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STATEMENT OF

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NATIONAL SECURITY AND INTERNATIONAL AFFAIRS DIVISION

BEFORE THE

SUBCOMMITTEE ON DEFENSE

HOUSE COMMITTEE ON APPROPRIATIONS

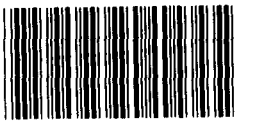
ON

FULL-TIME SUPPORT PERSONNEL PROGRAMS IN THE ARMY

AND AIR FORCE RESERVE COMPONENTS

Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to appear before you today to present our views on two issues of concern related to full-time support personnel in the Army and Air Force National Guard and Reserve. These two issues are (1) whether the planned growth in the full-time support programs in the Army and Air Force National Guard and Reserve is justified, and (2) whether proposed conversions of civilian technician positions in the Army Reserve to full-time, active duty positions would be cost-effective.



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FULL-TIME MANNING

We share your concern [as stated in your Report on the Department of Defense's (DOD) Fiscal Year 1983 Appropriations Act] that "growth in the full-time support personnel required by National Guard and Reserve units is to be provided by the least costly form of manpower, consistent with readiness requirements," and this concern has been the focus of recent GAO work.

As you know, the Army's Full-Time Manning (FTM) program, started in 1980, assigns additional full-time, active duty military personnel to selected units in the Army Guard and Reserve to improve their readiness. These personnel generally work in one of five functional areas: individual and unit training, administration and personnel, maintenance, supervision, and supply. During the 5 years from Fiscal Year 1984 through Fiscal Year 1988, the Army plans to substantially expand its program. The Fiscal Year 1984 request is $295 million--almost $127 million more than the funds authorized in Fiscal Year 1983. By Fiscal Year 1988, programmed costs will reach $557 million annually.

The Army initially allocated Full-Time Manning spaces to early deploying Army Guard and Reserve units. As more spaces are authorized, the Army will provide Full-Time Manning personnel to later deploying units, as well as to earlier

deploying units which already have some, but not all, of the Full-Time Manning personnel they desire. However, in the Army National Guard, every combat, combat support, and combat service support company-sized unit, regardless of unit priority, will have at least one FTM person authorized by the end of Fiscal Year 1983.

At the direction of the Army Vice Chief of Staff, from January 1981 through April 1983, the Army evaluated the program. The evaluation's purpose was to determine the program's effect on readiness. In 1982, the Army National Guard began a separate evaluation of the program because of concern that the Army's primary evaluation was not objectively measuring program effectiveness. This National Guard study will not be completed until early in fiscal year 1984.

Because of the concern of this Committee and others in Congress that planned increases in program expenditures should be justified, we examined the methodologies the Army used in both these evaluations to determine whether their designs would produce valid and reliable data. We concluded that methodological weaknesses in both the Army's primary evaluation and the separate Army National Guard evaluation were serious enough to limit the usefulness of the information developed about the program's effectiveness.

In our view, the Army's efforts to evaluate the impact of assigning Full-Time Manning personnel was biased because most of the personnel studied were assigned to earlier deploying units of the Army Guard and Reserve. These units, unlike the majority of Guard and Reserve units, generally are assigned most, if not all, of their required personnel and equipment. Further, because of their priority status, most of the units that participated in the Full-Time Manning program also receive other special resources, such as selective enlistment and reenlistment bonuses. As a result, in our view, any measured differences in readiness between units with and without Full-Time Manning personnel can be due to any of the several factors that differentiate them.

In addition to the methodological weaknesses in the Army's evaluations, we found that their evaluation results concerning program effectiveness were not consistently supported by other Army measures. Their conclusions were based on the subjective opinions of persons directly involved in the program and persons selected by the Army to monitor it, and they showed readiness improvements in every functional area evaluated. At the same time, however, quantitative data from two different Army reporting systems showed no consistent trend between 1979 and 1982 in the differences between units with and without Full-Time

Manning personnel, in 11 categories evaluated. While data for Army Reserve units reflect a positive trend, data for the Army National Guard are less conclusive.

We believe it is still feasible for the Army to conduct an evaluation with an experimental design whose results would enable the Congress to better judge the merits of the Army's future budget requests for the Full-Time Manning program. We have already suggested to Army officials an evaluation methodology they could use that would provide valid and reliable data on the program's effectiveness. The Army could begin collecting evaluation baseline data within the next few months before assigning Full-Time Manning personnel in Fiscal Year 1984 to units to be evaluated. In our view, final evaluation data collection should occur about 9 to 12 months after the Full-Time Manning personnel are assigned, that is, about August or September 1984. Consequently, the Army's preliminary evaluation results could be available to the Congress by the end of Fiscal Year 1984, if the Army quickly and successfully implements the proposed evaluation methodology.

The largest programmed increases in Full-Time Manning personnel are planned for Fiscal Years 1984 and 1985. Accordingly, we believe that the Army should limit the size of these substantial increases until it determines, on the basis of a better evaluation, whether the program is effective.

The Air Guard and Reserve also plan increases in full-time support personnel in Fiscal Year 1984. We believe that the Air

Force should also limit the size of these planned increases until either (1) the Army obtains valid and reliable data on the effectiveness of its Full-Time Manning program, or (2) the Air Force provides the Congress with definitive evidence on the cost-effectiveness of its programs.

MILITARY TECHNICIAN CONVERSIONS

Military technicians also are full-time support personnel. These men and women are Federal Government civilian employees assigned to provide support to Army and Air Force Guard and Reserve units. They are concurrently required, as a condition of employment, to be members of the Reserve component in which they work. Controversy concerning this type of full-time support has focused on the conversions of military technician positions to full-time, active duty Guard and Reserve positions. The primary areas of controversy are whether such conversions cost less and improve readiness.

