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EXPLORING MEANS OF ACHIEVING HIGHER RATES OF TREATMENT AND REHABILITATION AMONG ALCOHOLICS AND DRUG ADDICTS RECEIVING FEDERAL DISABILITY BENEFITS

HEARING

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

AND THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

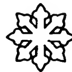
ONE HUNDRED THIRD CONGRESS

SECOND SESSION

FEBRUARY 10, 1994

Serial 103–75

Printed for the use of the Committee on Ways and Means



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EXPLORING MEANS OF ACHIEVING HIGHER RATES OF TREATMENT AND REHABILITATION AMONG ALCOHOLICS AND DRUG ADDICTS RECEIVING FEDERAL DISABILITY BENEFITS

THURSDAY, FEBRUARY 10, 1994

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security, Joint With
Subcommittee on Human Resources
Washington, D.C.

The subcommittees met, pursuant to call, at 11 a.m., in room 1310, Longworth House Office Building, Hon. Andrew Jacobs, Jr. presiding.

[The press release announcing the hearing follows:]

FOR IMMEDIATE RELEASE
WEDNESDAY, JANUARY 26, 1994

PRESS RELEASE #9
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-1721

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY, AND THE HONORABLE HAROLD FORD (D., TENN.), CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCE A JOINT HEARING TO EXPLORE MEANS OF ACHIEVING HIGHER RATES OF TREATMENT AND REHABILITATION AMONG ALCOHOLICS AND DRUG ADDICTS RECEIVING FEDERAL DISABILITY BENEFITS

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Social Security, and the Honorable Harold Ford (D., Tenn.), Chairman, Subcommittee on Human Resources, today announced that the Subcommittees will hold a joint hearing to explore means of achieving higher rates of treatment and rehabilitation among alcoholics and drug addicts receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits. The hearing will take place on Wednesday, February 9th, 1994, in room B-318 of the Rayburn House Office Building, beginning at 2:00 p.m.

BACKGROUND:

Substance Abusers' Eligibility for Disability Benefits - The Social Security Act provides for the payment of disability benefits to individuals who cannot work because of a medically determinable physical or mental impairment that has lasted, or is expected to last, for at least 12 months or to result in death. This disability standard applies to eligibility determinations under both the SSDI program and the SSI program.

In implementing this standard, the Social Security Administration (SSA) has developed listings of physical and mental impairments that it accepts as prima facie evidence of disability. SSA's listing of mental impairments includes "substance abuse disorders." To be awarded benefits under this listing, applicants must have a severe condition associated with alcoholism or drug abuse -- e.g., a personality disorder, chronic depression or anxiety, organ damage, or an organic mental disorder. Applicants whose drug- or alcohol-related impairments differ from those described in this listing are given an individual assessment by SSA and may be granted benefits on the basis of reduced overall functional capacity.

In addition to meeting the medical definition of disability, alcoholics and drug addicts who apply for SSI must comply with two statutory restrictions in order to receive benefits: (1) they must participate in a substance-abuse treatment program approved by SSA, and (2) their SSI benefits must be paid to another person or organization (a "representative payee") who is responsible for handling their finances. (Under SSA regulations, alcoholics and drug addicts who have another qualifying disability -- e.g., a heart condition, paralysis, or cancer -- are granted benefits on the basis of their non-drug-related impairment and are not subject to these requirements.)

Program Growth - At the request of the Subcommittees, the General Accounting Office (GAO) conducted a study of benefit awards to alcoholics and drug addicts in the SSI and SSDI programs. The GAO found that the number of SSI alcoholics and drug addicts who are subject to the above requirements tripled between 1990 and mid-1993, rising from 23,000 to 69,000. This increase exceeds significantly the

(MORE)

31 percent increase that occurred during 1990-93 in SSI payments to all disabled beneficiaries. The SSI alcoholic and drug addict population remains small in relative terms, however, constituting only 1.8 percent of all disabled SSI beneficiaries.

In the SSDI program, the number of alcoholics and drug addicts rose by approximately 35 percent between 1990 and mid-1993. This compares to an overall 1990-93 increase of 29 percent in the SSDI program. Extrapolating from SSI data, the GAO estimates that there are currently about 50,000 substance abusers receiving SSDI benefits. As in the SSI program, the group is small on a relative basis, constituting 1.3 percent of all SSDI beneficiaries.

Of the SSI substance-abuse population, 55 percent are alcoholics, 16 percent are drug addicts, and 29 percent have both addictions.

ENFORCEMENT OF SSI PROGRAM RESTRICTIONS:

Treatment - The GAO found little enforcement of the requirement that SSI beneficiaries who are disabled by alcoholism or drug addiction participate in treatment as a condition of eligibility. It reported that SSA has funded Referral and Monitoring Agencies (RMAs) in only 18 States to place and monitor beneficiaries in treatment. Due in large part to SSA funding limitations, these RMAs are monitoring only 51 percent of the SSI substance abusers residing within the 18 States and 44 percent of the SSI substance abuse population overall. In the remaining 32 States, SSA has established no mechanism for referring beneficiaries to treatment or monitoring them.

Representative Payees - In most instances, SSA satisfies the statutory requirement for a representative payee for SSI drug addicts and alcoholics by designating a family member or friend to manage monthly benefit checks. The GAO determined that 59 percent of representative payees for this group are family members, while 35 percent are friends, 2 percent are institutions, and 4 percent are social agencies.

Some critics question whether family members and friends of drug addicts and alcoholics should be permitted to serve as representative payees. By law, representative payees are required to spend the funds to provide for food, clothing, shelter, and necessary treatment for the beneficiary. However, drug addicts and alcoholics in their desperation to feed their destructive habits can become verbally and physically abusive to those who control access to their benefits. In an attempt to avoid confrontation, family and friends of drug addicts and alcoholics may simply turn the money over to the beneficiaries who in turn use it to buy drugs and alcohol.

In 1989, the Subcommittees on Social Security and Human Resources held a hearing on the representative payee program and heard testimony that drug-addict and alcoholic SSI recipients, who were required by law to have a representative payee themselves, were serving as representative payees for each other. In some cases, bartenders were serving as representative payees for their customers. In 1990, Congress enacted reforms to prevent this kind of abuse in the representative payee system, but some individuals who work with drug addicts and alcoholics assert that these problems with the representative payee program continue to exist.

FOCUS OF THE HEARING:

The Subcommittees are concerned by the sudden, sharp increase in disability benefit awards to alcoholics and drug addicts and want to understand its causes. Do the origins of this increase lie primarily

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in an increase in substance abuse in the general population? In higher application rates by substance abusers? In efforts by States to shift their welfare caseloads to the Federal government? In SSI outreach? Or in other factors?

The Subcommittees are particularly concerned that administrative barriers to treatment and rehabilitation may be contributing to the observed program growth. They encourage witnesses to address the following issues:

Availability of Treatment - Some observers hold that a shortage of treatment is the major barrier to rehabilitation of alcoholics an drug addicts. Others hold that there is no shortage of treatment facilities but that, due to a lack of resources, referral agencies do not have the personnel to place substance abusers in available rehabilitation programs. Is there a bottleneck in this service delivery system and, if so, where is it?

Reform of the Representative Payee Program - How does the present availability of SSI and SSDI benefits impinge on the success of efforts to treat substance abusers? Should the duration of cash benefits be limited? Should drug addicts and alcoholics be given vouchers for residential treatment instead of cash benefits? How frequently do family members and friends who serve as representative payees serve as a conduit to drugs and alcohol? Should family members and friends be prohibited from serving as representative payees? Should rehabilitation facilities be permitted to serve as representative payees? Are there additional SSI or SSDI program requirements that would be likely to improve rates of rehabilitation? If so, what are they?

DETAILS FOR SUBMISSIONS OF REQUESTS TO BE HEARD:

Requests to be heard at the hearing must be made by telephone to Harriett Lawler, Diane Kirkland or Karen Ponzurick [(202) 225-1721] no later than noon Tuesday, February 1, 1994. The telephone request should be followed by a formal written request to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. The staff of the Subcommittee on Social Security will notify by telephone those scheduled to appear as soon as possible after the filing deadline. Any questions concerning a scheduled appearance should be directed to the staff [(202) 225-9263].

In view of the limited time available to hear witnesses, the Subcommittees may not be able to accommodate all requests to be heard. Those persons and organizations not scheduled for an oral appearance are encouraged to submit written statements for the record of the hearing. All persons requesting to be heard, whether they are scheduled for oral testimony or not, will be notified as soon as possible after the filing deadline.

Witnesses scheduled to present oral testimony are required to summarize briefly their written statements in no more than five minutes. THE FIVE MINUTE RULE WILL BE STRICTLY ENFORCED. Subcommittee on Social Security Chairman Jacobs advises witnesses that they will be allowed no more than two "finally's" and one "in conclusion." The Congressional Budget Office and similar U.S. Government agencies may be granted an exception to these restrictions. The full written statement of each witness will be included in the printed record.

In order to assure the most productive use of the limited amount of time available to question witnesses, all witnesses scheduled to appear before the Subcommittee are required to submit 200 copies of their prepared statements to the Subcommittee on Social Security

(MORE)

office, room B-316 Rayburn House Office Building, at least 48 hours in advance of their scheduled appearance. Failure to do so may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement by the close of business, Wednesday, February 23, 1994, to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Social Security office, room B-316 Rayburn House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

●●●●●

***** NOTICE - CHANGE OF DATE AND LOCATION *****

FOR IMMEDIATE RELEASE
TUESDAY, FEBRUARY 8, 1994

PRESS RELEASE #9 - REVISED
SUBCOMMITTEE ON SOCIAL SECURITY
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1102 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, DC. 20515
TELEPHONE: (202) 225-1721

THE HONORABLE ANDY JACOBS, JR. (D., IND.), CHAIRMAN, SUBCOMMITTEE ON SOCIAL SECURITY, AND THE HONORABLE HAROLD FORD (D., TENN.), CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCE A CHANGE IN THE DATE AND LOCATION OF THE SUBCOMMITTEES' JOINT HEARING TO EXAMINE FEDERAL DISABILITY PAYMENTS TO ALCOHOLICS AND DRUG ADDICTS

The Honorable Andy Jacobs, Jr. (D., Ind.), Chairman, Subcommittee on Social Security, and the Honorable Harold Ford (D., Tenn.), Chairman, Subcommittee on Human Resources, today announced a change in the date and location of the Subcommittees' joint hearing to explore means of achieving higher rates of treatment and rehabilitation among alcoholics and drug addicts receiving Federal disability benefits. The hearing was previously scheduled to take place on Wednesday, February 9, 1994, in room B-318 of the Rayburn House Office Building, beginning at 2:00 p.m. **It has been rescheduled for Thursday, February 10, 1994, in room 1310 Longworth House Office Building, beginning at 11:00 a.m.**

All other details for the hearing remain the same. (See Subcommittee press release #9, dated January 26, 1994.)

* * * * *

Chairman JACOBS. The Human Resources and Social Security joint hearing is called to order. Our first witness today is my chairman of the Select Revenue Measures Subcommittee. I wonder if Mr. Kleczka would suffer the accommodation of Mr. Gekas managing a bill on the floor.

Would you mind if he goes after Mr. Rangel?

Mr. KLECZKA. That's pretty much suffering, but I will endure.

Chairman JACOBS. OK. Mr. Bunning has an opening statement. As far as I am concerned, I am against wasting money on people who don't deserve it in Social Security.

[The opening statement of Human Resources Subcommittee Chairman Ford follows:]

OPENING STATEMENT,
THE HONORABLE HAROLD E. FORD,
CHAIRMAN, SUBCOMMITTEE ON HUMAN RESOURCES,
COMMITTEE ON WAYS AND MEANS,
JOINT HEARING ON MEANS OF ACHIEVING
HIGHER RATES OF TREATMENT AND REHABILITATION
AMONG ALCOHOLICS AND DRUG ADDICTS
RECEIVING FEDERAL DISABILITY BENEFITS
FEBRUARY 10, 1994

Today I am pleased to join Chairman Jacobs in this joint hearing of the Subcommittees on Social Security and Human Resources. I hope this will be the beginning of coordinated efforts to improve all of the Social Security Administration's programs for the aged, blind, and disabled.

The main objective of this hearing is to find the means for achieving higher rates of treatment and rehabilitation among alcoholics and drug addicts receiving disability benefits under the Social Security Disability and Supplemental Security Income programs. Some observers might have other objectives in mind, but before anyone jumps to conclusions, let us take the time to hear the facts, to think clearly and carefully, and to draw balanced conclusions.

Yesterday, President Clinton released his National Drug Strategy report. It emphasizes treatment of hard-core drug users and drug education programs. The strategy includes an additional 355 million dollars to treat 140,000 hard-core drug users and 191 million more dollars for the States to fund teacher training and drug education programs. With an estimated 2.7 million hard-core drug abusers and a treatment capacity of only 1.4 million persons, we have a long way to go before we eradicate this scourge, but we must continue trying.

Recently, I was heartened to see that the number of Americans who admitted they had used an illicit drug in a prior month has fallen from 24 million in 1979 to 11.4 million in 1992. Three out of five illicit drug users use marijuana only. This implies that about 4.7 million drug users are using some other drug. Of these, about 1.3 million use cocaine, which is down from a peak of 5.8 million in 1985.

When we talk about drug addiction, let us not forget that alcohol abuse is the major problem. The number of Americans who admitted drinking five or more drinks per occasion on 5 or more days in the past month was 10 million in 1992. Unfortunately, unlike illicit drug use, the number of heavy drinkers has changed little in the last few years.

Although the national trends on drug abuse are downward, the same is not true of the Federal Social Security and Supplemental Security Income programs. As officials of the U.S. General Accounting Office will testify, the number of drug addicts and alcoholics on SSDI and SSI has grown substantially in the last five years to 250,000 persons, costing 1.4 billion dollars annually. However, the GAO also notes that over half of these individuals are on the rolls not because of their addictions, but because of medical problems, such as cancer or heart disease. Drug addicts and alcoholics on SSI who would not qualify for disability benefits if their addiction ended number around 70,000 and cost about 375 million dollars in benefits annually. Within the jurisdiction of the Subcommittee on Human Resources, it is this group that needs special attention.

Under the SSI program, drug addicts and alcoholics must be referred to substance abuse treatment and must have a third party, called a representative payee, handle their monthly checks for them. These checks are as much as 446 dollars monthly, and can reach much higher if retroactive benefits are due. With the President's new drug policy now announced, I hope many of the additional 140,000 treatment slots can go to those on SSDI and SSI so that these individuals will have a chance to return to a responsible and productive life without alcohol and drugs. In the meantime, I look forward to hearing the testimony today, and I hope the administration and the subcommittees can come up with some changes to the SSDI and SSI programs that will enhance the President's new policy.

Mr. BUNNING. Mr. Chairman, I will enter my opening statement in the record and ask unanimous consent to do so. I will yield to my good friend from Pennsylvania for his opening statement so we don't have two of them.

[The prepared statement follows:]

OPENING STATEMENT
THE HONORABLE JIM BUNNING
JOINT SOCIAL SECURITY AND HUMAN RESOURCES
SUBCOMMITTEE HEARING
FEBRUARY 9, 1994

CHAIRMAN FORD, AND ANDY, I APPRECIATE THE OPPORTUNITY FOR THIS HEARING TO REVIEW A GAO REPORT WHICH WAS COMPILED AT THE REQUEST OF BOTH OF OUR COMMITTEES.

THE PROCESS BY WHICH WE PAY SSI AND SOCIAL SECURITY DISABILITY BENEFITS TO DIABLED PEOPLE WHO ALSO HAPPEN TO BE DRUG ADDICTS AND ALCOHOLICS HAS TURNED INTO A REAL SCANDAL. ACCORDING TO THE GAO REPORT, WE ARE PAYING OUT ALMOST $1.4 BILLION IN BENEFITS TO SUBSTANCE ABUSERS A YEAR. BUT AT THE SAME TIME, WE HAVE HARDLY ANY OVERSIGHT ON THE USE OF THESE BENEFITS. AS A RESULT, IN MANY CASES WE ARE DIRECTLY SUBSIDIZING THE ADDICTIONS OF PEOPLE. WE MIGHT AS WELL BE GIVING MONEY DIRECTLY TO THE DRUG DEALERS.

IF WE DO NOTHING TO CORRECT THIS SITUATION, WE WILL BE GUILTY OF BEING "ENABLERS"--ENABLING THESE ADDICTS TO CONTINUE THEIR DEADLY HABITS AND AVOID TREATMENT.

BACK IN 1973, WHEN THE PROGRAM WAS ESTABLISHED, REGULATIONS WERE SET UP TO REQUIRE SUBSTANCE ABUSERS TO ACTUALLY PARTICIPATE IN TREATMENT PROGRAMS AND TO REQUIRE SSA TO LINE UP REPRESENTATIVE PAYEES TO RECEIVE THE BENEFITS INSTEAD OF GIVING FUNDS DIRECTLY TO DRUG ABUSERS AND ALCOHOLICS.

BUT LETS FACE IT-- THESE REQUIREMENTS EVEN THOUGH THEY ARE WELL INTENDED AND SOUND LIKE COMMON SENSE, JUST AREN'T WORKING. IT IS TIME WE IMPLEMENT A REAL OVERSIGHT PLAN THAT DOES WORK.

THE GAO REPORTS THAT SSA HAS COMPLIED WITH ITS RESPONSIBILITY TO FIND REPRESENTATIVE PAYEES FOR ALCOHOLICS AND DRUG ABUSERS. BUT THE CURRENT SYSTEM OF USING FRIENDS AND FAMILY AS PAYEES IS JUST NOT WORKING. ACCORDING TO THE GAO REPORT, FRIENDS AND RELATIVES ARE NOT NECESSARILY THE BEST PAYEES FOR ADDICTS AND THAT ONLY 51% OF THE PAYEES ACTUALLY TAKE RESPONSIBILITY FOR RENT PAYMENTS LET ALONE OTHER BILLS. AND GAO SHOWS THAT FRIENDS AND RELATIVES EXERCISE THE LEAST CONTROL OVER THESE BENEFITS AND ARE LIKELY TO TURN THEM OVER DIRECTLY TO THE BENEFICIARY. WE NEED TO CHANGE THE REPRESENTATIVE PAYEE SYSTEM.

ANOTHER IRONY IN THE SYSTEM IS THAT SUPPLEMENTAL SECURITY PAYMENTS FOR ADDICTS ARE SENT TO THEIR REPRESENTATIVE PAYEE, BUT DISABILITY PAYMENTS FOR THESE SAME PEOPLE, ARE SENT DIRECTLY TO THEM. THIS IS RIDICULOUS. COMMON SENSE SHOULD TELL US TO REQUIRE A REPRESENTATIVE PAYEE FOR ADDICTS UNDER BOTH PROGRAMS.

AND FINALLY, THE MOST SERIOUS FAILURE IN THIS PROGRAM IS THE FAILURE OF ANYONE TO MONITOR THE PARTICIPATION BY ADDICTS IN TREATMENT PROGRAMS. ADDICTS ARE REQUIRED TO BE ENROLLED IN A TREATMENT PROGRAM, HOWEVER, THERE IS NO FORMAL MONITORING TO MAKE SURE THAT THIS OCCURS. GAO REPORTS THAT AFTER 20 YEARS, ONLY 18 STATES HAVE AGREEMENTS WITH SSA FOR MONITORING PROGRAMS. AND AS OF AUGUST 1993, ONLY 10% OF THE ADDICTS RECEIVING BENEFITS WERE INDEED ENROLLED IN A TREATMENT PROGRAM. THIS IS SHAMEFUL AND WE HAVE TO CORRECT IT.

WE CANNOT ALLOW THIS PROGRAM TO CONTINUE IN THE SAME MANNER GIVEN THESE GAO FINDINGS. LEGISLATIVE REFORM IS DEFINITELY NEEDED, ALONG WITH MUCH CLOSER OVERSIGHT ACTIVITY ON OUR PART.

HR 3500, THE HOUSE REPUBLICAN WELFARE REFORM PROPOSAL OFFERS TWO RELEVANT SOLUTIONS TO THIS PROBLEM:

THIS PROPOSAL WOULD REQUIRE PERIODIC RANDOM DRUG TESTING TO DETERMINE WHETHER THE RECIPIENT IS USING ILLEGAL DRUGS. IF THE ADDICT IS USING DRUGS, THEN THE BENEFITS WOULD BE TERMINATED.

THE PROPOSAL WOULD ALSO AUTHORIZE GOVERNMENT AGENCIES TO ACT AS REPRESENTATIVE PAYEE. THESE SEEM TO BE LOGICAL PROPOSALS IN VIEW OF THIS GAO REPORT.

ALSO TODAY, I AM PLEASED THAT CONGRESSMAN GEKAS WILL BE TESTIFYING ABOUT HIS PROPOSAL WHICH WILL GO EVEN FURTHER.

I WANT TO THANK OUR WITNESSES FOR BEING HERE TODAY, I LOOK FORWARD TO YOUR INPUT.

STATEMENT OF HON. RICK SANTORUM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. SANTORUM. Thank you, Jim.

Thank you, Mr. Jacobs and Mr. Ford, for holding these hearings. The topic of the Social Security SSI program being out of control is in fact a very timely one. We have some charts, if you guys can put the charts up.

The first chart that you will see is enrollment in the disability part of the SSI program. It has quadrupled in the last 5 years. Over the first 15 years of the program, as shown in the first three bar graphs, the average annual increase in enrollment did not exceed 131,000 over the entire period. The average increase was about 96,000 per year.

But, in the last 5 years, no year has seen an increase of under 210,000, and the average is nearly 400,000 new people, about four times the average of the first 15 years. A major consequence of this enrollment increase is that we are now spending more and more money on the SSI program each year.

Figure 2 shows that spending, even in constant dollars, is increasing exponentially. Just in the past 5 years, spending has increased from less than $17 billion to nearly $29 billion.

It is often said the heart of our nation's deficit problem is the growth of entitlement programs, and health care is cited as the biggest problem in growth.

But, if you look at that chart, if you believe health care is a crisis, then SSI growth is a problem of Biblical proportions.

Entitlement growth is said to be uncontrollable, but it is our job in this committee to control those programs. If you look at chart 3 there are at least three reasons the SSI program is expanding beyond control. First, the number of disabled children receiving SSI benefits has increased nearly fivefold since the beginning of the program.

We have no doubt that Americans want to help disabled children, but there is good evidence that some children are being admitted who have disabilities that Congress did not have in mind when SSI was passed in 1972.

Mr. Kleczka, who testified before this committee on this issue before, will say more about this topic and I look forward to his testimony.

Second, as shown in figure 4, the number of aliens on SSI has also increased dramatically. In the last 10 years, between 1982 and 1992, alien SSI recipients increased fivefold, from a little over 100,000 to 600,000. In our view, only those over 75 years of age who receive SSI, should receive SSI. Anyone under that age should be dropped from the rolls.

That is in the Republican welfare reform proposal.

The third cause of growing SSI enrollment is drug addicts and alcoholics.

As shown in figure 5, the final chart, the number of addicts receiving SSI shows the same pattern as the number of children and number of aliens, namely rapid increases especially in recent years.

In the case of addicts, it appears that they are not too spaced out to recognize a good thing when the word comes around. Just in the past year, the rolls have increased by a shocking 50 percent, from

53,000 to 78,000. As in the case of immigrants, the basis for including addicts in this program should be questioned by this committee.

It is highly unlikely that when Congress passed the SSI program in 1972, that Members realized they would be writing a guaranteed annual income and medical care for addicts.

We have reports even recently of this money being used directly for the purchase of drugs and alcohol by the addicts. We are in fact supporting their habit. What we suggest in the Republican welfare reform bill is that addicts and alcoholics should be tested. If they test positive for illegal substances, they should be dropped from the rolls.

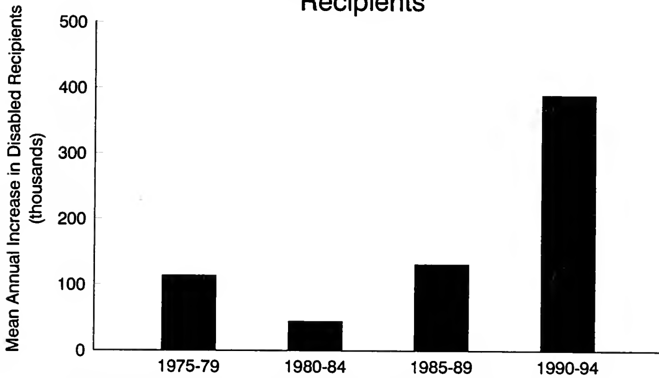
This should not be a support program, this should be a program to help people who have problems, but to move people beyond that problem.

I thank the Chairman for giving me the opportunity to make an opening statement. I look forward to the testimony today.

Chairman JACOBS. Thank you, Mr. Santorum.

[The charts referred to follow:]

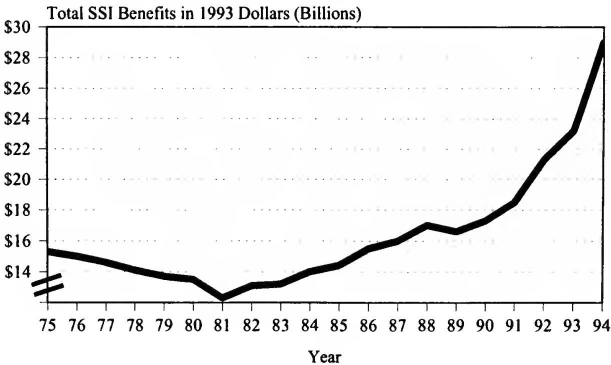
Figure 1.
Average Annual Increase in Number of Disabled SSI Recipients



Source: Green Book, 1993. Page 867. (Constant dollars compiled by Republican staff)

Figure 2.

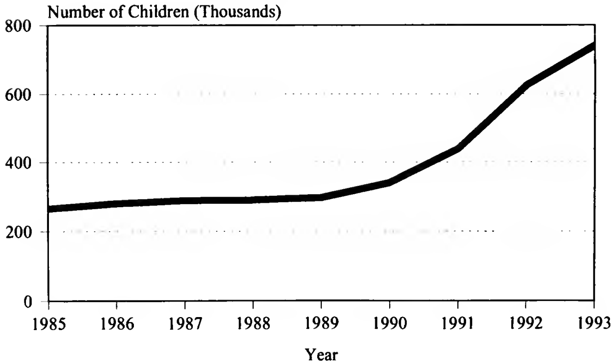
Total SSI Benefits in Constant Dollars, 1975-1994



Source: Green Book, 1993, pg. 867

Figure 3.

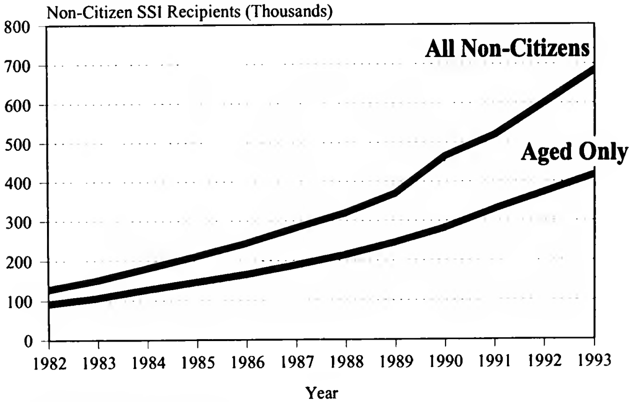
Children Receiving SSI Benefits, 1985-1993



Source: Congressional Budget Office.

Figure 4.

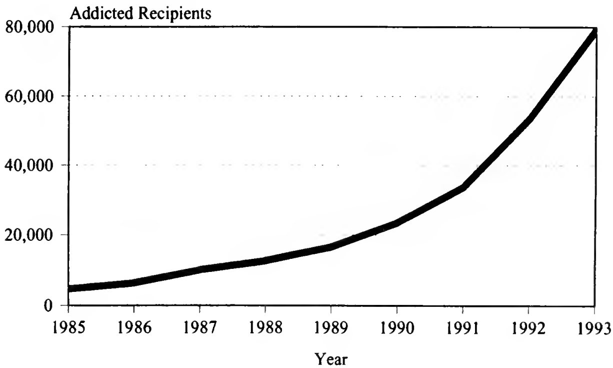
More and More Non-Citizens Receive SSI



Source: Department of Health and Human Services

Figure 5.

Explosion of Drug Addicts Receiving SSI, 1985-1993



Source: Social Security Administration

Chairman JACOBS. Mr. Reynolds has a brief comment.

Mr. REYNOLDS. Thank you, Mr. Chairman.

I have a brief comment that these hearings provide a tremendous opportunity for us to look at this problem that has in fact contributed to child abuse, not just in Chicago, but indeed in the United States.

I look forward to these hearings. Thank you very much.

Chairman JACOBS. I think we pass now to the professional ranks. Chairman Rangel undoubtedly knows as much and probably more than any other Member of Congress about drug abuse programs in the United States. He has given unstinting devotion to his efforts to alleviate the problem, and he is to be admired because he is that rare Member of Congress who understands that you don't solve this problem by slogans.

So we are honored to have you, sir.

Mr. RANGEL. Mr. Chairman, I would like at this time to yield to my friend and colleague who has to return to the floor.

Chairman JACOBS. He is also very generous.

STATEMENT OF HON. GEORGE W. GEKAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. GEKAS. I thank the Chair and I thank my colleagues for indulging me in going out of order.

In conjunction with the items Mr. Santorum has outlined in his opening statement, I want to submit for the record my written statement and five exhibits which go to these same problems which have been outlined today.

Title II and title XVI give drug addicts separate opportunities to go on with their habit for life without treatment, and legislation that we have offered goes to tightening up that system. Under title II, SSDI, a worker who is deemed disabled because of drug addiction may well go without treatment or conditionality for the rest of his life, his nonworking life, on SSDI simply because he is a drug addict.

We have to tighten that up and make sure that it is conditional for drug treatment and that there will come a time that he will go off SSDI because he has been successfully treated and cured of his addiction. That does not happen now. We have testimony in the exhibits of administrative law judges [ALJs] to that effect.

One egregious example in the exhibits I offer, and I wish you would pay close attention when you get it before you, is a letter by a prisoner or nonprisoner urging inmates to apply for SSI because it has gotten around to the prison population that they have an opportunity to go on SSI. Maybe some of them are totally disabled, but the very fact that there is a community within the prison growing directly to apply for SSI is mind boggling.

They are setting up their prison lawyers and prison contacts in the communication system in the prisons to take advantage of SSI as soon as possible. Some of us believe that they can apply while they are in prison under the present law. Some of us will accede that maybe that can happen only once they get out, but it becomes a way of life, and we are trying to cure that.

We have a responsibility on this regarding these problems in the administration. The copy of the bill to reform both SSI and title

II—SSDI in title II and SSI in title XVI to take care of the system where we can prevent a drug addict from naming his bartender as the representative payee, and thus they go on their merry way in conducting a lifelong addiction to drugs.

We want to tighten up how and when and where a representative payee can be named by a SSI person so that treatment—treatment for addiction—will be the No. 1 priority.

So that is the extent of my testimony. I want to offer this package of exhibits and ask the Chairman to record it in the record.

Chairman JACOBS. Without objection, we will do that. Thank you, George.

[The prepared statement and attachments follow:]

GEORGE W. GEKAS
17TH DISTRICT PENNSYLVANIA

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WEDNESDAY, FEBRUARY 9, 1994

STATEMENT

BY
THE HONORABLE GEORGE W. GEKAS,
MEMBER OF CONGRESS

BEFORE THE
HOUSE WAYS AND MEANS SUBCOMMITTEES ON HUMAN RESOURCES AND SOCIAL SECURITY

ON THE SUBJECT OF
FEDERAL GOVERNMENT DISABILITY BENEFIT PAYMENTS

MR. CHAIRMAN:

Thank you for holding this important hearing on the fraud, waste, and abuse perpetrated by the Social Security disability system. My focus will be on the unintended subsidization by the Social Security disability system of much of the drug and alcohol addiction that plagues our society.

Under current law, although Title XVI Supplemental Security Income (SSI) beneficiaries who have drug problems may be required to undergo treatment in order to receive benefits, there is no such parallel provision for those receiving Title II Social Security Disability Insurance (SSDI) benefits. Consequently, a worker who is an addict may remain for life on SSDI benefits due to his or her addiction, with no requirement to ever receive treatment.

Moreover, the current requirement for treatment under Title XVI (SSI) is ineffective. There are insufficient numbers of treatment centers -- or in some locales, no such centers -- and inadequate follow-up to assure compliance with treatment even where treatment centers exist. Worse, the effect of the current system is to provide an incentive to remain addicted: to assure continuance of benefits, a beneficiary must remain addicted. The system encourages just the wrong kind of behavior.

Another great weakness of the current program is the provision for representative payees. I am advised that often an addict becomes the representative payee for his friend and both continue to indulge in their addictive habits.

For a full explanation of this problem and a list of solutions, I have written a letter to the Social Security Administration (SSA), which

operates SSI and SSDI. To this date I have not received response. However, I do hope to work with SSA on this matter, since SSA is on the front line of this issue.

As you know, the House Republican Welfare Task Force bill includes a provision to terminate SSI benefits for drug addicts who test positive to drug tests. Welfare reform will not be comprehensive without provisions to reform SSI and SSDI.

For myself, I have introduced legislation (H.R.) requiring treatment for those addicts who are beneficiaries under Title II Social Security disability to conform with the Title XVI provisions for compliance with treatment. I will also support my colleague Congressman Bill Thomas' bill to provide for tightening of the provisions under Title XVI and for assuring compliance with treatment.

My legislation will also require that representative payees be public, charitable, and/or other reputable institutions. Moreover, my proposal will provide that administrative law judges may terminate benefits prospectively, retaining jurisdiction in proper cases to provide additional protection to the claimant and the taxpayer.

The result will be to take the individual out of addiction and off the rolls of the Social Security and SSI disability programs, producing great savings to the taxpayer. It will also go far in restoring the addict to a life of dignity and productive work.

Thank you for this opportunity to testify before this important hearing. I am advised that Senator Cohen is working on this same problem. So, with the cooperation of the Senate and the House Committee on Ways and Means, I look forward to a successful deliberative process to reform our welfare and Social Security systems before the end of the 103rd Congress.

* * *

GEORGE W. GEKAS
17TH DISTRICT PENNSYLVANIA

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TAB	SUBJECT
A	TESTIMONY
B	LETTER FROM ALJ (ADMINISTRATIVE LAW JUDGE)
C	LETTER URGING PRISONERS TO SIGN UP FOR SSI
)	RESPONSE FROM SOCIAL SECURITY ADMINISTRATION (SSA) IN RESPONSE TO GWG LETTER REGARDING DISABILITY PAYMENTS TO SUBSTANCE ABUSERS
E	H.R. 3814, BY GEKAS, TO REFORM THE SSDI FOR ABUSERS SYSTEM
F	GEKAS LETTER TO GENERAL ACCOUNTING OFFICE (GAO), REGARDING SSI DISABILITY PAYMENTS TO CHILDREN WHO ARE "NOT ACTING THEIR AGE"

[DUE TO POOR COPY QUALITY, SOME OF THE EXHIBITS LISTED ABOVE ARE BEING RETAINED IN THE COMMITTEE FILES.]

PRISONER ADVISORY

The following advisory was mailed to me by a Milwaukee administrative law judge (ALJ). As the page makes clear, prisoners are targeted to apply for SSI disability.

Social Security help for the disadvantaged

1) According to the Social Security Administration, serving time in prison makes you a member of a Disadvantage Minority.

2) Two or three months before you expect to get out, write to

Department of Health and Human services/. Social Security Administration P.O. Box 19001 Olympia, WA. 98507	OR	Social Security 6502 Odena Road Madison, WI. 53719

Or Phone 1 - 800 - 772 - 1213

1) Ask them for information about benefits for prisoners, under Public Law 93.365 or 92.603, Code R.C.W. 72.02.040; and also request the address of the regional Director of the Social Security Office in the area where you are going to be paroled to.

2) Write the Regional Director, saying that you have turned in your parole plans, and that you want to apply for the $980.00 per month in Social Security insurance Benefits. Ask that the application be sent to an address in your parole plans area. Details of this are covered in the R.C.W. 72.02.040. Be sure to keep a copy of the letter you send to the Regional Director.

3) When you get out, go down to the local Social Security office and apply for your benefits under R.C.W. 74.29.105. Take along a copy of the letter that you wrote to the Regional Director.

4) Being incarcerated also qualifies you for Disability Benefits. However these benefits are in a different category from the Disadvantaged Minority benefits and require a separate application at the Social Security Office. You will have to be persistent with this one, and may have to file the application 3 or 4 times. But once approved, you are eligible for $310.00 for every month that you were incarcerated.

5) Contact the U.S. Department of Social and Health Services and apply for vouchers for food, housing, and clothing, plus an immediate $180.00 in food stamps.

6) Contact the U.S. Housing and Urban Developement office. You may be eligible for low cost housing as well.

7) If you know a trade, the Division of vocational Rehabilitation can help you get started again under R.C.W. 72.02.100. Go to various stores to check out prices for clothes and tools, etc. that you will need and make a list to give to Voc. Rehab. You could get up to $1500.00, and even an extrs $100.00 Gate Money Your list of needs could include a building if you intend to go into business for yourself.

