NEW YORK STATE BAR ASSOCIATION

WORKSHOP F.

Moving Towards Civil Gideon

2014 Legal Assistance Partnership Conference

Hosted by:
The New York State Bar Association
and The Committee on Legal Aid

NYSBA

NEW YORK STATE BAR ASSOCIATION
2014 PARTNERSHIP CONFERENCE

F. TYPICAL MENTAL IMPAIRMENTS IN YOUNG ADULT SSI CLAIMS

AGENDA

September 11, 2014
11:45 a.m. – 1:15 p.m.

1.5 Transitional CLE Credits in Professional Practice.
Under New York's MCLE rule, this program has been approved for all attorneys, including newly admitted.

Panelists:
Catherine M. (Kate) Callery, Esq., Senior Attorney/DAP Coordinator, Empire Justice Center
Katrina H. Colistra, PsyD, NYS Licensed Psychologist/ Partner, New Paradigm Psychological Services, PLLC

I. Introduction to DSM **11:45 am – 12:15 pm**

a. Review of Significant Differences From DSM-IV-TR
b. Elimination of GAF
c. Changes to ID/MR Criteria
d. Adaptive Functioning Issues

II. Typical DSM-5 Diagnoses for Young Adults **12:15 pm – 12:45 pm**

a. ADHD
b. Conduct Disorder
c. Learning Disorders
d. Intellectual Disabilities
e. Mood and Anxiety Disorders
f. PTSD

III. Impact of Drug and Alcohol Addiction **12:45 pm – 1:00 pm**

a. DSM-IV vs. DSM-5
b. SSR 13-2p

IV. Residual Functional Capacity Assessments **1:00 pm – 1:15 pm**

a. Mental Demands of Work
b. WAIS Scores As Vocational Evidence

Table of Contents

Substantive Outline

F. TYPICAL MENTAL IMPAIRMENTS IN YOUNG ADULT SSI CLAIMS

OUTLINE

INTRODUCTION

Disability claims involving young adults with mental impairments can be particularly challenging for advocates. Advocates must have a basic understanding of the typical psychiatric diagnoses confronted by young adults in order to work with the young adult claimants and develop evidence to support their claims. Advocates need to understand typical diagnoses from the psychiatric perspective. Advocates also need to be familiar with significant changes in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM), especially as they relate to young adult claims. Advocates need to understand how to translate psychiatric evidence into functional limitations. Although the DSM-5 no longer uses Global Assessment of Functioning (GAF) scores, they will continue to play a role in terms of functional assessments. Subtest scores from formal intelligence tests may also be used to demonstrate vocational limitations in young adult cases, and to compensate for the lack of relevant vocational issues in typical young adult cases.

INTRODUCTION TO THE DSM-5

A. <u>American Psychiatric Association *Diagnostic Statistical Manual* (2013)</u>

1. DSM is the standard classification of mental disorders used by mental health professionals in the United States and contains a listing of diagnostic criteria for every psychiatric disorder recognized by the U.S. healthcare system.
    a. The previous edition, DSM-IV-TR, has been used by professionals in a wide array of contexts, including psychiatrists and other physicians, psychologists, social workers, nurses, occupational and rehabilitation therapists, and counselors, as well as by clinicians and researchers of many different orientations (e.g., biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems)
    b. Published by the American Psychiatric Association
    c. DSM-5 was released in May 2013
        i. *See* DSM-5 Released
        ii. http://www.empirejustice.org/issue-areas/disability-benefits/non-disability-issues/misc/dsm-5-released.html
    d. DSM is used in both clinical settings (inpatient, outpatient, partial hospital, consultation-liaison, clinic, private practice, and primary care) as well as with community populations.
    e. In addition to supplying detailed descriptions of diagnostic criteria, DSM is also a necessary tool for collecting and communicating accurate public health statistics about the diagnosis of psychiatric disorders. (From DSM-5.org)
        i. Among the most noticeable revisions to the Fifth Edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is the inclusion of dual codes for every mental disorder to account for the currently used ICD-9-CM codes as well as new ICD-10-CM codes.
        ii. Codes will be activated in October 2015 - American Psychiatric Association, Diagnostic Statistical Manual (2013)

f. Note that Listings of Impairments currently used by the Social Security Administration (SSA) are based on DSM-III

i. 20 C.F.R. , Subpart P, *Appendix #1*

ii. SSA proposed new mental listings more in accord with DSM-IV on August 19, 2010

a) http://www.gpo.gov/fdsys/pkg/FR-2010-08-19/pdf/2010-20247.pdf

b) Final regulations still not published

iii. Current listings were extended to January 2, 2015

a) http://www.gpo.gov/fdsys/pkg/FR-2013-12-03/html/2013-28836.htm

II. Review of significant differences between the DSM-IV-TR and DSM-5

A. Elimination from DSM-5 of Global Assessment of Functioning ("GAF") scores

1. The DSM-5 has "recommended that the GAF be dropped from the DSM-5 for several reasons, including its conceptual lack of clarity (i.e., including symptoms, suicide risk, and disabilities in its descriptors) and questionable psychometrics in routine practice." DSM-5 at 16

2. Section III of DSM-5 cites World Health Organization Disability Assessment Schedule ("WHO-DAS") 2.0 as the best current alternative for measuring disability

a. WHO-DAS 2.0 is a newer generic assessment instrument for health and disability.

i. Assesses six domains, including cognition, mobility, self-care, getting along, life activities, and participation.

ii. Quick way to produce standardized disability levels and profiles, is applicable across cultures in adult populations, and is currently available in six languages.

b. *See* http://www.who.int/classifications/icf/whodasii/en/

3. SSA has published has published internal instructions to its adjudicators, including ALJs, on interpretation of GAF scores.

a. SSA's Administrative Message (AM)-13066, effective July 22, 2013, and published on SSA's intranet

i. Attached as *Appendix #2*

ii. Also available as DAP #558

b. SSA reminds adjudicators that although DSM-5 eliminates the GAF, they will continue to receive and consider evidence that contains GAF scores

c. According to AM-13066, GAF scores will still be considered opinion evidence

d. But per the AM, there are numerous problems with the GAF's reliability, including lack of standardization of the scores

i. A GAF score should never be dispositive of impairment severity.

ii. A GAF provided by a treating source cannot be given controlling weight unless it is well supported and not inconsistent with other evidence.

iii. A GAF score should never be equated with particular listing level severity or residual functional capacity. According to the AM, it does not measure the ability to meet the mental demands of work.