The Air Force Guard and Reserve have no long-range plans for any conversions. In contrast, however, the Army Reserve has long-range plans to convert about 3,000 military technician positions at the unit level to full-time, active duty positions. These plans include 1,000 conversions in fiscal year 1984, if given Congressional authorization. Whereas the Army National Guard, according to information it provided to your Committee in April 1983, believes that such conversions are in

the best interest of Army readiness and implied that such actions would be taken shortly, the Guard has more recently decided that no actions would be taken.

In January of this year we analyzed an October 1982 report by a DOD contractor on the projected costs of technician conversions. This cost study was used by the Army Guard and Reserve and the Air Guard in developing the cost-benefit analyses submitted to your committee in April 1983, justifying the proposed mix of military technicians and active duty Guard and Reserve personnel. Overall, we concluded that the DOD contractor study appeared to be a generally reasonable guide for determining conversion costs, once the precise military grades of the active duty positions are established. However, if three technical weaknesses found in the contractor study are corrected, the guidelines would be of greater value.

First, they need to include the cost to the Government of the loss of tax revenue which occurs because the allowances of active duty Guard and Reserve personnel are not taxed. We believe the study should have included at least an estimate of costs to the Government of funding the tax advantage of these military personnel.

Second, they need to compute a more accurate estimate of military retired pay by using separate cost percentages for officers and enlisted personnel, instead of the same percentage

for both officers and enlisted. These estimates are readily available from DOD's Actuary Office.

Finally, they need to include, as an additional indirect cost of active duty Guard and Reserve personnel, an estimate of the costs of those personnel not assigned to units at any specified time. Such personnel include persons moving, attending school, being placed in a hospital or prison, or separating from the military.

Ultimately, however, whether additional costs or savings will result from technician conversions will depend on the specific grade structure of the respective changes. Under the Army Reserve's current plans, military technician positions would not be converted unless they become vacant through attrition or voluntary conversion. Therefore, the Army Reserve has no way of knowing the exact number of technician positions which would be converted at each GS grade level during Fiscal Year 1984 and later years. The Army Reserve has projected the number of technician positions which it believes will become vacant in Fiscal Year 1984, based primarily on past attrition experience. While useful in predicting broad expectations, we question the validity of using this information to predict specific additional costs or cost savings because the conclusions on costs are not based on specific positions identified for conversion. While such information cannot reasonably be developed for an

extended period, we believe that historical attrition data can be supplemented with data on specific upcoming losses and that this combination would provide a more defensible basis for projecting cost impact than historical attrition data alone.

Another important consideration in determining the validity of conversion cost comparisons will be the military grades of the active duty Guard and Reserve positions to which the technician positions will be converted. Costs of these full-time military positions can be calculated only after the services determine the precise military grades to be established for each technician position.

According to the Army Reserve's cost-benefit analysis submitted to your Committee, the Reserve proposes to squeeze technician positions in five GS grades (GS-5, 6, 7, 8, and 9) into only two full-time military grades (E-5 and E-6) after conversion. That is, the Army Reserve plans that the military grade for 1,000 technician positions to be converted will be a mix of 50 percent E-5's and 50 percent E-6's. However, 125 of the 1,000 technician positions projected to become vacant would have civilian grades of GS-8 or GS-9. According to the DOD contractor study's grade conversion equivalencies, GS-8 and GS-9 positions equate to military grades of E-8 and E-9, not E-5 and E-6. Obviously, if some of the conversions are to these higher military ranks, additional costs will be incurred.

The Reserve's planned conversion of technician positions in five GS grades to only two military grades also appears to be arbitrary. Under Civil Service rules, the distinctions between each of the five civilian grades are based on different job standards and the roles and responsibilities required for each position. Likewise, the specific military grades to which technician positions are converted also should be determined on the basis of manpower requirements analysis. Without this analysis, then, a projected mix of 50 percent E-5 and 50 percent E-6 cannot be supported. On a random sample basis, however, full-time military grade equivalents required for technician positions to be converted could be determined. Consequently, until such an analysis has been undertaken, it will not be possible to determine the relative costs of conversions.

Although Army National Guard officials have informed us that they have decided not to convert any technician positions in the immediate future, we nevertheless have comments on the cost-benefit analysis they submitted to your Committee in April.

The same criticisms we identified in the Army Reserve's cost-benefit analysis also apply to the Guard's analysis. This analysis states that future conversions, if approved, would result in cost savings and would generally be targeted at the GS-5 and GS-7 technician level. The Guard pointed out in its analysis that converting a GS-7 position (with a drilling Guard

grade of E-7) to a full-time military position of E-6 would save about $220 per position, but no explanation was provided as to how the Guard determined this military grade equivalent for a GS-7. If the GS-7 position were converted to a full-time military position of E-7 instead of E-6, there would be an additional cost of $5,140 (calculated on the basis of the DOD contractor study's cost tables). The Guard's cost-benefit analysis also failed to point out that converting a GS-5 military technician (who has a drilling Guard grade of E-5) to a full-time military grade of E-5 would result in an additional cost of $2,685 per position. In the final analysis, however, we cannot tell whether conversions in the Army National Guard would cost more or less than technician positions until specific information is provided on the number and required mix of civilian and military grades involved in the conversions.

Although the Air Guard and Reserve plan no conversions, they provided information to your Committee on their proposed growth in both technicians and full-time military personnel. However, neither the Air Guard nor Reserve addresses the comparative readiness benefits of technicians versus active duty Guard and Reserve personnel. Instead, each component merely states that its planned mix is necessary to maintain a high level of combat readiness. Interestingly, the Air Guard's planned mix emphasizes growth in active duty military personnel,

whereas the Air Reserve's growth is in military technician positions. Another weakness we identified in the Air Force Reserve's cost-benefit analysis is that it did not address the relative costs of technicians versus full-time, active duty Reservists.