8) For those wanting to go into business for themselves, the Small Business Administration might also give you a loan to start up; give them a call too. You might also want to contact the Minority Business Development Office within the Department of Commerce, they can provide financial help if you are trying to start a minority owned business.

You will get the details of all this stuff from the national Social Security Hdqrs. in Olympia. The paperwork will be a real chore, but it will probably be the best paying work you have ever done.

To apply at: Social Security administration
Mail to copy 310 W. Wisconsin AVE
53203

THE COMMISSIONER OF SOCIAL SECURITY
BALTIMORE, MARYLAND 21235

FEB 8 1994

The Honorable George W. Gekas
House of Representatives
Washington D.C. 20515-3817

Dear Mr. Gekas:

This is in response to your letter in which you expressed concern about Social Security and supplemental security income (SSI) payments to individuals who are addicted to drugs or alcohol. You proposed a number of changes to improve the current program, including extending the SSI provisions to title II recipients.

I share your concerns over allegations that SSI payments for people who are addicted to drugs and alcohol are being abused, and I want to assure you that the matter is receiving our utmost attention.

However, as you correctly noted, current law places more requirements on medically determined drug addicts or alcoholics who receive SSI benefits than on those who receive Social Security benefits. If drug addiction or alcoholism materially contributes to the decision that an individual is disabled for SSI purposes, the Social Security Act requires: (1) that the recipient accept available treatment as a condition of receiving benefits, and (2) that a representative payee be appointed to handle the SSI payments.

The Social Security Administration (SSA) has a program in place to refer SSI recipients who are medically determined drug addicts or alcoholics for available treatment and to monitor compliance with the treatment program. Failure to comply with these provisions will result in benefit suspension. Currently, SSA implements the referral and monitoring provisions through agreements or contracts with referral and monitoring agencies (RMA). Until recently, SSA had agreements or contracts with RMAs in only 18 States.

To improve the RMA process and to expand RMA coverage to all 50 States and the District of Columbia, SSA has collaborated closely with the Public Health Service's Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Care Financing Administration (HCFA) to improve the administration of the SSI drug addiction and alcoholism provisions of the SSI program. Through this collaboration, SSA has developed two initiatives.

The first is a standard model process aimed at improving the effectiveness of the referral and monitoring function. This standard model is being implemented through a formal contracting process with a goal of negotiating and implementing contracts to establish RMAs in all 50 States and the District of Columbia, and to improve the overall referral and monitoring process.

The ultimate objective of the referral and monitoring process is to assure that substance abusers are complying with their individual treatment plan requirements and, as a result of such treatment, are rehabilitated and can perform substantial gainful activity. To ensure the fulfillment of this objective, a key requirement of the RMA contract is that when feasible, and upon completion of treatment, the recipient be referred to the State vocational rehabilitation agency, or a private organization with the same purpose, for rehabilitation service or training.

To date, SSA has awarded RMA contracts under this new protocol in 33 States, including the District of Columbia. SSA anticipates awarding contracts for all States by the end of fiscal year 1994. These contracts represent a significant step forward in providing a comprehensive, uniform referral and monitoring process throughout the country.

Secondly, this collaboration with SAMHSA and HCFA has resulted in a pair of demonstration projects aimed at providing more effective treatment and rehabilitation services. The demonstration projects being conducted in conjunction with SAMHSA in Michigan and Washington will test alternatives for providing more effective treatment and rehabilitation services to recipients whose disabilities are based on substance abuse. A key objective of these demonstration projects is to address the difficulties encountered in selecting payees for these recipients by testing the use of treatment sources, RMAs, or other involved State or local agencies or organizations as representative payees.

In addition to these initiatives, the Department of Health and Human Services (HHS), Office of Planning and Evaluation, will be working with SSA, SAMHSA, and HCFA to further consider other alternative approaches to treatment for beneficiaries with this disease.

With respect to the selection of substance abusers as representative payees for other substance abusers, this may occur, but very infrequently. In a recent study we identified only 35 cases where recipients who were addicted to drugs or alcohol were payees for other recipients who were addicted to drugs or alcohol. We have taken corrective action so that either a new payee was selected or benefits were suspended pending appointment of a new payee. Currently, we are developing methods of systematically checking our benefit rolls to prevent this from occurring.

We have established guidelines to use in selecting payees that include public, charitable and other institutions as potential payees. However, we generally first consider as potential payees those relatives with custody of the beneficiary, legal guardians and concerned friends. These guidelines apply in all payee selections, not just those for substance abusers, and allow the SSA employee making the selection to use his/her judgment in finding the person, agency, or organization that will best serve the interests of the beneficiary. We have specific procedures for investigating payee applicants that must be followed, some of which are prescribed by law.

My goal is that SSA provide the best possible service in a comprehensive, uniform, and cost-effective manner. I believe that the continuing collaboration within DHHS to develop new initiatives to address our problems will ensure that we meet this goal and that we increase public confidence in our programs and our stewardship of them.

I appreciate this opportunity to respond to your concerns regarding these complex and difficult issues, and your ideas will be helpful in considering how to resolve them. We will be happy to work with you in this endeavor and will be in touch with your staff to discuss your proposals.

Sincerely,

Shirley S. Chater
Commissioner
of Social Security

GEORGE W. GEKAS
17TH DISTRICT PENNSYLVANIA

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February 10, 1994

Mr. Charles A. Bowsher
Comptroller General of the U.S.
General Accounting Office
441 G Street NW
Washington, D.C. 20548-0001

Dear Mr. Bowsher:

Please find enclosed a Washington Post article about Title XVI Supplemental Security Income (SSI) disability payments to children who are by no means disabled. I would appreciate a General Accounting Office (GAO) explanation of and justification for this problem.

As the article states, children who are not acting their age are getting almost $500/month. Not acting ones age is not a disability -- it is a discipline problem.

As you know, Congress is intent on cutting government spending, and surely one area ripe for cuts are disability payments to non-disabled people like misbehaving children or drug addicts. Social Security disability payments should go to people who are seriously disabled.

Much like the report you drafted for Senator Cohen on the problem of SSI and Social Security Disability Insurance (SSDI) payments for substance abusers, I would appreciate a report on the extent to which SSI and SSDI payments go to children with questionable disabilities.

Congressman Nick Smith has just introduced legislation in this regard. With your report in hand, I plan to work with Congressman Smith to introduce updated legislation to address the problems contained in the report you will draft for me.

Thanks in advance for your attention to this matter. Please address any questions or comments regarding this request to me or Charlie Frohman of my staff, at 225-4315.

Very truly yours,

GEORGE W. GEKAS
Member of Congress

GWG:cf
enclosure

Costs Soar for Children's Disability Program

How 26 Words Cost the Taxpayers Billions in New Entitlement Payments

By Bob Woodward
and Benjamin Weiser
Washington Post Staff Writers

Nora Cooke Porter, a pediatrician and lawyer, works on the front lines of the nation's entitlement system. She can barely contain her frustration as she flips through some of the thousands of applications for a federal aid program for disabled poor children that have passed through her Harrisburg, Pa., office over the last two years.

The files show, she says, that children who curse teachers, fight with classmates, perform poorly in school or display characteristics of routine rebellion are often diagnosed with behavioral disorders and therefore qualify for the program's cash benefits, which average $400 a month. Under a broad new federal standard prompted by a 1990 Supreme Court ruling, behavior that isn't "age appropriate" is considered a disability.

Porter feels her hands are tied by the new rules. She has tried to block benefits to children who, in her medical opinion, are not suffering from any disability. Her superiors have overruled her, and she has written detailed rebuttals. Last month, she was suspended without pay for her repeated protests, and she believes her job as a disability-review physician is in jeopardy.

Months before her suspension, she agreed to be interviewed because she believes that the children's disability program is an example of an entitlement system gone haywire. She hopes that her decision to speak out will draw attention from congressional or federal investigators.

The age-appropriate standard is only the most recent flaw in the program, according to Porter and others. They trace the program's problems to its origin: a vague, little-debated 26-word clause that was hastily inserted in a mammoth welfare bill passed in 1972.

Porter's criticisms are echoed by many others who work in the program. They say they sympathize with the children, many of whom are living in desperate poverty. But, they argue, the program does little to help them with their real troubles, especially since the majority of children who now qualify have mental disorders rather than physical ones.

How to provide for the country's neediest—the old, the young, the poor, the sick, the disabled, the disadvantaged—without bankrupting the Treasury has become one of the central governing questions of our time.

Earlier this week, The Washington Post published a series of articles on the rising cost of Medicaid, the health insurance program that is the government's largest entitlement for the poor. This article examines the little-known children's disability program, another entitlement for the poor, which is experiencing the same skyrocketing costs as Medicaid.

Last year, the children's disability program cost $3.6 billion. It was serving 770,000 at the end of December, a number that none of its sponsors imagined possible when it was enacted 20 years ago, they say. Because disability recipients automatically qualify for Medicaid, the program's rapid expansion also has led to hundreds of millions of dollars in additional costs for that entitlement program.

Children's disability is a component of a larger entitlement program called Supplemental Security Income, or SSI, which provides benefits to poor people who are elderly, disabled or blind. By law, entitlement programs guarantee government benefits to anyone who meets the qualifications set out in legislation or in regulations. Federal spending levels are mandatory, meaning they cannot be altered unless the law is changed.

What Can Happen

The history of the children's disability program illustrates what can happen when a law is enacted without much debate or study and then becomes subject to interpretation by regulators, advocates and the Supreme Court.

The new age-appropriate standard that Porter criticizes was written by federal regulators after the Supreme Court ruled that the law required the government to use a broader definition of disability in determining eligibility.

Since the court ruling, the number of children receiving benefits has more than doubled. The decision also led to lump-sum back payments for some 150,000 children who had been denied benefits under the old rules. These back payments—which averaged $15,000, with some as high as $75,000—have cost the government $2 billion since 1991, plus at least $287 million more in administration.

In a survey of state disability determination directors conducted last summer, more than half cited "inappropriate use of SSI funding" as the most common concern in their states. Parents or guardians are not required to use the money for therapeutic or medical aid. They can spend the cash payment as they please, as long as it benefits the child in some way. That rule has been interpreted to allow the purchase of a television set, a video game or a car.

"I really have to grapple with the idea that I'm allowing that parent to use the money any way they want to, fairly certain, given the history, that the child is not going to benefit," said a psychologist in the Washington disability determination office. "And that happens to us . . . eight times a day."

The lump-sum payments revealed what both supporters and critics of the program see as the absurdity of federal spending rules. Families receiving the back payments were required to spend the money within six months so that their sudden wealth would not make them ineligible for the income-based program.

Last summer, a group of disability experts and officials met in Washington to discuss the mission of the children's disability program. According to a confidential memo about the July 19 meeting, a congressional staff director "questioned exactly what we were trying to accomplish by giving disabled children benefits."

The response: "From a social policy perspective," the memo said, "it was interesting that no one really had a good answer"—not the policy experts, nor the people who run the program, nor even the people who oversee the legislation.

A Consolation Prize

The children's disability program began in 1972 as a kind of consolation prize.

The Senate had just killed the Nixon administration's proposal for a guaranteed minimum income for poor Americans. As a compromise, Congress established SSI to provide aid for the "deserving poor": the elderly, blind and disabled. Initially, no money was set aside for children.

Thomas C. Joe, a senior federal welfare official, inserted the 26-word clause that expanded SSI to cover children. It appeared in parentheses, as follows: "(or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)."

Joe, 58, now head of a Washington social policy think tank, said that expanding the program to cover disabled children was part of his "incremental strategy" to assist as many poor people as possible. It was a welfare program disguised as disability assistance.

There was no consideration of the financial or policy consequences or of other ways to aid disabled children, according to participants in drafting the original legislation. Nor was there any public hearing that even mentioned Joe's 26-word clause.

Joe acknowledged with some humor that he tucked the provision into the 697-page bill in order to sneak it through. "I was afraid that too many people were going to discover this and it would be a big controversy," he said. "This is a good example of democracy not at work," he added.

The Senate Finance Committee chairman at the time, Russell B. Long (D-La.), made a run at killing the provision. "Disabled children's needs for food, clothing and shelter are usually no greater than the needs of non-disabled children," his staff wrote in a Sept. 26, 1972, committee report. It said disabled children needed health care and rehabilitative services, not money, and noted that Medicaid already covered poor children's health costs in 48 states.

During the closed-door, marathon weekend House-Senate conference in October 1972 to reconcile different versions of the bill, hundreds of other welfare, Medicaid and Medicare issues were being resolved, and SSI received little attention.

"It wasn't thought of as a big deal," said Frank Crowley, a now-retired senior staffer who worked on the bill. "It was one of these annoying little details."

The 67-page report from the conference made no mention of how the issue was settled. J. William Kelley, a House Ways and Means Committee staffer at the time, has a copy of the only existing conference paper about Senate amendment No. 564, which called for dropping Joe's provision. The single sheet reads: "CONFIDENTIAL. Summary: The House bill authorizes payments to children under age 18. The Senate bill does not." The line under "Cost" was left blank.

When the conference report was presented to the House on Oct. 17, 1972, Rep. Phillip Burton (D-Calif.) rose to praise the new program. "Thanks to Tom Joe, this is now a reality," he said.

What Is Disability?

Joe's amendment became law without anyone addressing the obvious question: How do you define disability for a child?

Previously, disability assistance had been premised on the disabled person's inability to work. The purpose was to make up for lost income. The bill creating SSI defined a disabled adult as someone "unable to engage in any substantial gainful activity."

But children don't work, at least until they become teenagers. "It is ludicrous on its face to apply the same standard to children," said Joseph Humphreys, a former congressional staffer who worked on the 1972 bill. Humphreys called the 26 words "a punt by Congress" that left regulators to decide what to do.

The meaning of Joe's 26 words—especially the phrase "comparable severity"—has been controversial ever since. Even today, Joe said, he doesn't know exactly what the phrase was supposed to mean.

In writing regulations, the Social Security Administration, which runs SSI, said an adult was eligible if his or her disability appeared on a predetermined list of physical and mental impairments. If it didn't, the adult could still qualify by having a personal evaluation that determined that he or she was unable to work.

The regulations treated children differently. They had to manifest one of the listed impairments, such as acute leukemia, chronic epilepsy or serious mental retardation. Because children generally don't hold jobs, individual evaluations were not considered necessary.

In the early 1980s, the Reagan administration moved to slash the number of people on federal assistance programs, including SSI. One of the thousands of people affected was Brian Zebley, a 5-year-old retarded boy. His family filed a lawsuit, charging that the government was illegally denying benefits to Brian and other children.

As the case wound its way through the federal courts, it attracted a vigorous and passionate advocate—Jonathan Stein, a legal services lawyer in Philadelphia. The legal counterpart to Joe, Stein saw the courts as a way to extend benefits to the poor. He and a colleague, Richard Weishaupt, took Zebley's case all the way to the Supreme Court.

Stein spotted the logical flaw in the administration's way of determining eligibility: The "comparable severity" test could not be applied to children unless the methods of assessing disability in adults and children were themselves comparable. Children deserved the same kind of individual assessments that adults were receiving, Stein argued.

A Supreme Court case often carries the expectation that large constitutional, moral or social issues will be addressed. The Zebley case, however, was framed narrowly: Had the government properly interpreted the law? In 1990, in *Sullivan v. Zebley*, the Supreme Court ruled 7-2 in Zebley's favor and ordered the Social Security Administration to give children the same individual analysis as adults.

To implement the high court's ruling, the agency asked a panel of experts to settle the question: What is the work of a child?

The panel's answer, in the form of new regulations, is the primary cause of Nora Porter's complaints. The new rules defined a child as disabled if his impairments "substantially reduce" his ability to "grow, develop or mature physically, mentally or emotionally and thus to engage in age-appropriate activities of daily living." These activities ranged from learning, communicating and performing in school to interacting appropriately with peers and family members.

Social Security officials said the panel was seeking a common-sense way of comparing children and adults. In Porter's view, they failed. "Age appropriate is a fictitious standard," she said. "It applies to the perfect child, and any deviation from that allows someone to apply for and likely be declared disabled."

James Perrin, a Harvard Medical School pediatrician who helped develop the regulations, said Porter's criticism was unrealistic and out of touch. He said physicians need some standard to assess a child's behavior. "None of us can think about children without raising the question of age-appropriate behavior," he said. "There's no way of approaching children and adolescents without thinking about that."

Victory Provides Leverage

Stein's legal victory gave him enormous leverage over the children's disability program. According to federal and state officials, he became the program's de facto supervisor.

Stein regularly threatened to seek contempt-of-court citations when he felt the Social Security Administration wasn't implementing the rules fast enough. He also provided the news media with information on how the agency's foot-dragging was costing hundreds of thousands of disabled children money that the Supreme Court said they deserved.

One of Stein's most significant accomplishments was getting Social Security to review roughly 450,000 cases, dating to 1980, in which children had been denied benefits. This led to the 150,000 lump-sum back payments.

But not even Stein could do anything about the government's requirement that the recipients spend the money within six months to remain eligible for the program. Stein unsuccessfully tried to create an exception for back payment recipients, calling the rule "Kafkaesque."

The rules legitimized and even encouraged shopping sprees. In a case that both federal officials and program advocates said was fairly typical, Beverly Smith of Greenville, Ky., received a back payment in 1992 of $13,000 for her 11-year-old son, who is hyperactive and was deemed disabled under the new rules. Smith, who earns about $8,000 a year sweeping up in a local bank, said she was shocked to receive so much money at once.

She used the money to buy a car, a washer and dryer, a refrigerator, a stove, a television, a $2,500 computer and three jogging suits for her son, she said in a recent interview. She also repaired her bathroom, leaky roof and collapsed hallway floor.

The computer, she said, has helped her son to sit still for long periods of time for the first time in his life. The stove had to be fitted with protective glass doors because her son once started a fire in the kitchen.

Smith now receives a regular monthly SSI check from the government for $446, in addition to Medicaid benefits.

In other cases disability money—both the back payments and the monthly checks—has been spent on everything from medical expenses not covered by Medicaid to family vacations. In some cases, families have tried to avoid the spending sprees by establishing trust funds for the children, but such arrangements are legally complex and prohibitively expensive.

The Social Security Administration does require an accounting from the person who is entrusted with the child's check. But the agency does not have the resources to scrutinize spending on a large scale. A guardian is suspended only if an egregious misuse of the money is called to the agency's attention.

"When you get into programs like this," said Louis D. Enoff, a 30-year veteran of the Social Security Administration and its acting director until July 1993, "if you write something that's very, very tight, then you have great difficulty. . . . You're going to have to follow up with a tremendous administrative detail to follow it through. What are we going to do? Follow every penny and ask for check stubs? And go see the evidence?"

Enoff said he wasn't sure a purchase such as a car should be allowed. "Yeah, they may buy a new car, but it's not a Mercedes or something," he said. "That's probably benefiting the kid as much as anything, because he needs treatment and he gets better treatment. . . . If the child has to go to the hospital once a week, they're taking a cab now. So you pay for the car pretty quickly." He added, "I mean, I would not buy a car, maybe, if it was me."

Social Security officials said the evidence of abuse is small. "I believe that most people are honest people who really care about their kids," said Barry Eigen, a senior Social Security official. "They're not trying to beat somebody out of something. They need this."

Fractured Administration

Administration of the child disability program is divided among state and federal offices in a vast, fractured system where hardly anyone is responsible for seeing the big picture.

First, applicants visit federal Social Security offices, where financial eligibility for the program is determined. Then, the applications are sent to separate state offices, such as the one where Porter works in Harrisburg. The state offices determine medical eligibility. Finally, the cases return to the Social Security offices, which make the monthly payments and oversee the spending of the money.

Doctors and examiners in the state offices make their judgments on the basis of applications and medical assessments. They almost never meet the children they are evaluating or the parents who are spending the money. "Our work begins in the mailroom when we receive a file and ends in the mailroom when we send it back with an allowance or disallowance," said Myrtie Adkins, the Maryland office director.

Meanwhile, the Social Security officials who see the applicants have no input on the disability determination. "We don't question the decision," said Ruby Burrell, head of the Camp Springs, Md., Social Security office. "We don't even question if they are really disabled. It would be improper to do that. . . . You meet the criteria, you get the benefits."

Many recipients come from troubled families, where parents or guardians may have their own addictions or pathologies.

Karen Bolewicki, a senior examiner in Maryland for eight years, said "at least one-third" of her cases involve families in which a parent is a drug or alcohol abuser. And Maryanne Bongiovani, a psychologist in Maryland for five years with a PhD, said a quarter of the 4,000 children's cases she has reviewed involve sexual abuse by a family member.

Kenneth R. Carroll, a psychologist with a PhD and a former colleague of Porter's in Pennsylvania, said these troubled family situations made him uncomfortable approving certain applications. "Many of the problems these children manifest are largely traceable to parental neglect or abuse," said Carroll. "Behavioral and emotional problems or conduct disorders that are directly attributable to inadequate parenting are being called disabilities, and the parents are receiving a cash award for having achieved the problem."

But Leslie Ellwood, a pediatrician with Virginia's office of disability determination, said just because a disability stems from poor parenting doesn't mean the children do not deserve assistance. "You don't want to visit the sins of the parents on the child," Ellwood said.

To address all these complicated questions, the government has now written some 40,000 words to interpret Tom Joe's original 26-word phrase. "We're doing a lot here based on one little statement," said Louis Enoff. "And is this really what was meant?"

Researcher David Greenberg contributed to this report

SOARING COSTS

GROWTH OF THE CHILDREN'S DISABILITY PROGRAM

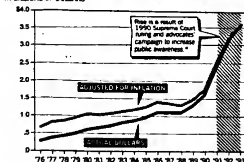
The children's disability program was enacted in 1972 as part of the Supplemental Security Income program. Payments began in 1976.

Recipients must have limited income to be eligible. Two examples:

- **A single working parent** with one disabled child receives the full SSI payment of $446 a month as long as the parent's earned income is less than $1,107 a month ($13,284 a year). As income increases, the SSI payment decreases correspondingly; if income exceeds $1,907 in any month, the family becomes ineligible.
- **A two-parent family with two children**, one of whom is disabled, receives the full benefit if its earned income is less than $1,685 a month ($20,220 a year). Partial payments are available as long as the family's income level is below $2,576 a month. Above that level, the family becomes ineligible.

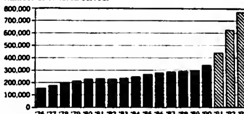
SOURCE: Social Security Administration

Benefits paid to families of children judged to be disabled:
IN BILLIONS OF DOLLARS



*Figures for 1991-93 do not include $2 billion in retroactive payments made after the 1990 Supreme Court ruling.

Number of children served:



THE WASHINGTON POST

Washington Post
2/14/94

Chairman JACOBS. Charlie, why don't we go to you.

STATEMENT OF HON. CHARLES B. RANGEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK, AND CHAIRMAN, CONGRESSIONAL CAUCUS ON NARCOTICS ABUSE AND CONTROL

Mr. RANGEL. Thank you. I think the drug problem facing the United States is one of the most important issues we should address. It amazes me how administration after administration continues to remind us how much money they are spending, but they don't tell us what they are doing. There is absolutely no accountability.

If we are talking about violent crime, as some people like the slogans, three strikes and you are out, my Governor says three strikes and you are in. The truth is you can spend millions keeping someone in jail and no one asks why the person is there. They now say most of the crimes committed are drug related, but we don't deal with the drug problem. We get more cops and more prisons.

If you want to deal with health problems, most of the costs we have in emergency rooms, the gunshot wounds, the AIDS problems, the diseases that are related to drugs and alcohol are really hemorrhaging the health bill. Yet we look at the health bill and they don't talk about the quality of service you get in treatment. All they talk about is you have access to treatment.

Of course if we talk about being productive and competitive, I don't know how we are going to do it if we have 1 million people in jail, 1 million on drugs, and people falling in the middle, and we don't know what they can do because we have not targeted this part of our population.

So what we have done is increased the number of addicts, increased the money spent on this, so when the issue came before me when I was chairman of the Select Narcotics Committee, no Secretary of Health and Human Services had been able to share with me their knowledge of the quality of service rendered because 90 percent of the money is being given to the States.

Having been a State legislator, unfortunately I know how the programs get it. The directors can impress you with the length of time they are there, or the fact that the director is an ex-addict or the fact he is a psychiatrist, but God forbid you should ask how many people and how long they have stayed off drugs after the program was completed.

So the Federal Government doesn't ask, the State doesn't ask, and when I found out that the Social Security Administration will be involved in disability payments, I said, my God, this is the time at long last that we will find accountability. Certainly if there is a disability, we have to find out that the recipient, the beneficiary, is going to try to get better. Who would want to save money more than the SSA?

But here we see once again there is no one asking whether or not the recipient is in treatment at all, and for those who are in treatment, there is no accountability as to what they are doing. It just seems to me that——

Chairman JACOBS. Barry Sullivan is testifying now.

81-535 O - 94 - 2

Mr. RANGEL. But when people are saying, my God, we are glad we shifted from supply side to reduction in demand, that would be great if I knew what were we doing in supply and how are you reducing demand? I assume they mean education, prevention, and treatment. I will buy all of that if you can only tell me what are you doing in education?

What is it that prevents a person from going on drugs, God knows. I think it means job training and jobs, but we don't talk about that either; but in the subject matter before this committee, we are now talking about treatment, so I can't get it from the Secretary of Health and Human Services, and I do hope that when the Social Security and SSI officials get here they might be able to explain what are we getting for the buck when we call it drug treatment?

[The prepared statement follows:]

Prepared Statement of

THE HONORABLE CHARLES B. RANGEL, CHAIRMAN
CONGRESSIONAL CAUCUS ON NARCOTICS ABUSE AND CONTROL

for hearing on

"MEANS OF ACHIEVING HIGHER RATES OF TREATMENT AND REHABILITATION AMONG ALCOHOLICS AND DRUG ADDICTS RECEIVING FEDERAL DISABILITY BENEFITS"

Good morning, messrs. chairmen, ladies and gentlemen.

The issue we are discussing today is an important one as we face worsening problems of substance abuse and poverty in a tight budgetary situation. I believe there is a connection between the surge in the number of disability benefit awards to substance abusers and the growing sense of helplessness among people who are living on the fringe of the economic and social mainstream of our society.

In 1992, as Chairman of the House Select Committee on Narcotics Abuse and Control, I engaged in a dialogue with officials of the U.S. Department of Health and Human Services about developing more creative ideas for attacking the complex problems of drug abuse. I was particularly concerned about press reports concerning SSI cash payments that were alleged to have been used by addicts to buy heroin and other illicit drugs. I also wanted to know why no one knew how many addicts who were supposedly receiving treatment to obtain their Social Security payments were actually in treatment programs or had been rehabilitated.

Former Secretary of HHS, Dr. Louis Sullivan, and his Social Security Administration Commissioner agreed that the incentive of SSI benefits provided a tool to encourage addicts into treatment, as Congress intended. SSI benefits also offered an excellent opportunity for the Federal Government to demonstrate what works in treatment

and rehabilitation by linking treatment with job training, job placement and other rehabilitative services. The key was improved monitoring and case management by SSA.

Addressing the need to tighten the system of managing federal benefits to and treatment for substance abusers, the HHS Center for Substance Abuse Treatment developed demonstration projects in two states that were targeted at improving monitoring and referral services for substance abusers and tightening the link between continued SSI eligibility for drug and alcohol disabled individuals and participation in monitored treatment and rehabilitation programs.

If these projects have been successful in bringing more control over the payment system and treatment services to those who need them, then they should be expanded.

Besides improving the system for payment of benefits, referrals, and monitoring of treatment we should also be looking at the quality of the treatment substance abusers are receiving. As we review the status of the current payment and treatment system for addict beneficiaries of SSA funds, we should take the opportunity to consider standards that would ensure quality treatment for everyone receiving such services.

We also need to ensure that a system of monitoring and accountability for the use of scarce resources is in place. It has been suggested that SSI and SSDI benefits have been used by addicts to purchase alcohol and drugs. We cannot allow any resources to be used to purchase the substances fueling our addiction problems -- including federal funds paid to substance abusers.

The cost of drug and alcohol abuse for this country is tremendous. The more substance abusers we can treat and return to productive rather than destructive lives the better for the future of our nation. Our goal should be providing every substance abuser with effective treatment -- not just the 250,000 drug and alcohol abusers who receive SSI and SSDI payments.

Thank you very much.

Chairman JACOBS. Thank you, Chairman Rangel.
Why don't you go ahead, and we can get this done and go vote?

STATEMENT OF HON. GERALD D. KLECZKA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. KLECZKA. Thank you, Mr. Chairman, I want to thank you and Chairman Ford for holding these hearings.

The growing criticism supplemental security income [SSI] has been receiving of late indicates that there are major problems existing in this program. The program was intended to provide assistance to low-income disabled, blind, and aged individuals. This intention is a noble one. If Federal assistance should go to anybody, it is to those whose conditions, due to no fault of their own, place them in severe economic hardship.

However, reports abound these days about how parts of the program are riddled with flaws and abuse. I would like to suggest, Mr. Chairman, that we consider reforms centered around two goals: First and foremost, to provide appropriate assistance to the low-income blind, disabled and aged, whom SSI was intended to assist; and second, to eliminate opportunities for abuse.

Reforms to achieve these goals will enable SSI to better serve the truly needy, while ensuring that the taxpayers are not being taken advantage of. Last October I spoke to your subcommittee about some of the abuses which I have seen in the SSI program for children.

I should direct the attention of the members to an excellent article in the Washington Post last week, which further explored some of the serious problems in the SSI children's program.

Today I would like to discuss some problems with the program for those classified as drug addicts and alcoholics, whom we term DA&As. I will pose questions which I think we should consider as we evaluate this well-intentioned program.

The first question is whether a substance addiction should qualify as a disability. If the answer is yes, then passing drug tests, as Mr. Santorum has suggested, should be both a mandatory and regular component of the program. If the answer is no, then maybe SSI is not the appropriate referral.

As we know, SSI recipients whose impairments are the result of drug or alcohol addictions are classified as DA&As. These recipients are required to seek treatment from an approved facility and receive SSI payments through a representative payee. However, these requirements are sometimes being ignored.

The General Accounting Office, as those officials will probably explain to you in testimony today, reported that only 9 percent of some 69,000 DA&As in August 1993 were known to be in treatment. This is very disturbing. GAO also reported that 84 percent of those DA&As had an unknown treatment status.

This lack of oversight is not completely the fault of the Social Security Administration. As we all have been hearing, Mr. Chairman, SSA is overwhelmed. Thus, we must find new administrative solutions and consider statutory changes to assist SSA with the administration of this program.

There is also the simple problem of providing treatment. Many claim that adequate treatment facilities do not exist. We must

clearly define what type of treatment is expected; then we should find ways to provide this treatment within the constraints of our available resources. That way, we will facilitate successful rehabilitation.

Know that we face a paradox here: Successful treatment can result in a cessation of benefits, creating an incentive to resist rehabilitation. For example, I have encountered a case where an SSI recipient admits to occasionally slipping off the wagon to prevent his losing benefit payments. We must correct this paradox, and we must demand that substance abusers seek treatment.

Another deep concern of mine lies in the representative payee system. My constituents tell me of recipients using SSI money to finance their habits. For example, a woman has repeatedly called my Milwaukee office with stories that her daughter's benefit checks were lost or stolen. It turns out they were not stolen. The woman used the SSI money to purchase drugs for herself.

The payee system also provides tremendous opportunities for fraud. One particular case is a homeless man whose payees have stolen from him. One of these was imprisoned for fraud. Although the man receives a combination of SSDI and SSI payments, these problems have made him unable to afford permanent shelter.

Chairman JACOBS. We are down to 4 minutes to get to the floor. Would you want to come back or hand it in?

Mr. KLECZKA. If the committee wants me to come back to respond to questions, I sure will.

Chairman JACOBS. It is at your discretion, whichever you wish.

Mr. KLECZKA. I think the bottomline, Mr. Chairman, as I tried to say, was not only do we have serious problems in the children's portion of SSI, but as we see in the charts and have heard from testimony, something clearly has to be done to improve the SSI program as it relates to alcoholics and drug addicts. I will leave the committee with that.

Hopefully, my statement will be part of the record.

Chairman JACOBS. Certainly.

[The prepared statement follows:]

Statement of Rep. Gerald D. Kleczka
Before the Subcommittee on Social Security
and the Subcommittee on Human Resources
February 9, 1994

Mr. Chairmen, I would like to thank both of you for holding this hearing. The growing criticism which the Supplemental Security Income program (SSI) has been receiving of late indicates that there are major problems existing in this program.

SSI payments were first granted in January 1974. The program was intended to provide assistance to low-income disabled, blind, and aged individuals. This intention is a noble one. If federal assistance should be granted to anyone, it is certainly those whose conditions, due to no fault of their own, place them in severe economic hardship.

However, reports abound these days about how parts of this program are riddled with flaws and abuse. On the 20th anniversary of the first SSI payments, it is only fitting that we in Congress begin to show a firm commitment to examining this program and to reevaluating the way some of these benefits are provided. I would like to suggest, Mr. Chairmen, that our efforts be centered around two main goals: foremost, (1) to provide appropriate assistance to the low-income blind, disabled, and aged individuals SSI was intended to assist; and (2) to eliminate opportunities for abuse. Reforms to achieve these goals will enable SSI to better serve the truly needy, while ensuring that the taxpayers are not being taken advantage of.

In October of 1993, I had the opportunity to address your subcommittee, Chairman Ford, about the most serious abuses appearing in the benefit program for children. At that time, I told your subcommittee about children being "coached" on actions which will help them maintain benefits or gain acceptance to the program. I also told you about the enormous backlog of cases created by the *Zebley* decision, which expanded the behavioral basis for receiving SSI benefits. That decision led to $2 billion in retroactive lump sum payments to those who had been previously denied benefits. Some of that money has been spent on cars and vacations, not medical treatment or rehabilitation.

Today, I would like to discuss some of the problems with the SSI program for those classified as drug addicts and alcoholics (DA&As). I would also like to pose some questions I think we should consider as we evaluate this well-intentioned program. The first question is whether a substance addiction qualifies as a disability. If the answer is yes, then passing drug tests should be both a mandatory and regular component of the program. If the answer is no, then maybe SSI is not the appropriate referral.

As we all know, a SSI recipient, whose impairment is the result of a drug or alcohol addiction, is classified as DA&A. These beneficiaries are required to seek treatment for their addictions from an approved facility and to receive SSI payments through a representative payee. It is these two areas which appear to create the greatest concern.

These requirements were established to ensure proper administration of benefits and an attempt at rehabilitation is made. However, some of these requirements are being ignored.

The General Accounting Office (GAO) -- as those officials will probably explain to you in their testimony today -- reported that only 9% of the 69,419 DA&As in current pay status in August 1993 were known to be in treatment.

Even more disturbing is the lack of monitoring given to these beneficiaries. GAO also reported that, according to SSA computer files, 84% of those DA&As in August 1993 had an unknown treatment status. That's approximately 58,000 of 69,000 recipients. That figure is alarming. Even when a referral and monitoring agency (RMA) was contracted to check compliance, GAO reported that less than half of the 30,255 DA&As being monitored were in treatment.

Clearly, there is a problem here, which we all must work together to correct. I do not wish to unfairly imply that this lack of oversight is completely the fault of SSA. As we all have been hearing, Mr. Chairmen, SSA is overwhelmed. From December 1980 to December 1990, a ten-year period, the total number of persons receiving federally administered SSI benefits increased by 675,000 to 4,817,127. However, from December 1990 to June 1993, just two-and-a-half years, the federal SSI rolls jumped by almost 1,000,000 recipients. We must find new administrative solutions and consider statutory changes to assist SSA with its task of ensuring compliance with the regulations and overall, appropriate utilization of benefits.

In addition to this administrative overload, there is a simple problem with providing treatment. Many claim that adequate treatment facilities do not exist. We must clearly define what type of treatment is expected for DA&As and to tailor this to meet the constraints of our available resources and to, hopefully, facilitate successful rehabilitation.

Know full well that successful treatment can result in the cessation of benefits, creating an incentive to resist rehabilitation. I have encountered a case where a SSI recipient admits to periodically "slipping off the wagon" to prevent losing benefit payments. We must institute incentives to correct this paradox, and we must demand that substance abusers seek treatment.

Another deep concern of mine lies in the representative payee system. My constituents tell me of SSI recipients using money to finance their habits. For example, a woman has repeatedly called my Milwaukee office with stories that her daughter's benefit checks were lost or stolen. It turns out that they were not stolen, the woman had been using the SSI money to purchase drugs for herself.

The payee system also provides tremendous opportunities for fraud. One particular case is a homeless man, whose payees have stolen from him on several occasions. One of these payees was even imprisoned for fraud. Although the man receives a combination of Social Security Disability and SSI payments, these problems have made him unable to afford permanent shelter.

These reports are not surprising when one considers how a payee is found. Payees are appointed by SSA officials, strongly considering the SSI recipient's suggestion. GAO reported that, considering those same 69,419 DA&As, almost 60% of payees were relatives of the recipient; the second largest group were friends, who comprised 34.5% of payees. It is no wonder that there are so many reports of abuse with over 90% of payees being friends or relatives of the substance abuser.