B. <u>Changes to name and criteria for Mental Retardation (MR)/ Intellectual Disability (ID)</u>

1. Mental Retardation is now Intellectual Disability
2. DSM-IV-TR required deficit in TWO of ten areas
    a. Communication
    b. Self-care
    c. Home living
    d. Social/Interpersonal skills
    e. Use of community resources
    f. Self-direction
    g. Functional academic skills
    h. Work
    i. Leisure
    j. Health and Safety
3. Same ten areas used by the Adaptive Behavior Assessment System-Second Edition ("ABAS-II") (or another adaptive instrument) measure
    a. ABAS-II
    b. Test score is used to determine level of severity of ID
4. DSM 5 requires deficit in ONE of three areas (Same three areas used by ABAS-II)
    a. Conceptual Skills (Provide examples of areas impacted)
    b. Social Skills (Provide examples of areas impacted)
    c. Practical Skills (Provide examples of areas impacted)
5. Amount of adaptive deficit is used to determine the severity of ID
    a. It is possible to have IQ score of 74 and be diagnosed MODERATE ID (due to deficits in adaptive functioning)
6. SSA also measures adaptive functioning in assessing disability based on ID
    a. Per Listing 12.05 Intellectual Disability (formerly Mental Retardation), "Intellectual disability refers to significantly sub average general intellectual functioning with deficits in adaptive functioning initially manifested during the developmental period; i.e., the evidence demonstrates or supports onset of the impairment before age 22"
    b. This "capsule definition" in the introductory paragraph to Listing 12.05 requires a separate showing of deficits in adaptive functioning arising from the claimant's cognitive limitations
        i. *See* , e.g., *Talavera v. Astrue*, 697 F.3d 145, 148 (2d Cir. 2012)
        ii. This requirement is in addition to the IQ scores required by certain subparts of Listing 12.05
7. What is adaptive functioning?

a. According to SSA, adaptive functioning is "the individual's progress in acquiring mental, academic, social and personal skills as compared with other unimpaired individuals of his/her same age. Indicators of adaptive behavior include … educational and social achievements."

i. POMS DI 24515.056D2, "Evaluation of Specific Issues – Mental Disorders – Determining Medical Equivalence

ii. https://secure.ssa.gov/apps10/poms.nsf/lnx/0424515056

b. Per the Court of Appeals, adaptive functioning refers to an individual's ability to cope with the challenges of ordinary everyday life

i. *Talavera v. Astrue,* 697 F.3d 145 at 152

ii. *Talavera* also specifies that the deficits in adaptive functioning "must arise from her cognitive limitations, rather than from a physical ailment or other infirmity"

a) 697 F.3d at 153

c. Measures of adaptive functioning

i. Adaptive Behavior Scale-School 2nd Edition (ABS-S:2)

ii. Scale of Independent Behavior-Revised (SIB-R)

iii. Vineland Adaptive Behavior Scales, Second Edition (Vineland-II)

iv. Adaptive Behavior Assessment System-Second Edition (ABAS-II)

d. Examples of Deficits

i. "Indeed, in 2001 Douglass received a composite score of 54 in adaptive behavior, signifying that 99.9 percent of his peers were better able than him to cope with the challenges of everyday life"

a) *Douglass v. Astrue*, 2012 WL 4094881 (2d Cir., Sept. 19, 2012)

ii. Evidence that claimant attended special education, or had difficulties in reading, writing or math indicative of deficits in adaptive functioning

a) *See,* e.g., *Goldthrite v. Astrue*, 2010 WL 2998660, at *4 (W.D.N.Y. 2010)

b) *MacMillan v. Astrue,* 2009 WL 4807311, at *6 (N.D.N.Y. Dec.7, 2009)

iii. Note that listing 12.05 does not require a complete lack of adaptive functioning

a) *See Ali v. Astrue*, 2010 WL 889550, at *5 (E.D.N.Y. Mar. 8, 2010) ("The claimant need not demonstrate that he is completely helpless or totally disabled.")

e. *See Appendix #3* - Questionnaire for assessing adaptive functioning

III. TYPICAL DSM-5 DIAGNOSES IN YOUNG ADULT CASES

A. Attention Deficit Hyperactivity Disorder (ADHD)

1. Characterized by a persistent pattern of inattention and/or hyperactivity/impulsivity that occurs in academic, occupational, or social settings.

2. Problems with attention include making careless mistakes, failing to complete tasks, problems staying organized and keeping track of things, becoming easily distracted, etc.

3. Problems with hyperactivity can include excessive fidgetiness and squirminess, running or climbing when it is not appropriate, excessive talking, and being constantly on the go.
4. Impulsivity can show up as impatience, difficulty awaiting one's turn, blurting out answers, and frequent interrupting, and beyond what is considered normal developmental issues.
5. Must impair functioning in other domains
    a. See three skill areas
        i. Conceptual Skills (Provide examples of areas impacted)
        ii. Social Skills (Provide examples of areas impacted)
        iii. Practical Skills (Provide examples of areas impacted)
6. Compare SSA's ADHD Listing 112.11 for children
    a. Manifested by developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity.
    b. The required level of severity for these disorders is met when the requirements in both A and B are satisfied.
        i. Medically documented findings of all three of the following:
            a) Marked inattention; and
            b) Marked impulsiveness; and
            c) Marked hyperactivity; AND
        ii. For older infants and toddlers (age 1 to attainment of age 3), resulting in at least one of the appropriate age-group criteria in paragraph B1 of 112.02; or, for children (age 3 to attainment of age 18), resulting in at least two of the appropriate age-group criteria in paragraph B2 of 112.02.

B. <u>Conduct Disorders</u>

1. A repetitive and persistent pattern of behavior in children and adolescents in which the rights of others or basic social rules are violated.
2. The child or adolescent usually exhibits these behavior patterns in a variety of settings—at home, at school, and in social situations—and they cause significant impairment in his or her social, academic, and family functioning.
3. Behaviors characteristic of conduct disorder include:
    a. Aggressive behavior that causes or threatens harm to other people or animals, such as bullying or intimidating others, often initiating physical fights, or being physically cruel to animals.
    b. Non-aggressive conduct that causes property loss or damage, such as fire-setting or the deliberate destruction of others' property.
    c. Deceitfulness or theft, such as breaking into someone's house or car, or lying or "conning" others.
    d. Serious rule violations, such as staying out at night when prohibited, running away from home overnight, or often being truant from school.
4. Comparable SSA Listing?