Because differences in the cost and readiness benefits of technicians versus active duty Guard and Reserve personnel are not readily apparent in the Air Guard and Reserve, we believe that these two components should be required to further justify their proposed mix, specifically addressing the relative cost and readiness benefits of technicians and active duty Guard and Reserve personnel.

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Mr. Chairman, this concludes my prepared statement. I will be pleased to answer any questions you may have.

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UNITED STATES GENERAL ACCOUNTING OFFICE
Washington, D.C.

FOR EXPECTED RELEASE
Expected at 9:15 a.m. EST
Friday, May 20, 1983
Cultural Center
Charleston, West Virginia

STATEMENT OF

PETER J. MCGOUGH, ASSOCIATE DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SELECT COMMITTEE ON AGING

UNITED STATES HOUSE OF REPRESENTATIVES

ON

SOCIAL SECURITY ADMINISTRATION'S PROGRAM

FOR REVIEWING THE DISABILITY OF PERSONS

WITH MENTAL IMPAIRMENTS

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Mr. Chairman and members of the Committee, we are pleased to be here today to discuss the Social Security Administration's (SSA's) current process for determining whether persons with mental impairments qualify for disability under SSA's two disability programs.[1] The actual adjudicative process is carried out by the various State Disability Determination Services (DDSs) following SSA guidelines and instructions.

As you know, on April 7, 1983, I testified on this subject before the Senate Special Committee on Aging. Our testimony then and today is based on work we began in September 1982 and which included thoroughly reviewing the Social Security Act, the corresponding regulations, and the decision-making process and criteria used by SSA to adjudicate mental disability claims.

We conducted our work at five DDSs in Illinois, Indiana, Ohio, and Pennsylvania; at SSA headquarters in Baltimore; and at a regional office in Chicago. We visited Pennsylvania because the Chairman's staff expressed interest in activities in that State. The other States were selected because of their proximity to our Cincinnati Regional Office, where we have staff experienced in auditing disability matters.

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[1]SSA administers two disability programs--the Social Security Disability Insurance program and the Supplemental Security Income program.

At each DDS we met with the Director, the Chief Medical Consultant, and the Medical Administrator. Overall, at the five DDSs, we interviewed 38 claims examiners individually, and more than 200 examiners in group discussions, 18 supervisors, 8 quality assurance chiefs, and 7 medical coordinators.

Our work at SSA included reviewing disability cases previously selected for review by SSA's quality assurance staffs. We also discussed adjudicative policies and procedures with disability program officials and several SSA physicians, including the Chief Medical Officer and the Chief Consultant for Psychiatry and Neurology.

In addition, we reviewed a total of 159 mental disability cases that had been recently adjudicated by SSA--130 of the cases were denials and terminations and 29 were allowances and continuances of benefits. We selected the cases from those available during our visits to the various locations and, as such, the results of our case reviews are not statistically representative of all cases adjudicated at the locations and are not projectable to the universe of SSA mental disability decisions. Of the cases selected, 40 denials or terminations were examined in detail by GAO's full-time clinical psychologist and mental health advisor.

Although our detailed case review is not projectable to the universe of all mental disability cases adjudicated, our findings have national implications. Our additional work and evi-

dence gathered at SSA headquarters strongly indicate that what we found is happening across the nation.

To provide a proper context for discussing the results of our review, I would like to explain briefly the evolution of events that preceded our review.

BACKGROUND--EVOLUTION OF EVENTS

In March 1981,[2] GAO reported to the Congress that SSA had not adequately followed up to verify that disability insurance beneficiaries remained disabled. The report said that, based on a nationwide sample case review conducted in 1979 by SSA, as many as 20 percent of the persons on the disability rolls were not disabled. SSA conducted a follow-up study in 1980 and 1981 and found that 26 percent of the beneficiaries on the rolls during July/September 1980 were not disabled.

Although we did not attempt to independently validate SSA's disability decisions in its initial study, our own study results showed that because of inadequate investigations and lack of follow-up on persons who were expected to medically improve, SSA had allowed many non-disabled persons to remain on the disability rolls. SSA's initial study, performed by experienced examiners and physicians, provided the only available estimate of the problem's magnitude.

Congressional concern over SSA's medical reexaminations and other inadequate review procedures led to the enactment of

[2]"More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries," HRD-81-48, March 3, 1981.

Section 311 of Public Law 96-265, known as the Social Security Disability Amendments of 1980. This section required that beginning January 1, 1982, SSA review, at least once every 3 years, the status of disabled beneficiaries whose disabilities have not been determined to be permanent. SSA began the reviews in April 1981. We said in our March 1981 report that resources were currently being used to review the continuing eligibility of Supplemental Security Income (SSI) recipients, and suggested they be shifted to reviewing the Disability Insurance (DI) rolls because of the higher benefit levels.

In previous testimonies regarding SSA's disability reexamination efforts,[3] we discussed the high termination rate, which was in excess of 40 percent through 1981 and 1982 (currently the termination rate is about 44 percent). Part of this high termination rate included people who had recovered and others who perhaps should never have received disability benefits. We pointed out, however, that many individuals losing their benefits had been on the rolls several years, still had severe impairments, and had experienced little or no medical improvement. We concluded that many of the terminations were caused because of a changed adjudicative process and climate, and poor State agency medical development practices.

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[3]We provided testimony on May 25, 1982, to the Subcommittee on Oversight of Government Management, Senate Committee on Governmental Affairs. We also testified on August 18, 1982, before the Senate Finance Committee.