We must find a way to select more impartial payees. Friends and relatives are, understandably, too often susceptible to influence from the beneficiary. Outside representatives must be found, so that we can ensure the proper administration of benefits. This is clearly in the best interest of both the payee and the taxpayer.

My state of Wisconsin provides one of the most generous SSI benefits in the nation. In 1994, an individual SSI recipient could receive a maximum federal benefit of $446 per month and a Wisconsin supplement of $84, for a total benefit of $530. With this much money at stake, the time has come to consider the possibility of a voucher system. Although there are possibilities for abuse in such a system as well, vouchers could help assure that SSI benefits to DA&As are used for their intended purpose.

There is an additional problem which applies to the entire SSI program. If a recipient's primary reason for meeting the disability requirements of SSI is not related to a drug or alcohol addiction, that recipient is not classified as DA&A, even if he or she has a substance addiction. Benefits to these recipients are, therefore, not contingent upon the treatment and payee requirements. We should search for an efficient way to identify and assist such people to combat their addictions and to ensure the appropriate use of their SSI benefits.

In conclusion, it is clear that there is a pressing need to reform this well-meaning program. Senator Herb Kohl of Wisconsin and I are currently working on legislation to reform the SSI program for drug addicts and alcoholics and the program for children. I have been in contact with the Department of Health and Human Services, which has indicated interest in working together to find a meaningful solution. Clearly, welfare reform legislation is an appropriate vehicle for this effort.

I hope, Mr. Chairmen, that we will be able to pool our efforts to enact reforms which will achieve the two goals I have mentioned: providing benefits to deserving low-income disabled, blind, and aged individuals, while closing the door on opportunities for abuse.

Thank you again, Mr. Chairmen, for allowing me this opportunity to present my concerns and ideas on reforming the SSI program.

Chairman JACOBS. We will recess long enough to cast a vote and come back.

[Recess].

Mr. REYNOLDS [presiding]. We are going to get going.

The next witness is going to be Toby Roth.

STATEMENT OF HON. TOBY ROTH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Mr. ROTH. Thank you, Mr. Chairman, and distinguished members of the Ways and Means Committee. I am delighted to appear here this morning.

The investigations of the GAO and Senator Cohen have told us that there are some 250,000 drug addicts and alcoholics receiving almost $1.5 billion in Social Security disability payments. This happened last year. There were no strings attached.

According to these reports, addicts are cashing checks and buying drugs on the same day. The American people are justifiably outraged that our Social Security system, which was set up to support working Americans in retirement, has degenerated into a cash cow for addicts.

During the past year, my House Republican Task Force on Social Security has held several hearings and forums on the Social Security tax increase passed into law last year. Our task force listened to ordinary senior citizens from Maine to California who opposed higher taxes on their Social Security benefits.

Thanks to these tax increases, seniors who once paid taxes on half of their benefits now must pay taxes on 85 percent of their benefits. These 6 million seniors will have to pay some $26 billion in new taxes on Social Security. Now, the same retirees are learning that Social Security is doling out money to addicts.

Just yesterday one of our senior citizens from Green Bay, a city I represent, called and was wondering how our Government that has raised his taxes can now find money to throw away on drugs.

I told him that this is why I was appearing before the committee this morning, to see if we can make some of these corrections that are obviously needed.

So I ask this committee to address this issue. This senior citizen and other hard-working Americans are outraged that our Social Security system has turned $1.5 billion over to people who use it for questionable ends, for example, like buying drugs and the like.

Mr. Chairman and members, it is time to impose some tough rules on SSDI recipients who are addicts. On Tuesday I joined my friend from Pennsylvania to introduce legislation to tighten the rules under which addicts collect payments.

Under our bill, addicts who receive title II SSDI benefits must register with reputable organizations to ensure that these benefits pay for treatment and not go right back on the street for drugs.

Additionally, administrative law judges may terminate benefits to recipients who continue to abuse the system.

I would ask, Mr. Chairman, that you and the members of your committee look at this legislation and see if we can correct this obvious oversight and mistake in the system.

Chairman JACOBS. Thank you, Mr. Roth. I appreciate your contribution. There are no questions for you. You are remarkably thorough.

Mr. ROTH. Thank you, Mr. Chairman.

[The prepared statement follows:]

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TRAVEL AND TOURISM CAUCUS
SPORTSMEN'S CAUCUS
RURAL CAUCUS
GRACE CAUCUS

CHAIRMAN, TASK FORCE ON
SOCIAL SECURITY

United States
House of Representatives

FOREIGN AFFAIRS COMMITTEE
ECONOMIC POLICY, TRADE AND ENVIRONMENT
ASIAN AND PACIFIC AFFAIRS

BANKING, FINANCE AND
URBAN AFFAIRS COMMITTEE
GENERAL OVERSIGHT AND INVESTIGATIONS
ECONOMIC GROWTH AND CREDIT FORMATION

STATEMENT BY THE HONORABLE TOBY ROTH
SUBCOMMITTEE ON SOCIAL SECURITY
HEARING ON SOCIAL SECURITY DISABILITY INSURANCE PROGRAM
FEBRUARY 10, 1994

MR. CHAIRMAN, THANK YOU FOR CONVENING THIS IMPORTANT HEARING AND I APPRECIATE THE OPPORTUNITY TO TESTIFY BEFORE THE SOCIAL SECURITY SUBCOMMITTEE.

THANKS TO THE INVESTIGATIONS OF THE GAO AND SENATOR COHEN, WE NOW KNOW THAT SOME 250 THOUSAND DRUG ADDICTS AND ALCOHOLICS RECEIVED 1.4 BILLION DOLLARS IN SOCIAL SECURITY DISABILITY INSURANCE PAYMENTS LAST YEAR, WITH NO STRINGS ATTACHED.

ACCORDING TO THESE REPORTS, ADDICTS ARE CASHING THEIR CHECKS AND BUYING DRUGS THE SAME DAY.

THE AMERICAN PEOPLE ARE OUTRAGED THAT OUR SOCIAL SECURITY SYSTEM -- WHICH WAS SET UP TO SUPPORT WORKING AMERICANS IN RETIREMENT -- HAS DEGENERATED INTO A CASH COW FOR ADDICTS.

DURING THE PAST YEAR, MY HOUSE REPUBLICAN TASK FORCE ON SOCIAL SECURITY HELD HALF A DOZEN HEARINGS AND FORUMS ON THE SOCIAL SECURITY TAX INCREASE PASSED INTO LAW LAST YEAR.

OUR TASK FORCE LISTENED TO ORDINARY SENIOR CITIZENS FROM MAINE TO CALIFORNIA WHO OPPOSED HIGHER TAXES ON THEIR SOCIAL SECURITY BENEFITS.

THANKS TO THIS TAX INCREASE, SENIORS WHO ONCE PAID TAXES ON HALF THEIR SOCIAL SECURITY BENEFITS, NOW MUST PAY TAXES ON 85 PERCENT OF THEIR BENEFITS.

THESE SIX MILLION SENIORS WILL HAVE TO PAY 26.3 BILLION DOLLARS IN NEW TAXES ON THEIR SOCIAL SECURITY.

NOW, THESE SAME RETIREES ARE LEARNING THAT SOCIAL SECURITY IS DOLING OUT MONEY TO ADDICTS.

JUST YESTERDAY I SPOKE TO A SENIOR CITIZEN IN GREEN BAY WHO WONDERED HOW THE SAME GOVERNMENT THAT RAISED HIS TAXES CAN FIND MONEY TO THROW AWAY ON DRUGS.

I AM ASKING THIS SUBCOMMITTEE THE SAME QUESTION.

THIS SENIOR CITIZEN AND OTHER HARD-WORKING AMERICANS ARE OUTRAGED THAT OUR SECURITY SYSTEM HAS TURNED INTO A 1.4 BILLION DOLLAR ENABLER TO THOUSANDS OF ADDICTS.

MR. CHAIRMAN, IT IS TIME TO IMPOSE SOME TOUGH RULES ON SSDI RECIPIENTS WHO ARE ADDICTS.

TUESDAY I JOINED MY FRIEND FROM PENNSYLVANIA TO INTRODUCE LEGISLATION TO TIGHTEN THE RULES UNDER WHICH ADDICTS COLLECT PAYMENTS.

UNDER OUR BILL, ADDICTS WHO RECEIVE TITLE TWO SSDI BENEFITS MUST REGISTER WITH REPUTABLE ORGANIZATIONS TO ENSURE THAT THEIR BENEFITS PAY FOR TREATMENT, NOT FOR DRUGS.

ADDITIONALLY, ADMINISTRATIVE LAW JUDGES MAY TERMINATE BENEFITS TO RECIPIENTS WHO CONTINUE TO ABUSE THE SYSTEM.

MR. CHAIRMAN, I URGE YOUR SUBCOMMITTEE TO ACT ON OUR BILL AND TO CONSIDER MR. COHEN'S EXCELLENT SUGGESTIONS FOR SSDI REFORM.

THE AMERICAN PEOPLE ARE LOOKING TO CONGRESS TO STOP THIS SCANDALOUS WASTE, AND I URGE MY COLLEAGUES TO LISTEN TO THE AMERICAN TAXPAYERS AND PUT A STOP TO THIS OUTRAGEOUS FRAUD AND ABUSE.

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Chairman JACOBS. Will the first panel—no, Ms. Ross from the General Accounting Office, Associate Director, Income Security Issues, Health, Education and Human Services Division and Barry Tice who is the person who is accompanying her.

STATEMENT OF JANE L. ROSS, ASSOCIATE DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY BARRY TICE, ASSISTANT DIRECTOR, INCOME SECURITY ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION

Ms. ROSS. Thank you, Mr. Chairman.

Chairman JACOBS. You can proceed in your usually concise manner.

Ms. ROSS. I would ask permission that my full statement be put in the record.

Chairman JACOBS. Without objection so ordered.

Ms. ROSS. Thank you for inviting me.

Mr. BUNNING. Will you pull the mike up so everybody can hear you?

Ms. ROSS. Yes, sir.

Thank you for inviting me to discuss disability benefits paid to drug addicts and alcoholics by the Social Security Administration. My testimony is based on the work that your subcommittee requested from the GAO.

I will discuss the rapid growth in the addict population and address SSA's poor record of monitoring treatment for this population. I will also talk about the need for more financial controls over payments to addicts and suggest that it may be time to rethink the program's basic design.

Let me give you the main points right away. GAO has found that at least 250,000 addicts receive disability benefits today at an annual cost of about $1.4 billion. The number of addicts is increasing at an alarming rate for reasons that are unknown. The vast majority of these addicts are receiving their benefits without any requirement that they be in treatment. Also, there is little assurance that the cash benefits are not being used for the purchase of drugs and alcohol.

Let me begin by providing some background information on how addicts qualify for DI and SSI benefits.

You can follow along on the chart that we have provided. Eligibility for disability benefits involving drug or alcohol addiction is determined like any other medical disorder. Benefits are awarded to persons who cannot work and whose physical or mental impairment will last for at least 12 months.

Those awarded benefits are to be periodically reviewed to determine whether they are still disabled. As you can see from the chart, substance addiction by itself can be a disabling impairment, no other physical or mental impairment is required.

The impairment must be established by medical evidence consisting of symptoms, signs, and laboratory findings. You can see that category applies to both the disability insurance and the SSI population. Then in particular within the SSI program, there is a special program for those addicts who qualify for disability solely be-

cause of their addiction. These individuals are required to have a third party manage their benefits and they are also required to participate in treatment for their addiction. This is called the SSI DA&A population.

As you can see, if you go to the bottom of the chart, we are estimating there are about 106,000 DI beneficiaries with substance addiction. For SSI beneficiaries, we are saying there are close to 150,000 and within that 150,000, there is the special category called DA&A which is about 70,000, as of last August.

I just want to be clear that the DA&A population is a subset of all the people who are called addicts under SSI.

I want to turn now to the growth in the number of addicts receiving benefits. As I said earlier, 250,000 addicts are now receiving DI and SSI benefits. Five years ago there were fewer than 100,000 on the rolls.

We should point out that more than half of these 250,000 addicts qualify for benefits based on medical problems independent of their addictions. For example, an addict may be eligible because of AIDS or cirrhosis of the liver, but all 250,000 of these people have addictions that are severe enough that the condition is included as part of their diagnosis.

Most of us would call them addicts.

Growth in the SSI DA&A population has also been substantial, from December 1989 through August 1993, the number increased from 17,000 to 70,000, more than a fourfold increase in 4 years.

If you look at our chart, it shows the growth in the number of addicts each year, and the point is that the number of people added to the rolls is increasing each year. The white bars or white-blue bars are the total SSI and DI claims. The black bars are the DA&A population.

Let me turn from growth to the treatment of the addicts.

The treatment status of the vast majority of addicts is unknown largely because three-fourths of SSA's addict population is not required to attend treatment. However, with respect to those addicts who are in the SSI DA&A program and for whom treatment is a requirement, SSA has done a poor job of monitoring compliance.

According to SSA records, only 9 percent of these DA&As are in treatment. The remainder are not in treatment or their treatment status is unknown.

SSA can designate an agency in each State called a referral and monitoring agency [RMA] to arrange and monitor treatment. But through 1993 SSA established these agencies in only 18 States.

Even in these 18 States, the RMAs were monitoring only half the addicts, and only half of the half they were monitoring were in treatment.

Moving from treatment to financial controls, many addicts don't have a representative payee, that is, someone to control benefit funds. While all persons in this SSI DA&A program must have a representative payee, less than half of the rest of the addicts have them.

When you look at the issue of effectiveness, there is data showing that friends and family are not always the best representative payee for addicts. They have a difficult time exercising strict controls over the funds and withstanding the abuse and pressure of

the addicts. Organizational payees tend to provide much greater control over the funds.

We have a series of recommendations for improving the way SSA deals with the addict population. It is clear that more effective treatment, referral, and monitoring must occur with the current DA&A population. We are encouraged by SSA's efforts in the last several months to move in this direction.

SSA also needs to strengthen its representative payee program. We believe that when possible SSA should use organizations as representative payees for addicts.

Also we believe that the representative payee requirement should be expanded to cover all DI and SSI addicts. The public must have confidence that these DI and SSI funds are being used for the basic program purposes of food, clothing, and shelter.

Over the longer term, we believe that the Congress should rethink the conditions under which addicts receive SSA program benefits and consider alternatives such as extending the requirement for treatment to all addicts receiving DI and SSI benefits.

Another approach would be to require addicts to be in treatment before they receive benefits.

This approach would in effect require applicants to put forth a good faith effort to try to rehabilitate themselves before they start to receive benefits.

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

Chairman JACOBS. Thank you, Ms. Ross.

[The prepared statement and attachment follow:]

Statement of Jane L. Ross
Associate Director, Health, Education,
and Human Services Division

Messrs. Chairmen and Members of the Subcommittees:

Thank you for inviting me to discuss disability benefits paid to drug addicts and alcoholics by the Social Security Administration (SSA). My testimony is based on the work your subcommittees requested.

We have found that at least 250,000 addicts receive disability benefits today at an annual cost to the Disability Insurance (DI) and Supplemental Security Income (SSI) programs of about $1.4 billion. The number of addicts receiving disability benefits has grown substantially during the last 5 years, with over half of those on the rolls being added during that time. The vast majority of these addicts are receiving their benefits without any requirement that they be in treatment. Also, there is little assurance that the cash benefits provided to them are being spent wisely and are not being used to support their addictions.

My testimony today discusses the rapid growth in the addict population. It also addresses SSA's poor record of monitoring treatment for this population. Finally, I will talk about the need for more financial controls over payments to addicts.

BACKGROUND

Let me begin by providing some background information on how addicts qualify for DI and SSI benefits. Eligibility for

disability benefits involving drug or alcohol addiction is determined like any other medical disorder. Benefits are awarded to persons who cannot work and whose physical or mental impairment will last for at least 12 months. Those awarded benefits are to be periodically reviewed to determine whether they are still disabled.

Substance addiction, by itself, can be a disabling medically determinable impairment. No additional physical or mental impairment is required. The impairment must be established by medical evidence consisting of symptoms, signs, and laboratory findings. (Appendix I provides a brief summary of how such disorders are evaluated.)

We should point out that more than half of the 250,000 addicts on the rolls qualify for benefits based on medical problems in addition to their addictions. For example, an addict may be eligible for benefits because of AIDS or disabling medical problems associated with heart disease or cancer. But all these people have addictions severe enough that the condition is included as a part of their diagnoses.

Under the SSI program, addicts who qualify for benefits on the basis of their addiction are required by law to have a third party, or representative payee, manage their benefits, and to participate in treatment for their addiction. Addicts included

in the SSI drug addiction and alcoholism (DA&A) program are those who would not qualify for disability if their addiction ended. There is no similar requirement in the DI program.

The objective of this special classification within the SSI program is to rehabilitate SSI recipients so that they will become productive members of society, and remove them from the SSI disability rolls. As of August 31, 1993, about 70,000 addicts[1] were in this SSI program. Most of them were alcoholics. Benefit payments to these individuals amount to about $285 million annually.

For SSI recipients put into the DA&A program, an SSA office arranges for a representative payee to manage the person's benefits. SSA also is responsible for treatment referral and monitoring. In some states--18 by the end of 1993--SSA sends the case to a referral and monitoring agency or RMA. RMAs are state government or private organizations that arrange treatment for the DA&As, monitor treatment participation, and report to SSA on treatment status.

The types of treatment provided for DA&As can range from intensive in-patient care to outpatient care in informal support group settings. SSA is not permitted to pay for treatment nor

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[1]By the end of December, 1993, the number of DA&As had risen to 78,000. Our analysis in this testimony is based on the DA&A caseload of 69,419 at the end of August.

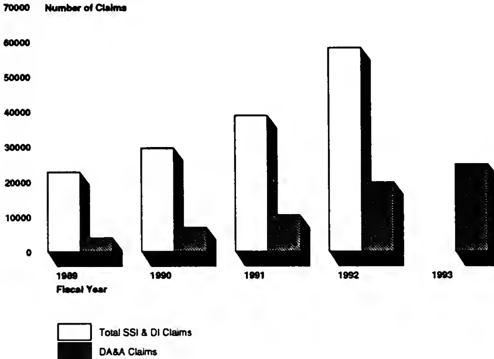
can the addict be required to pay for it. Some services can be covered by state Medicaid programs, but there are large state variations in the type, amount, duration, and scope of services provided. The amount of state and federal Medicaid funding for treatment for SSI DA&As is not known because states do not keep records on the specific services provided to this population.

I will now turn to the growth in the number of addicts receiving benefits, and SSA's poor record of monitoring treatment and controlling benefit payments to this group.

SUBSTANTIAL GROWTH IN PROGRAM ROLLS

The number of addicts receiving DI and SSI benefits has increased significantly in recent years, totalling about 250,000 persons today. Five years ago, there were fewer than 100,000 addicts on the rolls. Growth in the SSI DA&A population has also been substantial. From December 1989 through August 1993, the number increased from about 17,000 to 70,000, more than a 4-fold increase over the 4-year period. This growth is illustrated in the figure below.

Disability Claims Allowed Annually With an Addiction Diagnosis Compared with Increases in DA&A Cases (1989-1993)



NOTE: Number of claims allowed with addiction diagnoses is not available for 1993

There are many possible explanations for these increases, including increased SSI outreach and referrals from state welfare rolls, but the actual causes are not yet known.

THE TREATMENT STATUS OF THE VAST MAJORITY OF ADDICTS IS UNKNOWN

Except for some of the addicts in the SSI DA&A program, SSA does not know whether the vast majority of addicts are in treatment. The reason is that almost three-fourths of SSA's addict population is not required to attend treatment. With respect to those addicts who are in the DA&A program and for whom treatment is a requirement, only about 1 in 5 are in treatment.

SSA has done a poor job of monitoring compliance with the treatment requirement for the SSI DA&A addicts. While SSA has the capability to monitor treatment status through its computerized records and through RMA reporting, both methods are seriously deficient. According to SSA records, only about 9 percent of the DA&As are in treatment. The remainder are not in treatment (7 percent) or their treatment status is unknown (84 percent). This same situation was reported by the HHS Inspector General in a 1991 report.

Most of the DA&As are in those states with RMAs. As mentioned earlier, through 1993, SSA had established RMAs in only 18 states. For those states without RMAs, SSA regional offices were to assume responsibility for the treatment monitoring function. According to SSA, however, no evidence exists that the regions complied with this requirement.

About 85 percent (60,000) of the DA&As receiving benefits are in these RMA states. Of these addicts, however, RMAs report that only half of them are actually being monitored and only half of these (about 15,000) are actually in treatment. Data are not available to explain why the treatment status of about 30,000 DA&As in the RMA states is not being monitored.

There may have been an underreporting of addiction diagnoses and DA&As in those states without RMAs because SSA and state disability determination offices apparently gave low priority to identification of these cases. California, for example, has an RMA and has about 26,000 DA&As, while states such as Texas and Florida, without RMAs, have only 365 and 543 DA&As, respectively. Only 38 DA&As are reported for the District of Columbia, where there has been no RMA.

The poor monitoring of the treatment requirement may have also contributed to the relatively poor outcomes under the DA&A program. For example, during 1993, the RMAs reported that, on average, only 75 addicts successfully completed treatment each month. During this same time period, the rolls of the DA&A program were increasing by about 2,000 addicts a month.

SSA is currently establishing RMA monitoring in all fifty states and the District of Columbia. We believe this move, while belated, is nonetheless a good one. An SSA study showed that--in

comparison with a control group that did not receive RMA monitoring--the RMAs accomplished their basic mission of keeping addicts in treatment.

SSA, in conjunction with the Substance Abuse and Mental Health Services Administration (SAMHSA), has also initiated two demonstration projects in the states of Washington and Michigan in an effort to improve the DA&A program. Both projects are attempting to enhance case management and to develop improved referral and monitoring procedures that could be applied in other states.

EFFECTIVENESS OF REPRESENTATIVE PAYEE REQUIREMENT IS QUESTIONABLE

Many addicts do not have representative payees. We estimate, for example, that about 100,000 of the 250,000 beneficiaries with addiction disorders do not have payees. Studies in general have shown that, in those situations where payees are present, it is questionable how tightly they control the use of benefits. In the absence of tight controls, addicts are free to purchase drugs and alcohol to maintain their addictions. This situation leaves the government open to charges that it is an "enabler" because the benefits give addicts the means to support their addictions.

Virtually all addicts in the DA&A program have payees. Of approximately 185,000 addicts not in the DA&A program, however, less than half have representative payees.

There are little data showing how well representative payees do their job in controlling benefits for addicts. However, anecdotal data, including previous testimony before your subcommittees, suggest that the representative payee requirement is not working well. A previous study of the addict population by SSA found payee controls, particularly when the addicts' friends were the payees, to be lax in many cases.

This study also showed that organizational payees such as RMAs and treatment facilities tended to provide the greatest amount of control. In this regard, we believe that organizational payees would be in a better position to implement the stringent controls needed over benefits paid to addicts. Further, we believe that organizations are better prepared to deal with those situations where addicts are abusive or threatening.

Finding qualified payees for addicts has been a long-standing problem for SSA. Payees are generally not paid and serve on a voluntary basis.[2] These circumstances coupled with the potential

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[2]SSA is currently carrying out a demonstration program whereby qualified organizations can be paid up to $25 per month for acting as a representative payee. The fee is paid by the beneficiary.

for incurring abuse or threats make the representative payee job a difficult sell for SSA.

CONCLUSIONS

SSA payments to addicts are out of control. The number of addicts is increasing at an alarming rate for reasons that are unknown. The requirements for treatment are not being complied with or properly monitored. And, there is little assurance that benefit payments are not being used for the purchase of drugs and alcohol. SSA needs to take immediate action to deal with these problems and the Congress needs to reconsider the basic design of the DA&A program.

It is clear that more effective treatment referral and monitoring must occur with the current DA&A population. We are encouraged by SSA's recent and ongoing expansion of its RMA agreements which will provide national coverage for this population. However, simply establishing RMAs does not necessarily guarantee that all addicts will be monitored, much less be in treatment. SSA also needs to work closely with the RMAs and SAMHSA to better identify the treatment needs of these persons and to see that they receive the appropriate level of services.

SSA needs to strengthen and expand payee monitoring. We believe SSA should use organizations as representative payees to the

maximum extent possible. Organizations would be better able to implement the more stringent controls needed over benefits paid to addicts. One way to expand the use of organizations is to use RMAs to provide payee services. Making the RMA the payee would have the effect of consolidating case management functions, including treatment for addiction and money management.

As is the case with addicts in the DA&A program, we believe the representative payee requirement should be applied to all DI and SSI addicts. The very nature of their medical problems suggests to us that SSA should require representative payees for all addicts receiving benefits. This is not the case now. There is no regulatory or programmatic requirement for the addicts not in the SSI DA&A program to have a representative payee. The public must have confidence that these funds are being used for the basic program purposes of food, clothing, and shelter.

Over the longer term, we believe that the Congress should rethink the basic structure of the DA&A program and consider such alternatives as extending the requirement for treatment beyond this group to all addicts receiving DI & SSI benefits. Another approach would be to require addicts to be in treatment before they receive benefits. This approach would in effect require applicants to put forth a good faith effort to try to rehabilitate themselves before they start to receive benefits.

RECOMMENDATIONS TO THE SECRETARY
OF HEALTH AND HUMAN SERVICES

The Secretary should direct the Commissioner of SSA to strengthen the controls over disability benefits paid to addicts in the following ways:

-- take appropriate measures to ensure that all DA&As are accounted for and monitored as required;
-- require all addicts receiving DI and SSI benefits to have a representative payee;
-- use organizational payees for addicts to the maximum extent possible; and
-- consider making the RMAs the representative payees.

The Secretary should seek whatever additional legislative authority may be needed to meet these ends.

MATTERS FOR CONSIDERATION BY THE CONGRESS

In view of the twenty years of experience with the program and the limited progress in addressing the problems of addicted beneficiaries, the Congress should reconsider the DA&A program's basic design including alternative approaches.

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Messrs. Chairmen, this concludes my prepared statement. I will be happy to answer any questions you or other members of the subcommittees may have.

QUALIFYING FOR DISABILITY BENEFITS WITH SUBSTANCE ADDICTION

-- The Social Security Act provides for the payment of disability benefits to persons who cannot perform substantial gainful work and who have a medically determinable physical or mental impairment that has lasted or is expected to last for at least 12 months or to result in death.

-- Substance addiction can be a disabling medically determinable impairment. No additional physical or mental impairment is required. Eligibility for disability benefits involving substance addiction is determined like any other medical disorder.

-- The impairment must be established by medical evidence consisting of symptoms, signs, and laboratory findings. A finding of disability will depend on the severity and duration of the impairment and, where appropriate, the individual's remaining functional capacity. A functional assessment must consider the individual's ability to function over time, including periods of non-intoxification.

-- Individuals may manifest a wide variety of mental, neurological, gastrointestinal, and other symptoms, signs, and findings. These include such things as anxiety, depression, confusion, hallucinations, dizziness, blackouts, seizures, blurred vision, nausea, and liver dysfunction. In many cases, although not required for a finding of disability, individuals with substance addiction disorders also have coexisting mental or physical impairments.

-- Under the SSI program, there is a special classification for drug addicts and alcoholics (DA&A) when it is determined that the addiction is material to the finding of disability, or, said differently, when the individual would not qualify for disability if the addiction to drugs or alcohol were to end.

-- Those persons classified as "DA&A" are required by law to receive their benefits through a third party, or representative payee, and as a condition of eligibility, to undergo treatment, if available, for their addiction.

Chairman JACOBS. Mr. Bunning will inquire.

Mr. BUNNING. Thank you very much, Mr. Chairman.

It is a pretty discouraging report, Ms. Ross, to say the least.

It seems to me that the SSA payments to addicts are completely out of control. Based on your report, would you agree that we should require the monies that are sent to the addicts go to organizational payees? In your testimony you agreed that organizations had a heck of a lot more control of the money for those people that were receiving it than friends and family.

Is that right? Would it be better if we did it that way than the way it is being done now?

Ms. ROSS. The study from which we gathered the information about how well families and organizations control funds would certainly suggest pushing toward having organizations in as many cases as possible.

I don't know that requiring it is appropriate, but certainly pushing for that to be the primary choice for this particular set of people, yes.

Mr. BUNNING. You recommended Congress redesign the program and yet, as I understand it, the GAO is not overly optimistic about the likelihood of SSI recipients recovering and returning to work.

Can you explain why?

Ms. ROSS. Again, based on data that we have seen, the people in the SSI DA&A program tend to be in their late forties and early fifties, are alcoholics, and have little work record.

The idea you could put those people through treatment and through some sort of vocational rehabilitation and expect they will get back to a job probably won't happen all that often.

Nonetheless, we feel that we need to link these benefits to treatment. Social Security has not done enough yet for us to really know how successful rehabilitation could be with these folks.

Mr. BUNNING. In other words, you don't think there is enough accountability in the SSA to tell you the results of the program as it is now designed? You think there should be a lot more data available on how successful or unsuccessful this program has been?

Ms. ROSS. Yes, I do.

Mr. BUNNING. Let me jump to the restriction of benefits just a little bit. Would it change the picture if Congress required that the addict be in treatment for a period of time—3 or 6 months—before any cash payments were certified to the addict?

Ms. ROSS. GAO has not done any work on particular program alternatives, but that one sounds especially interesting. What we have said is we think that the public deserves to know that if people are receiving these benefits, there is some link to treatment.

Mr. BUNNING. Right now there is none?

Ms. ROSS. That's right.

Mr. BUNNING. In other words, if we require or put in restrictions that there be some treatment online prior to any benefits being approved, at least we would have started to track that person, whether they continued the treatment or not after they started to receive benefits.

Ms. ROSS. I think it is a very interesting option.

Mr. BUNNING. Maybe we should limit the duration of payments to those whose disability is based on addiction only?

Ms. ROSS. Again, we have not looked at that in particular. I guess our point of view at the moment is that we ought to make sure that Social Security is doing what the law now says ought to be done, that these people be monitored, that they be in treatment, and that once those things happen, we have a chance to assess how well it works.

Mr. BUNNING. We know there is a problem. We see the numbers and obviously the problem will not be solved if we continue to do what we have been doing. That is why we are having these hearings, and that is why we are going to attempt to change the law so we get a handle on the growth, and we don't directly pay to an addict their Social Security benefits.

What I am asking is, is it GAO's opinion or is it their suggestion that we might be able to do it and monitor better if an addict must be under treatment before he receive benefits? I think you have generally——

Ms. ROSS. Certainly we agree.

Mr. BUNNING. Thank you.

Chairman JACOBS. Thank you, Mr. Bunning.

Mr. Reynolds.

Mr. REYNOLDS. Thank you, Mr. Chairman. In your experience, Ms. Ross, in this area do you believe that punitive measures would have any real effect?

Ms. ROSS. I am not an expert on——

Mr. REYNOLDS. Just from your experience.

Ms. ROSS. All I can tell you is that we think that if you are going to pay public benefits, there ought to be a very tight link with treatment.

Mr. REYNOLDS. Also, with the payee, you suggested that possibly having an organization instead of members of the family—which I can understand. It seems to me that that might be a good idea.

But even with organizations, are organizations required to do certain things with the money and only those certain things? For example, if an organization is to get the money, are they to go out and buy the food, are they to give the money to the person that is an addict who is supposed to get it?

Ms. ROSS. They can dole out the money for various purposes and ask for receipts.

Mr. REYNOLDS. So what you are saying then is the organization—they don't in fact go out and buy the food and spend the money in a manner in which it is supposed to be spent. They just do in fact what the family members and other folks are supposed to do, which is give the money out to the person that is supposed to receive it; isn't that correct?

Ms. ROSS. I am not sure I exactly understand your question.

Mr. REYNOLDS. Let me be clear then.

It was suggested in your testimony that there was some value in having organizations more involved than family members.

I listened and heard that to mean that organizations, therefore, would have—because they would have more control over the money. My question is, why? Is it because organizations take the money and buy food and what they are supposed to buy? Or do organizations just give the money out to the addict, the person ad-

dicted that is supposed to get it just like a family member would give it?

Ms. ROSS. Our contention is that organizations have more control because in effect they say here is this much for rent, you take it to whatever place you are renting and bring me the receipt. You are not giving someone his or her entire monthly allotment all in one check.

Mr. REYNOLDS. Organizations give out the money and say bring back the receipt for rent and bring back the food or groceries.

Ms. ROSS. You may want to ask this question from Social Security who know a lot more about all the ways that representative payees may work. My understanding is not that people actually go do these tasks.

Mr. REYNOLDS. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Santorum.

Mr. SANTORUM. Thank you, Mr. Chairman. I think all the evidence that you have presented today and I talked about earlier shows there has been an explosion in addicts receiving SSI. Would you posit as to why?

Ms. ROSS. Well, as I said in the written testimony, I believe that no one is entirely certain how you can account for all the growth. There are, however, a number of possibilities. One is there has been an outreach program in SSI which may have brought in some substance abusers. In fact, outreach is something that SSA was urged to do.

A second possibility is that people running welfare programs or general assistance in the States are looking through their rolls to see if they have people who can qualify for SSI or DI benefits.

Mr. SANTORUM. Do you have any evidence to show that addicts are telling addicts?

Ms. ROSS. We didn't do any work that put us in contact with addicts.

Mr. SANTORUM. Advocacy groups, are they promoting or at least trying to find folks who are potentially eligible for this kind of benefit?

Ms. ROSS. They have been part of some outreach efforts.

Mr. SANTORUM. You talked about the SSI drug addicts and alcohol population, and said there were roughly 70,000 and that we spend roughly $285 million. These are people with an addiction and that is the reason they receive the benefit.

You said treatment is required, but only 9 percent of the people in the program receive treatment. Is that correct?

Ms. ROSS. Social Security only knows about 9 percent who receive treatment. For 85 percent, they don't know whether they are receiving treatment or not.

Mr. SANTORUM. Why don't they know?

Ms. ROSS. I don't know why they don't know. I think you should ask Social Security.

Mr. SANTORUM. Is it expensive to monitor someone to see if they are in treatment?

Ms. ROSS. The arrangements that are supposed to be made is having a monitoring agency in each State that can——

Mr. SANTORUM. So the monitoring agency isn't reporting to the SSA?

Ms. ROSS. As of October last year, there were monitoring agencies in only 18 States. That is after the program had been running for 20 years.

Mr. SANTORUM. Why is that? Is it the expense? This is the law. You are basically saying that we are not complying with the law here.

Ms. ROSS. Yes, I am.

Mr. SANTORUM. Is it the States are not complying with the law?

Ms. ROSS. No, it is Social Security. The agency, however, recently did sign an RMA contract to cover nearly all of the States.

Mr. SANTORUM. Do you have any idea how much it costs to monitor someone to see if they are receiving treatment?

Ms. ROSS. No, I don't.

Mr. SANTORUM. No idea at all?

Ms. ROSS. No.

Mr. SANTORUM. Could it be that the expense of monitoring someone could be almost in excess of some of the cost of the programs? Sounds like a fairly difficult thing to do if only 9 percent of the folks are doing it.

There must be some reason. What we found in a lot of programs is that implementation of monitoring is a very expensive thing to do.

Ms. ROSS. I do know that last year SSA spent $4 million on these 18 referral and monitoring agencies and this year they are planning to spend something like $20 million.

That doesn't seem like a huge expenditure of money to me when you are talking about benefit payments as large as I have described.

Mr. SANTORUM. The House Republican welfare bill has a proposal in it that says that if anyone who is on SSI for reasons of addiction, that they would be subject to random drug tests, and if they test positive for illegal drugs, they would be automatically dropped for at least 2 years from the program.

Do you have any response to that proposal?

Ms. ROSS. Again, we didn't do a detailed analysis of alternative programs, but I do think, as I said before, that the public wants to know that if people are receiving these benefits, that somebody is paying attention to whether they are in treatment or not. So there are a variety of ways that you could make sure whether people are——

Mr. SANTORUM. The basic reason we went after this is captured by the old saying that if you subsidize something, you get more of it; the fact is we are out there subsidizing folks who go out and commit acts upon their body, in many cases, illegal acts, getting illegal drugs and put themselves in a state of disability or addiction. And then we subsidize that behavior.

Is that the kind of behavior we want to subsidize at the Federal level? Do you think it is good public policy to reward, subsidize that behavior?

Ms. ROSS. Surely we don't want to subsidize addiction.

Mr. SANTORUM. I guess my question is, aside from the Social Security law, is there any other requirement that we provide this kind of subsidy? We have the SSI law that says we have to provide

this. I take it that is the case, we have to provide money for folks who are drug addicted, that is what the law says.

Is there anything else that requires us to do that?

Ms. ROSS. Just the disability insurance program which does the same thing.

Mr. SANTORUM. If we change the disability program, those folks would not be allowed to have cash benefits.

Ms. ROSS. Are you asking is it possible to change the law——

Mr. SANTORUM. Is that the only law that we have to change, I am asking.

Ms. ROSS. I think so.

Mr. SANTORUM. Thank you.