C. Learning Disabilities

1. A learning disability is a neurological condition that interferes with an individual's ability to store, process, or produce information.
2. Learning disabilities can affect one's ability to read, write, speak, spell, compute math, reason and also affect an individual's attention, memory, coordination, social skills and emotional maturity.
3. Common LDs
    a. Dyslexia.
        i. Causes problems with language skills, particularly reading.
        ii. People with dyslexia may have difficulty spelling, understanding sentences, and recognizing words they already know
    b. Dysgraphia
        i. Problems with handwriting.
        ii. Problems forming letters, writing within a defined space, and writing down their thoughts.
    c. Dyscalculia - math learning disability
        i. Difficulty understanding arithmetic concepts and doing such tasks as addition, multiplication, and measuring
    d. Dyspraxia
        i. Also termed sensory integration disorder
        ii. Involves problems with motor coordination that lead to poor balance and clumsiness.
        iii. Poor hand-eye coordination also causes difficulty with fine motor tasks such as putting puzzles together and coloring within the lines.
    e. Apraxia of speech
        i. Sometimes called verbal apraxia
        ii. Involves problems with speaking.
        iii. People with this disorder have trouble saying what they want to say correctly and consistently.
    f. Central auditory processing disorder
        i. Trouble understanding and remembering language-related tasks.
        ii. Difficulty explaining things, understanding jokes, and following directions.
        iii. Confuse words and are easily distracted
    g. Nonverbal learning disorders
        i. Strong verbal skills but great difficulty understanding facial expression and body language.
        ii. Physical clumsiness and trouble generalizing and following multistep directions.
    h. Visual perceptual/visual motor deficit
        i. People with this condition mix up letters; they might confuse "m" and "w" or "d" and "b," for example.

ii. They may also lose their place while reading, copy inaccurately, write messily, and cut paper clumsily

i. Aphasia

i. Also called dysphasia

ii. Difficulty understanding spoken language, poor reading comprehension, trouble with writing, and great difficulty finding words to express thoughts and feelings.

iii. Occurs when the language areas of the brain are damaged. In adults, it often is caused by stroke, but children may get aphasia from a brain tumor, head injury, or brain infection.

j. *See* http://www.nichd.nih.gov/health/topics/learning/conditioninfo/Pages/default.aspx

k. Comparable SSA listing?

D. <u>Intellectual disabilities (formerly Mental Retardation and Borderline Intellectual Functioning)</u>

1. Intellectual disability (ID), or mental retardation (MR), is a condition or syndrome and also a defining characteristic of other disorders, such as Down syndrome.
2. ID describes a heterogeneous group of conditions characterized by low or very low intelligence and deficits in adaptive behaviors without reference to etiology. [Sattler: 1988].
3. Compare SSA's Listing 12.05 and 112.05
4. See *supra*

E. <u>Mood and Anxiety Disorders</u>

1. Bipolar disorder

a. Also known as manic-depressive illness, a brain disorder that causes unusual shifts in mood, energy, and activity levels.

b. It can also make it hard to carry out day-to-day tasks, such as going to school or hanging out with friends.

c. Symptoms of bipolar disorder can be severe. They are different from the normal ups and downs that everyone goes through from time to time (more extreme shifts in mood).

d. Bipolar disorder symptoms can result in damaged relationships, poor school performance, and even suicide. But bipolar disorder can be treated, and many people with this illness can lead full and productive lives.

e. Symptoms of bipolar disorder often develop in the late teens or early adult years, but some people have their first symptoms during childhood. At least half of all cases start before age 25.

f. Compare SSA's Listings 12.04 – Affective Disorder

i. Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.

ii. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied

a) [A.] Medically documented persistence, either continuous or intermittent, of one of the following:

1)[1.] Depressive syndrome characterized by at least four of the following:

(a) [a.] Anhedonia or pervasive loss of interest in almost all activities; or

(b) [b.] Appetite disturbance with change in weight; or

(c) [c.] Sleep disturbance; or

(d) [d.] Psychomotor agitation or retardation; or

(e) [e.] Decreased energy; or

(f) [f.] Feelings of guilt or worthlessness; or

(g) [g.] Difficulty concentrating or thinking; or

(h) [h.] Thoughts of suicide; or

(i) [i.] Hallucinations, delusions, or paranoid thinking; or

2)[2.] Manic syndrome characterized by at least three of the following:

(a) [a.] Hyperactivity; or

(b) [b.] Pressure of speech; or

(c) [c.] Flight of ideas; or

(d) [d.] Inflated self-esteem; or

(e) [e.] Decreased need for sleep; or

(f) [f.] Easy distractibility; or

(g) [g.] Involvement in activities that have a high probability of painful consequences which are not recognized; or

(h) [h.] Hallucinations, delusions or paranoid thinking; or

3)Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes); AND

b) [B.] Resulting in at least two of the following:

1)[1.] Marked restriction of activities of daily living; or

2)[2.] Marked difficulties in maintaining social functioning; or

3)[3.] Marked difficulties in maintaining concentration, persistence, or pace; or

4)[4.] Repeated episodes of decompensation, each of extended duration; OR

c) [C.] Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1)[1.] Repeated episodes of decompensation, each of extended duration; or

2)[2.] A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or

3)[3.] Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

2. Depression
    a. Serious mood disorder, with symptoms including:
        i. Is irritable, sad, withdrawn, or bored most of the time.
        ii. Does not take pleasure in things he or she used to enjoy.
        iii. Loses or gains weight. (dramatic in short periods of time)
        iv. Sleeps too much or too little
        v. Feels hopeless, worthless, or guilty
        vi. Has trouble concentrating, thinking, or making decisions
        vii. Thinks about death or suicide a lot.
    b. Compare SSA's Listing 12.04, *supra*
3. Anxiety
    a. Anxiety disorders are the most common mental conditions in the general population, including in children and adolescents.
    b. Young people can present with a pattern of anxiety symptoms somewhat different from that typically seen in adults.
    c. One of the most common aspects of this difference is that children (especially younger ones) may not report overt worries or fears, but instead manifest pronounced physical symptoms.
    d. Compare SSA's Listing 12.06 for Anxiety Related Disorders
        i. In these disorders anxiety is either the predominant disturbance or it is experienced if the individual attempts to master symptoms; for example, confronting the dreaded object or situation in a phobic disorder or resisting the obsessions or compulsions in obsessive compulsive disorders. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in both A and C are satisfied

a) [A.] Medically documented findings of at least one of the following:

1)[1.] Generalized persistent anxiety accompanied by three out of four of the following signs or symptoms:

(a) [a]. Motor tension; or
(b) [b.] Autonomic hyperactivity; or
(c) [c.] Apprehensive expectation; or
(d) [d.] Vigilance and scanning; or

2)[2.] A persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation; or

3)[3.] Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week; or

4)[4.] Recurrent obsessions or compulsions which are a source of marked distress; or

5)[5.] Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress; AND

b) [B.] Resulting in at least two of the following:

1)[1.] Marked restriction of activities of daily living; or

2)[2.] Marked difficulties in maintaining social functioning; or

3)[3.] Marked difficulties in maintaining concentration, persistence, or pace; or

4)[4.] Repeated episodes of decompensation, each of extended duration. OR

c) [C.] Resulting in complete inability to function independently outside the area of one's home.