CURRENT CONDITIONS

Data from SSA's files[4] indicate that, as of August 1982, SSA had reexamined in its periodic review process about 305,400 individuals and terminated benefits in about 134,500 (or 44 percent) of the cases. About 74,800 cases reviewed involved persons with mental impairments and 31,700 (or 42 percent) of them were terminated. Of the 31,700 terminations, about 13,400 (or 42 percent) requested a reconsideration. At the reconsideration level the DDSs sustained the termination decision in 76 percent of the cases.

Our review revealed many of the same conditions we reported earlier. Although the scope of our review was limited, we found many individuals who had their benefits terminated despite having severe impairments, and in our opinion, having little or no capability to function in a competitive work environment. We had 40 of the denial and termination cases reviewed by our clinical psychologist and she concluded that in 27 of the cases the individuals could not function in their daily living without support and could not work in a competitive or stressful environment. In an additional 13 cases she concluded that more medical or psychosocial information or trial

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[4]In December 1982 we obtained SSA's computer file (based on completed SSA Form 833's--"Cessation or Continuance of Disability or Blindness Determination and Transmittal") of CDI actions for Disability Insurance recipients. The most recent data in the file were through August 1982.

work experiences were needed to make an informed decision. Several cases illustrating the reasons for our concerns about the appropriateness of the decisions to terminate benefits are summarized in an attachment to this testimony.

Our review revealed several weaknesses in SSA's and the DDSs' adjudicative policies and practices. Specific weaknesses we identified were:

(1) an overly restrictive interpretation of the criteria to meet SSA's medical listings, resulting principally from narrow assessments of individuals' daily activities;

(2) inadequate development and consideration of a person's residual functional capacity and vocational characteristics;

(3) inadequate development and use of existing medical evidence, resulting in an over-reliance and misuse of consultative examinations; and

(4) insufficient psychiatric resources in most State DDSs.

These problems are discussed in more detail below.

OVERLY RESTRICTIVE INTERPRETATION OF SSA'S MEDICAL CRITERIA

SSA's regulations contain a set of medical evaluation criteria--referred to as the medical listings--describing impairments that are presumed to be severe enough to prevent an individual from working. If a person meets the criteria, he or she is awarded disability.

Mental impairments in the listings are categorized as: (1) chronic brain syndromes, (2) functional psychotic disorders,

(3) functional nonpsychotic disorders, and (4) mental retardation. With the exception of mental retardation, the listings for mental impairments include an "A" part and a "B" part. For example, the listings for a schizophrenic (functional psychotic) disorder include part A--"manifested persistence of one or more of the following clinical signs: depression (or elation), agitation, psychomotor disturbances, hallucinations, or delusions...", and part B--"resulting persistence of marked restriction of daily activities and constriction of interest and seriously impaired ability to relate to other people". To be eligible for disability benefits, both part "A" and all of part "B" must be met.

Although the criteria for meeting the medical listings for mental impairments have not changed substantially since 1968,[5] it has become increasingly difficult for mentally-impaired individuals to meet the medical listings. As a result of our case reviews and discussions with examiners in 5 DDSs, the problem focuses principally on part B of the listings. Examiners were concluding that individuals did not meet part B based on very brief descriptions of the individuals' performing only rudimentary daily activities--such as watching television, visiting relatives, fixing basic meals, and doing basic shopping activities. Often little else positive was contained in the medical evidence.

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[5]The I.Q. levels for mental retardation were changed in 1979 to "59 or less," instead of "49 or less".

Hard Line Taken by SSA

We asked examiners why they were accepting a few positive signs as support that the individuals did not have a "marked restriction of daily activities and constriction of interests and seriously impaired ability to relate to other people" (as part B requires).

The examiners we interviewed told us it is difficult for them to determine when restriction of daily activities, constriction of interests, and inability to relate to other people are severe enough to meet the listings. The examiners also said SSA is taking a hard line in interpreting the criteria.

How the criteria are applied by SSA is of fundamental importance because cases are evaluated by SSA's quality assurance system, and State agencies look to case returns from SSA's Regional Office Disability Assessment Branches (DABs) as the clearest indicator of SSA's intent. State officials and examiners we spoke with unanimously perceive DAB returns over the past several years as intending to make it extremely difficult to meet the listings, and they have responded accordingly in their decisions. Several examiners told us that it only takes a few returns before you change the way you evaluate evidence.

We found that SSA's quality assurance case returns to the DDSs focused extensively on daily activities and current behavior. We reviewed some of these case returns where the DDS had determined the individuals were very severely mentally impaired

and were disabled, but the DAB returned the cases because the individuals had some daily activities, albeit extremely minimal ones. The following cases that we reviewed are illustrations of minimal activities which were judged as precluding the individuals from meeting the listings:

--A 34-year-old man was diagnosed as having mild mental retardation (I.Q. 61) - chronic brain syndrome associated with convulsive disorder, and slight speech impediment. He had a 6th grade education plus 2 years special education. The only work he had done was as a bathhouse attendant and lost the job because he could not handle it. He was allowed disability in 1969. In 1982 he was reexamined and the DDS decided on a continuance, apparently for meeting the listings.

SSA's quality assurance staff reversed the decision on November 8, 1982, as a termination, because he did not meet the listings. They said he has no significant restrictions in his interest or daily activities, although he showed overt signs of psychotic behavior. The CE report dated September 9, 1982, said he spent his day, "reading, watching television, and taking brisk walks. He does some housekeeping and cooking." The CE report also pointed out that personality tests substantiated organic brain syndrome characterized by perceptual-motor impairment and gaps in thinking. Bender [test] figures were disproportionate and poorly done. He was hysterical in his personality orientation and had poor socialization. He could not trust his own performance and was easily stressed. He could follow simple instructions if there was no stress involved. He lacked intellectual dependability and emotional stability for regular employment.