Chairman JACOBS. Mr. Camp.

Mr. CAMP. No questions.

Chairman JACOBS. Mr. Shaw.

Mr. SHAW. Ms. Ross, congratulations on the very, very good statement that you made. I think that you really pointed out what very graphically can be described as a growing problem.

I think Mr. Santorum put his finger on it, and the fact I think probably most of the American people would be outraged to find out is that someone is even receiving disability when they inflict it upon themselves. They take illegal drugs, and break the law in doing so, then come in and want to be supported by the Federal Government and the Social Security program.

There is no question in my mind but that we need to be sure that there are safeguards in there and if we are going to continue to subsidize this behavior or to pay people who have inflicted injury on themselves, that we at least monitor the addiction in some way. I think probably the best way to do it is to do drug testing on them.

If someone is continuing to add to their own problems, I don't see why anyone can argue that this should continue to be a problem for the Federal Government and that we owe them anything.

So I would hope that this hearing would lead to legislation on some of the proposals you mentioned in your concluding remarks, and that they would be adopted by this committee and put into place.

The monitoring is very important for those who are still addicts. They should certainly be treated but they should be monitored by the agency, not only to see if they are receiving treatment, but to see if they are drug free and let them know their benefits will come to an end if they are not. Otherwise we might as well make the check out directly to the drugdealer because we know that is probably where a great deal of it is going at this time, and it is absolutely necessary that we do that.

Now, the program is undoubtedly going to continue, the payments are going to be made, and I think that it is incumbent upon us and this committee to see that this money does not go to the drugdealer and that it does go to buy essentials of life for the addict.

Do you have any comment on any of that, anything I have said or Mr. Santorum has said which I picked up on?

Ms. ROSS. I certainly agree that if the program continues in its current form, you should put into place very effective financial controls as well as controls for monitoring treatment. Further, we

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recommend that these controls be expanded to the addicts beyond those now classified as SSI DA&A.

Mr. SHAW. Do you agree drug testing would be quite a problem?

Ms. ROSS. It certainly seems like one possible way to make sure that people are in treatment.

Mr. SHAW. Thank you.

Thank you, Mr. Chairman.

Chairman JACOBS. I have two questions. In your study did you perceive or discover any difficulty generally in obtaining representative payees? Does the Social Security Administration really have the luxury or ability to eliminate family members and close friends? Are there enough in the other category to administer the program as representative payees?

Ms. ROSS. I know that obtaining representative payees has been a difficult project for Social Security. They have over 5 million representative payees. I assume most of them are family members and friends, and for most categories of beneficiaries, for example, people whose mental abilities are impaired, I am sure family and friends are quite appropriate.

We are talking about 250,000 people that we think should be treated quite differently from that. I know that SSA is looking at using organizations as representative payees—as part of their demonstration projects.

Chairman JACOBS. Thank you.

Our colleague, Mr. Gekas, suggested that there might be applications by incarcerated felons in prisons for SSI benefits in consequence of addiction. In your study, did you find any case of that and, further, any case where an application was granted?

Ms. ROSS. We didn't look at where people were when they applied, so I can't speak to that directly, but we did have some information about people whose benefits had been suspended and about 1,000 of them were in jail.

So there must be some relationship to being in jail and not receiving benefits.

Again, I could provide more information for the record or I am sure Social Security knows the answer.

Chairman JACOBS. That should be the law of the land. Thank you very much for your contribution.

Our next witnesses include Hon. Shirley Chater, Ph.D., Commissioner, accompanied by Larry Thompson, Ph.D., Deputy Commissioner, and the Substance Abuse and Mental Health Services Administration represented by Michele Applegate, Acting Deputy Administrator, and Lisa Scheckel, the Acting Director.

Dr. Chater, as always you are most welcome. Sorry you had to wait so long to testify. Here you are at last.

STATEMENT OF HON. SHIRLEY SEARS CHATER, COMMISSIONER OF SOCIAL SECURITY, ACCOMPANIED BY LAWRENCE H. THOMPSON, PH.D., PRINCIPAL DEPUTY COMMISSIONER

Ms. CHATER. Thank you, sir.

Chairman Jacobs, Chairman Ford, members of the subcommittees, it is a pleasure to join you today. I welcome this opportunity to discuss some of the difficulties and also the very important is-

sues concerning payment of Social Security disability benefits and supplemental security income benefits to drug addicts and alcoholics.

I have extensive written testimony that responds to various questions that you raised in your letter of invitation. I would like to submit it for the record and summarize some of the key points for you this morning.

Chairman JACOBS. Without objection.

Ms. CHATER. In discussing this subject, I believe we can begin by establishing two points of consensus. First, the medical profession has clearly established that substance addiction is a disease and those who suffer from it are legitimately disabled. The Congress and the administration have concurred with this finding. Providing benefits to those who cannot work because of the disease reflects our compassion as a society.

The second point is that society also expects and has a right to expect that those individuals disabled by substance addiction will do all that they can to cooperate in curing themselves and becoming self-supporting.

The Social Security Administration, I want you to know, shares your desire for a benefit program that promotes and insists upon self-responsibility. Today I want to bring you up to date on what we are doing to strike that balance as we serve drug addicts and alcoholics [DA&As], a population that has grown so significantly in recent years.

Let me take a moment to address the rise in DA&A beneficiary numbers. At the beginning of fiscal year 1991, we know there were approximately 24,000 individuals on the SSI DA&A rolls. By the end of fiscal year 1993, that number had more than tripled to nearly 79,000.

You asked for an explanation of this large and rapid increase. While we do not have the kind of data needed to corroborate any particular hypothesis, there are several factors that have likely contributed to the growth in numbers.

First, at the urging of Congress, SSA has been conducting an active SSI outreach effort over the past several years. This program focused on homeless persons, many of whom have substance abuse problems. The increased awareness of the program by those eligible has naturally led to an increase in the enrollment figures.

Also, we have emphasized to the State disability determination services the importance of accurately identifying cases involving DA&A impairments, and further we expect that many more disabled individuals will be identified as DA&A by the DDSs in the States that have active referral and monitoring agencies to which they can easily refer these individuals. Because of these factors, we have reason to believe that there has been an increase in the number of cases correctly identified as DA&A without a corresponding increase in the number of actual drug addicts and alcoholics in the SSI program.

In other words, they are simply being categorized more accurately.

Once a substance addict is in the SSI program, SSA has the responsibility to administer and enforce two special requirements in the law: First, that DA&A individuals undergo appropriate treat-

ment for their addiction at approved facilities and that SSI payments for these individuals be made to a representative payee.

It is our goal to improve the administration of the DA&A program and we have recently made significant strides in this area.

Much of that improvement has taken place in the area of treatment, referral, and monitoring. Until recently, SSA has attempted to ensure beneficiary compliance with treatment and monitoring requirements through agreements with States and private contractors serving as referral and monitoring agencies [RMAs]. These agreements, I agree, were too few and too general.

As of October 1993, we had agreements in only 18 States covering just 45 percent of our DA&A population.

Also, the agreements did not provide specific guidance to the States as to how the RMAs should function on a day-to-day basis. As a result, we know very little about the treatment progress of SSI DA&A recipients and we can document few, if any, recoveries.

We have taken some major steps since then. We have developed, for example, a process that requires each RMA contractor to perform numerous specified tasks that will ensure better service and management oversight. The RMAs are required, first, to test each beneficiary regularly for signs of substance abuse; second, to monitor treatment progress on an ongoing basis; and third, to follow strict procedures in the event of treatment refusal or noncompliance.

These new contracts are now in place in 33 States, including the District of Columbia, and we expect to have the remaining States covered by the end of the fiscal year. We have also increased funding for these activities from $4 million in 1993, to $20 million in 1994, and to $36 million in fiscal year 1995.

This money will help to ensure that RMAs have the staff necessary to refer an increasing number of recipients to treatment sources.

We are also taking steps to improve the representative payee process. Paying benefits to a representative payee is, as you know, done to ensure that the benefits are used to meet the recipient's basic needs for food, shelter, clothing, and medical care, and not used for drugs or alcohol.

Representative payees are extremely conscientious in trying to meet their obligations and perform a difficult job. The system, however, is not perfect and some recipients are able to manipulate or intimidate their representative payees into giving them cash, which they can use to support their addictions.

The greatest difficulty we have is in finding qualified individuals to serve as representative payees for drug addicts and alcoholics. In the majority of Social Security and SSI representative payee cases in which the recipient is aged and/or unable to handle his own finances, family members serve as payees. We do not find as many family members who are willing to be payees for substance abusers.

Likewise, it is hard to find volunteers from community service groups to act as payees for DA&A recipients. Therefore we have had to turn more frequently than we would like to friends and acquaintances of the DA&A recipient. In an effort to meet this need for payees, we have begun a systematic recruitment effort aimed at

professionals from organizations like the National Association of Alcoholism and Drug Abuse Counselors and the National Coalition for the Homeless.

Most of these organizations have agreed to publicize the need for representative payees in their member publications.

We are also involved in a demonstration project with the Public Health Services' Substance Abuse and Mental Health Services Administration to test alternative sources for finding representative payees. You will hear more about that from my colleagues from SAMHSA.

We are looking, for example, at using referral and monitoring agencies or other individual State or local agencies to receive and manage the DA&A recipient's payments. Doing so would more closely link continued receipt of benefits to ongoing treatment and monitoring, and would reduce the ability of the recipient to pressure his or her payee for cash.

This is a beginning for us. We are open to new ideas to provide new ways of looking at the problem to improve every aspect of our administration of the program.

I do want you to know that we look forward to working with you and your subcommittees, to consider alternative approaches that will help us to reach our mutual goal for DA&A recipients to leave the benefit rolls and become productive members of our society.

Thank you for the opportunity, and we are pleased to answer your questions.

Chairman JACOBS. Thank you.

[The prepared statement and attachments follow:]

TESTIMONY OF SHIRLEY S. CHATER
COMMISSIONER OF SOCIAL SECURITY

Mr. Chairmen and Members of the Subcommittees, I am pleased to be here today to discuss issues relating to alcoholics and drug addicts receiving Social Security disability insurance (SSDI) and Supplemental Security Income (SSI) benefits. These are critically important issues to society, and I commend you for holding this hearing. I also want to stress our willingness to work with you and your Subcommittees to address your concerns about these serious issues.

Over the years, it has become clear to the medical profession that substance addiction is a disease and those who suffer from it are legitimately considered disabled. The Congress and the Administration have concurred with this finding. However, the American public has a right to expect that those disabled by substance addictions will not simply continue on the disability payment rolls without taking responsibility for themselves. Unlike many other disabled individuals, those suffering from substance abuse can, to varying degrees, influence their recovery by their own actions. The public has the right, therefore, to expect that they will instead seek to do all that they can to cooperate in curing themselves of their addiction and become self supporting.

Today, I will review with you steps that SSA has taken to improve administration of the SSI program in cases involving drug addiction and alcoholism (DA&A), reasonable program modifications we have been exploring, and other issues about which your Subcommittees have expressed interest.

Let me begin by reviewing the background of these programs and discussing the general eligibility requirements for persons disabled as a result of DA&A.

Background

The original legislation passed by Congress in 1972 to create the SSI program provided for eligibility based on DA&A, and included requirements that recipients accept treatment and have benefits paid to a representative payee.

In discussions preceding the enactment of legislation creating SSI, there were the same concerns that there are today about the potential for program abuse by individuals considered disabled as a result of substance addictions. Some advocated that the legislation provide both SSI cash benefits and treatment for individuals disabled by a substance addiction. Others argued that only a treatment program for drug addicts and alcoholics be established under a separate title of the Social Security Act. The latter approach reflected concerns that these individuals might receive cash payments without being involved or while being only marginally involved in treatment programs, and that cash payments might be used to purchase drugs or alcohol. In the end, Congress passed legislation which included the present eligibility requirements, under which SSI pays cash benefits to DA&A recipients who undergo appropriate and available treatment, but does not pay for the treatment itself.

Eligibility Requirements

The eligibility requirements based on DA&A are the same as for other disabling conditions. That is, an individual:

- o must have a medically determinable physical or mental impairment that has lasted or is expected to last for a continuous period of at least 12 months or to result in death, and
- o must be unable to perform substantial gainful activity because of the impairment.

Drug addiction and alcoholism are considered medically determinable impairments, and just as with any other impairment, a finding of inability to work depends on the severity and duration of the impairment, and the functional limitations caused by the impairment.

In addition to the medical requirements, Congress included two special requirements in the law for SSI recipients disabled fully by DA&A. It required that:

- o these individuals undergo appropriate treatment for their addiction at approved facilities when treatment is available, and allow their treatment to be monitored. As specified in the law, treatment must be available at no cost to the recipients or to SSA. Also,

- o they must receive their SSI payments through a representative payee.

These two special requirements do not apply to Social Security disability beneficiaries. Nor do they apply to SSI recipients who are determined to be disabled independently of their substance addictions. For example, those SSI recipients who are disabled by another impairment such as cirrhosis of the liver are not classified as drug addicts or alcoholics for purposes of applying these requirements.

General Information

There were very few DA&A recipients on the SSI rolls over the first decade of the SSI program. In the 1990's, however, there has been dramatic growth in the number of disability entitlements based on substance addiction, which includes both alcohol and drugs. The SSI DA&A rolls have escalated from around 24,000 (or 1.0 percent of the total SSI disabled population) at the beginning of fiscal year (FY) 1991 to about 79,000 (or 2.6 percent of the total SSI disabled population) by the end of 1993. Attached to my statement are two tables showing some statistics related to SSI DA&A recipients. I will discuss our thoughts on why this increase has occurred later in my testimony.

Of these 79,000 DA&A recipients on the SSI rolls, about 65,000 have little or no work history and therefore qualify for SSI only. The remaining 14,000 have worked and paid into Social Security long enough to qualify for Social Security disability benefits as well as for SSI. In addition, about 35,000 individuals whose only established disability is substance abuse receive just Social Security disability benefits based on their contributions to Social Security while they were employed.

The majority of SSI DA&A recipients are male, their average age is 42, and more suffer from alcoholism than drug abuse. Sixty-four percent of all SSI DA&A recipients reside in four States -- California (33 percent), Illinois (17 percent), Michigan (10 percent), and New York (4 percent).

Increase in SSI DA&A Rolls

As indicated above, there has been a dramatic growth in recent years in the number of disability benefit awards identified as being based on drug addiction and alcoholism. You asked for an explanation of the sudden increase. Unfortunately, we do not have the type of data needed to corroborate any particular hypothesis regarding this growth. However, we know of several factors that have likely contributed to the recent growth in the SSI DA&A rolls.

At the urging of Congress, we have been conducting an active SSI outreach effort in the past several years. The program is particularly focussed on the homeless, many of whom have substance abuse problems. This effort has been effective and has resulted in a greater awareness of the availability of SSI benefits for those with substance addictions.

We have also reemphasized the importance of accurately identifying cases involving DA&A impairments to the State Disability Determination Services (DDSs). In April 1991, we issued an extensive program directive which reiterated how existing policies for determining disability apply to the evaluation of substance addiction

disorders. In the last several years we also have issued periodic "reminder items" both nationally and regionally to emphasize the need to accurately identify DA&A cases.

Referral and Monitoring Agencies (RMAs) determine if appropriate treatment is available, refer beneficiaries to treatment, monitor treatment plans, and report to SSA if a beneficiary is not in compliance with the treatment plan. Consequently, we expect that many more disabled individuals will be identified as DA&A by DDSs in States that have active RMAs to which to refer these individuals. We suspect that this phenomenon explains the rapid DA&A growth in the Chicago region, for instance. The SSA regional office in Chicago has worked to ensure that every State in the region has a functional and active RMA, and we now find that Illinois and Michigan rank second and third in the nation in the number of identified DA&As.

We have reason to believe that the result of both of these factors has been an increase in the number of cases correctly identified as DA&A, even without any increase in the number of actual drug addicts and alcoholics in the SSI program. But the actual number of DA&A recipients on SSI undoubtedly has also grown due to greater awareness of the program's existence.

Recent cutbacks in general assistance programs in some States may also have contributed to the increase in the number of DA&A recipients.

Referral and Monitoring

Now let me turn to the issue of administering the two special DA&A provisions of the law -- treatment referral and monitoring and the requirement that individuals disabled by substance addictions be assigned representative payees. We have evaluated how SSA administered these provisions in the past, and realize that we need to make improvements, especially with regard to referral and monitoring.

Until recently, SSA has attempted to ensure compliance with the treatment and monitoring requirements through agreements with States and private contractors serving as RMAs. In past years, however, SSA found it difficult to establish agreements with RMAs covering all geographical locations in a uniform manner because of small workloads in some States and lack of funding to cover the whole country. As of October 1993, we had agreements in only 18 States and only 45 percent of DA&As were being monitored. In addition, the agreements that SSA did have were general in nature and did not provide specific guidance to the States as to how RMAs should function on a day-to-day basis. For example, the agreements did not require specific case intake and interview procedures, establish timeframes for referring recipients to treatment facilities, mandate specific monitoring periods, or establish requirements for dealing with noncompliance by DA&A recipients. As a result, we knew very little about the treatment progress of SSI recipients and could document few, if any, recoveries.

We realize that we were not completely fulfilling our referral and monitoring responsibilities. Thus in 1991, we began an ongoing and fruitful collaboration to improve these services with our sister agency in the Department of Health and Human Services, the Public Health Service's Substance Abuse and Mental Health Services Administration (SAMHSA). I am pleased to report that, based on our collaboration, we have taken major steps to improve referral and monitoring services. We have developed a contract process structured to require each RMA contractor to perform numerous specified tasks that will assure both better service to SSI recipients and greater management oversight on SSA's part of the referral and monitoring process. These new contracts which are now in place in 33 States, including the District of Columbia, contain provisions requiring RMAs to:

- review SSA files and conduct face-to-face interviews with each DA&A recipient;

- o involve the DA&A recipient's representative payee in the RMA process;
- o test each DA&A recipient regularly for signs of substance abuse;
- o monitor each DA&A recipient's treatment progress on an on-going basis (weekly for some period);
- o administer detailed procedures for dealing with instances of treatment refusal and non-compliance;
- o adhere to specific requirements for referring recipients for treatment; and
- o assess each DA&A recipient no later than the 24th month of treatment and, if appropriate, refer him or her for vocational rehabilitation.

SSA will now be able to monitor the RMAs to ensure compliance with the specific tasks they have agreed to perform. Further, we plan to have RMA contracts in place in the remaining States by the end of this fiscal year.

Finally, we have increased funding for these activities from $4 million in FY 1993 to $20 million in FY 1994. And there will be $36 million in funding for FY 1995, an 80 percent increase over FY 1994. The additional funding will allow us to serve about 69,000 DA&A recipients in FY 1995, close to twice the 39,500 recipients we expect to serve this fiscal year. It will also help to ensure that RMAs have the staff necessary to effectively set up treatment plans, refer DA&A recipients for treatment, and monitor their progress.

In addition to the steps we have already taken, we need to provide additional alternatives for providing effective treatment and rehabilitation. To accomplish this, we are working with SAMHSA on joint demonstration projects, two of which were awarded in September 1993, to test alternatives for providing effective treatment and rehabilitation services to SSI recipients disabled due to DA&A. Two alternatives that will be tested include in-depth case management of DA&A SSI recipients and the effect of paying for some treatment.

Mr. Chairmen, you also asked whether a shortage of treatment facilities is a major barrier, or whether there is a bottleneck in the service delivery system for providing treatment for DA&A recipients. Although many DA&A recipients are not in treatment, the monitoring process has not been systematic enough for us to know whether a shortage of treatment services was a significant factor in preventing treatment. I would call to the Subcommittees' attention, however, the major new investment in treatment in the President's FY 1995 budget.

With regard to the question concerning a bottleneck in service delivery, I would have to say that, although in the past many DA&A recipients were not referred to treatment generally because RMAs were unavailable or because of insufficient funding, we have taken steps to improve that situation. We remain committed to making whatever changes are necessary to get these recipients on a path to self sufficiency.

Representative Payees

I would now like to discuss the requirement that DA&A recipients receive their benefits through a representative payee.

The Congress provided for this requirement because it was concerned that DA&A recipients might use cash assistance to support their addictions. Paying benefits to a responsible third party was seen as a way of meeting the recipient's basic needs, without supporting his addiction, and paying benefits to representative payees has achieved this

goal to some extent. Representative payees are instructed to use benefits to provide for the recipient's basic needs, such as shelter, food, clothing, and medical care.

We believe that most payees are conscientious in trying to meet these obligations. However, this can be a difficult task in the case of some DA&A recipients. Since these individuals know the amounts of their monthly payments, they sometimes manipulate or intimidate their representative payees into giving them cash.

As difficult as it may sometimes be to find qualified payees, virtually all persons identified as receiving SSI payments based on DA&A have representative payees. Although family members serve as payees in the majority of Social Security and SSI representative payee cases, we do not find as many family members who are willing to be payees for addicts. This means that we must often select friends and acquaintances as payees for DA&A recipients.

Some have suggested that family members who serve as representative payees for DA&A recipients are more likely than a disinterested individual or organization to make cash available to the recipient. We do not know the extent to which this may occur. Of course, a family member might just as well be the person most dedicated to ensuring that the DA&A recipient does not use any benefits to support his addiction. Unfortunately, no amount of investigation by SSA can guarantee that any person selected to be a representative payee will not at some point yield to pressure from the recipient to give him some cash.

We have for some time been working with community service groups to provide volunteer representative payees for beneficiaries who need them. However, it is often difficult to find volunteers willing to serve as payees for substance abusers.

In an effort to meet this need, we have begun a systematic recruitment effort aimed at professionals who serve these recipients. Last summer, we met with representatives of several organizations serving substance abusers. These included the National Association of Alcoholism and Drug Abuse Counsellors, the National Association of Addiction and Treatment Providers, the Mental Health Policy Resource Center, the National Coalition for the Homeless, and the National Coalition of Hispanic Health and Human Services Organizations. Most of these organizations have agreed to publicize the need for representative payees in their member publications. In addition, one organization is considering how to initiate a demonstration program in one large city. In general, the national organizations we have contacted have said that funding shortages to cover their administrative costs are the primary barrier to providing payee services.

In addition, based on legislation enacted in 1990, over the past three years we have experimented with paying certain qualified organizations to serve as representative payees and have had a positive response. We are considering a legislative proposal to extend the life of this provision and to include ways to broaden the coverage to additional organizations, as well as further changes in the provision to make the representative payee process work better for the DA&A population.

Another initiative affecting representative payee selection is part of the demonstration projects with SAMHSA, which I mentioned earlier. The demonstrations will attempt to address some of the difficulties encountered in selecting payees for DA&A recipients by testing alternative sources, such as referral and monitoring agencies or other involved State or local agencies or organizations, to receive and manage the DA&A recipients' payments. Selecting the RMA as the representative payee would more closely link continued receipt of benefits to ongoing treatment and monitoring and would also reduce the ability of the recipient to pressure his individual payee for cash.

Steps Toward Solutions

It is our goal to improve administration of the SSI program for DA&A recipients, and we have recently made great strides in that effort.

Improving the SSI program for the DA&A population is a multi-step process, however, and the solutions do not rest with SSA alone. Solving these problems will require close coordination and cooperation among HHS components such as SSA, SAMHSA, and the Health Care Financing Administration, which all have special expertise to contribute. We at SSA are continuing to work closely with our colleagues in other HHS components to consider additional approaches to assisting this recipient population.

For example, we recently implemented some initiatives to improve the treatment and monitoring process. The next step is to gain some experience with these initiatives and determine how our improved referral and monitoring system improved the availability of treatment for DA&A recipients. Further, we need to complete and evaluate the demonstration projects we are conducting with SAMHSA to determine other alternatives for providing effective services for DA&A recipients. At that point, I think we will be better prepared to determine what our next steps should be.

Conclusion

Mr. Chairmen, I think that we all recognize that these are difficult issues which require careful consideration. We need to treat those suffering from DA&A equitably and with compassion, but we also need to ensure that the program includes strong motivation for beneficiaries to improve their condition and become self supporting.

We will be happy to work with your Subcommittees, other Federal agencies, advocacy groups, and other interested parties to consider approaches that will help us to reach our mutual goal of providing an effective means for DA&A recipients to become productive members of our society. Since we obviously need to proceed cautiously before making significant changes in the program, we may want to consider pilots or demonstration projects to test and gain experience with any potential changes.

Attachments

TOTAL NUMBER OF SSI BLIND/DISABLED and SSI DA&A RECIPIENTS BY NUMBER AND PERCENT

YEAR	SSI Blind/Disabled Recipients aged 18-64.		
	TOTAL	DA&A Recipients	
		Number	Percent of total
1975	1,678,000	10,000	0.6
1976	1,686,000	9,000	0.5
1977	1,730,000	6,000	0.3
1978	1,706,000	5,000	0.3
1979	1,680,000	4,000	0.2
1980	1,686,000	5,000	0.3
1981	1,669,000	4,000	0.2
1982	1,618,000	4,000	0.2
1983	1,661,000	3,000	0.2
1984	1,775,000	4,000	0.2
1985	1,840,000	5,000	0.3
1986	2,021,000	7,000	0.3
1987	2,128,000	10,000	0.5
1988	2,215,000	13,000	0.6
1989	2,318,000	17,000	0.7
1990	2,462,000	24,000	1.0
1991	2,604,000	34,000	1.3
1992	2,859,000	54,000	1.9
1993	3,071,000	79,000	2.6

Demographics of Supplemental Security Income(SSI) & Drug Addicted and Alcoholic (DA&A) Recipients

		TOTAL SSI BLIND/ DISABLED[1] (percentages)	SSI DA&A[2] (percentages)
Recipient Profile:			
Age:	18-29	18	10
	30-39	23	34
	40-49	21	35
	50-59	23	18
	Total	85	97
Gender:	Male	44	71
	Female	56	29
TYPES OF REPRESENTATIVE PAYEES:			
	Relative	71	60
	Social Agency	7	4
	Mental and Non-Mental Institutions	11	1
	Other	11	35
GEOGRAPHIC BREAKDOWN: (States with highest percentage of SSI DA&A recipients)			
	1. CA	16	33
	2. IL	5	17
	3. MI	4	10
	4. NY	9	4

[1] Includes SSI blind and disabled recipients aged 18-64, as of December 1993.

[2] Includes SSI recipients disabled by drug addiction and alcoholism aged 18-64,as of December 1993.

Chairman JACOBS. Ms. Applegate.

STATEMENT OF MICHELE APPLEGATE, ACTING DEPUTY ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY LISA SCHECKEL, ACTING DIRECTOR, CENTER FOR SUBSTANCE ABUSE TREATMENT

Ms. APPLEGATE. Mr. Chairman, and distinguished members of the subcommittee, thank you for the opportunity for the Substance Abuse and Mental Health Services Administration, or SAMHSA, to testify today about substance abuse as a disease, our success in treating substance abusers, and our collaborative efforts with the Social Security Administration.

I am accompanied today by the Acting Deputy—Acting Director of the Center for Substance Abuse Treatment, Lisa Scheckel. Since SAMHSA has not testified before these subcommittees, I would like to share some background with you.

SAMHSA, like SSA, is part of a coordinated network of service agencies within the Department of Health and Human Services. Our mission is to reduce the incidence and prevalence of substance abuse and mental health disorders, and to improve treatment for them.

Before I get into specifics, I wanted to emphasize a few general points. One, that substance abuse is a serious disabling disease. Two, we can treat substance abusers effectively. And three, we believe the SSI program presents an opportunity to get substance abusers into treatment, and we are working collaboratively with SSA to finds ways to do that.

It is important for society to recognize that substance abuse is a chronic, relapsing disease. Many individuals do not achieve sobriety the first time, but can through successive treatment. Individuals who are hardcore substance abusers suffer from cognitive impairment and changes in brain chemistry, and often have several medical problems, including AIDS.

With regard to the prevalence of substance abuse as reported in our National Household Survey on Drug Abuse, the number of substance abusers has declined significantly from a high of 24 million in 1979 down to 11.4 million in 1992. The number of people with serious alcohol problems has dropped from 9.1 million in 1990 to 7.7 million in 1992.

However, some indicators, such as drug-related emergency room episodes, indicate that the number of heavy drug abusers are not diminishing. Yesterday the President announced his new national drug control strategy. This includes a focus on hardcore or heavy drug abusers.

The Office of National Drug Control Policy [ONDCP] estimated that there are 2.7 million such users. Mr. Chairman, it is important to understand that not all hardcore substance abusers would be eligible for SSI. I want to stress that many of them continue to work in spite of substance abuse problems.

Despite a doubling of federally supported treatment funds in the past 5 years, there are some places in this country with insufficient treatment capacity. The President's fiscal year 1995 budget pro-

poses a $345 million initiative to expand treatment for up to 74,000 additional hardcore substance abusers. It is important that we increase capacity for treatment if we are going to effectively reach this population.

This particular initiative, in fact, will provide increased funds for treatment per person so that we can give this population the kind of intensive, extended services that they need to recover.

Also, one of the most important parts of the administration's health care proposal is that it would include substance abuse treatment as a part of health care coverage. We have to recognize that until we have the appropriate level of treatment on demand without delay, we will continue to pay for a problem that we cannot reduce.

Let me turn to some specifics about treatment.

We know we can successfully intervene with substance abusers, even the hardcore. Patients completing treatment and fully participating in aftercare have a high probability of sustained recovery.

So you can have a feel for some successful approaches with specific populations, let me give you just a few quick examples. One is Center Point in San Rafael, Calif. This program targets African-American and Hispanic populations who have abused drugs for most of their adult life, commonly heroin or cocaine.

Center Point's treatment effort is a sophisticated blend of intensive peer group support and family therapy. Of the individuals completing treatment, 87 percent were drug free at the time of followup and 76 percent were employed.

Another example is the Pima County jail project in Tucson, Ariz. The patients are substance abusers, jailed for felony convictions. This program provides services to them while they are incarcerated as well as afterward to ensure sustained recovery. Of the graduates, 72 percent of the men and 86 percent of the women who completed the program were working at the time of followup.

These important examples of treatment that are tailored to particular populations are helping us in our efforts to work with our sister agency, the Social Security Administration. These efforts are aimed at improving successful treatment of substance abusers who are involved with the SSI program.

SAMHSA and SSA began this collaboration several years ago. We have been particularly interested in facilitating a relationship that we hope will strengthen that program, specifically, to involve the State substance abuse agencies in working hand-in-hand with the SSI offices. This should help make sure that there is appropriate assessment and referral and treatment of patients.

We have had several meetings to bring these officials together. We have also had a joint working group with SSA to develop recommendations for effective referral and monitoring agencies, including recommended policies and standards for their work.

In fiscal year 1993, based on the efforts of this work group, our Center for Substance Abuse Treatment and SSA awarded support for two new demonstration projects. The goal of these demonstrations is to look at ways to improve administration of the SSI program for the substance abusing population, and assist these recipients in achieving sobriety and becoming productive members of society.

The State of Washington received one of these demonstration grants. In that State, the single State drug abuse agency is providing intensive case management services for substance abusers when they enter the system through their completion of treatment and successful vocational rehab.

We know from research and experience that individuals whose treatment is monitored are more likely to stay in treatment. And as I said before, there is a direct correlation between length of stay and success in treatment.

Both SSA and SAMHSA will be closely monitoring the grant and attempting to obtain data on what works most successfully with this population. We believe the SSI program is an important source of support for those most affected by long-term substance abuse, one that can serve as a catalyst to effective treatment and rehabilitation if there is effective referral and monitoring.

Thank you for this opportunity to share our views.

[The prepared statement follows:]

TESTIMONY OF MICHELE APPLEGATE, ACTING DEPUTY ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairmen and distinguished Members of the Subcommittees:

Thank you for the opportunity for the Substance Abuse and Mental Health Services Administration (SAMHSA) to testify this afternoon about substance abuse as a disability, the prevalence of substance abuse in the country, the availability of treatment for substance abusers, and the collaborative efforts between the Social Security Administration (SSA) and SAMHSA in addressing the needs of Supplemental Security Income (SSI) recipients who suffer from alcohol and other drug abuse disorders.

My name is Michele Applegate, and I am Acting Deputy Administrator for SAMHSA. I am testifying in place of Dr. Elaine Johnson, the Acting Administrator who, unfortunately, is not available today.

SAMHSA, like SSA, is part of the coordinated network of service agencies within the Department of Health and Human Services (HHS). SAMHSA was established in October of 1992 as part of the Public Health Service (PHS) as a result of the Alcohol, Drug Abuse, and Mental Health Administration Reorganization Act of 1992. The Act transferred the research functions of the old Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) to the National Institutes of Health. SAMHSA is comprised of the Center for Mental Health Services, the Center for Substance Abuse Prevention, and the Center for Substance Abuse Treatment. Its mission is to reduce both the incidence and prevalence of substance abuse and mental health problems; improve treatment outcomes; improve access and decrease barriers to high quality effective programs; and provide national leadership to ensure the best use of knowledge derived from science and service-program evaluations to prevent and treat mental and addictive disorders.

Substance Abuse is a Disability

Substance Abuse is a chronic, relapsing disease complicated by physiological, environmental, neuro-psychiatric, and economic factors. Many individuals who are hard core substance abusers, both drug addicts and alcoholics, suffer from cognitive impairment and changes in brain chemistry that severely affect their functioning. Typically, hard core users are in need of significant primary health care. They are much more likely than other populations to be HIV positive, and/or to be infected with drug-resistant tuberculosis. Many of them also have mental health problems.

Prevalence

Estimating the size of the substance abusing population is both controversial and extremely difficult, in part because definitions of the term "substance abuser" vary. The National Household Survey on Drug Abuse, which is published by PHS, found that the rate of illicit drug use nationally reached a peak in 1979, when 13.7 percent of the population ages 12 and older were current users of an illicit drug. This translated into about 24 million illicit drug users of all types and frequencies. Since 1979, largely due to the combined prevention and treatment efforts of the Federal, State and local governments and many private organizations, the rate has come down, reaching 5.5 percent in 1992, or approximately 11.4 million illicit drug users.

However, not all trends are favorable. While indicators show that casual drug use has declined, some indicators of the consequences of drug abuse, such as hospital emergency room episodes from our Drug Abuse Warning Network, have shown continuing upward trends, suggesting that the number of heavy drug users, who are more likely to affect these data on consequences, is not diminishing.

Yesterday the White House Office of National Drug Control Policy (ONDCP) released its National Drug Control Strategy. Using its definition, ONDCP estimates that there are 2.7 million hard-core drug users. The PHS National Household Survey on Drug Abuse estimated the number of individuals who have a serious alcohol problem at 7.7

million in 1992 -- a drop from 9.1 million in 1990. We are currently working with ONDCP to improve and strengthen our ability to accurately estimate the size of the hard core drug abuse population and with the National Institute on Alcoholism and Alcohol Abuse with regard to the number of individuals with a serious alcohol problem.

Mr. Chairmen, it is important to understand that not all hard core substance abusers would likely be eligible for SSI. I want to stress that many of them continue to work in spite of substance abuse problems.

Resources for Substance Abuse Treatment

The most recent research shows that the combined Federal, State, local government and private expenditure on substance abuse services in 1990 was approximately $13.7 billion dollars. The total Federal contribution to this effort has more than doubled in the past five years. Despite our increased efforts, however, insufficient treatment capacity remains in many areas of the country.

The President's FY 1995 budget proposes a new $345 million initiative for the treatment of hard-core substance abusers. This will include new funds within the Substance Abuse Block Grant to target new intensive-treatment funds to communities hard hit by hard-core users and new demonstration projects to better integrate treatment services for hard-core users into primary and managed-care systems. With this, nearly 311,000 people will receive treatment for drug abuse through Federally-supported slots in FY 1995, an increase of 60,000 from FY 1994. Of these treatment slots, up to 74,000 will be available for individuals suffering from hard-core addictive disorders. The President's FY 1995 budget also proposes an additional $10 million for the expansion of treatment of hard-core substance abusers among the American Indian and Alaskan Native populations. The President's Health Security Act demonstrates the Administration's commitment to increasing the availability of substance abuse treatment by including such treatment in the comprehensive benefit package.

Treatment of Substance Abuse

We know we can successfully intervene with substance abusers, even the hard core. Our experience is that program compliance, continuity of care and length of stay lead to improved treatment outcomes. Patients completing treatment, and fully participating in aftercare have a high probability of sustained recovery. It is important to remember that some types of treatment services are more effective for certain patients than other types, but no single mode of treatment is universally effective for all, or even most, individuals.

Research has yielded several crucial components for any successful substance abuse treatment program. These include:

- Detailed patient assessments at intake and throughout the patient's program;
- The development of detailed multi-disciplinary treatment plans;
- A comprehensive continuum of patient care including medical management, medication, psychotherapy, and psycho-social rehabilitation; and
- Continued aftercare, to prevent the patient's relapse.

These components, when combined effectively, can eliminate patients' alcohol and illicit drug use, improve their physical and mental well-being, and increase their employment and social functioning.