F. <u>Post-Traumatic Stress Disorder ("PTSD")</u>

1. DSM-5 identifies the trigger to PTSD as exposure to actual or threatened death, serious injury or sexual violation. The exposure must result from one or more of the following scenarios, in which the individual:

a. Criterion A
   i. Directly experiences the traumatic event;
   ii. Witnesses the traumatic event in person;
   iii. Learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or
   iv. Experiences first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related).
b. Criterion B: Intrusion or Re-experiencing
c. Criterion C: Avoidant symptoms

d. Criterion D: Negative alterations in mood or cognitions
e. Criterion E: Increased arousal symptoms
f. Criteria F, G and H

2. The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning.

3. It is not the physiological result of another medical condition, medication, drugs or alcohol. Symptoms must persist for at least one month.

4. Compared to DSM-IV-TR, the diagnostic criteria for DSM-5:

a. Draws a clearer line when detailing what constitutes a traumatic event. (Sexual assault is specifically included, for example, as is a recurring exposure that could apply to police officers or first responders.)

b. Language stipulating an individual's response to the event; intense fear, helplessness or horror, according to DSM-IV-TR has been deleted because that criterion proved to have no utility in predicting the onset of PTSD.

c. DSM-5 pays more attention to the behavioral symptoms that accompany PTSD and proposes four distinct diagnostic clusters instead of three. (Criteria listed above.)

d. Re-experiencing covers spontaneous memories of the traumatic event, recurrent dreams related to it, flashbacks or other intense or prolonged psychological distress. Avoidance refers to distressing memories, thoughts, feelings or external reminders of the event.

e. Negative cognitions and mood represents myriad feelings, from a persistent and distorted sense of blame of self or others, to estrangement from others or markedly diminished interest in activities, to an inability to remember key aspects of the event.

f. Arousal is marked by aggressive, reckless or self-destructive behavior, sleep disturbances, hyper- vigilance or related problems. The current manual emphasizes the "flight" aspect associated with PTSD; the criteria of DSM-5 also account for the "fight" reaction often seen.

g. The number of symptoms that must be identified depends on the cluster. DSM-5 would only require that a disturbance continue for more than a month and would eliminate the distinction between acute and chronic phases of PTSD.

5. Comparable SSA Listing

a. *See supra,* 12.06 for Anxiety-related Disorders or 112.06 for Anxiety Disorders

IV. IMPACT OF DRUG OR ALCOHOL ADDICTION (DAA) ON MENTAL IMPAIRMENTS

A. DSM–IV described two distinct disorders, alcohol abuse and alcohol dependence, with specific criteria for each.

1. Under DSM–IV, the diagnostic criteria for abuse and dependence were distinct: anyone meeting one or more of the "abuse" criteria (see items 1 through 4) within a 12-month period would receive the "abuse" diagnosis.

2. Anyone with three or more of the "dependence" criteria (see items 5 through 11) during the same 12-month period would receive a "dependence" diagnosis.

B. DSM–5 integrates the two DSM–IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder (AUD) with mild, moderate, and severe sub-classifications.

1. Under DSM–5, anyone meeting any two of the 11 criteria during the same 12-month period would receive a diagnosis of AUD.
2. The severity of an AUD—mild, moderate, or severe—is based on the number of criteria met.
3. DSM–5 eliminates legal problems as a criterion.
4. DSM–5 adds craving as a criterion for an AUD diagnosis. It was not included in DSM–IV

C. Per SSA, DAA is not a disability

1. Under the enactment of the 1996 Contract with America Advancement Act ("CAAA"), a claimant will not be found disabled if DAA would be a contributing factor to the finding of disability
2. Social Security Ruling (SSR) 13-2p - Evaluating Cases Involving Drug Addiction and Alcoholism (DAA) - was issued on February 20, 2013
    a. Purpose is to explain SSA's policies for determining whether DAA is a contributing factor material to a determination of disability.
    b. http://ssa.gov/OP_Home/rulings/di/01/SSR2013-02-di-01.html
3. Materially will only arise in cases with a medically determinable Substance Use Disorder, as defined in the DSM, *supra*
    a. There must be objective medical evidence of the disorder from an acceptable medical source.
    b. Evidence that merely shows that the claimant uses drugs or alcohol does not in itself establish a Substance Use Disorder
    c. DAA does not include occasional use of alcohol or illegal drugs, or a history of occasional use
    d. Does not include nicotine-related disorders, caffeine-induced disorders, fetal alcohol syndrome, or fetal cocaine exposure
    e. Does not include use of or addiction to prescribed medications **taken as prescribed**, including methadone and narcotics.
4. SSR clearly establishes that it is the claimant's burden to prove that DAA is not material to a finding of disability.
    a. *See Cage v. Commissioner of Social Security*, 692 F.3d 118 (2d Cir. 2012)
    b. *Cage* also holds that the ALJ does not on a medical opinion to determine materiality
5. SSR does not clarify whether a claimant with co-morbid psychiatric impairments, could meet his or her burden of proving non-materiality with an opinion from a treating source that the psychiatric impairment would continue to be disabling even without the DAA
    a. If unable to project, does the tie still go to the claimant?
    b. *See*, e.g., *Orr v. Barnhart*, 375 F.Supp.2d 193 (W.D.N.Y. 2005)
        i. "When it is not possible to 'separate the mental restrictions and limitations imposed by DAA and the various other mental disorder shown

by the evidence, a finding of 'not material' would be appropriate.")
ii. Citing Social Security Administration Emergency Teletype, No. EM-96200 at Answer 29 (August 30, 1996), which has been superseded by SSR 13-2p

V. RESIDUAL FUNCTIONAL CAPACITY (RFC) ASSESSMENTS AND PSYCHIATRIC DIAGNOSES

A. Mental demands of work

1. Understanding, remembering and carrying out instructions; responding appropriately to supervision, co-workers, and work pressure in a work setting.
2. 20 C.F.R. §416.945(c).
3. *See also* POMS DI 25020.010

B. Sample mental RFC attached as *Appendix #4*

C. Intelligence test sub scores as vocational evidence

1. WAIS-IV (Wechsler Adult Intelligence Scale) includes five subtests/scores
   a. Verbal Comprehension Index(VCI)
   b. Perceptual Reasoning Index (PRI)
   c. Working Memory Index (WMI)
   d. Processing Speed Index (PSI)
   e. Full Scale IQ (FSIQ)
2. Some subtests may be more vocationally relevant
3. *See* attached Mental RFC subtest grid (*Appendix #5)*

Young Adult Case Summary

TYPICAL AGE-18 REVIEW CASE SUMMARY

Justin Young was awarded SSI at the age of 14 and is now appealing the denial of his age-18 redetermination. His childhood featured domestic abuse and trauma. At age 5, he was thrown against a sink and witnessed his father choke his mother. When he was 12, he was diagnosed with major depressive disorder, recurrent with social phobia.