In our judgment, he met the listings.

--A 50-year-old woman was allowed disability in June 1975, with a diagnosis of depressive reaction. She was reexamined (medical diary) in early 1977 and benefits were terminated in April 1977. She reapplied for benefits and was allowed in September 1978 with a diagnosis of schizophrenic reaction-chronic-undifferentiated type. She was reexamined in December 1979 and the DDS continued benefits. SSA's quality assurance review returned the case as a termination in January 1980 on the basis of a CE report that she got along with family and had a few friends with whom she visited and drank coffee. SSA concluded that she did not meet or equal the listings and had the residual functional capacity to do unskilled work. The same CE report, however, said she had suicide attempts, inappropriate behavior, was withdrawn, was unable to relate to others, could not do simple repetitive tasks for competitive fees, could not understand written or oral instructions, could not socialize with supervisors or co-workers, and could not tolerate work pressures for unskilled work.

We concluded that the CE report supported a decision for meeting the listings based on her impairment and adverse daily activities.

The following comment in a December 1981 letter to SSA's Chicago Regional Office from the DDS Director in Wisconsin addresses the impact of the DAB reviews in setting the adjudicative climate:

"The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny. The rationales for these denials as promulgated by DAB reviewers, seems to be based on the most minimal possible understanding of mental impairments in terms of their effect on individuals, on the fluctuations involved in the behavior of those with such impairments, and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capability of going

> out in the competitive world and obtaining and holding a job with the normal stresses, under supervision and with the necessity to be able to perform consistently."

We spoke to SSA's chief psychiatrist and two other SSA psychiatrists about our findings and about the difficulties in making medical assessments of an individual's daily activities (part B). They said to make a severity determination of a person's daily activities it is necessary to evaluate comprehensively the quality of the activity, how often it is done, whether independently or under supervision, with what degree of comprehension, and how appropriate the activity is. Other considerations should include whether the claimant is living independently or in a supervised/structured environment; or is on medication and the effects of it; and whether the claimant is in remission and the time spans between relapses.

Concerns Raised That the Criteria to Meet the Listings Are Overly Restrictive

The American Psychiatric Association (APA), in a letter dated June 29, 1982, to the SSA Commissioner, recommended a change in parts A and B of the listings for all mental disorders other than mental retardation. They recommended a change to part A to eliminate the current requirements that the claimant must manifest active symptoms upon examinations, and require, instead, that examinations recognize and evaluate the nature and severity of the illness even if the signs are not continuously present. The APA also suggested that, where a person evidences one or more of the clinical signs ("A") and demonstrates any two

(for functional psychotic disorders) or three (for non-functional disorders) of the "B" criteria, that should be sufficient to establish disability. They also recommended that any evaluation of an individual's daily activities as stated in part B should consider such issues as ".... frequency, appropriateness, autonomy and comprehension."

In 1982, the Chicago Regional Medical Consultant for SSA wrote that it is:

> "practically impossible to meet the Listings ... for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization... In fact an individual may be commitable due to mental illness according to the State's Mental Health Codes and yet found capable of 'unskilled work' utilizing our disability standards..."

Virtually every examiner that we talked with echoed these observations. We were told that to meet the listings an individual had to be actively and continually manifesting clinical signs. Even claimants severely impaired, and currently or recently hospitalized, were found not disabled.

Our group discussions with examiners produced comments to the effect that unless a claimant was "flat on his back in an institution," "comatose," or "in a catatonic state," he or she would not meet the listings. While these statements may be exaggerated, they are indicative of the examiners' perceptions.

RESIDUAL FUNCTIONAL CAPACITY AND VOCATIONAL CHARACTERISTICS ARE NOT APPROPRIATELY CONSIDERED

When an individual fails to meet the listings but the impairment still limits his or her ability to perform basic work functions, SSA's process to determine disability requires that an assessment be made of the individual's residual functional capacity (RFC). In mental impairments an RFC should consider such factors as, "capacity to understand, to carry out and remember instructions, and to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting." If the RFC assessment finds the individual incapable of doing his or her previous work, an assessment must then be made of the individual's RFC and such vocational characteristics as age, education, and work skills to see if he or she can do other work in the national economy.

As difficult as it is to meet the criteria in the medical listings, the chances of a younger individual getting or sustaining benefits based on RFC and vocational factors is extremely slim. As we found in many of the cases we reviewed, when an individual does not meet the listings, SSA's guidance to the States resulted in a virtual presumption that he or she has the RFC to do basic work activities or unskilled work.

We traced the evolution of this policy guidance back to April 1979 with SSA's publication of Informational Digest 79-32. The digest stated in part that "the capacity for unskilled work... in and of itself represents substantial work

capability and would generally be sufficient to project a favorable vocational adjustment for claimants with solely mental impairments."

SSA's chief psychiatrist elaborated on this issue in a May 1980 memorandum to SSA's New York Regional Office, when he said that a psychiatric impairment rating below meeting the listings signifies the ability to engage in substantial gainful activity at a level of unskilled work or higher. He also said that making an RFC assessment would be "redundant."

This policy was reiterated by SSA's Chief Medical Officer in a November 1980 letter to the Chicago Regional Office by stating:

> "Where the overall psychiatric rating is less than meets or equals [the listings] the individual retains a mental RFC for at least some type of unskilled work activity."

This policy guidance was not confined to one or two regions but had national dissemination. At least six other SSA regional offices requested clarification of this policy. SSA's Associate Commissioner for Operational Policy and Procedures responded similarly to the other regions, as indicated in a December 1980 response to the Kansas City Regional Office by stating:

> "In reference to ... question concerning adjudication of psychiatric cases short of listing severity, with a finding that a mental impairment does not (or does no longer) meet or equal the Listing, it will generally follow that the individual has the capacity for at least unskilled work.