An example of a good treatment program is the SISTERS program in Chattanooga, Tennessee. This program is designed to meet the specific needs of African American mothers residing in five public housing communities. SISTERS provides a continuum of therapeutic services and continuing care programs for women with substance abuse

problems. Treatment services include outreach and education, free-standing residential detoxification, short-term residential rehabilitation, nonresidential and intensive outpatient treatment. Most clients served by the program use more than one substance, including: alcohol, crack/cocaine, tranquilizers, sedatives, and inhalants. Women receiving services are given physical and mental examinations and tested for hepatitis, tuberculosis, AIDS, and sexually transmitted diseases. Patients and their partners, parents, and other family members receive family counseling. A unique aspect of this program is the long-term one-to-one relationship that develops between patients and counselors. The counselors move through the housing projects recruiting individuals in need of treatment and stay with them through and after treatment.

Another example is Center Point in San Rafael, California, just north of San Francisco. This program targets African American and Hispanic populations who have abused drugs for most of their adult life, commonly heroin or cocaine. The facility provides medically-supervised residential drug detoxification, and HIV/AIDS testing and counseling service. Center Point's treatment effort is a sophisticated blend of intensive peer-group support and family therapy. An important component of the program is its significant reentry services to assist patients as they transition back into society. Center Point has had 273 individuals graduated Center Point's six month program between July 1985 and June 1993. Of them, 189 were drug free resulting in a success rate of 87 percent at the time of the survey. Of the 273, 76 percent (or 182) were employed.

A third example, the Amity-Pima County Jail Project in Tucson, Arizona is a modified therapeutic community program providing individual and group counseling, peer support and family involvement. The patients are hard-core substance abusers, both alcoholics and drug addicts, who have been jailed for felony convictions. The program is six to twelve months in length and follows the individuals after they have reentered society. Of the entire population of graduates, 72 percent of the men and 86 percent of the women who completed the program were working at the time of the survey. Surveys further indicate the criminal recidivism rate is half what it is for those who do not complete the program.

Cooperative Efforts with SSA

State substance abuse agencies have the responsibility for coordinating public sector treatment in their States, and therefore, can be of help in meeting the goals of the SSI program for the DA&A population. When SAMHSA began collaboration with SSA several years ago, we knew it would be critical to work with these State officials to understand their constraints in dealing with substance abusers who might be eligible for SSI enrollment. In 1991, as part of the Secretary's service integration initiative, we arranged a number of opportunities for SSA officials to meet with representatives from State substance abuse agencies. We also established a joint working group with SSA to act on recommendations emanating from these various sessions.

The work group concentrated on the following issues and actions:

- Establishing effective Referral and Monitoring Agencies (RMAs) in all States.
- Setting policies, priorities and standards for the structure, treatment referral and subsequent monitoring activities/procedures of RMAs. In fact, the new RMA protocol is based on the work group's deliberations.

In FY 1993, based on the efforts of this work group, the Center for Substance Abuse Treatment and SSA awarded support for two new demonstration projects to look more carefully at what works in referral and monitoring. We plan a few additional awards in FY 1994. These projects were jointly developed with SSA and are now being jointly monitored. We are holding our first meeting with the recipients of these cooperative agreements in March.

Let me briefly review some of the goals of this demonstration.

First, our overall goal is to look at ways that SSA might improve administration of the SSI program for the DA&A population. Whatever modifications are made should assist recipients to achieve sobriety and become productive. The approach we are taking in these demonstrations further recognizes the need for a wide spectrum of services and support for this population and the absolute need for a coordinated case management approach.

We are encouraging our projects to look at a variety of means to achieve this goal including:

- o Developing better ways to match individual patients with appropriate treatment and to enhance opportunities for their recovery.
- o Developing criteria to determine what constitutes failure to comply with treatment, while at the same time effectively and humanely dealing with relapse as an inherent characteristic of addiction.
- o Ensuring the identification of individuals or agencies that are qualified, willing, and available to serve as representative payees and evaluating their effectiveness.

There are States with effective referral and monitoring systems for SSI recipients who are suffering from addictive disorders. Illinois, Michigan and Wisconsin, among others, have developed systems like that in the State of Washington where the single State agency is responsible for providing intensive case management services from the moment these individuals enter the system. We know from research and experience that individuals whose treatment is monitored are more likely to stay in treatment and, as I said before, there is a direct correlation between length of stay and success in treatment.

These case management services are supported by an automated tracking system managed by the single State agency. This system is tied into other State agencies responsible for providing other services that these multi-impaired individuals may need, including primary health care and employment assistance. The system allows case managers to know what is happening with a particular patient at any moment in time.

The State of Washington received one of the two awards under the Center for Substance Abuse Treatment program I mentioned earlier. Both SSA and SAMHSA will be closely monitoring that grant to see if there are further improvements in the model that can be made.

We in SAMHSA are extremely pleased with our working relationship with SSA and we look forward to our continued joint efforts to provide the services and support that these individuals need. Such intra-departmental efforts are important to SAMHSA in helping to ensure that substance abusers receive the full range of health and human services they need to recover.

We believe that SSI is an important source of support for those most affected by long term substance abuse, one that can be used as a catalyst for them to pursue effective treatment and rehabilitation. We advocate a comprehensive approach to care, case management and financial management linked to the overall system as the means of ensuring that recipients make progress toward self sufficiency.

We appreciate this opportunity to present our views. We look forward to a continued relationship with SSA and to sharing the knowledge we will gain from our demonstrations as to what works best to ensure effective referral, monitoring and treatment outcomes for individuals suffering from the diseases of alcoholism and addiction.

Chairman JACOBS. Chairman Ford.

Chairman FORD. Thank you.

Let me apologize to some of the witnesses that testified earlier, I had a flight delay earlier this morning. Let me thank you, Commissioner, for your testimony and for the visit I had last week with you in my office.

One of the witnesses implied that prison inmates can receive SSI benefits. Is there any truth to that statement at all?

Ms. CHATER. No, sir, people who are in prison are not eligible to receive SSI benefits.

Chairman FORD. They are not eligible at all?

Ms. CHATER. No.

Chairman FORD. Do you send brochures and pamphlets to prisons for these inmates?

Ms. CHATER. No.

Chairman FORD. Would they be eligible after they leave the institution?

Ms. CHATER. Only if they met the qualifications.

Chairman FORD. The aged, the blind, and disabled requirement?

Ms. CHATER. Yes.

Chairman FORD. A couple of other questions. It is my understanding that SSA does not pay for treatment and substance abusers cannot be required to pay for the treatment, thus leaving that to Medicaid and leaving it up to States; is that true?

Ms. CHATER. That is true. Social Security doesn't actually pay for the treatment. We pay for the referring and monitoring agency to find places for them to receive treatment.

Chairman FORD. How should we approach this when we see that alcohol and drug abusers receive supplemental security income, and representative payees are not fully in place?

Are there any legislative recommendations that Congress should submit to make sure that SSI payments go directly for treatment? What about requiring the Department of Health and Human Services to be responsible for SSI recipients receiving some type of a treatment?

Ms. CHATER. I think that the demonstration projects that we have in place, and the fact that we now have contracts with States who will put into place the referral and monitoring agencies, I think, all of those initiatives that we have underway now will give us some data to better answer your question.

We do know that there are some referral and monitoring agencies that are very effective in making sure that people are referred—that these particular clients are referred to treatment centers. And we know that some of the people who are referred actually get better.

So I think there is a lot of hope here. And I am hoping that we can continue to work with you based on some more substantial data to see just what the alternatives ought to be in the future.

Chairman FORD. Since you don't require representative payees, is there a recommendation?

Ms. CHATER. We do require it.

Chairman FORD. You do require it? Do you require representative payees to make sure that the recipient receives some type of treatment when it is a DA&A case?

Ms. CHATER. We don't require specifically that the representative payee assume that responsibility.

Chairman FORD. Would that be much of a problem for the representative payee?

Ms. CHATER. The representative payee now, according to the law, is supposed to be sure that the money goes for food, shelter and medical care.

Chairman FORD. I heard that in your testimony.

Ms. CHATER. And therefore it would seem that if a person requires medical treatment, including treatment of alcoholism or drug addiction, that could be an objective.

Chairman FORD. Are you having representative payees held accountable for the recipients? In some cases you have a place where you might find liquor store owners who might be the representative payees; is that correct?

Ms. CHATER. There may be a few. It is difficult for us to find representative payees who are willing to take on this responsibility. For example, they don't receive any payment, generally speaking, to do this. They are reluctant to do it.

Family members sometimes feel terribly pressured and give in to the addict or perhaps experience abusive behavior of some sort. So we look hard for people who would be responsible. But it has been difficult.

Chairman FORD. When the SSI recipient receives a large lump sum of benefits, oftentimes there might be some cases, we are hearing, that the representative payees are in fact being paid or some type of a financial contribution is being made to these representative payees; is that correct?

Ms. CHATER. Larry, is there a $25 payment here?

Mr. THOMPSON. Well, they could have an attorney or somebody that represented them as they were trying to get their award. And under the law, they can pay that person out of the lump sum award. That is not a representative payee. I am talking about somebody who represents them to the agency as they are arguing their case in order to get awarded benefits, which is a lawyer or some sort of a representative like that.

The representative payee, on the other hand, is somebody who on a continuing basis gets the check on their behalf. Those people are not supposed to use any of that money themselves. They are supposed to use all of the money——

Chairman FORD. What do you call the other person, the middle person?

Mr. THOMPSON. I guess a representative. Not a payee. I think frequently it is a lawyer.

Chairman FORD. I am speaking of nonlawyers who might represent——

Mr. THOMPSON. They can play the same role. They don't have to be an attorney. But that is an official registered representative of that client as that client argues his case before any awarding of benefits. The argument is whether that person really is disabled.

Chairman FORD. Is there any such thing as a time limit on SSI recipients and alcohol and drugs?

Mr. THOMPSON. No, there is no time limit. There is one situation under which we allow the representative payees to collect some

money to help offset their expenses, and that is a special demonstration project which the Congress enacted several years ago, and actually if you do nothing, it will expire on July 1, 1994.

And under that, we have the authority to enter into agreements with a limited number of nonprofit organizations who can then take up to $25 a month out of the checks of the beneficiaries and can serve as representative payees. A couple of those are doing that on behalf of drug addicts and alcoholics in California.

Chairman FORD. What if they enter into a program and were completely rehabilitated, would they continue to receive SSI benefits?

Ms. CHATER. No, they wouldn't, if they were rehabilitated and went back to work, they would no longer receive benefits.

Chairman FORD. The President is talking about a 2-year time limit. What do you think about a 2-year time limit for supplemental security income benefits for drug addicts and alcoholics?

Ms. CHATER. I personally think it is difficult to know what the time limit should be. Alcoholics and drug addicts need to be treated one-on-one because there are so many variables with the illness, including psychological and socioeconomic conditions.

And so for some people 2 years may be exactly the right time. For others it may be less and for still others longer. I am not prepared to say that there is a magic time.

Chairman FORD. We are only talking about those disabilities that would qualify a person to receive the benefits.

Ms. CHATER. Yes.

Chairman FORD. That is all Mr. Chairman. Thank you.

Chairman JACOBS. Mr. Bunning.

Mr. BUNNING. Thank you. Welcome Commissioner Chater and all others that are at the table.

I would like to ask if you agree with the conclusion of GAO that SSA payments to addicts are out of control? That is the conclusion in the GAO report. And what would you recommend, if you feel that way, what would you recommend at this time to change it?

Ms. CHATER. The actual payment to a person diagnosed with a disability is not very much, so if that is the notion of out of control, I would have to say that that piece of it is not out of control.

I think that the fact that we are having more people apply for disability benefits and we are acknowledging those eligible and giving them benefits is certainly on the increase.

Mr. BUNNING. I think that is completely different than what the GAO report said. I think they said it is completely out of control. You are saying that it is something that is growing and we are taking care of it.

Is it completely out of control or isn't it? Do you agree with the report or disagree?

Ms. CHATER. I don't think we have enough information to say that it is out of control. I agree that SSA has not done as much as it should have done in the past.

Mr. BUNNING. We have had this law and program on the books for 20 years. And we had a study done by the Inspector General and a report in 1991, that said there were similar problems with this particular program.

Now, I read or heard what you have said that you have done to try to correct this. I have listened to your testimony that we now have agreements with 33 States, and have 18 States monitoring only 45 percent.

The 33 States, how many people do they monitor? What percentage of people are they monitoring?

Ms. CHATER. Unfortunately, I suspect that we will only be able to monitor 50 percent of the people in those 33 States.

Mr. BUNNING. Are you telling me that we are picking up only 5 percent in the new 15 States?

Ms. CHATER. I think that is true.

Mr. THOMPSON. The prior agreements in 18 States monitored 45 percent of the people. We expect that to increase to 58 percent of the DA&As residing in States that have contracts in fiscal year 1994 and we hope to have 100 percent in the future.

Now, the next question is how much money can we put out under these contracts in order to pay for the monitoring.

Mr. BUNNING. You said your budget has increased $29 to $36 million.

Mr. THOMPSON. We had requested $36 million in fiscal year 1995 to pay for this, but it now looks like that may not be enough.

Mr. BUNNING. Commissioner, you said that they are going to be tested. These people in these programs are going to be tested for abuse. What kind of test are we going to do on them?

Ms. CHATER. Well, the drug testing will take a sample of blood and see if they have been taking drugs.

Mr. BUNNING. Then we are going to do what was normally a test for drug or alcohol abuse?

Ms. CHATER. Yes.

Mr. BUNNING. Analysis of some sort for blood or urine or whatever it might be?

Ms. CHATER. Yes.

Mr. BUNNING. And that is being done in these monitoring centers?

Ms. CHATER. It is going to be done as part of new contracts that have been signed this year.

Mr. BUNNING. Presently, the District of Columbia does not have a monitoring agency here; is that correct?

Ms. CHATER. They have a contract in the District of Columbia.

Mr. BUNNING. But they do not have one yet?

Mr. THOMPSON. Awarded January 14.

Ms. CHATER. Of this year.

Mr. BUNNING. Is it true that SSI has only identified 38 addicts in the District of Columbia?

Ms. CHATER. According to our records.

Mr. BUNNING. Thirty-eight?

Ms. CHATER. According to our records, yes.

Mr. BUNNING. Would you find that unusual, since I believe that our committee could walk out three blocks and discover more than that before dinner this evening?

Ms. CHATER. It does seem low, but that is only the number on our records.

Mr. THOMPSON. I think, Mr. Bunning, that illustrates what we would fully expect, that if we get an RMA operating in the District

of Columbia effectively, a lot more would be identified among future applicants.

Mr. BUNNING. Well, I would hope that that would be the case, but I would hope that we would get control over how many people we are referring, and where we are referring them. We need your suggestions, particularly on how we can get a better handle on the explosion of the dollars that are going out into this program.

Mr. THOMPSON. One of the causes of the explosion is that the people were there already, we just didn't properly identify them. It is like the District of Columbia with its 38 cases that were identified. When the monitoring agencies began to be effective in other States, more applicants got identified properly.

And if you look at States where they had effective monitoring agencies, they all of a sudden have a lot of addicts identified. So there are addicts on the program who should have been identified as DA&As but who have not been identified, and we hope they will get into treatment.

In the short run, one of the signs of success is that the number properly identified will increase.

Mr. BUNNING. Let me ask another payee question. One of GAO's findings concerning the dually entitled beneficiaries. Despite the fact that the SSI payment goes to a representative payee, because of addiction, many of the same people are paid regular Social Security benefits directly.

Wouldn't that be a contradiction? Why wouldn't they take one check and go buy drugs with it? This other check that is coming for their disability, why would that be more restricted by going to a payee?

Ms. CHATER. I agree that as a public policy it doesn't make much sense. I think the reason it is the way it is is simply historical.

Mr. BUNNING. Do you believe that you would have a suggestion for this committee or subcommittees that we might alter the law? Should we make sure that dually entitled people don't have the ability to buy drugs with Social Security money?

Ms. CHATER. I believe that we should treat both population groups the same way.

Mr. BUNNING. Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Reynolds.

Mr. REYNOLDS. Thank you, Mr. Chairman.

A question on the payee issue. By the way, thank you so much for coming today giving your testimony.

The question was raised about the representative payee and whether or not it was a good idea to have a member of the family or immediate relative or an organization to serve as the payee. What was implied in the testimony was that if you had an organization instead of someone close to the family or family member, that somehow that was a better way of monitoring the money.

I read that to mean that somehow the organization would have control over the money. That is what I think most people would believe. However, that isn't the case, is it? I mean, if a payee gets the money and they are supposed to give it to the person they are supposed to give it to, do they actually go to the grocery store or the landlord and pay the rent for the person?

Ms. CHATER. I understand that some representative payees actually do make sure that food is provided and that some actually pay the rent or at least give the rent money to the client and require that they bring back a receipt, as we heard earlier.

And you may want to have my colleagues here from SAMHSA talk to you about the demonstration projects and the way we are using an organization for representative payee. But it is not currently a requirement in order for an organization to be a payee to make purchases directly and get receipts to make sure that this money is being used for what it is supposed to be used for.

Mr. REYNOLDS. What happens when you can't find an organization to be the payee, and there are other addicts in the family, and you know this for sure, and you are looking for an outside payee and you can't find one. What happens then?

Ms. CHATER. We go to friends and acquaintances and ask a friend to serve as the representative payee.

Mr. REYNOLDS. And they say they don't want to. I am trying to get it clear in my mind what would happen if you couldn't find an outside payee and you couldn't rely on family members, what happens?

Ms. CHATER. The check would not be mailed until there was somebody to mail it to.

Mr. REYNOLDS. So a person would not get the benefits if they couldn't find a payee? My last question is involving drug testing. Are all—and I am new here so I don't know the answer to this question. It is a rhetorical question—are all recipients required by law to submit themselves to drug testing if, in fact, they receive this money?

Ms. CHATER. No, the contracts that we are writing now with the State monitoring and referral agencies, have a stipulation that one way to be sure that the client is in compliance with the treatment program is to do checks periodically to see if they are on or off drugs.

Mr. REYNOLDS. What if, in fact, the State of Illinois wants to monitor someone and they say we want you to take a test, and the person receiving the money and supposedly is in treatment decides they don't want to take the test, what happens? What does the State of Illinois do in those cases? What are they authorized to do I should say?

Ms. CHATER. I don't know the answer to that question.

Mr. THOMPSON. They would tell us. If this testing periodically is a normal part of the treatment program and they don't submit to the test, then they are not fulfilling the requirements of the treatment program. Under the contract, the RMA should inform us and we would suspend benefits until such time as the individual came into compliance with the treatment program.

Mr. REYNOLDS. My last question is along the same lines. If it is a part of the program, then there is some way of enforcing it. What I am really getting at here is it appears to me that there is no real way of enforcing this, whether it is testing to find out if folks are really actually going to treatment, or if we are giving money to people either through their family members who are the payee or to organizations. It doesn't seem to me at first glance and looking at this over the last several weeks dealing with this from a homeless

perspective and also from a child abuse perspective, 80 percent of the families in Illinois who abuse their children have been addicted to drugs, or there have been drugs involved, and so if some of these family members are in fact getting money from the Federal Government to further their addiction, then we really have to figure out a way to enforce getting the money.

And so it doesn't seem to me that there is a whole lot of enforcement. What would anyone on the panel do to enforce what we are trying to do to make this tougher and to get this drug abuse out of the system?

Ms. APPLEGATE. Mr. Reynolds, in our treatment programs under SAMHSA, we are very concerned with making sure that clients do participate in the programs. In our demonstration efforts, working with SSA, we have been trying to look at different ways to enforce the requirement that people stay in treatment and that they are achieving positive outcomes.

And, we are hoping that these linkages between the referral and monitoring agencies and the State and local providers will help to make sure that these outcomes occur.

Mr. REYNOLDS. Thank you, Mr. Chairman.

Chairman FORD. Mr. Chairman, I have another question just to follow up on that one, if you don't mind. Would it be more beneficial for the program to focus on treatment than cash assistance, since substance abuse, especially alcohol abuse, is a major problem in this country?

Commissioner.

Ms. CHATER. Treatment is certainly the most important part of a program, because that is what is going to take people off the rolls. So if we can find ways to emphasize that, yes.

Chairman JACOBS. Mr. Santorum.

Mr. SANTORUM. Thank you, Mr. Chairman. The testimony I am hearing—I came into this room concerned that there was an explosion in the SSI population. I am now convinced we have only seen the beginning of it. What you two have testified, what Dr. Thompson and Commissioner Chater have testified is that we have only touched the tip of the iceberg here, that we are going to go cut and use the effective tools used in States like California and Michigan to go out and bring a whole bunch of new people to the SSI rolls.

Four States comprise 65 percent of the population on this program, and it is the four States that I assume are doing the effective job in going out and trying to recruit addicts. Are you saying that New York State which has only 4 percent of the addict population while Illinois has 17 percent is an accurate reflection of the addiction problem in those two States?

I suspect if Mr. Bunning's number is right, that you have only identified 38 addicts in the District of Columbia, that we have a whole lot more people to find. So this is just the beginning. This is the tip of the iceberg. We are going to see a real explosion here in SSI, and there is absolutely no one at the gate.

There is no one monitoring who is coming in and how they are going to get out. Your testimony says, as a result, we know very little about the treatment process of SSI recipients and can document few if any recoveries so what we are doing is recruiting people to come on to SSI, and then we are going to provide them all

the money they need in cash assistance and treatment and Medicaid and referral and monitoring, and we are going to go set up programs to get representative payees, we are going to create this whole new system for people who have not been identified yet.

Is that what we are saying here today, that that is just the beginning?

Ms. CHATER. I think it is true that more people will be added to the rolls as we continue our outreach efforts and as we put into place——

Mr. SANTORUM. Are we talking about doubling or tripling the rolls in the next year or so?

Ms. CHATER. I don't know.

Mr. SANTORUM. Do we know that?

Mr. THOMPSON. We don't know for a fact, but I think I may have misspoken.

Mr. SANTORUM. We increased by 25,000 in the last 12 months.

Mr. THOMPSON. The point I was making is that there are a lot of people who are already on the rolls. There are a lot of people who are on the rolls who ought to be classified as DA&As but aren't.

Mr. SANTORUM. What percent? You make that statement.

Chairman JACOBS. He didn't make a statement. I couldn't hear him. Would you finish, please?

Mr. THOMPSON. I said we believe, and we were using the District of Columbia as an example, that 38 is an underestimate of the number of people that ought to be classified as drug addicts and alcoholics, and one of the things that the Commissioner testified to is that the agency has emphasized to the State disability determination units the importance of correctly classifying people who are being awarded benefits. Now the question is are they drug addicts? Should they have representative payees and should they be in treatment?

And one of the reasons that the numbers have increased is that it is not totally an increase in the number of DA&As coming on the rolls; it is an increase in the accuracy of our initial coding of new applicants.

Mr. SANTORUM. You said that in your testimony and I am saying what numbers do you have to back that up?

Mr. THOMPSON. I think if you look at the distribution of the DA&A beneficiaries in the States, you will discover, for example, that the States in the Chicago region have an unusually high number of DA&As. We happen to know that that region is one that had some of the most effective monitoring agencies, and then because they had effective monitoring agencies, the State said this is worth the trouble to identify these people because we know that there is an effective monitoring agency that might take care of them.

If you look at the data by State—the big increase in Illinois, Michigan, and some of those States—I think Illinois and Michigan have more than New York does.

Mr. SANTORUM. That is nice, but you haven't answered my question. What evidence do you have that we are not just reclassifying people on the roll? That is a very strong statement that you made. You left the impression with me that that is exactly what is going on.

Tell me what the facts are. How many people are being reclassified? This is a statement that you made that gave me the impression, and you said it twice, once in your testimony and once in response to a question that that is what is going on here. We are not adding new people.

Are you adding new people or reclassifying?

Mr. THOMPSON. Let me clarify my remarks. We are both adding new people and classifying them more accurately. We said in our statement that we do not have exact counts. We don't have the evidence that we would like to have to answer specifically why the rolls are increasing. I believe there are several important factors at work here.

One of them is the improved initial classification of new applicants that I just discussed. Now, clearly, the total number of people who are getting SSI disability has been rising the last 4 or 5 years, and the number of new claims has been rising. The increase of new people coming onto the rolls—one of the things that we think is causing that is the outreach.

Mr. SANTORUM. I would request that you provide to the committee some evidence of the statements that you made that in fact a major cause of the increasing rolls of the DA&A population is the fact of reclassification.

I would like to see those numbers because you made that comment in your testimony, you answered my question as to why the increasing rolls with that. And if it is a 5 percent part of the problem, it is not a good answer.

The answer, from what I am seeing of the overall growth in all SSI, and even a larger growth in the DA&A population, is that one is not just sucking from the other.

Rather, we in fact are going out there and identifying many more people, and we have absolutely nothing in the system to turn these people over and get them back out.

I guess that leads to my next question. You say in your testimony that if someone refuses treatment, that you follow strict procedures. Now, that is nice, but what does that mean? If someone refuses treatment, what does that mean?

Ms. CHATER. It means that the referral and monitoring agents for clients who refuse to undergo treatment report those clients to us and their checks are stopped.

Mr. SANTORUM. Their checks are stopped immediately if they refuse treatment?

Ms. CHATER. Yes.

Mr. SANTORUM. How many people have you stopped their checks in the last years?

Ms. CHATER. Although I can't tell you how many people in total had their checks stopped last year, our statistics show that in December 1993 about 11,000 DA&A recipients had their checks suspended that month for 1 or more of 10 possible reasons, including noncompliance with treatment requirements.

Mr. SANTORUM. Is there any way to get that information as to how many people are cut off based on refusing treatment?

Ms. CHATER. I suppose we could look at 11,000 cases. We would have to do it manually. It is not represented on our database that way.

Mr. SANTORUM. Can you posit a reason why the majority of those people were cut off?

Mr. THOMPSON. No, we have——

Mr. SANTORUM. You have no data that shows this?

Mr. THOMPSON. We have several reasons to terminate a benefit, all of which are represented by the same code in the computer data. We know that there were 11,000 DA&A suspensions total in December 1993. And one of the reasons that you get that code is that you refuse treatment. Several other reasons get you the same code.

Mr. SANTORUM. What are you suggesting that we do, if in fact my argument is the right one, Dr. Thompson, that we are not simply reclassifying, but that we are in fact seeing an enormous explosion and based on the monitoring and referral services that SSA is out there aggressively trying to bring more people into the system, and that the enrollment growth we have seen so far is like nothing compared to what we may see 2 years from now. We may quadruple or even go beyond our population here.

What are you folks doing to make sure that this does not become an enormous program that just is going to suck a tremendous amount of resources out of the Social Security system?

Ms. CHATER. Our goal is to take people off the rolls, to make them able to work again and become self-supporting. So what we are planning to do, in addition to working with SAMHSA and our demonstration projects, is look for new and alternative ways to deal with this problem.

We want to continue to look for ways to associate our clients with the treatment programs. We think that one major way of doing that is giving us an opportunity to work with States through these contracts where we will require much more specific feedback. We can collect data and analyze it and make some decisions about what the next steps in the program ought to be.

Mr. SANTORUM. Do you feel that someone who has been on SSI for a period of 1 or 2 years and has tested positive for drugs and continues to test positive for drugs should continue to receive SSI?

Ms. CHATER. I think it is an individual problem, that it would be hard for me to say.

Mr. SANTORUM. So the answer is, yes, that you think——

Ms. SCHECKEL. Actually that is a clinical judgment. There has been some rhetoric this morning about relapse, and addictive disorders in general. I would like to state for the record that relapse is endemic to the disease of addiction and should not, in and of itself, constitute a basis for removal from the SSI rolls.

In the demonstration programs that CSAT is conducting with SSA in the States of Washington and Michigan, we are exploring how to manage this problem, as well as how to manage the representative payee problem and to tighten the referral and monitoring function.

With regard to relapse, let me share with you how Washington State handles it because it is reasonable from the clinical, economic, and social perspectives. Even if patients relapse, they must meet two of three criteria to be removed from SSI. They must have refused to comply with treatment, they must have refused to comply with attempts to contact them, or they must have left the pro-

gram against medical advice. These criteria together are accepted and reasonable in terms of making a determination of patient willingness and commitment to recover.

Addiction is a medical problem. Recovery is very difficult to attain and maintain, and relapse is an acceptable part of the course of recovery. It is going to happen. The goal is to keep these people in treatment to help them manage their relapse to the point where they can attain and maintain sustained recovery, and it happens. It happens all the time.

In our demonstration programs, we are also developing the representative payee function. In Washington State, for example, representative payees are contracted for and placed onsite in the treatment facilities.

Mr. Reynolds, you had some questions earlier about how agencies might perform these functions better than family members or others close to our patients. The answer is that while addictive disorders and their manifestations are difficult to handle, clinicians who deal with these people every day know these problems well, understand addictive behaviors and know how to grapple with them.

If the flow of funds and their management is tied to a treatment protocol and adherence to that treatment protocol, then the prospect for treatment completion and sustained recovery can be enhanced. When a payee is an agency accountable for managing these funds, then they can also utilize leverage with the treatment facility to ensure that the funds are used wisely.

For example, a patient who is new to treatment would be transported to pay rent, would be transported to purchase money orders to pay bills, and would be transported to the grocery store as part of a group. Until such time as that individual demonstrated the capability to be responsible with managing his or her own funds, that responsibility would not be accorded to the patient. The treatment professionals that are closest to the patient are best positioned to make these determinations.

Last, on the issue of testing, testing is a regular course in effective treatment programs. Testing, though, is used to monitor patient compliance with treatment and to gauge the need to alter the treatment protocol. It is not used as a cause to oust the patient from treatment.

A clinician would no more oust a patient from treatment based on relapse than would a doctor oust a diabetic for mismanaging his or her insulin and going into insulin shock.

Mr. SANTORUM. If I can ask the followup question, you make a strong statement on behalf of treatment, and I think that is great, and that we should provide treatment for people who are willing and making an effort to break their dependency.

If someone is not willing and not able that do so, the question we have—I have, anyway, is what is society's obligation to continue to provide cash assistance to that person. I would have no problem, per se, for someone still having availability of treatment.

I don't like the prospect of the Federal Government giving someone cash to continue their drug problem. The GAO report says that people are going out and using that cash assistance to go out and

buy drugs to further their dependency. The problem is not, as far as I am concerned, with the treatment.

My problem is that we are, in fact, encouraging addiction by giving money to people to go out and do things that are counterproductive to the treatment prospects and that is No. 1.

No. 2, I question overall the programs that you are talking about and how much money that we are spending on these programs. Commissioner Chater talked about finding no recoveries, none. That is what she said: Document few if any recoveries on the SSI program. Is this a population that is well suited for treatment and recovery, or are we dealing with a much more chronic, lower probability of success population that is going to, in fact, just continue to use more and more and more resources with little if any evidence of efficacy?

Ms. SCHECKEL. I do not want to presuppose the intent of the Commissioner's statements, but I believe that she said that we are not sure at this juncture to what extent we can anticipate recovery rates or the cost benefits. It is fair to say that infrastructure that is managing and overseeing this problem has not, to date, conducted that function effectively.

The data which we require to answer your questions are very limited, but we do have data in certain States like Illinois and like Washington.

You are asking for a policy judgment. And the answer is difficult to provide because the infrastructure is so eroded. For example, we know that these patients are very chronically disabled. When it comes to treatment availability and treatment effectiveness, we know in a lot of jurisdictions treatment is either unavailable or the right kind of treatment is not available.

What works for the hoi polloi does not work for these multiply diagnosed, chronically impaired patients. The fact is that until we make appropriate treatment available, get these people into treatment programs and monitor their progress, we can not provide you answers with regard to precise cost benefits and duration of enrollment in the program.

We have a lot of scientific information, and we have anecdotal practical experience with a few States that indicates that we can get addicts into recovery, but treatment availability is still a problem in many of these jurisdictions.

Chairman JACOBS. Mr. Reynolds, would like to ask one quick question?

Mr. REYNOLDS. I heard what you said about Washington State. I still haven't really heard anything as far as payees are concerned, other than the fact that they are professionals so they know how to deal with this and so they can handle it better.

I am looking for built-in rules and ways of guaranteeing that cash does not go for drugs. Would it be an idea to do vouchers instead of cash?

Ms. SCHECKEL. We have this information at our disposal and could provide it for the record. There are standards in place in several States that appear to be very effective and we would be glad to provide this information for the record.

Mr. REYNOLDS. I would really appreciate that.

Chairman JACOBS. We thank the panel, and we must rush off.

[Recess.]

Chairman FORD. The subcommittees will come to order.

Before I call upon Mr. Flemming, we have one of our colleagues who had a conflict in his schedule this morning, but is here now, a member of the full Committee on Ways and Means. We are delighted to have Congressman Thomas of California with us.

Bill, we will recognize you at this point.

STATEMENT OF HON. WILLIAM M. THOMAS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. THOMAS. Thank you very much, Mr. Chairman.

I apologize for not being here during the Members panel. We have an ongoing Health Subcommittee hearing that seems to be ongoing all the time, and today was the last day.

I want to thank you for holding this important hearing on the program which provides the supplemental security income disability benefits to drug addicts, and also for allowing me to testify.

I have introduced a bill, H.R. 1712, which I believe resolves the basic problems found in the current program. Let me talk to you a moment about how I came to introduce a bill. On February 28, 1992, in the newspaper in my hometown, the Bakersfield Californian, a reporter, Lois Henry, ran a series of articles on the growing number of drug addicts and alcoholics who were receiving SSI disability benefits based on their habits.

This was the first time I was aware of it and, as a Member of Congress, you well know that there are people who come to you and say how come you didn't know about this. The answer is, no one pointed it out to us. We are not omniscient.

But frankly the first story reported a steady increase in the number of drug addicts being arrested by local police while in the possession of large sums of money. It might not seem odd ordinarily except these large sums of money were received from the Social Security Administration as back SSI disability payments. It was also reported these funds were used by addicts to purchase alcohol and drugs to feed their habits.

Subsequent stories as well as other newspaper articles began to pick up the issue and told of representative payees who were being threatened and lied to by alcoholics and drug addicts receiving SSI disability payments in order to get the money and continue to feed their habit.

The oversight system which is supposed to assure that alcoholics and drug addicts receiving SSI payments attend treatment programs were found after the fact to be very ineffective. When or if the monitoring organization discovered that an addict failed to participate in treatment, the addict would be reported to the Social Security Administration. However, instead of having benefits canceled, as is required under current law, the addict would be called into the Social Security office and made to promise that they would participate in treatment in the future, and there was some hand holding and hand wringing, and then they would be reinstated. According to Social Security administrators, an addict would usually be reported five or six times before action to eliminate benefits would be taken, and that action would usually be challenged and

overturned often because of the inconsistency with which the penalty was applied.

In looking at that entire panoply of problems, we attempted to resolve each of these, first, addicts using SSI disability funds to feed their habit; second, addicts threatening or cheating their representative payee, and addicts not being penalized for failing to participate in the treatment program in the first place. I worked with law enforcement officials, local drug treatment professionals, local and—State and national Social Security agencies, representatives of alcoholics who had been the subject of these very clever attempts to extort and cajole to get them to go along, representative payees, county welfare agents, and we put together what is in front of you, H.R. 1712.

Let me briefly discuss the way we believe a solution can be presented. We make three basic reforms in the current SSI disability program.

First, the bill would allow government agencies to become representative payees. They are willing to do this. However, it is currently prohibited under the law and frankly we need to increase the 10 percent benefits cap on payments that can be received by the payee because in penciling out the costs, they did not believe they could adequately perform all administrative oversight costs to principally county agencies without the 10 percent provision. We think that is reasonable. By allowing government agencies such as county welfare probation or health departments to become representative payees will assure the money is used for the purposes intended and not to feed the addict's habits.

Also, I believe this will allow for better coordination of treatment and other government assistance that may be available to the SSI recipient because you close the circle of those people who are there to help and to oversee and to assist with the monies for those purposes. Second, all persons receiving SSI disability payments based on an alcohol or drug addiction would be required to enroll and actively participate in an outpatient treatment program for 3 months before receiving Federal payments, that is show me the behavior before you get the money. The recipient would still receive Medicaid during the 3-month waiting treatment period which can be used to pay for treatment. After the 3-month period, the addict's progress is reviewed.

If the person is found to be actively participating in treatment and progressing toward recovery, yet is still considered disabled, then monthly payments would begin the fourth month. The treatment would continue. If the person is found to be refusing treatment and not progressing toward recovery, then the State can continue the waiting period indefinitely and would have the choice as to whether or not to continue paying for treatment. A little bit of carrot and stick. These reforms would provide a strong incentive for addicts not only to actively say they are participating in a program, but actively participating in treatment and become once again a contributing member of society.

Finally, Mr. Chairman, we would establish realistic penalties for those who failed to continue their required treatment after the initial 3-month period. After the first offense, Federal SSI disability payments would be discontinued until the person actively

participates in a treatment program for 2 weeks. Withheld funds are not returned. You don't promise good behavior and get a reimbursement for missed dollars.

After the second offense, Federal SSI payments are discontinued until the person actively participates in a treatment program for 2 months and withheld funds are not returned. Behavior has consequences and continued positive behavior toward treatment is rewarded. Other behavior is not rewarded.

After the third time it is reported that the SSI recipient is not actively participating in the treatment program, Federal SSI disability payments are stopped.