Justin entered junior high school but his performance suffered due to absences. At age 14, testing revealed full scale IQ of 99, difficulty with short-term memory, speed, and attention. Recommendations included small class size, extra time, separate test locations, and assistive devices such as tape recorders, charts and written instructions. He was awarded SSI at this time based on depression with social phobia, and a learning disorder.

By the 9th grade, Justin was experiencing extreme social phobia and refused to go to school. He attended 2 high schools before being transferred to a residential school. For that year and the 2 that followed, Justin re-enrolled in school but stopped attending after a few months because of anxiety. He was homeschooled for the remainder of each year.

By age 17, Justin's symptoms had increased. Treatment records for this time period note depressed mood, anhedonia, insomnia, appetite changes, and social phobia. He was prescribed Lexapro. He found his first job as a salesperson at a busy bakery, but he was fired after less than two months for taking too many breaks. He began experiencing an increase in anxiety-related symptoms, including being startled by noises. His diagnosis was major depressive disorder, mild but with recent onset of generalized anxiety disorder.

An IEP was issued recommending general education with special education teacher support services 3 periods per week. It found his behavior was not interfering with his education because although he suffered from social phobia, medications prescribed were only for insomnia.

At age 18, Justin re-enrolled in school but began skipping therapy, finding it a "waste of time." He was also using marijuana with frequency. His therapist contracted with him to enter a substance abuse program if he used during the week and continued to miss class. Justin ultimately dropped out of both school and therapy. He found a job at a clothing store, but the position ended after 2 months, following a disagreement with his boss. The following year, Justin was hospitalized for 5 days; he wasn't getting out of bed and reported suicidal ideation.

At age 20, Justin obtained a GED. He also found a job taking orders in a café, but he was fired for being too slow. His age-18 reconsideration is denied at this time.

At age 21, Justin resumed therapy, but attended only sporadically. His diagnoses included ADHD, major depressive disorder, mild with anxiety, learning disorder and cannabis abuse.

Justin is now 22 and working towards a bachelor's degree. Accommodations from the Office for Students with Disabilities include double time and special quiet room for tests. He also receives

assistance from a program aimed to support “at risk” students with counseling and other supports. His grades ranged from B+ to F in the first year but now range from B- to A.

Justin is no longer in treatment because the clinic he was attending closed. He is ambivalent about finding a new therapist and about his claim for benefits. His mother reports that he sleeps all day and is able to achieve good grades because he has chosen easy classes in the afternoon.

AM-13066 (GAF Scores)

Instruction

Identification Number	**AM-13066**	**Effective Date:** 07/22/2013
Intended Audience:		.
Originating Office:		.

Title:	**Global Assessment of Functioning (GAF) Evidence in Disability Adjudication**

Type:	AM - Admin Messages
Program:	**Disability**

Link To Reference:	See **References** at the end of this AM.

Retention Date: January 22, 2014

A. Purpose

This AM provides guidance to all State and Federal adjudicators (including administrative law judges) on how to consider Global Assessment of Functioning (GAF) ratings when assessing disability claims involving mental disorders. GAF ratings are frequently included in medical evidence and consultative examination reports from mental health care professionals. We consider a GAF rating as opinion evidence. As with other opinion evidence, the extent to which an adjudicator can rely on the GAF rating as a measure of impairment severity and mental functioning depends on whether the GAF rating is consistent with other evidence, how familiar the rater is with the claimant, and the rater's expertise.

B. Background

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published periodically by the American Psychiatric Association (APA), provides the common language and standard criteria for classification of mental disorders. The DSM, Fourth Edition, Text Revision (DSM-IV-TR) provided for a multi-axial assessment of mental disorders. Axis I

covered clinical disorders; Axis II covered personality disorders and mental retardation; Axis III covered general medical conditions; Axis IV considered psychosocial and environmental problems; and Axis V, also known as the GAF, reported the clinician's judgment of a person's overall level of functioning.

NOTE: Recently the APA published a fifth edition (DSM-5) that does not include GAF rating for assessment of mental disorders. However, we will continue to receive and consider GAF in medical evidence.

C. What is the GAF?

The GAF is a rating reporting the clinician's judgment of a person's ability to function in daily life. See DSM-IV-TR, p. 32. It reflects the clinician's subjective judgment about the person's symptom severity and psychological, social, and occupational functioning. The rating does not reflect impairment in function caused by physical or environmental limitations.

Each 10-point range within the GAF has two components: one that covers symptom severity, and a second covering functioning. If a person's symptom severity and level of functioning differ, the GAF rating reflects the lower rating. In other words, a person with a number of psychological symptoms and very few functional limitations would get a GAF score consistent with his or her reported psychological symptoms (DSM-IV-TR, p. 33).

D. Problems with using the GAF to evaluate disability

The problem with using the GAF to evaluate disability is that there is no way to standardize measurement and evaluation. Researchers have pointed out numerous problems with the GAF - from the choice of rating scale, to the choice of anchor points, to the limited instructions to clinicians for rating GAFs within the 10-point intervals. Some researchers suggested that abandoning the GAF altogether in favor of a 5-point scale, might make ratings more accurate.

Other researchers had questions about the anchor points of the scale, because it is unclear whether other key words or examples would result in a better GAF. The anchor points are indicators that help the clinician establish the GAF rating. The current anchor points are generally inclusion criteria. For example, "occasionally failing to maintain personal hygiene" is a criterion that could result in a GAF rating of 20-11. Some researchers believe adding exclusion criteria to the anchors might promote better inter-rater reliability. An exclusion criterion might be "do not rate GAF lower than 20 if the individual is clean but somewhat disheveled".

As another example, some researchers have expressed concern that, as managed-care companies continue to set practice standards and quality guidelines, and the trend towards accountability for clinical outcomes continues to grow, practitioners may be

under increasing pressure to use GAF ratings and DSM diagnoses in inappropriate ways to ensure insurance coverage for treatment.