> "Accordingly, where it has been concluded that the listing is neither met nor equalled and the inability to perform unskilled work is found, a second look at the medical findings is warranted. If the reassessment of the medical does not support a finding of 'meets' (or 'equals') then the restrictions indicated by the functional assessment are overstated and a reassessment of the actual residual functional capacity would be in order".

On March 3, 1981, the Regional Commissioner, Kansas City, wrote to SSA: "Following the logic described in ... your memorandum, the likelihood of a vocational allowance for a mental impairment would appear to be extremely remote."

We discussed with SSA's Chief Medical Officer, the chief psychiatrist, and two other SSA psychiatrists their rationale for saying that an individual with a severe impairment, who does not meet the listings, still maintains the mental RFC for unskilled work. First, they defined unskilled work (they refer to it now as basic work activity) as work that is tantamount to doing competitive work. They said that a person who does not meet the listings has the cognitive power to do "bottom of the barrel," simple, or unskilled type jobs. If an individual could not perform even unskilled work, he or she should be rated a "5" (meets the listings) on a psychiatric review form and presumed disabled. Less than a "5" means the ability to do simple work. They emphasized that they are not saying the person can, in fact, work. The physician's job, they pointed out, is to make the medical assessment. They told us that the decision to de-

termine a person disabled or not is a vocational decision made by the examiners.

We asked the psychiatrists: "if the examiners are told a person had the mental ability to understand and do unskilled work, could not one logically conclude that a person can, in fact, work, if an unskilled job were available in the national economy?" One of SSA's psychiatrists told us that he can understand how the examiners would reach such a conclusion and that is probably the message that is being sent out to them through SSA's DAB case reviews. He said that he sees cases where individuals get a "3" or "4" rating (severe, but not severe enough to meet the listings) and are determined not disabled, when he knows the individuals are precluded from competitive work. For example, he said that he was currently reviewing a case involving a mentally retarded woman with an I.Q. in the low 60s. He assigned, according to present procedures, a "4" rating. He said the decision will result in a denial even though he knows that there is no way the individual could possibly work competitively.

Several examiners told us that DAB and other quality assurance returns have given them a clear message to terminate benefits for younger workers who do not meet the medical listings.

Minnesota class action suit

In May 1982 the Mental Health Association of Minnesota filed a class action suit against SSA's policies regarding

mental impairments in the Fourth Division Minnesota District Court. The court concluded that,

> "...A new policy was developed by SSA beginning in early 1980 concerning eligibility for mentally impaired claimants. In accordance with that policy, SSA determined that persons whose mental impairment does not meet or equal the Listing of Impairments retain sufficient residual functional capacity to do at least unskilled work."

The court ruled in favor of the Association and said, in part, of SSA's policy that:

> "The policy ... is arbitrary, capricious, irrational, and an abuse of discretion.
>
> "By use of this policy, the defendant has terminated the benefits of and denied new benefits to class members without proper assessment of the individuals' capacity to engage in substantial gainful activity."

As required by the court, the Commissioner, SSA, sent a memorandum to all Regional Commissioners on January 3, 1983, stating in effect that to presume a person who does not meet or equal the listings maintains the RFC to perform unskilled work is contrary to federal regulations. The memorandum reiterated SSA's policy that "... the sequential evaluation process must continue in the claim with consideration of vocational factors in light of the claimants' residual functional capacity (RFC)."

In addition, in March 1983, SSA issued instructions to the DDSs dealing with mental impairments and their effects on individual work abilities. The instructions say:

"Where a person's only impairment is mental, is not a listing severity, but does prevent the person from meeting the mental demands of past relevant work, it may also prevent the transferability of acquired work skills. The final consideration is whether the person can be expected to perform unskilled work. The basic mental demands of competitive, remunerative, unskilled work include the abilities (on a sustained basis) to understand, carry out, and remember simple instructions; to respond appropriately to supervision, coworkers, and usual work situations; and to deal with changes in a routine work setting. A substantial loss of ability to meet any of these basic work-related activities would severely limit the potential occupational base.

"Where there is no exertional impairment, unskilled jobs at all levels of exertion constitute the potential occupational base for persons who can meet the mental demands of unskilled work. These jobs ordinarily involve dealing primarily with objects, rather than with data or people, and they generally provide substantial vocational opportunity for persons with solely mental impairments. In a relatively few instances, persons with this large job base will be found disabled because of adversities in age, education, and work experience."

The instructions provided greater flexibility for determining the ability of a mentally disabled person to do work and may result in more accurate disability decisions. However, the instructions also provide guidance which can be interpreted very restrictively and, if so interpreted, "not disabled" decisions will continue for cases where severe mental impairments exist.

Also, the first week of April 1983, SSA issued additional instructions to clarify the RFC criteria for adjudicating mental disabilities. The new instructions do not change existing procedures, but are intended to make sure the adjudicators clearly understand the existing procedures for evaluating the

RFC assessments and considering the vocational factors in cases of mental impairments.

INADEQUATE DEVELOPMENT AND USE OF EXISTING MEDICAL EVIDENCE

The Social Security Act requires that mental impairments causing disability be demonstrated by medically acceptable clinical techniques. When possible, all medical evidence should be obtained from existing sources, including treating physicians and institutions.

Often, treating sources cannot, or do not, provide enough information for the examiners to make a disability decision. The DDS must then purchase the medical evidence in the form of a medical examination, generally referred to as a consultative examination (CE). CEs are needed to

--clarify medical evidence,

--obtain necessary data not otherwise available, or

--resolve conflicts or inconsistencies in the evidence obtained.