The Social Security Administration has reported a rapid increase in the number of persons receiving disability SSI payments in recent years for drug or alcohol addiction. In California alone the number has risen, I am told, to almost 8,000. The current program fails the American taxpayers by not ensuring that they receive the kind of treatment they need and frankly deserve.

H.R. 1712 would make reforms in the SSI disability program that are long overdue, Mr. Chairman, and reforms that will save money, but also ultimately make sure that the assistance that substance abusers need and are disabled by their addiction are received.

I urge the subcommittee, you have heard testimony and will continue to hear testimony in the area, but this area needs to be reformed and we believe H.R. 1712 provides a framework that not only protects the taxpayer, but makes sure the people who are in need of treatment actually receive it and benefit from it.

I thank the Chairman very much.

[An attachment to Mr. Thomas' statement follows:]

SSI DISABILITY REFORM -- H.R. 1712

Addicts Treated Before Receiving Assistance. Any SSI Disability recipient who is addicted to drugs or alcohol must be enrolled in and actively participate in an outpatient rehabilitation program for three months before they can receive federal payments. The recipient will still be eligible for Medicaid during this three-month waiting/treatment period.

States Provide Treatment. Each state would develop a program for reimbursing alcohol and drug abuse treatment centers which provide outpatient care for SSI Disability recipients during the three-month waiting/treatment period.

Addicts Reviewed Before Receiving Assistance. During the three-month waiting period, the State must review the progress of the SSI Disability recipient.

> If the recipient is **progressing** towards recovery or is recovered, but is still considered disabled under the SSI Disability program, then monthly payments will begin the fourth month.
>
> If the recipient is **not progressing**, then the State may continue the waiting period indefinitely and continue to pay for treatment through the Medicaid program.

Addicts Must Continue Treatment. If the state determines that a recipient must continue outpatient treatment for alcohol or drug abuse after he/she begins receiving regular monthly payments, the recipient must continue to actively participate in the treatment program or be subject to the following penalties:

> **1st offense** -- Federal SSI payments are withheld until the person has actively participated in the treatment program for two weeks. Withheld funds are not returned after the two week period.
>
> **2nd offense** -- Federal SSI payments are withheld until the person has actively participated in the treatment program for two months. Withheld payments are not returned.
>
> **3rd offense** -- Federal SSI payments are stopped.

Government Agencies to be Payees. Government agencies (such as Kern County) would be allowed to be a paid representative payee and be permitted (along with other paid payees) to collect from an SSI recipient a monthly fee for expenses not to exceed 10% of the monthly Federal and State benefit.

Standards Developed. The Department of Health and Human Services must work with drug and alcohol treatment professionals to develop standards for treatment rograms, and with States to develop progress review guidelines.

Chairman FORD. Thank you, Mr. Thomas.

We have quite a few other witnesses, but there are two quick questions that I would like to ask of you.

This 10 percent to the representative payee that you mention in your testimony, is that in addition to the SSI payment?

Mr. THOMAS. The problem is today government agencies can't be utilized and the amount is currently a dollar amount rather than a fixed percentage. It is a $25 amount rather than a fixed percentage.

We went to a 10 percent amount which then would provide sufficient administrative overhead costs out of the monies to allow these government agencies to do it without losing money.

Chairman FORD. It is not an additional 10 percent, but 10 percent of the SSI payment?

Mr. THOMAS. No. Currently it is $25 and frankly you will find it difficult to find people to put up with the grief for that amount. The government agencies would not do it at a loss and at $25 they couldn't perform the function. Ten percent would cover the cost and we thought it was a reasonable amount.

Chairman FORD. You mentioned treatment for SSI applicants prior to receiving benefits. Does this mean they have already met the means tested qualification part of the program?

Mr. THOMAS. They would receive the Medicaid from the State——

Chairman FORD. They would have met the treatment requirements in your bill prior to receiving SSI benefits?

Mr. THOMAS. Right.

Chairman FORD. Would they receive any type of Medicaid needs allowance in that 90-day period?

Mr. THOMAS. Based on need, yes, just as during the primary period.

Chairman FORD. Just the 3 month primary period.

Mr. THOMAS. Right.

Chairman FORD. Thank you, Mr. Thomas.

Mr. THOMAS. Thank you.

Chairman FORD. The subcommittees are very happy to have with us today Hon. Arthur Flemming, the chair of Save Our Security Coalition, former Secretary of the Health and Human Services of this country.

Dr. Flemming, I am very happy as chairman of the Subcommittee on Human Resources to have you testify once again. We will recognize you at this time and you may proceed, sir.

STATEMENT OF HON. ARTHUR S. FLEMMING, CHAIR, SAVE OUR SECURITY COALITION, FORMER SECRETARY, U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. FLEMMING. Thank you very, very much, Mr. Chairman. I appreciate the opportunity of participating in this hearing.

Yesterday I did spend about 3 hours in the Health Subcommittee and had the opportunity to testify there, so all together I have spent time with three subcommittees.

Chairman FORD. So your expertise is needed in all these subcommittees.

Mr. FLEMMING. I appreciate it and I have got a lot out of it. As I listened to the testimony today, I feel that some of the witnesses and some of the members of the committee have made an excellent case for the national community pooling its resources, public and private, and at long last providing this Nation with a universal coverage for health care, and I am delighted that this committee is getting into some of those very same issues.

On August 25, 1992, a group of which I was chairman filed with the Social Security Commissioner a report known as the Supplemental Security Income Modernization Report which was based on a 2-year study of the SSI program together with about 19 colleagues.

We included in that report two major recommendations on the representative payee program. I recommend that these two recommendations be considered by the two committees.

We recommended, first of all, that Congress codify the legislation on representative payees so as to make it very clear what the Congress and the President mandate in the way of recruitment, training, and monitoring of representative payees.

We recommend that the Congress also set forth in the legislation authorization of specific funds to implement the representative payee program. The members of the SSI modernization project found that the Congress had directed the Social Security Administration to institute representative payee programs but never has allocated funds for these activities.

This has meant that other employees, particularly claims personnel, have had to endeavor to absorb responsibility for recruiting, training, and monitoring of representative payees.

As a result, this government has an understaffed payee program and at the same time a seriously understaffed disability program, for example, endeavoring to grapple with the backlog of at least 700,000 persons.

This understaffing is the direct result of arbitrarily reducing in the 1980s the Social Security Administration staff from 80,000 to 63,000, a staffing pattern that now calls for approximately 65,000.

This understaffing it seems to me seriously undermines confidence in our form of government. If the government seeks to achieve a higher rate of treatment among alcoholic and drug addicts, the express purpose of this hearing, it can do so by correcting this understaffing.

This is true whether alcoholic and drug addicts are to receive cash benefits or vouchers which could be converted into cash. In either event, representative payees are needed to implement a cash benefit or voucher program or both and to help build bridges between alcohol and drug addicts and public and private services.

The Ways and Means Committee, I think, rendered a great service in proposing the representative payee program. You open up tremendous opportunities for our Nation's volunteer programs. But a volunteer program to be effective must be adequately staffed.

Now, we must convince the Appropriations Committee that if this Nation is to benefit from the services of these volunteers, which I think is a great service, we must provide the program with adequate support.

That is the one point I would like to make as far as this hearing is concerned.

We made many other recommendations on SSI and I think it is important for this committee to keep in mind that SSI is a program for the poorest of the poor and, as we suggest, additional responsibilities in treating alcohol and drug addicts we must keep them in mind. It is a program for the poorest of the poor where the income floor is below the poverty line. That obviously limits what the people on these rolls can and cannot do.

[The prepared statement follows:]

OUTLINE OF TESTIMONY

BY

ARTHUR S. FLEMMING
CHAIR, SAVE OUR SECURITY COALITION

I. Introduction

A. I appreciate the opportunity of testifying before the Subcommittees on Social Security and Human Resources to explore means of achieving higher rates of treatment among alcoholics and drug addicts receiving Social Security Disability Insurance (SSDI) and Supplementary Security Income (SSI) benefits.

B. In addition to meeting the Social Security's medical definition of disability, alcohol and drug addicts who apply for the Supplemental Income (SSI) must comply, according to a bill passed by the Congress and signed by the President, with two provisions in order to receive benefits: (1) they must participate in a substance abuse treatment program approved by the Social Security Administration, and (2) their SSI benefits must be paid to another person or organization (a "representative payee") who is responsible for handling their finances.

C. On August 15, 1992, a group of which I was chairman, filed with the Social Security Commissioner a report known as the "Supplemental Security Income Modernization Report" which was based on a two-year study of the SSI program.

1. We included in that report two major recommendations on the Representative Payee Program which is now applicable to 27 per cent of the SSI beneficiaries.

2. I recommend that these two recommendations be considered by the two committees.

II. Body

A. We recommended to the Congress legislation which would codify and, where necessary, expand on existing law in order to clearly set forth the intent of Congress and the President to mandate the recruitment, training, and monitoring of representative trainees.

1. This legislation should provide reasonable reimbursement of expenses to non-relative, non-accustodial representative payees from administrative funds.

2. It should likewise provide for agency reimbursement from administrative funds for expenses incurred by agencies which contract with the Social Security Administration in order to help the Social Security Administration obtain representative payees.

3. These expenses should not be deducted from the SSI benefits.

B. The Congress should also set forth in the legislation specific authorization of funds to implement the representative payee program.

1. The members of the SSI Modernization Project found that the Congress has directed SSA to institute representative payee programs but never has allocated funds for these activities.

2. This has meant that other employees, particularly claims personnel, have had to endeavor to absorb responsibility for recruiting and training representative payees.

3. As a result this government has an understaffed representative payee program and, at the same time, a seriously understaffed disability program endeavoring to grapple with a backlog of at least 700,000 persons.
   a. This understaffing is the direct result of arbitrarily reducing in the 1980s the Social Security Administration staff from 80,000 to 63,000.
   b. Its staffing pattern now calls for approximately 65,000.
4. This understaffing seriously undermines confidence in our form of government.

C. If the government seeks to achieve higher rates of treatment among alcoholic and drug addicts it can do so by correcting this understaffing.
1. This is true whether alcoholic and drug addicts are to receive cash benefits or vouchers which could be converted into cash.
2. In either event representative psyees are needed to implement a cash benefits or vouchers program or both and to help build bridges between alcoholic snd drug addicts.

III. Conclusion

A. The Ways and Means Committee rendered a great service in proposing the representative payee program.

B. You opened up tremendous opportunities for our nation's volunteer program.

C. Now we must convince the Appropriations Committee that if this nation is to benefit from these "free" services we must provide the program with adequate support.

Chairman FORD. Thank you, Dr. Flemming.

I agree with you when we talk about the SSI program, in general. But when we are talking about drug addicts and alcoholics, you mention very little about treatment.

As we focus on drug addicts and alcoholics, certainly this is a problem that is out there in our society and SSI benefits should be made readily available.

But at the same time treatment is something that I think we have to focus on at this point in time. Treatment from the standpoint of bringing the addicts and alcoholics we are talking about off the SSI rolls and putting them back to being productive citizens once again.

Mr. FLEMMING. Mr. Chairman, I agree with you completely. As one who has become accustomed to testifying under the 5-minute rule, I normally concentrate on just one issue. If the committee decides to discuss other issues with me, I would be very happy to do it.

Chairman FORD. You know those lights really don't apply to silver-tongued giants of oratory like you.

Mr. FLEMMING. OK.

There is no question at all but that treatment is a very vital issue. For example, as far as the SSI program is concerned, we have a work incentive program, and that anticipates that not only alcohol and drug addicts, but other disabled persons, persons on the SSI rolls will come to the place where they can move back into the work force, and we hope that some of them can, maybe all of them, go off the SSI rolls.

But I listened to the discussion today on treatment and when we remember that we are dealing with the poorest of the poor, and that their benefits have a floor which is below the poverty line, that illustrates to me again the fact that this Nation desperately needs a universal coverage health care program so that we will not have to consider the individual resources of the individual who could participate effectively in a treatment program and who could undoubtedly be led off the rolls to a place where he or she can once again take their place in the work force of this country.

Now, I agree that that is a terribly important aspect of it, and I hope this committee and the Health Subcommittee, will consider that because I believe this: Some of these programs can be very effective and that people can reach a place where they once again become working members of our community.

That should be the resolve of all of us. It seems to me that the objective of the disability program is to help people realize their highest possibilities. Certainly in order to realize their highest possibilities, they do have to participate in very effective treatment programs. That way they don't have to live their days thinking that they have to stay on the disability program.

Chairman FORD. Thank you, Dr. Flemming.

Mr. Bunning.

Mr. BUNNING. I would like to thank you for your testimony, Dr. Flemming. We always appreciate your insight.

Mr. FLEMMING. Thank you.

Chairman FORD. Thank you very much, Dr. Flemming.

Nancy Meyer, Calvary Women's Shelter; Thomas Schatz, Council for Citizens Against Government Waste; Jeffrey Rabin, Nancy Katz of the SSI Advocacy Project, and Les Brown, Chicagoland SSI Coalition.

The Chair will recognize you in the order that I have called your names.

Ms. Meyer.

STATEMENT OF NANCY J. MEYER, EXECUTIVE DIRECTOR, CALVARY WOMEN'S SHELTER, WASHINGTON, D.C.

Ms. MEYER. Good afternoon, Mr. Chairman, committee members, thank you for this opportunity to be here today to share with you some of my experiences. I am currently the executive director of Calvary Women's Shelter which is an emergency overnight shelter for homeless women in Washington, D.C.

I am here today to discuss a variety of issues associated with substance abuse and Social Security benefits. I represent not only my experience working with no and low income homeless substance abusers in the Nation's Capital, but my own personal experience.

I am the daughter of a recipient of Social Security disability benefits due to substance abuse and as well I am the administrator of programs which serve those in need of these benefits. My hope for these hearings is that I can help provide some understanding of the complexity, some of the ambiguity, the difficulty, but ultimately the necessity of providing adequate and sustained benefits, treatment, and other necessary life-sustaining supports to seriously impaired substance abusers.

Please allow me to explain from my own experience. In the last years my father lived in a rundown boardinghouse in the commercial district of Hackensack, N.J. He had no cooking facilities and could not meet the requirements of the special diet he was required to follow. His room was small and dingy with no private bath and cost way more than half the Social Security income that he received.

He had no phone and I would often call him at a pay phone nearby to check on him regularly.

I sent him things to supplement his income, socks in the winter, jackets, those kinds of things. I could not, however, support him, my disabled father, on my income.

Yet only a mile away from this very boardinghouse he lived at, at one point he lived nearby with a wife and two children in a lower class area, pursued their version of the American dream owning their own home, owning two cars and hope for much more.

But in the end, their dreams were dashed and the tenacity of their alcoholism prevailed only to find in the end that they would be deserted by the very same system that they came to believe in completely.

On one hand, without the benefits, my disabled father would have been left to survive on the streets, without cash income, we found there was no housing available for him. On the other hand, the benefits were so small that there was much he did do without.

This situation exacerbated his frail condition and made daily life difficult, to say the least. The difficulty which he did not surmount in spite of his then sobriety, he died there several years ago.

I would like to point out that in my work I have known many other substance abusers like my father from those types of backgrounds. This is what I see every day at the shelter. I see Randy and Nicki and Emma who are determined to turn their lives around, but with little resources and no choices to sustain the very basics of their lives through their struggle with substance abuse.

I need to add at this point that we at the shelter do not have any documented cases of clients receiving entitlements based on substance abuse eligibility alone. That is from discussing with social workers at my agency and I have also discussed that with other social workers and programs around the city, that we cannot identify anyone who has gotten those benefits, and even though there are plenty of people we could have identified who need those benefits.

Even when certain programs are supposed to be in place, they are often underfunded and inadequate and poorly implemented. This is especially deadly for those afflicted with substance abuse disorder, and often what we see is that folks that we work with cannot get into programs for months on end.

Once they are in a program, it may only be for 7 days, it may be for 28 days, they do not get the sustained treatment necessary for their recovery.

When these determined women, in the case of my shelter, cannot access adequate housing, health care, supportive services, treatment and aftercare, their struggle to overcome their addiction takes on monstrous proportions that are insurmountable.

There is a need for the type of program that Secretary Cisneros has outlined for the homeless, a comprehensive continuum of cares targeted specifically for substance abusers. This would provide a comprehensive array of issues for treatment and aftercare that would assist with other life needs in order to make treatment and recovery a real possibility.

And I wanted to add that in terms of some of the issues, in terms of giving folks cash benefits, what we have found is that when people don't receive those benefits, the services need to be provided from other agencies and other places. What we are seeing is that it is focusing on localities or on private agencies. So one way or the other there needs to be funds available to treat and deal with this issue.

That is the end of my prepared statement. I would be happy to answer any questions.

[The prepared statement follows:]

Subcommittee on Social Security
Committee on Ways and Means
U.S. House of Representatives
February 9, 1994

My name is Nancy J. Meyer. I am the Executive Director of Calvary Women's Shelter which is an emergency overnight shelter for homeless women in Washington, D.C. I am here today to discuss a variety of issues associated with substance abuse and social security benefits. I represent not only my experience working with no or low income, homeless substance abusers in the nation's capital but my own personal experience. I am the daughter of a recipient of Social Security disability benefits due to substance abuse and the administrator of programs which serve those in need of these benefits.

I believe that telling you my own story might help you understand the complexity, some of the ambiguity, the difficulty, but ultimately the necessity of providing adequate and sustained benefits to seriously impaired substance abusers.

Please allow me to explain. I grew up in an average lower middle class family in Teaneck, New Jersey. My neighborhood was an old and stable one where my mother had grown up as well and where she meet my father. My parents married and settled down to going about the business of supporting and raising a family. Both my parents worked very hard and eventually put my father through night school where after seven long years he earned his undergraduate degree. Dad was able to secure better employment with his degree and things seemed to be going well -- for awhile. From the outside, we seemed like the perfect all American family, two hard working parents, two nice kids, a house and the future.

Yet, this time took its toll and was also marked by the increasing use of alcohol by both of my parents. By the time I left home at 18 my father's alcohol use had become chronic and severe. He continued to work but with difficulty. Soon after I left, my parent's decided to divorce and my father quietly feel apart. His alcohol use increased even more, he erratically showed up for work and eventually lost his job. On Christmas eve, my mother found him in his apartment, alone, and unconscious. When the ambulance came, they thought he was dead. Thank god he wasn't.

My father who had worked very hard for all these years to help support the family had no health insurance and very little money. He was taken to a community hospital and was in intensive care for an extended period of time and was hospitalized for about 6 months. Fortunately there was a caring social worker at the hospital who helped my mother and myself try to begin to make sense of what would happen to my father. He was now homeless and destitute with no where to go and no income. What a terrible realization for me that after all his hard work he would have almost nothing. With a tiny income myself, I knew we needed help.

With a great deal of effort the three of us set in motion the services that he might be able to access. He had no housing, no income and could not work. Housing and income were critical first steps. There was no public housing available so the only option was to apply for some kind of benefits so that Dad could access housing directly. This is one of the main problems for those that are poor and disabled. After some time and bureaucratic running around we were able to get Dad on social security disability partly because of the documented severity (by the hospital) of his substance abuse and related physical disabilities and mainly through dogmatic perseverance. Now he had about $400 to live on per month and had to pay for housing and all his other living expenses. Eventually my mother was very fortunate to find a boarding house (that was not that terrible) where Dad paid more then half of his income to live. He wasn't allowed to cook in his

room and spent substantial funds on eating at a local diner although he was supposed to be on a special diet that was almost impossible to accommodate given his living conditions. I supplemented his income by sending him things I knew he needed like clothes and toiletries.

My father lived six years in this boarding house before he died of a heart attack from the damage caused by the alcohol. That was six years we had together to get to know one another - again. It seemed that he did not drink after his intensive hospitalization but I could not tell you for sure that he didn't. It seemed that he didn't but if he did, it was on a very small scale and one which he seemed to be able to manage. I can say that I never saw him drunk after he moved into the boarding house. Although it was struggle for Dad to make it on his own on his tiny SSI income, it enabled him to live independently with a modicum of dignity. This is what every program should aim to provide: dignity, independence, and more. The more should include access to comprehensive treatment, housing, income, health care, and substance abuse programs and aftercare. My father struggled by those six years with very little. It was not enough.

Yet, if my father had not been able to receive the cash benefits he did -- he would have been out on the streets and probably would have died soon after his release from the hospital. Because of the very small income from SSI that he received he was able to have a place of his own and take care of himself. He was able to live completely independently which is what he wanted His alcoholism was very severe and without the SSI income he would have had absolutely no choices and quite possibly no housing.

This is what I see everyday at my job. I see people with no resources and no choices to sustain the very basics of their lives through their struggle with substance abuse. Even when certain programs are supposed to be in place, they are often underfunded and inadequate. This is especially true and deadly for those afflicted with a substance abuse disorder.

Please allow me summarize the following pertinent points:

1. At Calvary Shelter, I have never known of anyone that our casemanager has been able to get on SSI disability with substance abuse as the primary disability. I have spoken several other providers of services to homeless women who have indicated a similar pattern of data. We have found the eligibility criteria extremely difficult to meet. Generally the client applies and is not awarded benefits which then requires a lengthy appeal process that generally requires support from agencies such as the Washington Legal Clinic for the Homeless. Clients we serve usually receive SSI disability due to other disabling conditions and not substance abuse. We do have clients who are disabled from a substance abuse disorder, who cannot work, have no income or housing and who cannot get benefits.

2. Availability of Treatment - We have found that availability of treatment is irregular in both access to programs, quality of programs, variety of programs, and in terms of aftercare. This leads to a crazy quilt of differing options for clients and very negligeable results. Especially over the last several years, funding for community based programs has substantially decreased. For example, sometimes there are spaces available for clients in a 28 day residential program but more often then not there is no place for clients to go after treatment. Often they can't stay with whomever they had been living because it may have been part of the substance abusing environment that they had been living in. And there is no where else for them to go to with no income or resources. Also, if their substance abuse condition is not severe enough they will not qualify for SSI benefits and even if they did qualify the process takes so long that it would not, in the short term, provide assistance. Often, they return to the shelter environment which is not necessarily a drug free environment or supportive of their recovery. This perpetuates a dead end cycle for substance abusers who cannot progress beyond initial treatment into sustained recovery. The result of this erratic treatment is the continuing downward spiral of substance abusers lives and the resultant serious and related disorders. Hence, one possible source of increased SSI benefits

for the most serious and virtually debilitated substance abuser. The current literature clearly shows that care and treatment for substance abusers needs to be more then a 4 week program. There is a need for what Secretary Cisneros calls a "continuum of care" for substance abusers specifically which provides a comprehensive array of progressive options for treatment and aftercare that consider the complexity of substance abuser's lives, needs, and environment. This type of model needs to fully funded and fully implemented to show results.

3. Disabling Conditions - The general decrease in funding for programs and services and for general assistance by states has decreased the availability of services. The widespread expansion of economic hardship has created a general increase in poverty and related problems. At Calvary Shelter I have seen that our clients have had decreasing access to necessary public resources and the cluster of disempowering conditions that they struggle to overcome now requires more resources. The result at our program is the increasing growth of our agency and its services as we strive to provide a more comprehensive approach to meet the needs of our clients. From last year to this year, our operating budget has doubled. Clients struggling with substance abuse have no housing, no income, no employment. They are not only dealing with the substance abuse but with the lack of necessary life sustaining supports.

4. The social misperceptions and moral grand standing about substance abusers and especially those who are poor should not get in the way of providing critical life services to those who are terminally ill with substance addiction.

Without adequate benefits, services, and commitment to those that are disabled with substance abuse disorders, many more mothers, fathers, sisters, lovers, and friends will die on the streets, in shelters and in other substandard living conditions. Substance abuse is a complex problem which needs the commitment of our hearts, our minds, and our dollars over long periods of time.

Chairman FORD. Thank you very much.
Now we will hear from Thomas Schatz.

STATEMENT OF THOMAS A. SCHATZ, PRESIDENT, COUNCIL FOR CITIZENS AGAINST GOVERNMENT WASTE

Mr. SCHATZ. I am Thomas Schatz, President of the Council for Citizens Against Government Waste. I thank you for the opportunity to appear here today to express our grave concerns about the Social Security Administration's management of the cash benefit program, supplemental security income. We are particularly concerned about drug addicts and alcoholics who receive benefits under the disability portion of the program.

You have acknowledged the problem by holding this hearing and we welcome your attention to this issue. I come before the subcommittee today not as an expert witness on drug abuse, alcoholism, or disabilities but as the president of a veteran waste-fighting organization with over 600,000 members which has for 10 years advocated responsible governing and prudent use of our tax dollars.

If we set out to create a fictitious government program which epitomized all that can, and does go wrong with government programs, we couldn't have created a more perfect example. Unfortunately, the SSI program as it applies to drug addicts and alcoholics [DA&As], is for real and so is the $1.4 billion in tax dollars it gobbled up last year alone.

This program shows many symptoms of being out of control: Weak management, program oversight, and monitoring that is almost nonexistent, and a vague and dubious mission. More important we have mounting evidence that fraud is running rampant throughout the program.

Worse yet, people are overdosing, are drinking themselves to death using SSI cash. And that is the most unconscionable waste of all.

Since many DA&A recipients know they will not be monitored and do not undergo treatment, putting hundreds of dollars in cash in their hands at one time without accounting for it is a little like putting a loaded gun in the hands of a suicidal person. There have been many recipients using these checks to subsidize drug and alcohol binges, sometimes with fatal results.

We know from experience that the aforementioned gross management weaknesses leave Federal programs like this open to abuse. It also provides an opportunity to reinvent or fix the problems. Our recommendations for change are straightforward and commonsense, based on two overwhelming needs: To stop wasting the taxpayers' money, and to stop the waste of lives caused through the SSI program.

To address the focus of this hearing, we first must address the lack of incentives to enter treatment, and the disincentives to not just ignore treatment but to perpetuate disability.

The addict knows: I can get money through this program by showing the disability induced by addiction. I get no money by staying clean and earning a living. I get no money if I stay in treatment and overcome my disability.

The core problem with the DA&A portion of the SSI program is that the person who receives a benefit has a strong financial incen-

tive that can at times outweigh the motivation to improve his condition. By reversing this situation, you would achieve the subcommittee's goals.

Before addressing the long-term problems, there is one use of our tax dollars that really should be eliminated now. We endorse Senator Cohen's amendment to immediately cut off SSI money to beneficiaries who deal drugs and claim such activity is not gainful employment. There are two conflicting circuit court cases on this matter, and this subcommittee can do a lot to change that and make sure the law is fixed.

As part of a comprehensive approach to reform, CCGW supports: Eliminating cash payments to recipients, using the funds instead to provide closely monitored inkind support, possibly vouchers. This could also address the representative payee problem. Eliminate lump sum cash payments or hold these large sums in trust for the beneficiary to prevent drug and drinking binges, that Tuesday night's NBC Dateline program pointed out can lead to death; enforce SSA's own regulations regarding noncompliance and cut off any recipient who refuses to participate in any treatment programs; provide increased substance abuse treatment funds from the money saved by cutting off substance abusers who refuse or avoid treatment; substantially improve monitoring of compliance.

The Social Security Administration's efforts to establish referral monitoring agencies in States where they do not now exist is a step in the right direction. But this is a 20-year-old program, Mr. Chairman, and it is a little bit suspect that all of a sudden there is a great deal of publicity about this, and SSA comes around and says, we are going to fix the problem. A lot needs to be done. The subcommittees need to continue their strong oversight. Using the principles of reinventing government, hold SSA, State, and local authorities accountable for the results of increased monitoring and treatment as well as eligibility determinations. Separate legal and illegal substance abuse and eliminate eligibility for those who obtain disability due to illegal drug use. This was actually considered by the Senate 20 years ago when this program first came out.

I want to briefly read from a CRS report that is dated January 7, 1993. Initially, the Senate sought to exclude drug addicts and alcoholics from the SSI by putting them in a separate program. The Members thought these DA&As would need more than the cash payment SSI could provide, that they would need treatment, case management and close monitoring, so they would not use the SSI benefits to feed their addiction. It was great foresight. Unfortunately, what has resulted is massive waste in this program.

These problems, Mr. Chairman, do not exist in a vacuum. On the one hand, we are spending billions of dollars, putting at risk the lives of thousands of law enforcement officers, to fight the war on drugs. On the other hand, we have turned the Federal Government and the American taxpayer in some sense into a drugdealer and abettor of criminal behavior.

Unless significant changes are made, the DA&A program will continue to be a misguided and deadly abuse of our tax dollars.

That concludes my oral remarks. I would appreciate having my written statement entered into the record.

[The prepared statement follows:]

NEWS

Testimony of Thomas A. Schatz, President, The Council for Citizens Against Government Waste before the Subcommittee on Social Security and the Subcommittee on Human Resources Committee on Ways and Means February 9, 1994

Mr. Chairman, on behalf of the Council for Citizens Against Government Waste (CCAGW), thank you for the opportunity to appear today to express our grave concerns about the Social Security Administration's (SSA) management of the cash benefit program, Supplemental Security Income (SSI). We are concerned particularly about drug addicts and alcoholics who receive benefits under the disability portion of the program.

I come before the Committee today not as an expert witness on drug abuse or alcoholism, nor as an expert witness on disabilities. But I am the president of a veteran waste-fighting organization with over 600,000 members which has for ten years advocated responsible governing and the prudent use of our tax dollars.

If we had set out to create a fictitious government program which epitomized all that can, and does, go wrong with government programs, we couldn't have created a more perfect example. Unfortunately, the SSI program as it applies to drug addicts and alcoholics, is <u>for real</u> and so is the $1.4 billion in tax dollars it gobbled up last year alone.

This program shows all the symptoms of being out of control: weak management, program oversight that is almost nonexistent, a vague and dubious mission. More important, reliable evidence is mounting that fraud is rampant in this program. Talk about waste...so-called beneficiaries are getting wasted, all right, and using our tax dollars to do it.

Worse yet, people are overdosing and drinking themselves to death using SSI cash. And <u>that</u> is the most unconscionable waste of all.

Ask the SSA how many SSI beneficiaries are currently receiving checks and, up until today, you'd probably get the same pat answer that SSA spokesman Phil Gambino has repeated in the press over and over again. Drug addicts and alcoholics (DA & As) make up <u>only</u> 1.5% of the SSI population, he keeps saying. By our reckoning, that would have been <u>only</u> about 94,000 people, a large enough number, in our view, of human beings who are victimized by the co-dependency of SSI. The GAO tells us that the actual number for DA & As in the SSI program is closer to 150,000. The alarming truth is that the SSA doesn't seem to have the foggiest idea how many drug addicts and alcoholics are currently receiving benefits.

In order to qualify for SSI disability benefits as a drug addict or an alcoholic, an individual is required to be undergoing treatment if available and appropriate. Yet, the Department of Health and Human Service's Office of the Inspector General's (IG) Report in 1991 said that, at that time, a staggering 92% of DA & A SSI recipients could not be confirmed to be in treatment. Moreover, evidence indicates that program noncompliance is epidemic, and not because treatment is unavailable. In a significant number of cases, beneficiaries are <u>refusing</u> to undergo treatment, knowing full well that SSA has abdicated its role in monitoring the progress of DA & A recipients. The IG has said that current DA & A recipients can expect to have their cases reviewed only once every three years. By 1991, the SSA had removed only 193 people from SSI rolls because their disability due to alcoholism or drug addiction had ceased. If this figure is correct, this program is a colossal failure.

This monitoring weakness is particularly pernicious in view of the fact that DA & As have the power, through a change of behavior, to overcome their addictions,

recover their lives, get off the SSI rolls and get back to work. Disability, as defined by SSI, is a condition which is expected to last for more than a year or to lead to death.

Drug addiction and alcoholism can result in death, of course, and can last more than a year, if the drinking and drugging continue unabated. And with the SSA's lax enforcement of the treatment requirement, you can almost count on that. It's a vicious, unnecessary, and costly cycle. Unfortunately, an individual with a debilitating heart problem, a paraplegic, or an individual in the advanced stages of AIDS or multiple sclerosis, cannot go into a treatment program and recover. So, from the start, this program is flawed. We should not be spending taxpayer dollars for a self-induced disability. To continue to spend it recklessly is outrageous. Because alcoholics and drug addicts can rid themselves of their disabilities through treatment, the very least we should do is hold them responsible for their recovery.

There is a lot confusion in the initial diagnostic phase of the SSI program for disability due to drug addiction or alcoholism. For example, the applicant with a primary diagnosis of drug addiction or alcoholism is presumed to be unfit to handle his or her own finances and is required to have a representative payee. That makes sense on the face of it. However, there seems to be no mechanism available to determine whether the chosen payee has a history of drug use or alcoholism. What's more, an SSI recipient can change payees as often as he likes. The representative payee system is rife with fraud, with SSI checks going to bars to pay off bar tabs, to other drug addicts, or to convicted felons. And, if the applicant manages to avoid a <u>primary</u> diagnosis of drug addiction and alcoholism, he or she is required neither to have a payee nor to seek treatment. In practical terms, this simply means that thousands of DA & As are getting SSI cash, with absolutely no strings attached.

A drug addict or alcoholic, if denied SSI benefits on the first try, can appeal his or her case. In some regions of the country, these appeals can take up to two years. If approved, he is then entitled to receive a lump-sum payment,retroactive to the date they first made his application. These checks can run as high as $8,000.

Considering the fact that many SSI recipients are not undergoing treatment, putting this kind of money into their hands is like putting a loaded gun in the hand of a suicidal person. Sadly, it may already be too late for some. There have been numerous reports of SSI recipients using these checks to subsidize drug and alcohol binges, with fatal results.

We know from experience that the aforementioned kinds of gross management weaknesses leave federal programs open to abuse. We think it's safe to say that, right now, the DA & A portion of the SSI program is being systematically defrauded. This pillaging is costing the taxpayers hundreds of millions of dollars and it is costing people their lives.

Our recommendations for change are straight-forward and common sense, based on one overwhelming need: to stop wasting the taxpayer's money. To those who say "wait" or "study," we would say "you just don't get it. It's not your money being wasted, it is ours. It's not your life that's endangered, it's the very people who are supposed to benefit from this program."

In the short run, we would suggest some management triage. First, the SSA should be required to slow enrollment of new beneficiaries in the DA & A portion of the program. Instead, they should shift their spending priorities to monitoring and evaluating their current caseload. The GAO already addressed this problem in a report issued last year. We should explore seriously the idea of shifting SSI outlays for drug addicts and alcoholics away from cash benefits and into a strictly monitored voucher system or a direct payment to qualified drug treatment facilities.

We strongly support a call for random drug testing, a provision currently included in HR. 3500. One positive drug test should disqualify an individual from further benefits. We give our qualified support to having the SSA's Referral Monitoring Agencies act as representative payees in states where they already exist, especially when lump-sum retroactive payments are involved. We most certainly do not advocate increased spending to enact these management improvements. These changes can, and should, be made within current budgetary constraints. They are sensible and reasonable.

In an age of reinventing government, we also urge you to reconsider the mission of this program. The taxpayers will, in their wisdom, want to know why we

are spending $1.4 billion each year for a program which, as it is currently being mismanaged by the SSA, subsidizes drug use and alcoholism. Though your hearing gives us hope for change, we are skeptical that the SSA will move to regain control of this program anytime soon. In the face of repeated reports of widespread abuse, drug overdoses and alcohol poisoning, it has been impotent. The agency either hasn't noticed, or worse, doesn't care, that American tax dollars by the billions are being used to subsidize the purchase and use of alcohol and, even more insidious, illegal drugs. The prevailing ethos seems to be, get the money out the door and call it a job well done.

Mr. Chairman, this program – and all its problems – doesn't exist in a vacuum. With one hand, we are spending billions of dollars and putting at risk the lives of thousands of law enforcement officers to fight the "war on drugs." President Clinton, in his recent State of the Union Address, and every Member of Congress, at one time or another, has publicly decried the outrage of widespread illegal drug use. Getting tough on violent crime, which is intertwined with illegal drug use, has become a national crusade. Yet, with the other hand, we have turned the federal government, and the American taxpayer, into a drug dealer and an abettor of criminal behavior.

Whether you subscribe to the current notion of drug addiction and alcoholism as a permanent condition, the fact remains that we must set priorities. The President has just submitted a fiscal year 1995 budget that begins to address the fiscal restraints in Washington. When so many are being asked to sacrifice and have stepped up to the plate and done so, when there is a significant backlog of disabled people waiting for benefits, is this program really a prudent use of our tax dollars? Our answer, and the answer of our 600,000 members, is a resounding no.

Chairman FORD. Your written statement and the written statements of all the witnesses will be made a part of the record. There is a recorded vote on the House floor, but I am going to hear from Ms. Katz at this point. In the next 5 or 6 minutes, however, we will have to take a short recess.

Ms. Katz.

STATEMENT OF NANCY J. KATZ, PROJECT DIRECTOR, SSI ADVOCACY PROJECT, LEGAL ASSISTANCE FOUNDATION OF CHICAGO

Ms. KATZ. Thank you very much. My name is Nancy Katz. I am an attorney, chairperson of the Chicago Bar Association's Social Security Law Committee, and cochair of the Cook County Hospital Advisory Committee for Women and Children with HIV Program. My comments are made here today in my capacity as project director of the SSI Advocacy Project of the Legal Assistance Foundation of Chicago.