Research has also identified the propensity of some clinicians to give inflated or unrealistically low GAF ratings because the GAF rating instructions in the DSM-IV-TR are unclear. In general, inter-rater reliability ratings are low in the clinical setting because there is great variability of training and experience levels amongst clinicians. These rating problems, alone or in combination, can lead to improper assessment of impairment severity.

1. **GAF ratings are not standardized**

The GAF is neither standardized nor based on normative data. A GAF rating compares the patient with the distinctive population of patients the clinician has known. This limits direct comparability of GAF scores assigned by different evaluators or even by the same evaluator at substantially different points in time.

Although the GAF rating is numerical, the actual number assigned can be misleading because the score does not quantify differences in function between people. For example, a GAF score of 75 does not mean a person is functioning 10 units better than a person with a score of 65, nor does a GAF of 40 indicate a person is functioning half as well as a person with a score of 80.

GAF ratings assigned by different clinicians are inconsistent because of the lack of standardization. In a clinical (i.e., treatment and evaluation) setting, inter-rater reliability is generally low because of variability of training and experience levels among clinicians. This means adjudicators cannot draw reliable inferences from differences in GAF ratings assigned by different clinicians or from a single GAF score in isolation

2. **GAF is not designed to predict outcome**

Clinicians use the GAF to help plan and measure the impact of treatment (see DSM-IV-TR, p. 32). It is of limited value for assessing prognosis or treatment outcome and other measures are better indicators of outcome. For example, research suggests the highest level of functioning for a period of time is a better predictor of prognosis than the lowest level of functioning for a time period.

3. **GAF ratings need supporting detail**

The GAF scale anchors are very general and there can be a significant variation in how clinicians rate a GAF. For example, if a claimant has a GAF of 20, it could mean that he or she is not maintaining minimal personal hygiene (a clinical observation), or that the claimant has some potential to hurt himself or others (a clinical judgment). Interpreting the GAF rating requires knowing what the clinician was focusing on when assigning the overall rating. Although the DSM-IV-TR recommends assigning a rating reflecting the

lower assessment when symptom severity and level of functioning differ, evaluators rarely note whether the score reflects function, symptoms, or both.

E. Weighing GAF ratings as opinion evidence

For purposes of the Social Security disability programs, when it comes from an acceptable medical source, a GAF rating is a medical opinion as defined in 20 CFR §§ 404.1527(a)(2) and 416.927(a)(2). An adjudicator considers a GAF score with all of the relevant evidence in the case file and weighs a GAF rating as required by §§ 20 CFR 404.1527(c), 416.927(c), and SSR 06-03p, while keeping the following in mind:

The GAF is unlike most other opinion evidence we evaluate because it is a rating. However, as with other opinion evidence, a GAF needs supporting evidence to be given much weight. By itself, the GAF cannot be used to “raise” or “lower” someone’s level of function. The GAF is only a snapshot opinion about the level of functioning. It is one opinion that we consider with all the evidence about a person’s functioning. Unless the clinician clearly explains the reasons behind his or her GAF rating, and the period to which the rating applies, it does not provide a reliable longitudinal picture of the claimant’s mental functioning for a disability analysis.

A GAF score is never dispositive of impairment severity. **DO NOT:**

- Give controlling weight to a GAF from a treating source unless it is well supported and not inconsistent with the other evidence.

When case evidence includes a GAF from a treating source and you do not give it controlling weight, you must provide good reasons in the personalized disability explanation or decision notice.

- Equate any particular GAF score with a listing-level limitation.

You cannot use a GAF rating to determine whether a claimant’s impairment meets the diagnostic criteria of mental retardation in listing 12.05, because the rating lacks specificity, may not reflect a claimant’s functioning over time, and is not a standardized measure of anything, including intelligence and adaptive behavior.

- Equate a particular GAF score with a particular mental residual functional capacity assessment.

The GAF does not measure the ability to meet the mental demands of unskilled work. There have been no published studies of how, or if, GAF scores relate to meeting the demands of unskilled work. Additionally, there is no correlation between GAF scores and the B criteria in the mental disorders listings.

Questions

Direct all program–related and technical questions to your RO support staff or PSC OA staff. RO support staff or PSC OA staff may refer questions or problems to their Central Office contacts.

References:

20 CFR 404.1502 General definitions and terms for subpart P
20 CFR 416.902 General definitions and terms for subpart I
20 CFR 404.1520a Evaluation of mental impairments
20 CFR 416. 920a Evaluation of mental impairments
20 CFR 404.1527 Evaluating opinion evidence
20 CFR 416.927 Evaluating opinion evidence
SSR 96-2p Titles II and XVI: Giving controlling Weight to Treating Source Medical Opinions
SSR 06-03p Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies
DI 22505.001 Medical Evidence of Record (MER) Policies
DI 22505.003 Medical and Other Evidence of an Individual's Impairment(s)
DI 22505.007 Developing Initial Evidence from Medical Sources
DI 24510.065 Section III of SSA-4734-F4-SUP Functional Capacity Assessment
DI 24515.002 Evaluating Opinion Evidence – Basic Policy
DI 24515.003 Weighing Medical Opinions from Treating Sources and Other Medical Sources
DI 24515.004 Giving Controlling Weight to Treating Source Medical Opinions (SSR 96-2p)
DI 24515.005 Evaluating Noncontrolling Treating Source Medical Opinions
DI 24515.006 Evaluating Nontreating Source Medical Opinions
DI 24515.008 Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not "Acceptable Medical Sources" in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies (SSR 06-03p)
DI 26530.015 Personalized Disability Explanation in Initial Closed Period, Unfavorable Onset Date, and DWB Allowances Where the Month Of Entitlement is Restricted to January 1991 Under P.L. 101-508
DI 26530.020 Personalized Disability Explanation in Initial Denials
DI 33015.020 Writing the Disability Hearing Officer's (DHO's) Decision
HALLEX 1-2-5-1 Evidence – General
HALLEX 1-2-5-14 Obtaining Medical Evidence from a Treating Source or Other Medical Source
Acta Psychiatr Scand. *2007 Apr; 115(4):326-30*. Are GAF scores reliable in routine clinical use? Vatnaland T, Vatnaland J, Friis S, Opjordsmoen S.
Psychiatr Serv. 2002 Jun 53(6) 730-7. Global Assessment of Functioning Ratings and the Allocation and Outcomes of Mental Health Services. Moos RH, Nichol AC, Moos BS.
Journal of Evaluation in Clinical Practice Volume 18, Issue 2, *pages 502–507, April 2012* Reliability and validity of the Global Assessment of Functioning Scale in clinical outpatients with depressive disorders, Esther M. V. Grootenboer MD, Erik J. Giltay MD

PhD, Rosalind van der Lem MD, Tineke van Veen MD PhD, Nic J. A. van der Wee MD PhD, Frans G. Zitman MD PhD.
Ann Gen Psychiatry. 2010 May 7;9:20. doi: 10.1186/1744-859X-9-20. Global Assessment of Functioning (GAF): properties and frontier of current knowledge. Aas IH.
Journal of Mental Health Counseling, Jul 1, 2002. Does the Global Assessment of Functioning assess functioning? (Research), Plake, Edmund V.
The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR), American Psychiatric Association (2000).

