a subset of the 251 comprehensive evaluations. Was disability by SSA approved; denied; or outcome unknown?

Results

Primary Diagnosis

Each person was given a single primary diagnosis. 24% (n = 60) of the individuals had a primary diagnosis of schizophrenia or delusional disorder. 22% (n = 54) had a primary diagnosis of major depression. Post-traumatic stress disorder was the primary diagnosis for 13% (n = 32). Dementia, intellectual disability, learning disorder, attention-deficit disorder, and cognitive disorder collectively accounted for 12% (n = 30) of the primary diagnoses. Bipolar disorder was the primary diagnosis for 11% (n = 27). Obsessive–compulsive disorder was the primary diagnosis for 10% (n = 25). Generalized anxiety or panic/agoraphobia was the primary diagnosis for 7% (n = 18). Somatic symptom disorder and autistic spectrum accounted for the remaining five individuals.

Co-occurring Conditions and Features

A comprehensive diagnostic interview revealed that in addition to a primary diagnosis there were multiple, vocationally relevant and vocationally-limiting co-morbid or co-occurring psychiatric symptoms or features. These co-occurring conditions may not have attained diagnostic specificity, but still conferred significant vocational limitations. These co-occurring conditions were often elicited only by diligent, time-consuming interviewing.

There was a remarkably high prevalence of *obsessive–compulsive symptomatology* across the diagnostic spectrum. 63% (n = 158) of patients were found to have clinically significant obsessive–compulsive symptomatology. “Clinically significant” meant that the symptoms were reported as distracting, time-consuming, or causing interpersonal friction. Additional patients reported obsessive–compulsive symptomatology, but there was no description of functional impairment; they were not tallied. Cleaning compulsions

(n = 54), symmetry compulsions (n = 39), and obsessive thinking (n = 37) were the three most common symptoms reported.

Obsessive and compulsive symptoms distract attention and degrade productivity. Persons with symmetry compulsions can get provoked to anger when others intrude to rearrange. Perfectionism slows work performance. Obsessive persons, who need to be repeatedly reassured, drain the patience of co-workers and supervisors. During a diagnostic interview, obsessive persons may give no answer for fear of giving the wrong answer. They may be very slow to respond until they are sure that they are giving the “correct” answer. They are reluctant to estimate, approximate, or guess. At work and during the interview they keep seeking clarification. They may be endlessly circumstantial or appear evasive. The interviewer experiences the same sense of frustration as coworkers or supervisors.

Obsessive–compulsive patients can evoke impatient feelings, hostility, and suspicions of malingering in an unwary interviewer. Few of the patients with obsessions and compulsions thrust forth the symptoms. The features were often long-standing and not perceived as impairments by patients. Families were often a more reliable source for reporting troublesome obsessive–compulsive symptoms.

There was a 12% (n = 30) prevalence for *social anxiety*. Only those individuals who spontaneously and literally volunteered the complaint: “I can’t be around groups of people” were tabulated. This is a “low-ball” prevalence because it excludes people who may have used other words to describe their reluctance, avoidance, or withdrawal. These people may be able to perform solitary work, but they cannot travel independently to a worksite on public transportation.

Cognitive impairments were widespread. The Montreal Cognitive Assessment (MoCA) (Nasreddine et al. 2005) was administered to 240 patients. Eleven patients either refused testing or were simply too disorganized to be engaged in reliable testing. The average MoCA score for the 240 patients was 19. This is well into the range of moderate or moderately severe cognitive impairment. The normal range for the MoCA is 26–30. Only 24 patients scored 26 or above on the MoCA. At work, persons with cognitive impairments cannot remember instructions, they become bewildered by abstraction, they calculate poorly and do not appreciate temporal concepts, and they are beset by deficits in executive functioning.

Presumptive *Intellectual disability* was present in 43% (n = 107). This is also a “low-ball” prevalence since patients were tallied as intellectually disabled only if they, or collaterals, provided a history of “special education” placement. Persons who simply described themselves as having been a “slow learner” were not included. Some older patients may have gone through the educational system before there were mandates for special education placement. Others may

have not wished to reveal special education placement. Work performance is impaired in areas such as comprehension, calculation, literacy, and social judgment.

Anosognosia is the deficit in executive functioning that causes an individual to fail to appreciate the fact of their illness or disability. All patients knew that they were being interviewed by a psychiatrist. All interviews were conducted at a mental health facility. All patients were asked the same introductory question: “What is the nature of your disabling condition?” Despite the obvious psychiatric context, 23% ($n=58$) gave an initial response or “chief complaint” that was totally physical or somatic. An additional eight individuals (3%) gave an initial response: “I can work!” These responses are consistent with anosognosia. This type of response would be misleading and self-damaging in the context of a brief or superficial diagnostic evaluation where a claimant’s words are taken literally.

As is traditional, all patients were given a global rating as to whether they were a “reliable” historian, a “marginal” historian, or a “poor historian.” 53% ($N=133$) were rated as poor historians, most frequently because of anosognosia.

Duration of a Comprehensive Evaluation

The comprehensive evaluations faced no time restriction. The agency at which the interviews were conducted has never (in over 50 years) maintained required or recommended time limits for any psychiatric service. All evaluations were timed. The examiner (the author) was paid by the hour. The average duration of the 251 diagnostic evaluations was 84 min.

The 84 min included administration of the MoCA (usually 11–13 min). Time spent reviewing records, interviewing collaterals, or preparing the report was separate from the 84 min.

Collaterals

Almost all patients were interviewed in the presence of family or caseworkers. Collaterals act as “fact checkers.” They offer invaluable corrections for anosognosia. They provide additional clinical and functional insights that may have been missed by the interviewer. Incorporating collateral information in the diagnostic and functional formulation should not be viewed as an optional or ancillary endeavor.