Every year we work with hundreds of individuals with substance abuse problems. Over the past 3 years, my project alone helped over 1,000 individuals who were unable to work due to their addiction obtain SSI or Social Security benefits. We are on the frontline of the battlefield, and we see daily how substance addiction disorders have destroyed the lives of individuals and their families and ravaged our communities.

We have also seen how SSI benefits can stabilize an individual and allow him or her to actually participate in and benefit from treatment. Therefore, I would like to make clear that based on our experience and the experience of our clients, we support the present governmental policy regarding the provision of SSI benefits to disabled addicted individuals.

Substance addiction disorders are a disease. They are an illness. They prevent many people from being able to work. They are not a moral failure. We feel that the present policy of coupling benefits with mandatory treatment efforts and representative payment is humane, it is forward thinking, and it is cost effective. For many, SSI benefits provide the subsistence level income that allows them to have access to the basic necessities of life such as food and shelter, while they undergo treatment.

I would like to put to rest certain misconceptions about the SSI benefit program that I hear time and time again, including today. Contrary to what some say their constituents feel, SSI benefits are not a cash cow for addicts. Nor does the SSI program "dole out money to addicts." In order to get Social Security disability or SSI benefits, you must meet the definition of disability contained within the Social Security Act. You must show more than the fact that you take drugs or alcohol. You must show that your addiction is so severe that it completely impairs your ability to function in the work world. Much documentation is required, and indeed it is very difficult to be found disabled on the basis of a substance addiction disorder.

Turning now to some of the flaws in the program, we agree that there are serious concerns regarding the treatment requirement and the representative payee requirement. I know that Jeff Rabin, a colleague of mine from Chicago, will be talking about the referral

and monitoring agency in the State of Illinois. I would like to discuss the shortage of treatment slots in our State.

In November 1993, in Illinois, there were as many as 5,000 persons on known waiting lists for treatment slots. The lack of residential treatment is particularly acute and in part is caused by problems with the Medicaid program.

In my written testimony, I adopt certain of the recommendations of the National Association of State Alcohol and Drug Abuse Directors, who have some very sound recommendations for using the Medicaid system to increase the number of residential treatment slots. I think, however, that limiting the duration of SSI benefits or substituting vouchers for cash benefits would pose additional barriers to treatment and rehabilitation, and will not provide the access that individuals need to obtain treatment.

As we heard earlier, individuals vary. People have special needs. We have people with dual diagnoses, people with HIV. There is a wide variety of modalities of treatment available. And for some people, residential treatment vouchers may work. Others need the cash benefits for food and shelter while they engage in other kinds of outpatient treatment. So let's not limit the options available to individuals in treatment by proposing a very restrictive voucher system.

Turning to the representative payee requirement, it is our experience that organizations serve as the best representative payees for people with substance addiction disorders. We encourage the Social Security Administration to do more to work with organizations to make that an attractive and viable alternative for the organizations.

We also encourage Social Security to employ more rigorous screening standards for proposed representative payees, and to actually require payees to provide periodic written accounting of the benefits, which Social Security is allowed to do currently under its regulations.

Until there are more representative payee services available, however, in the not-for-profit sector, we oppose any absolute restriction on family members serving as payees.

Thank you very much for the opportunity to testify today.

[The prepared statement follows:]

TESTIMONY OF NANCY J. KATZ

SUBCOMMITTEE ON SOCIAL SECURITY
SUBCOMMITTEE ON HUMAN RESOURCES
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

February 9, 1994

I. INTRODUCTION

Good afternoon. My name is Nancy Katz. I am an attorney, Project Director of the SSI Advocacy Project of the Legal Assistance Foundation of Chicago, Chairperson of the Chicago Bar Association's Social Security Law Committee, and Co-Chair of the Cook County Hospital's Advisory Committee for the Women and Children with HIV Program. Before beginning my testimony, I would like to thank Chairman Jacobs and Chairman Ford and the members of the Subcommittees on Social Security and Human Resources for the opportunity to appear and to present my comments on the issue of SSI and Social Security Disability Insurance benefits for individuals suffering from substance addiction disorders. My comments are made in my capacity as Project Director of the SSI Advocacy Project of the Legal Assistance Foundation of Chicago.

Every year the SSI Advocacy Project and other offices of the Legal Assistance Foundation of Chicago work with hundreds of individuals who have substance abuse problems. Over the past three years the SSI Advocacy Project alone helped over one thousand individuals who were unable to work due to their addiction disorders obtain SSI or Social Security benefits. We are on the front line of the battlefield and we see daily how substance addiction disorders have destroyed the lives of individuals and their families and ravaged our communities. We have also seen how SSI benefits can stabilize an individual and allow him or her to actually participate in and benefit from treatment.

Therefore, before I turn to the specific questions posed by the Subcommittees, I would like to make clear that based on our experience and the experience of our clients, we support the present governmental policy regarding the provision of SSI benefits to disabled addicted individuals. Substance addiction disorders are illnesses that prevent many individuals from being able to work, and those individuals whose impairments rise to this level meet the statutory definition of disability contained in the Social Security Act. We feel that the present policy of coupling benefits with mandatory treatment efforts and representative payment is humane, forward thinking, and cost effective. For many individuals, SSI benefits provide a subsistence level income that allows them to have access to the basic necessities of life, such as food and shelter, while they undergo treatment. There is no question, however, that improvements need to be made in SSA's enforcement and management of the treatment requirement and in the representative payee system.

I would also like to put to rest a misconception about SSI benefits that I hear time and time again - that when substance addicted individuals obtain SSI benefits they are pulling some kind of "scam." This public perception has also been articulated as: "All you have to do is tell Social Security that you are a drug addict or alcoholic and you will get benefits." Both these impressions are incorrect. In order to meet the definition of disability, an individual must show more than the fact that he or she drinks to excess or takes drugs. The individual must show that the addiction is so severe that it completely impairs the ability to **function** in the work world. In more technical terms, the addiction must impair the individual's mental functional ability to perform the basic tasks of simple, unskilled work, such as understanding, carrying out and remembering one to two step

instructions, responding appropriately to supervision, coworkers and usual work situations, and dealing with changes in a routine work setting. To demonstrate this requires extensive documentation of the loss of functioning as well as of the addiction itself. Indeed, it is very difficult to be found disabled on the basis of a substance addiction disorder.

II. REASONS FOR THE INCREASE IN BENEFIT AWARDS TO DISABLED ADDICTED INDIVIDUALS

The GAO study has shown that the number of SSI recipients found disabled on the basis of alcohol and substance abuse has risen rather dramatically over the last three years. Illinois is one of the states with the highest number of awards. The Subcommittees' concern over the growth of benefit awards to this population seems to indicate they may believe that the disability benefits are being awarded inappropriately. But, in Chicago, as in other places, substance addiction disorders have grown to tragic epidemic levels. As legal services providers, we see daily the horrors of this epidemic - children placed in foster care, families evicted and jobs lost because of substance abuse. The Social Security Administration ("SSA") cannot walk away from this problem. Rather, it is essential that the SSA work hand-in-hand with treatment providers to provide alternatives for people suffering from these illnesses.

I would like to address some of the reasons why Illinois has such a relatively high incidence of obtaining benefits for substance addicted individuals. There is no question that the elimination of general assistance benefits and increased SSI outreach has raised public awareness of the availability of SSI benefits as a resource. However, one major reason that individuals have been successful in obtaining benefits on the basis of substance addiction disorders is that Illinois has an experienced and well established advocacy network that assists SSI applicants in their claims for benefits. Legal services programs and private practitioners across the state actively represent SSI claimants and provide high quality advocacy at all stages of the administrative process.

Three programs sponsored by the Illinois Department of Public Aid ("IDPA") have made this advocacy possible. First, the IDPA will pay for psychological evaluations for recipients who need them to document applications for SSI. Since many SSI applicants have spotty or inadequate medical documentation of their addictions, these psychological evaluations provide objective medical evidence that establishes the addictive disease and the functional impairments that result from the addiction.

Second, the IDPA will pay attorneys a fee for successfully representing SSI applicants at Administrative Law Judge Hearings. The fee is set as 25% of the maximum SSI award for one year. This fee program has greatly increased the availability of legal resources for individuals who are appealing denials of their SSI benefits. Legal representation increases individuals' chances of being awarded benefits because knowledgeable representatives can review the administrative records and secure the additional information necessary to support claims.

Third, for the last five years the IDPA has funded the SSI Advocacy Project of the Legal Assistance Foundation of Chicago, to provide legal representation to individuals at the initial application stage and at the reconsideration stage of the administrative review process. The IDPA determines if applicants are probably disabled and eligible for SSI and refers those applicants to the SSI Advocacy Project. The project, in turn, works closely with the Illinois Bureau of Disability Determination Services ("BDDS"), the state agency that makes initial and reconsideration decisions for SSA. Paralegals assist individuals in applying for SSI benefits and work to secure the necessary

medical and other evidence necessary to document the disabling nature of their addictions. In addition, because of the face-to-face contact paralegals have with clients, the paralegals often are the first to discover that an individual has not disclosed to SSA that a substance addiction is a contributing factor in the disability.

Over the past three years alone, this project has assisted over one thousand individuals to obtain SSI benefits due to their substance addiction disorders. Moreover, there is no question that the Project has sensitized the state DDS to the often disabling nature of substance addiction disorders.

III. THE TREATMENT REQUIREMENT

Once an individual is found disabled and eligible for SSI on the basis of a substance addiction, the individual must participate in appropriate treatment if it is available. SSA contracts with Referral and Monitoring Agencies ("RMA") in some states in order to enforce this requirement. Illinois has an RMA, an organization called Treatment Alternatives for Special Clients (T.A.S.C.). This agency assesses and refers individuals to appropriate treatment facilities and monitors their participation. While having an RMA in the state of Illinois is a step in the right direction, as the Subcommittees rightly point out in their press release regarding this hearing, there are still major problems with the treatment requirement. I would like to address the specific concerns raised by the Subcommittees.

A. Shortage of Treatment Slots

The Subcommittees have asked whether the lack of treatment is a barrier to rehabilitation for drug addicts. There is no question that there are not enough free and appropriate treatment slots available for substance abusers, particularly for recipients with dual diagnoses or special needs.[1] In November of 1993 in Illinois, there were as many as 5,000 persons on known waiting lists for treatment slots.[2] The lack of residential treatment opportunities is a particular problem because residential treatment is often necessary for an individual to successfully battle a substance addiction disorder.

One reason for the lack of treatment slots is the failure of the Medicaid program to adequately cover the costs of non-hospital residential treatment programs. Medicaid is the federal program that provides medical assistance for the poor. Most SSI recipients are Medicaid eligible. In a very questionable interpretation of the Social Security Act, the Health Care Financing Administration ("HCFA"), which administers the Medicaid program, has determined that residential substance abuse treatment facilities of more than 16 beds are "Institutions for Mental Disease" ("IMD") and, therefore, are not eligible for Medicaid reimbursement. This limits the number of beds a facility can maintain and still be eligible for Medicaid reimbursement, and as a result, capacity is reduced and provision of services is less efficient and cost effective.

As a solution to this problem, we encourage the Subcommittees to consider the following recommendations of the National Association of State Alcohol and Drug Abuse Directors:

> "1. The Federal Government and Congress should recognize alcoholism and substance abuse as separate, diagnosable and treatable illnesses, rather than as subcategories of mental illnesses. This would, in theory, eliminate the application of the IMD exclusion to substance abuse treatment services.
>
> 2. Per the 1990 Moynihan amendment [to the Medicaid statute, 42 U.S.C. §1396d(a)], alcoholism and substance abuse treatment services should be immediately recognized by HCFA as eligible

for reimbursement in any appropriate setting.

3. At a minimum HCFA should provide immediate alternative relief ... by removing the IMD exclusion from alcohol and other drug residential treatment programs, or by increasing the 16 bed limit to 40 to expand capacity....

4. The Federal Government and Congress should provide reimbursement for the most cost effective treatment setting possible. Generally, hospital treatment programs are significantly more costly than non-hospital programs, yet both settings use similar treatment practices and protocols; and non-hospital treatment programs are more philosophically suited and experienced in serving poor and indigent substance abusers."[3]

B. Effect of SSI Benefits on Treatment/Changes in Duration or Form of Benefits

The Subcommittees also have inquired whether the availability of SSI and SSDI benefits impinge on the success of efforts to treat substance abusers, and if so: 1) whether the duration of cash benefits should be limited; or 2) whether vouchers for residential treatment should be given instead of cash grants.

Rather than being seen as impinging on the success of treatment efforts, SSI benefits should be viewed as often providing the precondition for many to successfully complete treatment. SSI benefits allow individuals to secure food, shelter, and clothing and have enough stability to regularly participate in rehabilitative efforts.

It is true, however, that fear of losing SSI benefits may cause anxiety in individuals who are nearing successful completion of treatment programs but are not yet quite able to reenter the work world. Limiting the duration of benefits would only increase the anxiety and pressure on these individuals and impede their recovery. Instead, Congress should consider developing a "bridge" program for individuals who successfully complete rehabilitation programs. Benefits should be continued while individuals participate in training or vocational rehabilitation efforts, and then gradually be reduced. This would provide an incentive to recovery rather than a disincentive to completion of treatment.

Limiting the duration of SSI benefits or substituting vouchers for residential treatment instead of cash grants also would provide additional barriers to treatment and rehabilitation. These proposals would reduce the treatment options available and, thus, would be detrimental to rehabilitative efforts. Treatment services must be geared to the individual needs of the addict. Different subpopulations - such as the elderly, the HIV positive population, persons with dual diagnoses, and pregnant women - have unique health and mental health needs.[4] There are a wide variety of treatment modalities available, including medical detoxification, social setting detoxification, short-term rehabilitation, long-term rehabilitation, residential methadone, residential aftercare, outpatient methadone, and intensive outpatient. Some individuals will need to utilize more than one type of program, and some will take more time than others to successfully complete treatment. Some may have to repeat treatment. Therefore, changes in the SSI benefits program that would limit an individual's choice of treatment or duration of treatment will be counterproductive.

IV. THE REPRESENTATIVE PAYEE REQUIREMENT

When individuals are found disabled on the basis of substance addiction disorders, their SSI benefits must be paid to representative payees. These payees are responsible for seeing that the benefits are used for proper purposes such as providing

food, shelter and clothing, and not to further the individuals addictions. This requirement protects addicted individuals who would otherwise use their benefits to support their habits.

In their press release, the Subcommittees correctly identify some of the worst problems with the present representative payee system - family members who are frightened into turning over benefits directly to the recipients, and addicts and other inadequate individuals serving as representative payees for recipients. Unfortunately, there are often no alternative payees. While there have been some small advances by SSA in screening payees and in encouraging organizations to serve as payees by allowing them to charge a nominal amount, as advocates, we still regularly struggle to find responsible individuals or organizations to serve as payees for our clients.

SSA must do more to encourage social service and mental health organizations, who are trained in working with substance abusers, to provide representative payee services. As a first step, we encourage Congress to require SSA to offer demonstration grants for organizations to test various models of representative payee services for individuals found disabled on the basis of substance addictions. We also encourage SSA to employ more rigorous screening standards for proposed representative payees for substance addicted individuals and to require payees to provide periodic written accounting of the benefits. Until there are more representative payee services available, however, we oppose any absolute restriction on family members serving as representative payees for substance abusers.

V. CONCLUSION

Thank you for this opportunity to present testimony. We appreciate your Subcommittees' interest in these very difficult issues. We will be happy to answer any questions that you might have and to work with you to develop solutions to the problems we have identified.

Respectfully Submitted,

Nancy Katz

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1. "Commitment To Excellence, FY93 State Plan, A Comprehensive State Plan and Human Services Plan for Prevention /Intervention/Treatment of Alcohol and Other Drug Dependency for the Fiscal Years 1991/1993," Illinois Department of Alcohol and Substance Abuse ("IDASA"), Division of Planning, p. 78.

2. "Coverage of Substance Abuse Treatment Under Medicaid/The IMD Exclusion," Position Paper of the Illinois Department of Alcoholism and Substance Abuse ("IDASA"), Nov. 19, 1993, p. 5.

3. *See* IDASA Position Paper, p. 2.

4. IDASA FY93 State Plan, p. 78.

Chairman FORD. Thank you, Ms. Katz.
Mr. Rabin.

STATEMENT OF JEFFREY A. RABIN, ESQ., JEFFREY A. RABIN AND ASSOCIATES, LTD., CHICAGO, ILL.

Mr. RABIN. Thank you, Mr. Chairman. I am an attorney in private practice in Chicago. My practice is concentrated solely in representing people trying to get SSI and disability benefits. Of the about 400 hearings my office conducted last year before administrative law judges, approximately 60 percent of our clients were substance abusers.

It is very easy, and we have heard a lot today, for people to point to an abuse of the system and make that into a case that the entire system is flawed. And I think that is overstating the actual situation. We have many clients in our office who have gotten into treatment before their hearing, who have gotten into treatment after their hearing, and have used the benefits in an appropriate manner and have recovered.

We have a client named Mike. Mike missed his first appointment with me because he was a drug addict and an alcoholic living on the streets of Chicago and eating food out of the dumpster of McDonald's, and he had gotten food poisoning. He came to the hearing drunk and passed out on the washroom floor in the downtown office building.

By the time he had come to the second hearing, however, he had been in treatment and was sober. We won his benefits. It has been 5 years now. Not only has Mike not used drugs or had anything to drink, he has run a halfway house, he sponsors other people in AA, he runs AA meetings himself, and he is rebuilding his life with his family.

I think it is important to keep the total context in mind, that this is a program that is sound and that it is a program that works. The problem that we have with this program is that it is not being effectively administered.

And I point to my experience of the problem with the referral in monitoring agencies and the lack of adequate funding. I have had the opportunity in the last week to read the recent reports, the yearend reports from the referral and monitoring agency in Illinois. In Illinois, we have identified 13,060 DA&A people receiving benefits.

Of that total, only 3,924 are actually receiving monitoring from the RMA, and of that, only 1,097 are identified to be in treatment. That is less than 7.6 percent of the total DA&A cases in the State.

Mr. Thompson came in and explained that Social Security has increased the funding for DA&As in the future, and that is true. I had the opportunity to read the request for bid. They asked the agency to only consider monitoring 4,900 people. That is with the expanded funding they provided, they are still only calling for monitoring of less than 40 percent of the total DA&A population in Illinois.

I believe this is a good program. I believe that this program offers people a second chance. You are giving people a carrot. We will help you get into treatment, we will provide you the cash incentives to get into treatment, but the system has to administer the

stick; that is, if you are assigned appropriate treatment, reasonable efforts are made to get you into treatment, and you are not able to comply or you refuse to comply with appropriate treatment, then you are suspended and ultimately terminated.

And if you use that carrot and stick, you avoid some of the abuse we have heard talked about today, you eliminate some of the cash strain on Social Security, and you provide assistance to those people who want and deserve a second chance, that society is willing to assist.

I believe what should happen is that Social Security should be instructed to enforce the rules that are already on the books for RMAs. I believe funding should be increased for RMAs so that quality case management can be done. It is very difficult to do the job of an RMA. There are a lot of people with dual diagnosis problems. There is an inadequate number of treatment facilities. And it is a serious problem.

But with President Clinton's suggestion or proposal yesterday to increase funding for treatments significantly, and with appropriate funding to the RMAs so that not just 40 percent of the people, DA&A people are being monitored, but 100 percent are being monitored, we will help those that are willing to accept the treatment, and we can discontinue benefits to those who are not willing to accept that treatment or willing to accept that second chance.

With respect to representative——

Chairman FORD. Let me go ahead and break. I have about 4 minutes to walk over to the Capitol and vote, if the panel would bear with us for a few minutes. There may be another vote immediately afterward.

I understand this is a recommittal vote. If it is, it will probably be about 12 minutes. If not, we will recess for 6 or 7 minutes. Thank you.

[Recess.]

Chairman FORD. The committee will come to order.

Mr. Rabin, I know that you and the other panelists are very tired of waiting. I didn't think I was going to return either with three votes, and I had to wait on them rather than walk back over.

The committee will recognize you once again, Mr. Rabin. Sorry to interrupt.

Mr. RABIN. No problem. I just really wanted to make two more brief points or one point and then sum up.

With respect to title II or SSI benefits, there was earlier testimony that I fully concur with. The act should be amended to require treatment for representative payees for title II recipients who are being paid primarily because of their substance abuse. That finding can be made by the district office, but in my experience, the finding is not routinely made. I think those people should also be required to be in treatment and have representative payees.

To sum up, I don't believe that we need a total revamping of the SSI system to resolve the problems as it relates to benefits being paid to substance abusers. We have rules, regulations, and systems that are already in place and have been written, and in some instances adopted, and in many cases working very well. But what we need to do is require Social Security to fully fund and fully enforce the mechanisms and systems that are currently in place.

That will go a long way toward eliminating the abuses and the abusers who are refusing to get treatment and return back to a productive work force, and alleviate a lot of the frustration that people experience with the SSI system.

Thank you.

[The prepared statement follows:]

TESTIMONY OF JEFFREY A. RABIN, ESQ.
CHICAGO, ILLINOIS

At the outset I would like to thank the Ways and Means Subcommittee on Human Resources and the Subcommittee on Social Security for holding this hearing on current issues relating to substance abusers and the receipt of disability benefits under the Social Security Act. This program can play an important role in the restructuring and revitalization of our communities and it requires the continued supervision of Congress. It is my hope that this hearing will generate new ideas which will lead to the strengthening of the Social Security disability programs.

I am an attorney in private practice in Chicago, Illinois. I have been representing people seeking disability benefits under the Social Security Act for more than ten years and have concentrated my law practice almost exclusively in this area of the law for the last six years. In 1992 my associates and I represented clients at almost 400 administrative hearings in the Chicago area. The primary medical impairment afflicting about 60% of our clients is substance abuse. As a result, I have become familiar with many treatment programs in Northern Illinois by referring my clients for treatment, by accepting their clients for representation and by speaking on current Social Security law and practice to members of the community. In this statement, and in my oral testimony, I am testifying on my own behalf, based upon my experience working daily with substance abusers, treatment facilities and the Social Security Administration.

OVERVIEW

It is important to remain aware of what Social Security benefits offer to a chronic substance abuser. For many persons this program provides something which they have never received: a **second chance**. Many of these people live on a precipice -- they bounce between family, the streets, the crack house, the shelter, the abandoned building and the prison. Many of these people have been molested as children, raised by addicts, surrounded by drugs and abused by spouses. Their parents can no longer help, their only friends are addicts, the school system failed and their addiction is overwhelming. Many are bright individuals who, for many reasons, have made poor decisions and now have no hope, no goals, no dreams. When asked what they see in their future just three, four or five years away, they most commonly respond: "Who knows, I'll be dead by then." These are sad comments from twenty and thirty year old people.

It must be recognized that these "out of control" addicts can not sustain normal work activity. Their primary means of survival is "hustling" on the streets. But the SSI program does offer an alternative. By proffering the "carrot" of both a cash flow which is more certain than street crime, and of a better future, Social Security benefits provide an incentive to enter into drug and alcohol treatment. Once that person is found to be totally disabled, Social Security can then use its "stick", i.e. termination of benefits, to compel continued participation in the treatment program. While it can be debated whether a financial incentive to obtain treatment should be necessary, the reality is that the monthly benefits provide additional motivation for a person to leave the streets, and leverage to keep him from returning.

I have represented a number of people who have entered into treatment before their hearings and, due to the backlog, are free of drugs and working by the time they see the administrative law judge. These success stories mandate that this program be strengthened, not restricted or gutted as some have suggested. Obviously, not all substance abusers succeed in their treatment attempts and many people misuse the benefits to purchase drugs.

It is the failure of the Social Security Administration (SSA) to identify persons who are non-compliant and, where appropriate, suspend or terminate benefits, which causes generalized frustration with this system. If persons who repeatedly refuse to comply with treatment were removed from the system, there would be less problems with representative payees and an erasure of the perception that SSI benefits are a lifetime support mechanism for the addict.

ISSUES

This hearing has been convened to consider a number of issues, including the increase in applications from people suffering from substance abuse, the availability of treatment for substance abusers, reform of the representative payee program and what problems exist in getting substance abusers into treatment. My experience is that the last issue -- getting substance abusers into treatment -- requires the most immediate attention.

The failure of the Social Security Administration (SSA) to enforce its Regulations requiring treatment is the underlying cause for the need for these hearings. Many persons incorrectly perceive that this program serves only as a means of funneling cash to addicts who use that money to purchase drugs. This program, if properly administered, can significantly improve our communities and decrease the number of persons devastated by substance addiction.

1. THE SOCIAL SECURITY ADMINISTRATION SHOULD ENFORCE ITS TREATMENT REQUIREMENTS.

The Regulations relating to the receipt of SSI benefits by substance abusers require that they enter into treatment programs. The benefits are to be paid only while the claimant is actively participating in treatment. Referral and monitoring agencies have ostensibly been retained to make certain these rules are being followed, and to advise SSA when participation can not be established. Unfortunately, this is not happening.

In more than ten years of representing substance abuse clients, I have received only four letters from the Social Security Administration advising that my clients have been suspended from the program for failing to obtain treatment. I have successfully represented hundreds of substance abusers and, with much regret, I believe that a great many more than four are no longer in treatment.

In my state, SSA has entered into a contract with the Illinois Department of Alcohol and Substance Abuse (DASA), to act as the Referral and Monitoring Agency (RMA). DASA has subsequently subcontracted the day to day operation of the RMA program to an agency known as TASC (Treatment Alternatives to Street Crime).

While the existence of the contract is meaningful, the facts are disheartening. As of December, 1993, SSA has reported that there are 13,060 drug addicts and/or alcoholics (DA/A) in pay status in Illinois. TASC, however, reports a year end caseload of only 3,924. This means that just 30% of the people in pay status were even being monitored. Of that 30%, only 1,092 had actually been interviewed and placed into treatment. The rest were either waiting for interviews or waiting to be assigned appropriate programs. **Therefore, of all of the DA/A cases being paid in Illinois, Social Security is monitoring less than one-third, and only 7.59% are known to be in treatment.** No one knows about the balance of the recipients.

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There are three causes for this inadequate performance:

1. There is insufficient funding. The current RMA contract only provides funds for minimal monitoring of a small percentage of the substance abusers receiving benefits. Staffing is restricted and the current caseloads at TASC preclude quality management. Further, SSA recently issued requests for proposals to renew the RMA contract. In the request, Illinois bidders are told to plan on monitoring a total of 4,294 referrals in 1994, despite SSA knowing that more than 13,000 people actually require monitoring.

2. There is inconsistent application of the program at the Social Security field offices. TASC has reported that approximately 85% of those terminated by TASC for repeatedly failing to appear for appointments, or for failing to comply with treatment, are re-referred by the Social Security District Office. While many are re-referred because their terminations from TASC were related to mail problems or lack of understanding; others are abusing the benefits and should be considered for suspension.

3. There is a lack of adequate treatment facilities, which will be considered below.

Problems also arise when TASC reports that an individual has "completed" a program. That does not necessarily signify medical improvement indicating the ability to return to sustained employment, however some caseworkers immediately terminate benefits. Consideration must be given to proper definitions of both completion of treatment and medical improvement.

SSA must be compelled to properly enforce its own Regulations relating to treatment requirements to prevent abuse, to restore credibility and to protect financial resources from being misused.

2. THERE ARE NOT ENOUGH TREATMENT PROGRAMS.

I am not an expert in substance abuse treatment. Through my experience with my clients, however, I have identified three modalities of treatment in the Chicago area. I classify these as: 1) the residential facility; 2) the outpatient program; and, 3) the recovery home. Funding is not adequate for any system.

Residential facilities generally provide strict living conditions and substance abuse treatment at the home. The Gateway Foundation, Human Resources Development Institute, SASI and the Salvation Army are among those agencies operating well-run programs. Unfortunately, many of these programs rely on funding from the State of Illinois which is being restricted each year. When originally conceived, these programs provided treatment for up to one year with a gradual release back into the community. Now, funding sources generally limit treatment to four months -- this is simply not long enough to reform lifestyle habits learned over decades. The benefits of this limited treatment are further nullified by the client's return to his old community and the general lack of meaningful job opportunities in the inner city.

The second treatment mechanism are outpatient programs. These generally provide one-on-one counseling and group meetings at the treatment center. There is often an intensive six to ten week period of treatment where the patient attends every day. After that, many programs cut back to two or three meetings a week. My experience is that the failure to remove the abuser from his familiar milieu lessens the chances of success. It is difficult to conquer an addiction, especially when someone is drinking or using drugs on every corner, down the hall and in the nearby parks.

I generally try to refer my clients to "recovery homes". These facilities are drug free environments in which abusers live but do not receive treatment. Counselling and group meetings are usually provided by outpatient programs on a contractual basis. The recovery home operator provides food, a drug and alcohol free living environment and limited case management services. The advantage these programs have over residential facilities is that they are generally not State funded and do not have time limitations.

I have clients who have been living and working for more than two years in recovery homes. The problem is that the lack of State funding makes operation of these homes very difficult and operators become dependent on their clients' public aid benefits and food stamps. While these programs are not well-known and are generally not sophisticated businesses, I have found that they are often successful. These programs often accept women with children. They have difficulty, however, accepting heroin addicts who will suffer from withdrawals and are limited in their ability to help individuals with multiple physical and mental impairments.

There needs to be more funding for long-term treatment. Many of the medical experts who testify at Social Security hearings explain that at least one year of residential treatment is required to minimize the likelihood of relapse. There also must be more funding for mental health programs to serve the dual diagnosis population. Many of these clients are suffering from multiple mental problems and need specialized treatment facilities.

3. CHANGES NEED TO BE MADE TO THE REPRESENTATIVE PAYEE SYSTEM.

One major change should be adopted immediately: Title II (SSDI) recipients should have the same requirement for a representative payee, and for treatment, as SSI recipients. Currently Title II recipients identified by an Administrative Law Judge as substance abusers are not required to have a representative payee unless the District Office makes an independent assessment that one is necessary. My experience is that this rarely happens. Title II recipients generally receive larger retroactive awards and greater monthly benefits and need just as much protection as SSI beneficiaries.

Greater consideration should be given to establishing treatment facilities as representative payees. The Gateway Foundation has had excellent success fulfilling this role for its residential programs. Also, consideration should be given to designating a portion of the benefits as fees for the services provided by treatment facilities. While there is a possibility of abuse, it is easier to hold the treatment facilities accountable than to locate individuals who inappropriately handle disabled person's benefits.

4. APPLICATIONS FROM SUBSTANCE ABUSERS HAVE INCREASED.

There are several reasons for the increase in applications for benefits from substance abusers. The first is the gradual elimination of general assistance in Illinois. Except for certain narrow categories, welfare has been eliminated for adults not caring for children. The only way to obtain cash benefits, food stamps, and a Medicaid card in Illinois is to file an application for SSI benefits and provide medical documentation to the Illinois Department of Public Aid showing probable eligibility for SSI. Many people who had been living for years on the $154.00 monthly cash grant from Public Aid had to file for SSI to preserve even a meager lifestyle.

A second reason for the increase in applications relates to SSA's failure to mandate treatment as noted above. For a small percentage of claimants, SSI does seem to be a means of subsidizing substance abuse. If the odds are only three out of ten in Illinois that a claimant will be monitored, it is tempting to apply for benefits and not worry about having to go to treatment.

A third, and much more significant, impetus for the increase in SSI applications is the decrease in inner city jobs. In the past many positions existed in which an alcoholic or occasional drug addict could function. These jobs are gone and so are the alternatives available to many of these claimants. Even treatment loses its significance if meaningful jobs are not available for people who have recovered from their addiction.

Fourth, many treatment programs refer their clients to Social Security. Most need their clients to be receiving Public Aid so that they have some cash, food stamps and a Medicaid card to pay part of the costs. Since there is no Public Aid without an active SSI claim, an application must be filed or the treatment facilities can not accept the client. Further, while in treatment and after completion, the individual must be able to live without the need to revert to "street hustling". Even though SSI benefits are still well below poverty level income, they represent a substantial lifestyle to many of these claimants. Finally, after treatment in a residential program, benefits accumulated by the facility as representative payee can be used for a security deposit on a new apartment outside of the old neighborhood, a suit of clothes and a resume.

Fifth, SSA is doing more outreach. There are some SSA caseworkers going to the homeless shelters working with various social welfare agencies to find eligible applicants. This obviously increases the caseload and many of these shelters harbor people suffering from substance addictions.

CAVEAT

While I believe that the Social Security Administration should be more diligent in terminating persons who refuse to comply with the treatment requirement, this must be done only with consideration of the intent of the program and the nature of the clients. Many of these people are truly "dual diagnosis", i.e. they have severe mental impairments independent of the substance abuse problem. Many may require two or three treatment placements before an appropriate program is identified. Further, most will require long periods of treatment which may last for more than a year before they could safely live life without drugs and alcohol and be able to return to work without fear of relapse.

CONCLUSION

Persons who repeatedly refuse to comply with treatment requirements should be suspended, and ultimately terminated from the program. However, regulations for this process must be crafted carefully. Control over deciding on appropriate treatment, the length of treatment, and what constitutes compliance should be in the hands of substance abuse treatment experts. Close attention should be paid to people who are dually diagnosed. Also, the failure to define "completion" can lead to devastating results for a person who may have completed an intensive two month treatment program but needs many more months of counselling and sobriety before sustained work activity is realistic. If SSA finds medical improvement and ends benefits, relapse is nearly certain.

Given these caveats I recommend:

1. SSA must fully fund RMAs in each State so that all DA/A cases are monitored.

2. Substance abuse treatment programs should be studied and successful models emulated throughout the country. SSA should consider funding these programs. Money can be transferred from government programs designed to prevent drugs from coming into the United States -- we can reduce the demand for drugs much easier than we can prevent the supply and with much greater long-term benefits.

3. Carefully crafted guidelines should be created with the assistance of treatment experts to determine who should be compelled to be in treatment, and at what point recipients of SSI should be suspended or terminated. SSA should train its staff to consistently enforce these rules.

4. Title II recipients should be under the same requirements as SSI recipients.

I greatly appreciate the opportunity to present my views to this Committee.

Respectfully submitted,

Jeffrey A. Rabin, Esq.

Chairman FORD. Thank you very much.
Mr. Brown.

STATEMENT OF LES BROWN, MEMBER, PUBLIC POLICY COMMITTEE, CHICAGOLAND SSI COALITION, ON BEHALF OF DIANE FAGER, MEMBER, ADVOCACY AND PUBLIC POLICY COMMITTEE, CHICAGOLAND SSI COALITION

Mr. BROWN. Thank you for the opportunity to testify today and for holding these hearings.

Chairman FORD. You are with the Chicago SSI Coalition, but Diane Fager is supposed to be here?

Mr. BROWN. Yes. I am here on her behalf. I am Les Brown. I am founder of the Chicago Coalition for the Homeless. I am working as its policy coordinator and, as such, I staff the longstanding Alcohol and Substance Abuse Committee. I am well aware of these problems as they exist in Chicago.

Today I am testifying on behalf of the Public Policy Committee of the Chicagoland SSI Coalition. The coalition was established 1 year ago in response to the concerns with the shortcomings in the Social Security income program and the devastating effects on the Chicago area. The coalition is comprised of more than 80 social service and advocacy groups.

It seems highly appropriate that this hearing is being held at this time when the larger issues of welfare reform, crime, and health care are being addressed and debated by the Congress and the President. Unless these and other major issues are adequately addressed, the numbers of citizens turning to drugs and alcohol for relief will continue to dramatically increase.

We cannot solve the problems of alcohol and substance abuse with interdiction and law enforcement alone. We can't solve it by locking hundreds and thousands of our citizens up in prisons in an ever-growing and expensive prison system. It is costing us more than $30,000 per year, per prisoner, in Illinois. Seventy percent are in there because of drug or alcohol-related problems.

We have to have housing. We have to have jobs that pay a living wage. We have to have treatment that is real. And there is a lot of talk about people getting money and abusing the money. And we need to cut back, we can't spend all this money. Well, what are we talking about here? We are talking about people who get as little as $100 a week.

These aren't people who are laughing all the way to the bank. These are folks who can't afford housing, folks who can't balance rent with food and clothing and other expenses, so they wind up on the streets and they wind up homeless, and episodically homeless.

Many of them have alcohol and substance abuse problems, partly because of the despair and hopelessness they feel and sense in their hearts.

I think the SSI program is a good program. It needs to continue. It has flaws. They need to be corrected. We talk about mandatory treatment. Let's put that into some perspective. It is a rather moot point in Chicago to talk about mandatory treatment when there are no treatment resources.

Many homeless folks in Chicago and others who have alcohol and substance abuse problems want treatment. They may be able to go into a detox center and dry out, but when they look for longer term residential treatment, it is not available. They may wait as long as 6 months. In the meantime, they are waiting in environments hardly conducive to sobriety. I think many of us would probably succumb to further abuse of substances if we were in those kinds of situations.

I think that President Clinton took a step in the right direction when he made his recent commitment to provide treatment for 140,000 hardcore substance abusers. It is a small step considering the degree of the problem, but a step in the right direction nonetheless.