Adaptive Skills Questionnaire

Adaptive Skills Questionnaire

This form is designed to gather information about how this client typically functions in their everyday life compared to non-disabled individuals who are the same age.

Name of Client/Patient: _____ Client/Patient Age: _____

Name of Person Completing Form: _____

Background on Person Completing Form

1. Your Relationship to Client/Patient: _____

2. How long have you known them? _____

3. In what all contexts/areas have you observed this person's behavior? (Please check all that apply)

__ Classroom __ Professional Office __ Interacting peers their age

__ In the home ___ In the workplace ___ Other: (describe)_____

4. Are you familiar with what types of things non-disabled individuals (the same age as this client/patient) usually can and cannot do? _____ Yes _____ No

5. If yes, how do you know what types of things non-disabled individuals the same age as this client/patient usually can and can't do? (Please describe)

_____

_____

6. If you are a service provider, do you (or have you) work(ed) with clients the same as this client who are non-disabled? ___ Yes __No

If you answered YES to Question #4, please answer the following questions. If you answered NO to Question #4, please skip to Question #19 now.

7. Compared to non-disabled individuals of the same age, how would you rate this client's academic skills (e.g., reading level, understanding what they are reading, vocabulary level, writing skills, math skills)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

8. Compared to non-disabled individuals of the same age, how would you rate this client's academic achievement (e.g., class grades, yearly progression)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

9. Compared to non-disabled individuals of the same age, how would rate this client's social skills?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

10. Compared to non-disabled individuals of the same age, how would you rate this client's communication skills (e.g., ability to clearly express themselves, to follow conversations and understand them, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

11. Compared to non-disabled individuals of the same age, how would you rate this client's personal hygiene skills (e.g., maintaining a neat/clean appearance, bathing, toileting, dental care, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

12. Compared to non-disabled individuals of the same age, how would you rate this client's ability to get along with other people (e.g., classmates, coworkers, other customers in a store, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

13. Compared to non-disabled individuals of the same age, how would you rate this client's ability to cope with stress/frustration/disappointment?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

14. Compared to non-disabled individuals of the same age, how would you rate this client's ability to solve his/her own problems?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

15. Compared to non-disabled individuals of the same age, how would you rate this client's ability to use appropriate nonverbal communication to interact with other people (e.g., knowing not to laugh when someone is crying or seriously injured, able to use pointing or gestures to express themselves)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

16. Compared to non-disabled individuals of the same age, how would you rate this client's ability to recognize safety concerns and to respond appropriately (e.g.,

noticing that there is smoke in the room and knowing what to do, knowing to look both ways before crossing the street and actually doing it before crossing, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____
_____

17. Compared to non-disabled individuals of the same age, how would you rate this client's ability to understand, remember, and follow a schedule or routine independently?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

18. Compared to non-disabled individuals of the same age, how would you rate this client's ability to recognize medical issues and take appropriate action (e.g., applying basic first aid to a cut, knowing when to call 911, knowing when to call the doctor versus going to the hospital, etc.)?

__ Better/Higher __ Same __ Worse/Lower ___ Don't Know

Please describe your reason(s) for the answer you gave, including any specific examples of problems you have observed in this area:

_____
_____

Please answer the following questions based on your knowledge of and/or observation of the client.

19. Does the client typically start a task or project independently and follow it through to completion without outside assistance/supervision (e.g., reminders, prompts)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____
_____

20. Does the client typically listen to, remember, and follow directions given to them without outside assistance or supervision (e.g., reminders, prompts)?

____ Yes ___ No ___Don't Know

If NO, please describe:
_____
_____

21. Is the client typically able to break larger tasks or goals into smaller more manageable steps without outside assistance/supervision?

____ Yes ___ No ___Don't Know

If NO, please describe:
_____
_____

22. Is the client typically able to sort through information, identify what is important and prioritize it (e.g., if they have 20 things to get done, are they typically able to determine what really needs to be done now and what can wait until a later time)?

____ Yes ___ No ___Don't Know

If NO, please describe:
_____
_____

23. Did the client have special education services in high school?

____ Yes ___ No ___Don't Know

23a. If yes:
Did they have their own aide?

____ Yes ___ No ___Don't Know

Did they have speech/language therapy?

____ Yes ___ No ___Don't Know

24. Does the client know all of the steps to do their own laundry (without outside assistance or supervision)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

25. Does the client know how to cook meals for themselves?

____ Yes ___ No ___Don't Know

25a. If yes:

Have they ever caught food (or the kitchen on fire)?

____ Yes ___ No ___Don't Know

Have they ever forgotten that they had food on the stove or in the oven?

____ Yes ___ No ___Don't Know

25b. If NO to Question #25, please describe:

_____

_____

26. Does the client know if they have enough money to make purchases at a store (e.g., Can they estimate what their purchases cost before they are given the total by the cashier?)?

____ Yes ___ No ___Don't Know

27. Have they ever had to put items back in the store because they did not have enough money to pay for what they brought to the checkout?

____ Yes ___ No ___Don't Know

28. Are they able to calculate change on purchases (e.g., Do they know if they are getting the right amount of money back)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____

_____

29. Do they understand the value of money (e.g., that $100 is more valuable than $5)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____
_____

30. In an unfamiliar store/location, do they know how to get assistance in finding an item that they are looking for (e.g., a restroom, a certain item to purchase, etc.)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____
_____

31. Is the client aware of safety issues in crowded public locations (e.g., the possibility of theft, knowing to stay alert)?

____ Yes ___ No ___Don't Know

If NO, please describe:

_____
_____

32. Is the client easily manipulated or taken advantage of?

____ Yes ___ No ___Don't Know

If yes, please describe:

_____
_____
_____

33. Are there any other ways in which you think the client may lack the mental, academic, social, personal, conceptual, or practical skills that non-disabled individuals of the same age have? If so, please describe:

_____
_____
_____
_____
_____
_____
_____
_____

Mental RFC Assessment

MENTAL IMPAIRMENT QUESTIONNAIRE

NAME: _____ SSN: _____

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes and test results* as appropriate.