Collaterals were all provided with a standard admonition at the outset of the interview: “I want you to be here, but I want you *JUST* to listen. At the end of the visit, I promise you, I won’t let you leave without giving you an opportunity to tell me anything that I may have missed out on or misunderstood.” The patient was also told to answer questions as best they could without turning to the collateral: “No fair asking for help!” Intrusions by the collateral or distraction

by the patient was never a problem. Bringing in a collateral source after the conclusion of an individual evaluation, is of minimal value. The collateral source does not know what misinformation may have been imparted.

Stigmatizing Features

Thirty seven percent ($n=92$) of the cohort reported ten or more lifetime arrests. 29% ($n=72$) of the 251 persons reported two or more penitentiary terms. 52% ($n=130$) reported a period of active substance abuse at some time during the previous 5 years. Disability claimants may be unsettling. There may be an extreme social distance between claimants and evaluators. They may not be likeable. None of this should diminish their rate of approval for disability.

Outcome After a Comprehensive Evaluation

Follow-up was conducted on all evaluations ($n=124$) performed from 7/7/2015 through 10/25/2017. 48% ($n=60$) were approved for disability. 21% ($n=26$) were denied. 25% ($n=31$) were lost to follow-up or never filed a disability application. 6% ($n=7$) were still pending.

Discussion

This report reveals that initial applicants for disability under Social Security come with multiple mental impairments, not just a primary diagnosis. Regardless of the more obvious primary diagnosis they are burdened with co-occurring obsessive–compulsive features, social anxiety, cognitive impairments, intellectual disability, anosognosia, and socially stigmatizing features. The breadth, severity, and functional impairments associated with these co-occurring conditions is only revealed with comprehensive (time-consuming) diagnostic interviewing and collateral interviewing. Increased appreciation of co-occurring conditions by SSA and more sophisticated interviewing will increase rates of approval at the initial determination level.

Unfortunately, the current system may create bias in favor of denial by not offering incentives to provide comprehensive evaluations. 48% of initial applications are sent by SSA for a “consultative examination” (C/E) by a consultant retained by the state agency determining disability. In the case of psychiatric claims, 78% of these examinations are conducted by psychologists; only 12% by psychiatrists (Wittenburg et al. 2012). Social Security regulations allow a diagnostic evaluation, a C/E, as brief as 40 min (DI 39545 2014). The consultant’s incentive is to maximize profit by conducting as quick an interview as acceptable. C/E consultants are generally paid per evaluation, not paid for their time. Time-consuming questions, standardized testing such as the

MoCA, and collateral interviews that may benefit a claimant are costly to the consultant.

The SOAR program (Kauff et al. 2016) notes a negative correlation between going for a psychiatric “consultative examination” or C/E, and being awarded disability. The authors of that SOAR study further state: “the consultative exam provider may not be able to obtain a complete picture of the individual’s condition and functioning in one short session.” SOAR programs have been funded by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The dependence of the disability determination system on “consultative examinations” confers an additional problem. An applicant who does not attend a scheduled “consultative examination” runs a high risk of being denied for failure to comply with a request from the state agency. We do not know how many persons fail to attend a “consultative examination” due to paranoid delusions, agoraphobia, social anxiety, compulsive rituals impeding egress, or other symptoms. A potential paradox emerges: There may be people who are being denied disability under Social Security because they are disabled.

The disability determination system needs to be rehabilitated. Intensive casework assistance (i.e.: SOAR) should be available to all applicants. Incentives should be developed to encourage more treating practitioners to report to SSA. Incentives should be developed to encourage treating practitioners and consultative examiners to perform comprehensive evaluations. SSA must be more appreciative of the co-occurring conditions that burden claimants. Denials for failure to attend scheduled consultative examinations must be carefully scrutinized.

As advocates for our patients, we should insist on equitable determination of disability.

Compliance with Ethical Standards

Conflict of interest The author declares that he has no conflicts of interest.

References

- Dennis, D., Lassiter, M., Connolly, W. H., & Lupfer, K. S. (2011). Helping adults who are homeless gain disability benefits: The SSI/SSDI outreach, access, and recovery (SOAR) program. *Psychiatric Services*, 62(11), 1373–1376.
- DI 39545.250 Consultative examination (CE) scheduling intervals (March 18, 2014). Social Security Administration Program Operations Manual System (POMS). <https://secure.ssa.gov/poms.nst/lnx/0439545250#a>.
- Kauff, J. F., Clary, E., Lupfer, K. S., & Fischer, P. J. (2016). An evaluation of SOAR: Implementation and outcomes of an effort to improve access to SSI and SSDI. *Psychiatric Services*, 67(10), 1098–1102.
- McCauley, E., & Samples, L. (2017). Navigating the disability determination process from the perspective of incarcerated adults with serious mental illness. *Community Mental Health Journal*, 53(8), 905–915.
- Nasreddine, Z., Phillips, N., Bedirian, V., et al. (2005). The montreal cognitive assessment: A brief screening tool for mild cognitive impairment. *Journal of the American Geriatrics Society*, 53, 695–699.
- SSI Annual Statistical Report. (2016). (Released November 2017) SSA Publication No. 13-11827. Washington, DC. Social Security Administration. Table 70, p. 144.
- Wittenburg, D., Steinagle, G., Frost, S., & Fine, R. (November 4, 2012). An assessment of consultative examination (CE) processes, content, and quality: Findings from the CE review data. Final Report. Contract Number: SS00-09-60106. Submitted to: Social Security Administration Office of Program Development and Research. Submitted by: Mathematica Policy Research.