In many of the cases we reviewed, the existing medical evidence of record, including evidence already in the case file, had not, in our judgment, been appropriately considered. Rather, undue reliance was often given to the CE reports, using them as the primary evidence on which decisions were based.

Examiners we spoke to at the five DDSs visited confirmed this. In our group discussions with examiners, they told us they order CEs automatically when they receive the case

folders. They pointed out that it is almost a waste of time developing thorough longitudinal histories on a person who has some positive characteristics, which they interpret as not meeting the listings. They pointed out to us that if a medical/vocational allowance is warranted they would have to develop the claimant's negative characteristics fully, which is time-consuming, and in the end they feel the case would probably be returned from the DAB because the person would be viewed as being able to do unskilled work. The examiners say they are then penalized on two counts--their backlogs increase and an error is charged against them.

Examiners also said that, because of production and processing time goals to adjudicate cases, they are reluctant to wait for or obtain all the historical data. They said it is much easier and faster to develop and justify a medical/vocational termination with a positive CE report.

Further, examiners said it takes much longer to obtain historical medical evidence for mental impairments than for other body system cases because (1) treating psychiatrists are more reluctant to turn over patients' files; and (2) hospitals and mental health institutions are not timely in providing patient reports, and in both instances time consuming followups are necessary to get the data.

The problems with over-relying on a CE report is that the CE physician rarely has the complete medical history to assess the patient, which can result in the physician relying on the

individual's condition at that particular point in time and on the individual's description of his or her history and daily activities. The illness itself may prevent the claimant from accurately portraying such information. Also, if claimants want to appear normal, they may exaggerate their conditions or activities.

For example, we investigated a claim involving a beneficiary with schizophrenia and mental retardation whose benefits were terminated based on a consultative exam. Two previous CE exams conducted a year and one-half earlier gave the beneficiary a prognosis of "poor" and "nil." The new exam found him to be functioning well. When we visited the beneficiary he was living in a restricted residential facility and participating in a sheltered workshop. He had misrepresented many facts concerning his living arrangements, daily activities, and work capabilities to the current CE physician. The facility administrator, the floor nurse, the workshop plant manager, and a work evaluation specialist all felt he was incapable of independent living, and of obtaining and keeping competitive employment at any skill level.

Examiners told us that SSA's policy of focusing on daily activities often leads to an over-reliance on CE examinations, which always describe claimants' daily activities. As we said earlier, because of SSA's restrictive interpretations of the medical listings, any positive daily activities that the claimant does are likely to result in a disability denial.

CE reports usually describe the daily activities as he or she "watches television," "visits relatives," "shops," "cooks own meals," etc. Examiners, however, cannot assess the quality of a person's daily functioning and behavior from a simple description of activities.

For example, we investigated a periodic review case involving a schizophrenic who did not meet the listings and was terminated. A CE report based largely on the claimant's statements said he visited friends, played the piano, participated in family activities, and that his schizophrenia was controlled by medication. We talked to the claimant's treating psychiatrists and found (1) medication was an extraordinarily steep dose (100 mg. prolixin decanoate every 2 weeks)--by itself indicating a severe illness--and he still has frequent relapses and (2) daily activities were overstated--friends turned out to be psychiatric social workers and piano playing consisted of aimless doodling.

Scheduling and performing CEs before the historical medical evidence is obtained can also result in unnecessary costs and detract from the CE physician's ability to accurately assess the severity of the impairment and the quality of the claimant's ability to perform daily functional activities. We believe this is important because, as we will explain next, SSA and State psychiatric resources are severely limited, and yet SSA and the States are not using purchased psychiatric resources to fill this void.

In a discussion with the SSA psychiatrists, they confirmed that it is unlikely that a thorough psychiatric evaluation can be performed on an individual in a CE session without the individual's medical history, prior work history, workshop evaluations, and history of daily activities. These necessary elements are often lacking in CE reports, and do not appear to be developed by the State examiners.

STATE PSYCHIATRIC RESOURCES ARE SEVERELY LIMITED

In the five DDSs visited, three did not have any psychiatrists reviewing cases and two were significantly understaffed relative to SSA's psychiatric requirements. Also, examiners received only limited psychiatric training. Because the process encompasses a medical (psychiatric) evaluation that is highly complex, we asked SSA's psychiatrists whether a lay person or a non-psychiatric physician has the expertise to make such an assessment. They said examiners would not be technically qualified nor would most physicians of other medical specialties.

The chief medical consultant at one DDS said neither he nor the other staff doctors feel qualified to make a severity or psychiatric review form assessment. At another DDS, the chief medical consultant said the same thing, except he added that a physician specializing in internal medicine might be qualified. The physicians on his staff, however, were not specialists in internal medicine.

Overall, we found that there is a shortage of in-house psychiatric medical staff available for advice within the SSA/State adjudicative system. An SSA study found all six States in the Chicago region were lacking sufficient psychiatric resources. The States combined had only 50 percent of the minimum number of psychiatric-hours needed for proper case review. Nationally, as of December 1982, four States and the District of Columbia had no in-house psychiatrists, and 36 others had, by SSA standards, a deficiency in the minimum psychiatric-hours required.

SSA and State officials said the limited fee rates established by the States are significantly less than a competitive rate and thus, they cannot hire or contract with more psychiatrists.

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Mr. Chairman, that concludes my statement, and we will be happy to answer any questions you or the Committee members may have.

ATTACHMENT

EXAMPLES OF CASES WHERE GAO'S PSYCHOLOGIST QUESTIONED SSA'S DECISION THAT CLAIMANTS COULD WORK

--A 32-year-old paranoid schizophrenic man with an I.Q. of 88 was on the disability rolls since 1976. The claimant takes psychotropic medication and lives at home with his family, who supervise his daily activities. He has no friends, is isolated, exhibits poor emotional control, and has phobias. He has difficulty comprehending and is incapable of managing his own funds. He works 5 hours one day a week as a janitor's assistant in a church, a charity job. He must be heavily supervised. He attends day treatment three days a week. He previously failed work rehabilitation. His prognosis is listed as poor.