1. Frequency and length of contact: _____

_____

2. DSM-IV Multiaxial Evaluation:

Axis I: _____ Axis IV: _____

Axis II: _____ Axis V: Current GAF: _____

Axis III: _____ Highest GAF Past year: _____

3. Treatment:

_____

_____

4. Medications with notation of any side effects:

_____

_____

5. Prognosis:

_____

6. Findings on mental status examination:

_____

_____

7. Signs and Symptoms

_____

_____

8. Does this individual have a medically/psychologically determinable impairment that produces symptoms that he/she describes to you?

YES ☐ NO ☐

9. The above-described conditions have existed to this degree of severity since at least

_____

10. Can the individual manage benefits in his or her own best interest?

YES ☐ NO ☐

11. Degree to which mental conditions affect patient's ability to do work-related activities on a day-to-day basis in a competitive (8 hours per day – 5 days per week) work setting:

NONE/SLIGHT: not significantly impaired
MODERATE: able to perform at 80-85% of normal expected productivity
MODERATELY SEVERE: able to perform at 60-80% of normal expected productivity
SEVERE: totally precluded

	Mental Abilities	None/Slight	Moderate	Moderately Severe	Severe
A	remember locations and work like procedures				
B	understand, remember or carry out one-step instructions				
C	make simple work-related decisions				
D	ask simple questions or request assistance				
E	understand, remember, or carry out multi-step instructions				
F	maintain concentration and attention for extended periods.				
G	perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances				
H	sustain an ordinary routine without special supervision				
I	take public transportation				
J	work in coordination with or proximity to others without being unduly distracted by them				
K	complete a normal workday/week without interruptions from psychologically based symptoms				
L	perform at a consistent pace				
M	be aware of normal hazards and take appropriate precautions				
N	accept instructions and respond appropriately to criticism from supervisors				
O	get along with coworkers or peers without unduly distracting them or exhibiting behavioral extremes				
P	maintain socially appropriate behavior				
Q	meet basic standards of neatness and cleanliness				
R	respond appropriately to changes in a routine work setting				

12. Is this individual currently using drugs and/or alcohol?
YES ☐ NO ☐

13. Would the restrictions persist if the individual stopped using?
YES ☐ NO ☐
If yes, please explain:

_____

_____

14. Does your patient have a low IQ or reduced intellectual functioning?
YES ☐ NO ☐

*Please explain (with reference to specific test results):

_____

_____

15. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom?
YES ☐ NO ☐

*If yes, please explain: _____

_____

16. Do your patient's mental impairments ever cause intermittent symptoms or exacerbations severe enough that they would cause him/her to need to take unscheduled work breaks during a shift if he/she was at a full-time job?
YES ☐ NO ☐

*If yes, please explain: _____

_____

17. Do your patient's mental impairments ever cause intermittent symptoms or exacerbations severe enough that would cause him/her to take unscheduled days off work if they were at a full time job?
YES ☐ NO ☐

If yes, then how many days per month would the patient be absent from work on average?
____ 1 day ____2 days ____ 3 days ____ More than 3 days

_____ _____
Date Signature Title

_____
Printed/Typed Name

_____
M.D. Signature

_____
Printed/Typed Name

Mental RFC WAIS Subtests Grid

Reprinted with permission from Ron Houston, PhD.

MENTAL RFC

WAIS Subtests	Remember locations work like procedures	Understand remember very short and simple instructions	Understand remember detailed instructions
Arithmetic	**X**	**X**	**X**
Letter/Num Sequencing	**X**	**X**	**X**
Coding	**X**	**X**	

Understanding and Memory

Sustained Concentration and Persistence

WAIS Subtests	**Carry out very short and simple instructions**	**Carry out detailed instructions**	**Maintain attention & concentration for extended periods**	**make simple work-related decisions**
Digits Span Forward Backward	 X X		X	
Letter/Numb Sequencing	X	X	X	
Coding	X		X	
Symbol Search	X		X	
Arithmetic	X	X	X	
Object Assembly	X	X	X	
Block Design	X	X	X	
P. Arrange.	X	X	X	X
Matrix Reason			X	X
Visual Puzzles			X	X
Figure Weight			X	X
Similarities				X
Comprehension				X

Developed by Ronald Houston, Ph.D, Houston, Texas, and reprinted with his permission.

Biographies

Catherine M. (Kate) Callery is the Disability Advocacy Project (DAP) Coordinator at the Empire Justice Center in Rochester, New York, focusing on Social Security and Supplemental Security Income disability issues. She is a graduate of Smith College and the University of Connecticut Law School. She is admitted to practice in Connecticut (1979) and New York (1983). Kate serves as coordinator of the Western New York DAP Task Force and has presented trainings for the National Organization of Social Security Claimants' Representatives (NOSSCR), the New York State Bar Association, the Monroe County Bar Association and various DAP conferences. She has represented numerous clients before the Social Security Administration and in federal court.

Katrina H. Colistra earned her Master's Degree in criminal justice in from Northeastern University in 2000. She went on to earn her doctorate in clinical psychology from The Massachusetts School of Professional Psychology in 2007. While in graduate school she specialized in Forensic Psychology and trained in various forensic settings including the Federal Medical Center in Devens, MA; The Massachusetts Treatment Center for Sexually Dangerous Persons in Bridgewater, MA; The Division of Youth Services in Boston, MA; and Bedford Policy Institute in Braintree, MA. In these settings she began her work with people who committed sexual offenses, which led to her interest and completion of her doctoral project entitled, An Investigation of Common Factors in Those Who Dropout or Do Not Complete Sex Offender Specific Treatment. She then completed her pre-doctoral training as an intern at The Federal Correctional Complex in Butner, NC, where her rotations included the residential sex offender treatment program, as well as forensic and general population rotations.

Following her graduation she was employed with the New York State Office of Mental Health in the Bureau of Sex Offender Evaluation Assessment and Treatment, where she worked as a Psychiatric Examiner following her licensure. The duties of this position included evaluating detained sex offenders in New York State for the presence of a Mental Abnormality and Dangerousness. She routinely testified to her findings in Supreme Courts across the state. In her position she educated the courts on sex offender related issues and collaborated with various stakeholder agencies on a routine basis.

After five years with New York State Office of Mental Health, she formed a private forensic practice with a colleague which specializes in forensic evaluations for the court and provides treatment to a variety of special populations. On a daily basis she manages a variety of duties that include providing treatment to groups and individuals, conducting a variety of forensic evaluations, teaching undergraduate courses at local colleges, as well as general business duties.