This claimant's benefits were terminated in January 1983, when the DDS concluded that he retained the capacity for simple, repetitive tasks.

--A 31-year-old man with an I.Q. of 68 was on the disability rolls since 1976. The claimant has a history of epilepsy and paranoid and catatonic episodes and was hospitalized in 1960, 1961, and 1980. The claimant lives with his mother and a brother (the mother is the claimant's representative payee) and is in treatment at a mental health clinic. Between 1973 and 1976 the claimant worked intermittently as a dishwasher in a sheltered workshop and hospital, terminating this work because it was too

stressful. A psychological exam reported that the claimant exhibited high anxiety, confusion, poor auditory and visual memory, motor area deficits, and decompensated under stress. The mother and brother reported evidence of deterioration, seclusiveness, and inappropriate responses. CE psychiatrists reported the claimant does not appear capable of coping with even minimal stress. Claimant's judgment is evaluated as poor.

This claimant's benefits were terminated in October 1982 because the DDS concluded that the claimant had the RFC to understand, carry out, and remember instructions; to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting; and to do unskilled work.

--A 30-year-old acute schizophrenic man with borderline mental retardation held several jobs as a gas station attendant prior to 1976, when he was adjudged incompetent to manage himself or his money and began receiving disability benefits. Institutionalized in 1978 and 1982, he has been in treatment since August 1982 at a mental health center. Treating psychiatrists have evaluated the claimant as restless, depressed, self-preoccupied, distractible, quarrelsome, ruminative, and disruptive. A psychological exam showed that the claimant was suspicious, paranoid, depressed, and unable to function under

pressure. A CE report said the claimant "may not be able to do repetitive tasks. May not be able to understand stress and pressures associated with day-to-day activity. Probably not able to manage own funds."

This claimant's benefits were terminated in October 1982 because the DDS concluded that the claimant had the RFC to understand, carry out, and remember instructions; to respond appropriately to supervision, coworkers, and customary work pressures in a routine work setting; and to perform unskilled work.

--A 33-year-old chronic paranoid schizophrenic man, who in the past worked intermittently at unskilled jobs. The claimant was hospitalized in 1973, 1974, 1978, 1979, 1980, 1981, and in April 1982. His disability payments began in June 1978 and he has a representative payee. Reexamined in June 1981, he met the listings and his benefits were continued. The claimant was again re-examined in July and August 1982. An August 1982 psychiatrist's report says of the claimant: "Client's paranoid and persecutory thinking would probably make it very difficult for him to tolerate the pressures associated with achieving production requirements. His ability to retain concentration long enough to perform tasks is also questionable. Hostility towards authority figures would probably cause him to have great difficulty carrying out instructions given by the supervisor.

Medication, primarily phenothizines and anti-psychotics, appears to help the claimant in controlling aggressive impulses and staying in touch with reality. Long-term chemotherapy, supportive psychotherapy, and hospitalization during crisis will be needed to maintain the client in the community."

This claimant's benefits were terminated in September 1982 because the DDS concluded that the claimant was able to care for himself, relate adequately to others, and understand and carry out instructions. He was determined to be able to do unskilled work.

--A 53-year-old mildly retarded schizophrenic man whose benefits began in September 1975, had them continued after reexaminations in 1977 and 1978. The claimant was hospitalized in 1975, 1976, and twice in 1977. The claimant has advanced Tardive Dyskinesia, cannot sleep at night, and lives in supervised nursing home. The attending physician stated the claimant is unable to read or write, has anorexia, poor judgment, no insight, and limited comprehension. He fears that people plot against him and has no contacts outside of the nursing home. The claimant needs help in managing money. The CE report considered the claimant to be oriented to time and place and found that he spoke relevantly and coherently.

This claimant's benefits were terminated in November 1982 because the DDS concluded that the claimant was

well oriented to time, place, and person; was able to understand, remember, and carry out simple one- or two-step job instructions; and could do unskilled work.

--A 30-year-old paranoid schizophrenic man was in a partial hospitalization program and functioning at a basic level on medication, according to two psychiatric evaluations. The claimant, who has been on the rolls since January 1975, has a diminished effect, cannot manage his own funds (his mother is his representative payee), is withdrawn, has no interests, and exhibits poor thought process, insight, and judgment. He decompensates under stress.

This claimant's benefits were terminated in June 1982 because the DDS concluded that he could do relevant past work.

--A 56-year-old registered nurse was diagnosed as depressed with paranoid features, complicated by alcoholism and possibly early Alzheimer's disease. She was institutionalized in 1967, 1970, 1979, and July 1982. The claimant worked as a registered nurse for 29 years until 1977. She was allowed disability in April 1978. A CE physician in 1978 felt the disability was sufficient not to establish a medical diary date. In 1980 the claimant was placed in Goodwill Industries as a nurse's aide. She had a breakdown in October 1981 and has been living in a nursing home. Though active and social and

offering a normal appearance, the claimant functions under supervision with constant reminders. The nursing home is her representative payee. The claimant needs help dressing and taking medicine. She needs to be reminded to eat. She has a hobby and goes to yard sales with encouragement. Her treating physician and nursing home personnel say she is deteriorating and cannot function except in a structured supervised environment. When the claimant lived alone, she neglected her home, became depressed, and did not eat and did not keep herself clean.

Disability benefits were terminated in October 1982 on the basis that she is oriented in 3 spheres, has a satisfactory memory, has good contact with reality, is neat and clean in appearance, and functions adequately in daily activities.