But we must address the flaws within the SSI program, and we hear a lot about cheaters and people that are taking advantage of the system, but I think in reality we and the system are the ones that are cheating people that are trying to use the system.

As I have already said, treatment is required but it is unavailable. In some instances, the treatment that is available is a counselor, one or two times a week. This doesn't work for hardcore substance abusers who need long-term residential treatment. They need that kind of treatment combined with supportive housing services, job training, and jobs that pay a living wage. We can't divorce these larger issues from this problem.

Assuming we had the treatment facilities, which we don't at this point in time, and assuming they were successful, and many of them can and will be, where is the person to go once he or she is out of that treatment? If there is no housing available, if there is no job training, no jobs, the person is going to go back to the street, the cycle is going to start all over again. We are going to increase the welfare rolls and folks will be incarcerated at great expense to themselves and the taxpayers.

I agree with some of the comments that have been made today, particularly in regards to the protective pay system. I think organizations, and primarily those organizations that are also engaged in treatment, might be the most appropriate protective payee organizations. The problem, as it seems to me, among other things, is that there aren't available funds or adequate funds to support those organizations to provide that service.

In Chicago, the primary organization providing this service is called Treatment Alternatives for Special Clients [TASC]. My understanding is that they have a total of five staff including secretary, and they have 3,000 clients to work with. Well, clearly not a lot is going to get done with a system like that. So I think there needs to be an increase in funds to support organizations that would be willing to come forward and provide protective payee services.

SSA, my understanding is, could use more staff. It is difficult for them to barely keep up with the processing of applications and monitoring what is going on here. And so as a result of that, there are tremendous backlogs. Folks do wind up getting large amounts of money in one fell swoop, and I don't think a lot of people who are alcohol or substance abusers are equipped to make those kinds of decisions with a big lump sum of money. More staff at the SSA

level to ensure payments are made on a regular basis and not in one lump sum would be a help, I think.

And I guess we have heard most of it today, so I won't repeat a lot more. I would like to say we have success stories out there. This system works. It has flaws, it needs to be improved, but it works. And again, let me remind you, we are talking about the poorest of the poor. We are not talking about somebody who talks about going to treatment at the latest in-vogue treatment program that might exist.

Kitty Dukakis, as you may know, was an alcoholic. She had a press conference and talked about how she was an alcoholic, and everyone cheered. She then went off to treatment. I tried to imagine someone on the corner of Madison Street in Chicago announcing they have an addiction problem and they are going into treatment. First of all, they would be labeled a wino, not an alcoholic. Second, that treatment would not be available.

But here is a success story related to one of the clients I mentioned before. His name is Larry. He began to drink alcohol at age 6, and by 12 he was using heroin, Ts and blues, and drinking on a regular basis. At 15, he began to use LSD. He dropped out of school and later entered the Air Force and was discharged after 7 months due to his alcohol and drug abuse. After returning home, he became violent and destructive and developed many health problems, including seizures and posttraumatic stress disorder.

Larry spent most of his time walking in streets and hanging out on corners begging for money. He was referred to the SSI program at Social Security and placed in treatment in a hospital in Chicago, where he successfully completed his treatment. Larry now attends Alcoholics Anonymous support group meetings and is involved in a work incentive program through the SSA. He hopes to soon have a full-time job and his own apartment. Larry says this is the first time in many years he has been sober. He has begun to repair his relationship with family members and has a new outlook on life.

So we have the know-how, we have the ability to provide the kind of resources that help people who are engaged in alcoholic and substance abuse. We know how to fix the problem. What we need is the political will and the resources to do that.

Thank you very much.

[The prepared statement of Diane Fager follows:]

TESTIMONY OF DIANE FAGER AND MARK E. PEYSAKHOVICH CHICAGOLAND SSI COALITION

Gentlemen, before beginning, I would like to thank the members of these subcommittees for holding this important hearing and also for the opportunity to present this testimony.

My name is Diane Fager. I am a member of the Advocacy and Public Policy Committee for the Chicagoland SSI Coalition (Coalition). In addition, I work for the Chicago Coalition for the Homeless (CCH). In that capacity, I coordinate the Mental Health and Substance Abuse Committee for CCH. The Chicagoland SSI Coalition was established one year ago in response to growing concern with the shortcomings in the Supplemental Security Income (SSI) program and their devastating effects on the Chicago area. Currently, the Coalition is comprised of more than eighty social service and advocacy organizations representing the SSI constituency in the area. In the last year, we have had the opportunity to work with hundreds of SSI clients and advocates and to document their problems and concerns.

I would like to begin by praising the SSI and SSDI programs. In terms of substance abuse related problems, the programs are doing exactly what they were intended to do; they are acting as a bottom line safety net for people who are certainly disabled beyond any ability to engage in gainful activity. In light of the negative attention this issue has recently received, it should be pointed out again that only a tiny portion of the SSI and SSDI populations are classified as substance abusers. The federal disability programs are effective in identifying clients who could benefit from substance abuse treatment. It is the shortage of realistic long-term treatment options and an ineffective system of tracking that lead to low rates of recovery among DA&A clients.

I would like to stress that we support the suggestions contained in the SSI Modernization Project Final Report of the Experts published in 1992 and the SSI reform legislation sponsored by your colleague, Congresswoman Carrie Meek. Many of the systemic problems that are faced by the DA&A beneficiaries could be resolved by implementing this legislation.

One component of the Meek bill calls for a staffing increase within the SSA. In addition to having more staff to properly monitor DA&A cases, SSI applications and appeals would be processed faster. By eliminating backlogs, an important barrier in substance abuse treatment would be eliminated. As you know, SSI benefits are retroactive. This means that a substance abuser, having gotten SSI at some stage of appeal, may get a bulk payment of thousands of dollars which needs to be spent in six months. Many specialists and clients agree that retroactive bulk payments leave substance abusers with choices they are not equipped to make. We suggest that by eliminating long waits in the application process many other problems may also be eased or solved.

Inadequate staffing is especially problematic because we feel that the numbers of substance abuse cases will continue to grow. This growth can be attributed to three main reasons. First, the elimination of state General Assistance (GA) programs throughout the country has left thousands of people with SSI as their only hope for survival. The elimination of Illinois' GA program has resulted in 80,000 people loosing their state benefits. This has certainly contributed to the high concentration of SSI DA&A cases in Illinois. In addition, it is within the fiscal interest of states to shift clients from the state to the federal rolls.

Second, advocates for the poor see SSI as a program with great potential to help economically disadvantaged addicts. Thus, efforts to get addicts on SSI have increased throughout the country, and especially in large urban settings. In Chicago, the Legal Assistance Foundation's SSI Advocacy Project deserves special commendation for assisting thousands of eligible clients in obtaining badly needed disability benefits.

Finally, research has shown that substance abuse rates in the United States are directly proportional to the rates of poverty, unemployment, and homelessness. Thus, as the urban underclass

continues to grow, the job market shrinks, and stocks of affordable housing are depleted the numbers of Americans disabled by alcohol and substance abuse will continue to rise.

The SSI program could, with some improvements, drastically increase its effectiveness. However, it will require dramatic increases in funding to produce results. We feel that national priorities should be shifted away from the unsuccessful War on Drugs to greater investment in highly successful comprehensive treatment models.

You already know from the recent GAO report that the referral and monitoring mechanism has failed (in the places where it exists at all). Due to a lack of funding the SSA can barely keep up with the monitoring requirements set by Congress. Thus, it seems that any treatment and monitoring that is done takes place primarily to create a paper trail and satisfy reporting requirements rather than to rehabilitate clients. In Chicago, for example, the contracted RMA is Treatment Alternatives for Special Clients (TASC), Inc. To the best of our knowledge, the resources allocated to TASC by the SSA allow them to maintain a staff of only 5, including secretarial staff, to work with 3,000 clients referred by the SSA. Clearly, this is not enough to deal with comprehensive case management of long-term addicts.

There are an estimated 23 million addicts and alcoholics in the United States and only 90,000 federally financed treatment slots. There is not enough effective treatment and much of the available treatment is simply not enough to make a difference. The substance abuse cases accepted by the SSA as severe enough for a disability determination present formidable treatment challenges. Most of these addicts have long histories of substance abuse illnesses which do not lend themselves to outpatient treatment and counseling. Simply put, it is not enough to go see a counselor several times a week and then go back to the environment which is conducive to continued substance abuse. The only way to break the cycle of addiction is to have long-term, residential treatment programs with small worker - client ratios, comprehensive wrap-around services including job training and life skills training, and access to affordable housing.

It is important to point out that many SSI DA&A clients are homeless or partially homeless. Anyone who is faced with living in Chicago's homeless shelters after completing even the best drug treatment program cannot be expected to stay "clean". Experts agree that recovering addicts must be removed from situations which are likely to cause them slip back into their old habits. Thus, housing alternatives with support services targeted toward recovering addicts must be made available. Hope for the future is an important component for recovery and, in order to cure addiction, underlying economic and societal problems must also be addressed.

Similarly, the representative payee system is not functioning properly. In many cases it is a burden for SSI recipients - especially substance abusers - to find a trustworthy payee. We believe that the requirements for representative payees should be more stringent and that more serious accounting and reporting mechanisms be instituted. For example, payees could be required to attend regular reporting sessions with the SSA. Many payee problems could be resolved if long-term treatment programs and post-treatment supportive housing were available for all DA&A cases. In this instance, such programs should administer the checks and must be funded to do so.

Current procedures which allow part of the monthly check to be used by social service agencies to recoup administrative expenses are a step in the right direction. However, agencies in Chicago do not see this revenue source as substantial enough to accept the heavy burden of administering clients' benefits. In addition, clients should not be expected to spend their resources to secure a representative payee. We suggest that alternative ways to compensate agencies should be developed.

While the representative payee sometimes serves as a conduit to drugs and alcohol, a more frequent problem is misappropriation of funds by representative payees. Current SSA procedures and federal laws do not adequately protect the client from such abuse and do not provide for effective recovery and enforcement procedures. Much stronger investigative and law enforcement procedures need to be instituted in order to protect the client and, in some instances, the payee. A client who is victimized by a dishonest payee can wait months for any action and when such action comes it is too little and too late. In many cases, the client is afraid to report such abuse because they feel that their benefits would be cut off. For example, one SSI recipient recently reported of loosing his benefits for over four months after he complained to the SSA about his representative payee.

It would be unwise to prohibit family members and friends from acting as payees in all cases. In some instances this would mean alienating the recipient from an important social support structure. On the other hand, the payee should be aware that he is accepting an important responsibility. SSA's current attempts to maintain a database on dishonest representative payees should be expanded. A representative payee who is pilfering a client's benefits should never have an opportunity to prey on another victim.

It is also unrealistic to give clients vouchers for residential treatment rather than cash benefits. Such procedures would be based on an assumption that residential treatment is readily available and that the RMAs are in place and effective. Disability benefits are generally used to purchase food and pay for rent. The client would be caught in a bureaucratic purgatory: not being able to access treatment and not having any means to survive. Too often, clients receive notices from the SSA saying that treatment is "not currently available and we will contact you later."

I would like to conclude by telling you a success story that demonstrates the tremendous potential of SSI's carrot and stick approach. This is a story of one of TASC's clients. "Larry" began to drink alcohol at age 6 and by 12 he was using heroin, T's, and Blues and drinking on a regular basis. At 15 he began to use LSD. He dropped out of school and later entered the Air Force. He was discharged after 7 months, due to his alcohol and drug abuse. After returning home he became violent and destructive. He developed many health problems, including seizures and Post Traumatic Stress Disorder.

Larry spent most of his time walking the streets and hanging out on corners begging for money. He was referred to the TASC SSI program by the Social Security Administration. He was placed into treatment at Hines VA Hospital in Chicago where he successfully completed his treatment. Larry now attends Alcoholics Anonymous and Narcotics Anonymous support group meetings and is involved in a work incentive program through the SSA. He hopes to soon have a full-time job and his own apartment. Larry says this is his first time in many years he has been sober. He has begun to repair his relationship with family members and has a new outlook on life.

Thank you, once again, for the opportunity to present testimony today. I am happy to answer any questions you may have now or at a later date.

Respectfully Submitted,

Diane Fager and Mark E. Peysakhovich
Chicagoland SSI Coalition

Chairman FORD. Thank you very much, Mr. Brown. Let me ask you, Mr. Schatz, can you offer any recommendations for funding the SSI program? What changes should be made and where should the funding of the program and these reform measures come from?

Mr. SCHATZ. Mr. Chairman, there are clearly some management problems that need to be fixed. I think if SSA moves in that direction, and we get management under control, we can then talk about how to provide additional funding, possibly from savings from eliminating people from the rolls that are not on it.

I understand from some of the other testimony that there is a large group of people still waiting to get on. There is also within the capability of the current budget system the ability to move money around from programs that may or may not be effective to those that might be. And that is one of the judgments that this committee, subcommittee and Ways and Means itself, in fact, needs to make when you are faced with restricted amounts of money that can be allocated for various programs.

Chairman FORD. What about time limits like—we refer to time limits in the welfare reform proposal. What about time limits here?

Mr. SCHATZ. You have to look at, at what point is somebody not complying with what needs to be done to get out of the system. One of the questions Social Security could not answer was how many people have been rehabilitated under this program. You have heard a few success stories, but SSA didn't really come up with any. So we need to look at that kind of situation and make a determination of what the kind of reasonable time somebody should be in this kind of program will really be.

Chairman FORD. Ms. Katz, earlier today we had GAO testify that most DA&As who receive Federal disability benefits are not participating in any treatment program. If this information is accurate, how can we justify giving benefits to DA&As who are not participating in a treatment program?

Mr. SCHATZ. Mr. Chairman, I think that is the role——

Chairman FORD. Ms. Katz.

Ms. KATZ. We have a Katz and a Schatz. I think that the GAO study could only track those DA&A SSI cases they were aware of, and so the only information they have are those that they know through the RMAs, and we have heard that very few people are actually being referred by the RMAs, so I am not sure it is true that many substance abusers—I do not believe that substance abusers are not in treatment.

From my own clients, and we see thousands of them, we see people who are in and out of treatment programs quite a bit. I can think of very few clients who have never been in treatment. We see people that have quite a number of treatment failures, so I don't believe that it is true that SSI recipients have never been in treatment.

I believe that some SSI recipients have had a number of treatment failures and many are not getting the kind of monitoring and encouragement and direction that they need to find accurate treatment and appropriate treatment.

Chairman FORD. I think I said that most recipients do not participate.

Ms. KATZ. And that is not my experience as an advocate. Most do participate at some point in their using career.

Chairman FORD. Could you explain in more detail why you are against establishing a voucher system for DA&As?

Ms. KATZ. Yes, I can, as I explained in my written testimony, there are a wide variety of treatment modalities that may be useful to individuals, depending on the type of addiction that they have and their special needs. There are alternatives, including medical detoxification, social setting detoxification, short-term rehabilitation, long-term rehabilitation, residential methadone, outpatient methadone, aftercare programs.

A voucher system that could be used solely for treatment would not allow people to access food and shelter in an aftercare program. We will leave people in a lurch when they most need the cash benefits to establish a life for themselves in a way to move from treatment to vocational rehabilitation.

I think it is too narrow and restrictive of a solution. I think the better solution is to put money into the RMA and make sure they monitor people and help people access the kind of treatment that is available for them.

And I also believe that changes are needed to the Medicaid system so that more residential treatment can be paid for through the Medicaid system.

Chairman FORD. Well, that is true today, though, isn't it?

Ms. KATZ. What is true today is that Medicaid does not pay for many types of residential treatment if the setting includes more than 16 beds. They are classified as institutes for mental disease and Medicaid does not pay for them.

That artificially limits the size of residential treatment programs which could, in a more cost-effective way, treat more individuals. Because of this artifact in the Medicaid system, we have limited the access for SSI recipients to residential treatment.

Chairman FORD. But if we have a national health care package to come into place, we will.

Ms. KATZ. That will go a long way in solving some of the problems.

Chairman FORD. We have TennCare that was implemented in our State as of January 1, not that I am a big fan or supporter of this, but I know it provides the Medicaid coverage for drug abuse addiction as well.

It might be very minimum funds, and there is a lot of complaints maybe from some of the providers, but at least it is there.

Let me thank the panel once again for coming. I want to apologize for holding you at the witness table for so long, but I can't do anything about the votes on the House floor. Once again, thank you very much.

Ms. KATZ. Thank you.

Mr. SCHATZ. Thank you.

[A question for the record for Mr. Schatz from Mr. Bunning and Mr. Schatz' response follows:]

Q. Mr. Schatz, you have seen many programs that waste limited tax dollars. In your opinion, is this the worst abuse of tax dollars ever?

A. There are programs that waste more money, but few that so directly waste lives. That tragic abuse of our tax dollars must be stopped.

Chairman FORD. We would like to call the next panel. I am not going to try this one. Angela Rojas-Dedenbach, with the Michigan Rehabilitation Services, the director, and also Dr. Dan Flavin, the National Council on Alcoholism and Drug Dependence. Linda Wolf Jones, executive director of Therapeutic Communities of America, and Thomas A. Anderman.

I really appreciate you tolerating me not pronouncing your name correctly.

Ms. ROJAS-DEDENBACH. Everybody does it. Don't worry about it.

Chairman FORD. You are the first witness. Would you, please pronounce your name for me?

Ms. ROJAS-DEDENBACH. Rojas-Dedenbach.

Chairman FORD. Thank you very much.

STATEMENT OF ANGELA ROJAS-DEDENBACH, DIRECTOR, MICHIGAN DRUG ABUSE AND ALCOHOLISM REFERRAL AND MONITORING AGENCY

Ms. ROJAS-DEDENBACH. Mr. Ford, I am going to address you because we have lost a number of the other gentlemen that were sitting here before.

Our agency strongly supports the efforts to explore ways to improve the DA&A program's effectiveness and cost efficiency, and strongly believes that the key to achieving this goal is in the redesign of the DA&A process to assure that policies and procedures reflect an understanding of the unique manifestations of chemical dependency as a disability, and the special habilitation and rehabilitation needs of the SSI addicted population.

In the interest of time, I am going to go through five key areas that we believe need reform and review by your subcommittee:

The first one is disbursement of benefits. We strongly believe that the legislative intent of mandatory requirements is lost when benefits are disbursed without enforcement of conditions. With this population, boundaries need to be clear, concise, and consistently enforced. Award procedures should support the intent of the legislation by assuring coverage for treatment and testing, and this has been talked about today, Mr. Chairman. There is no Medicaid coverage for testing, at least in my State. I don't know about other States.

Chairman FORD. We have just implemented a new managed care system under the Medicaid program. That is the only reason why it would be in Tennessee.

Ms. ROJAS-DEDENBACH. Award procedures should support the intent of the legislation by assuring coverage for treatment and testing is available, but making the release of cash benefits contingent upon proof of abstinence and active involvement in treatment and rehabilitation.

No. 2: Noncompliance suspension and benefit reinstatement. The current procedures are a weak link in the system. Documented noncompliance should result in prompt suspension of checks, and reinstatements should be based on actual evidence of compliance and not just on a statement of "intent to comply." This procedure results in manipulation and abuse. Addicted persons have a very difficult time following through on their commitments.

There is also a need for a clear definition of demonstrated compliance. We don't have a definition of demonstrated compliance.

Our agency has come up with a system where we use a progressive discipline model. We require 30, 60, and 90 days of treatment compliance in first, second, and third offenses, before we recommend reinstatement of benefits.

We strongly recommend the adoption of measures that limit the number of reinstatements after noncompliance. Benefits should be terminated in cases of repeated noncompliance. This would decrease administrative costs and also improve the program's credibility with the general public.

No. 3: Accessibility to treatment. Contrary to some reports in the media, at least in Michigan, we are not experiencing a shortage of Medicaid covered treatment services. In fact, we have treatment providers knocking on our doors requesting additional referrals. Our clients are considered better risks. Because of our involvement, they comply better with the treatment plans outlined, and thus treatment providers find they are a cost efficient use of their resources.

The major access bottleneck in Michigan is in the RMA system. Our waiting list is currently 5,900 recipients and at current funding levels, we cannot keep up with the receipt rate of 350 cases per month. If this level of funding is maintained, our waiting list will climb to 12,000 within the next 3 years.

No. 4: The scope of the monitoring process and its relationship to rehabilitation rates. It is our belief that in order to achieve higher rates of rehabilitation with this SSI population, the scope of the monitoring process needs to be broadened. Focusing only on treatment creates a revolving door effect. Beneficiaries are discharged to their former addictive environment without the skills they need to achieve a lasting and productive recovery. Without fail, this precipitates their return to substances and to the SSI rolls. We strongly recommend that it is assured that treatment plans include referrals to job skills training, educational advancement, vocational rehabilitation, and other support services.

We recommend maximizing the use of the SSA work incentives that are already in place. Our agency's emphasis on this approach has resulted in successful rehabilitations without visible impact on cost per case.

No. 5: The representative payee program. We believe that the current procedures for selecting payees is inappropriate for this population. Codependent relatives, friends, and other parties that could become conduits to the use of drugs and alcohol should not be allowed to be given payee responsibilities.

Professional payees who are familiar—and that is very critical, Mr. Chairman—who are familiar with the behavior and manifestations of addiction should be given preference. We believe the program has great potential to be a very effective and cost efficient service delivery system, but in order to achieve this potential, the reform has to assure responsiveness to the unique needs of addicts.

Thank you.

[The prepared statement and attachments follow:]

STATEMENT OF ANGELA ROJAS-DEDENBACH
DIRECTOR, MICHIGAN DRUG ABUSE AND ALCOHOLISM REFERRAL AND MONITORING AGENCY

CHAIRMAN JACOBS, CHAIRMAN FORD, AND SUBCOMMITTEE MEMBERS:

My name is Angela Rojas-Dedenbach, and I am the Director of the Michigan Drug Abuse and Alcoholism Referral and Monitoring Agency (RMA). Our agency is under contract with the Social Security Administration to enforce Supplemental Security Income (SSI) mandatory treatment provisions for disabled drug addicts and alcoholics. Our agency has been in existence for almost five years, and it serves up to 1,100 recipients per year with only six full time equivalents (FTE's). I congratulate you on your efforts to closely examine this service delivery system, and explore means of achieving higher rates of treatment and rehabilitation among those disabled by chemical dependence. We all know attention to this matter is long overdue.

The input I provide to you today is based on first hand experience with a system that has struggled for years to rehabilitate the SSI disabled chemically dependent population with limited success. You will note that the comments and recommendations that follow suggest that there needs to be a global redesign of this service delivery system.

The redesign of this program needs to be based on the recognition that addicts suffer a unique disability with different behavioral manifestations than other physical, or even mental illnesses. This redesign should not only assure that policies and procedures are congruent and responsive to the needs of disabled addicts, but also assure that all components involved in the DA/A process understand the disabling elements of chemical dependence.

Some of the ideas offered here for improvement of the monitoring process are already being utilized by the Michigan RMA, and although we have not had the resources to conduct scientific follow-up studies, we believe our approach to monitoring this population is resulting in more successful interventions. Fortunately, we will soon have an opportunity to test our ideas, as we implement the recently awarded grant to conduct a SSI Managed Care Demonstration Project designed to test innovative approaches to monitoring and rehabilitation of SSI disabled addicts.

I. PROGRAM GROWTH AND INCREASED COSTS

As you can see in EXHIBIT A, in Michigan, drug abuse and alcohol (DA/A) referrals have increased dramatically in the past five years. Although part of this growth has been a result of factors beyond this program, we believe most of the growth is related to inadequate DA/A policies and procedures.

Michigan Growth Factors Not Related To DA/A Program Policy.-

Our agency's outreach activities, designed to develop strong working relationships with the state's client service community, have resulted in increased awareness of the existence of this program not just by the state Disability Determination Service, but also by treatment and other service providers and the general public. We believe this awareness has had some impact on the number of DA/A applications and DA/A coded awards.

In 1991, the administration of Republican Governor John Engler cut the state's General Assistance (GA) Program, and implemented initiatives to assure all State Disability Assistance (SDA) applicants also apply for SSI disability benefits. These measures are still having a significant impact on the number of SSI applicants.

In 1992 and 1993, the state initiated additional outreach initiatives that targeted drug addicts and alcoholics, with the purpose of encouraging them to file for SSI disability benefits. This has contributed significantly to our the growth of the Michigan DA/A program.

Growth Factors and Increased Costs Related to Program Policy/Procedure.-

The following are some DA/A program weaknesses that we believe are having significant impact, not just on growth, but also in increased program costs. I include recommendations for changes based on the Michigan RMA's experience with the

current process, and some initiatives we believe make a positive difference in improving outcomes.

DA/A ELIGIBILITY CRITERIA:

Ill-defined DA/A eligibility criteria and continuing disability review guidelines are generating questionable benefit awards and benefit continuations under this category. A significant number of beneficiaries referred to the RMA suffer not just addiction, but also other severe mental and/or physical impairments, that often render them unable to complete treatment and rehabilitation plans. (See EXHIBIT B for Diagnostic Breakdown) It seems that there is need for better guidelines for evaluation of the impact of combined impairments on potential for rehabilitation before DA/A coding determination is made.

Recommendation:

> *Clarify DA/A eligibility criteria and continuing disability review parameters, incorporating elements of addiction disease progression and recovery, and an evaluation of the impact of the combination of physical, mental, and addiction impairments on rehabilitation potential. This will assure accurate DA/A eligibility awards, proper identification of beneficiaries with potential for rehabilitation, and post-treatment continuing disability reviews that result in timely and appropriate termination of benefits. Currently, we believe that inappropriate DA/A referrals at the initial and continuing disability review levels are having a significant impact on workload and operational costs of this program.*

DISBURSEMENT OF BENEFITS:

Disbursement of benefits without enforcement of mandatory treatment requirements is defeating the purpose of the DA/A provisions, and it has become an incentive to abuse the system.

Recommendations:

> *Explore establishing regulations that only activate Medicaid coverage for treatment, but hold distribution of cash benefits until the monitoring process is in effect, and/or the beneficiary produces evidence of ongoing abstinence and active pursuit of treatment.*
>
> *Assure that resource allocations for the monitoring process are commensurate with the actual number of DA/A beneficiaries in pay status, to discourage frivolous applications by individuals who deliberately take advantage of program waiting lists.*

NON-COMPLIANCE PROCEDURES

Weak non-compliance procedures have become an incentive for drug or alcohol abusers to apply for benefits alleging addiction, and also a disincentive to remain compliant with treatment plans after benefits have been awarded. Currently the only requirement for reinstatement of benefits after a documented non-compliance is the beneficiary's signature of a statement of "intent to comply". As you probably know, for an addict, it is easy to promise, but very hard to follow through.

Recommendation:

> *Strengthen non-compliance suspension and reinstatement procedures by establishing regulations that limit the number of reinstatements non-compliant beneficiaries are entitled to, and assure no reinstatements are made unless there is proof of abstinence and active participation in treatment. We recommend a "progressive discipline" model that we believe would discourage abuses of the system: First instance of non-compliance results in a 30 day check suspension, a second, in a 60 day suspension, a third in a 90 day suspension, and a fourth would result in immediate termination of benefits. It should be assured that after each suspension, reinstatement of cash benefits would not be made on a "promise" to comply, but on actual evidence of abstinence, and active involvement in treatment. Regulations should also assure suspensions are processed in a timely manner to prevent over-payments to non-compliant beneficiaries.*

THE MONITORING PROCESS
The current narrow scope of the referral and monitoring process, which focuses only on treatment, and not in a comprehensive rehabilitation plan, is creating a costly "revolving door effect". DA/A recipients who complete treatment are often discharged to their former addictive environment, without the tools and skills they need to accomplish a lasting and productive recovery, thus precipitating their relapse and return to the benefit rolls.
Recommendation:

> *Develop procedures that require a broader monitoring scope. Treatment plans should include the utilization of Social Security Work Incentives, and directs beneficiaries towards job skills training, educational advancement, vocational rehabilitation, and ultimate return to the workforce. In Michigan, we are already operating the program under this approach with some success, and we believe it is a crucial element in the ultimate success and cost-efficiency of this program. (See EXHIBIT C 1. & 2. for success stories)*

DURATION OF CASH BENEFITS
Duration of cash benefits should not be subject to an arbitrary time limitation. An efficient, full rehabilitation oriented monitoring process should be emphasized. Without proper monitoring, time limited benefits would equate to "time limited free cash" that would likely be used to support substance abusing behavior for that period of time. Arbitrary limitation may result in untimely termination of severely addicted clients who are compliant, and whose treatment plan may require three to four years to complete. As an alternative that would not be punitive to compliant beneficiaries, we strongly recommend the inclusion of a strictly enforced "progressive discipline" model in non-compliance procedures, such as the one I described above.

II. AVAILABILITY OF TREATMENT

In Michigan, the current administration made drastic changes in Medicaid coverage for substance abuse treatment. Coverage for residential treatment and non-medical detoxification was eliminated in 1991. Coverage is only available for Intensive Out-patient and Regular Out-patient treatment.

There is no coverage of "urine drops" and drug screens. The following are issues that need to be considered in order to assure availability of appropriate treatment for DA/A beneficiaries:

TREATMENT WAITING LISTS
It is important to note that treatment waiting lists only affect indigent and non-insured services. RMA directors in Region V report that there is no shortage of treatment services that are covered by Medicaid or other forms of insurance. In fact, in most instances, DA/A clients are given priority for placement, as providers benefit from the RMA's close monitoring and enforcement of the treatment plans they lay out. In Michigan, lack of availability of residential treatment services for the severely addicted makes it difficult to secure APPROPRIATE treatment for them. And the lack of funding for "urine drops" and drug screens makes it difficult to properly document compliance.
Recommendation:

> *To assure that enforcement of mandatory treatment requirements meets the intent of the legislation, it is essential that availability of funding for appropriate treatment and testing services is assured in all states. If Medicaid or other form of coverage cannot be made available, a voucher system for non-covered services may be a good alternative.*

RMA WAITING LISTS
It seems that the major bottleneck in Michigan as well as other states is the RMAs' "waiting lists". The Michigan RMA is receiving DA/A referrals at the rate of 350 per month, and our "waiting list" is growing at an alarming rate. (See EXHIBIT D for summary). Currently we have 5,900 recipients in pay status who are waiting to be

monitored. Our 1994 projected funding level will allow us to serve 1,861 recipients. If maintained, this level of funding will result in an estimated 12,000 recipient waiting list at the end of three years, all of them receiving benefits they may potentially misuse if not properly monitored.

Recommendation:

A redesign plan for this program should include adequate resource allocations for the monitoring process, to assure no recipients receive benefits without being monitored. Incremental allocations that keep pace with growth rates should be seriously considered, to allow for the gradual elimination of waiting lists within a two to three year period, depending on the number of recipients awaiting monitoring across the nation.

III. REFORM OF THE REPRESENTATIVE PAYEE PROGRAM

Drastic reform of representative payee procedures for DA/A recipients is urgently needed if this program is to assure proper utilization of disbursed benefits. Under the current system, many payees are intimidated into allowing misuse of benefit funds, or they are also users of drugs and alcohol themselves. This makes the enforcement of compliance with treatment plans very difficult for the RMA's. We do not believe limitation of cash benefits is the answer.

Recommendations:

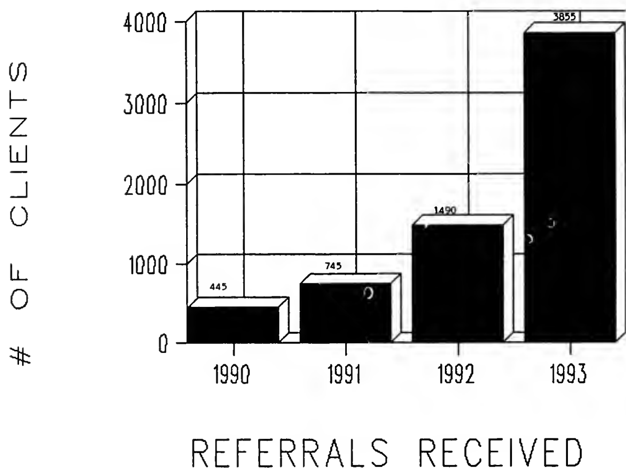
There needs to be representative payee regulations that take into consideration the nature of the disease of addiction. Potential co-dependent relatives, friends or other parties that may become conduits to the use of drugs and alcohol should not be allowed to become representative payees. Client service agencies that are familiar with the behavioral manifestations of addiction should be given preference.

Benefit conditions should make it very clear to beneficiaries and their representative payees that funds will only flow if recipients pursue, and remain compliant with, a comprehensive rehabilitation plan that includes treatment and vocational rehabilitation, and return to the workforce as a final objective.

***Chairmen and Subcommittee Members,** the SSI Drug Abuse and Alcohol program has the potential to be a very effective and cost efficient service delivery system. A comprehensive review and redesign is essential and urgent. Eligibility and continuing disability review criteria, adequate resources for appropriate treatment, better funding levels for monitoring activities, and improved procedures to handle payeeship and non-compliance must be part of this redesign. This redesign must also assure that policies and procedures are responsive to this unique disability's recovery and rehabilitation needs. Such a redesign, I can assure you, will go a long way, not just to assure proper disbursement and use of benefit funds, but also to improve rehabilitation outcomes, which ultimately will result in significant savings in General Revenue expenditures.*

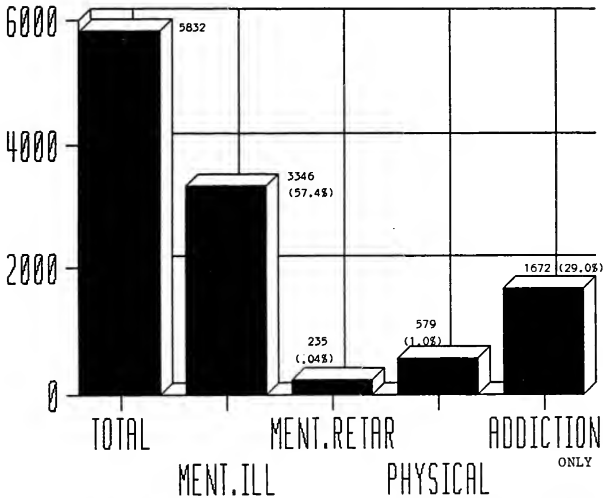
Thank you for allowing me the opportunity to share the Michigan RMA's perspective at this time.

(EXHIBIT A)



(EXHIBIT B)

MI DA/A POPULATION *



DIAGNOSTIC BREAKDOWN

* Figures as of 07/93

(EXHIBIT C.1.)

MICHIGAN RMA SUCCESS STORIES

YVONNE, female, age 41, awarded benefits in January, 1991. Only impairment, severe addiction to COCAINE. A high school graduate with two years of college, she had held a well paying job. Raised in an alcoholic home, was given alcohol in her baby bottle. Started drinking heavily at age 10, and added pills, cocaine, and marijuana in her teens.

The Michigan RMA initiated referral and monitoring in May, 1991, with referral to OUTPATIENT ADDICTION TREATMENT. As significant psychiatric issues surfaced during the first six months of substance abuse counseling, a referral to MENTAL HEALTH SERVICES was added to her treatment plan. She was still having difficulty stabilizing her recovery. She was, then, referred to A 30-DAY RESIDENTIAL PROGRAM in May, 1992. This was Yvonne's turning point. She was released to a community out-patient program, she became better focused on her recovery, and in February, 1993 the RMA referred her to MICHIGAN REHABILITATION SERVICES (MRS). Her goal is to become a Special Education Teacher.

After two (2) years of intensive referral and monitoring, in July of 1993, the RMA was notified that Yvonne had an Individualized Written Rehabilitation Program (IWRP), was a full-time student at a major university, and had been clean and sober for over one (1) year. The RMA closed the case, advising the Social Security Administration that Yvonne may qualify for the 301 Work Incentive Provision.

LEONARD, 41-year old male, diagnosed as Primary Mental Illness, Sociopathic Personality Disorder with suicide attempts. Raised in an addictive family environment, with history of ALCOHOL and COCAINE abuse since age 15, and use of HEROIN while in prison.

When the RMA initiated monitoring in February, 1990, Leonard was living in an Adult Foster Care Home. Referrals were made to COMMUNITY MENTAL HEALTH and a SUBSTANCE ABUSE TREATMENT programs, and the RMA initiated monitoring of both treatment tracks. Stabilizing his sobriety was very difficult for Leonard, and in November, 1990, the RMA processed a request for NON-COMPLIANCE SUSPENSION. In March, 1991, as Leonard returned to treatment, the RMA reopened the monitoring process.

With the support of his church, friends, family members, and the intensive monitoring activities of the RMA's Referral Specialist, Leonard began to stabilize and focus on his recovery. After two (2) years of intensive monitoring, in June, 1993, the RMA referred him to MICHIGAN REHABILITATION SERVICES while he continued his treatment plan. Leonard is currently enrolled in a work training program on a full-time basis, and is well on his way to full rehabilitation. He is a now a good candidate for the 301 provisions of the Social Security Work Incentive Program.

(EXHIBIT C.2.)

MICHIGAN RMA SUCCESS STORIES

GADDIS, a 45 year old male, 10th grade education, diagnosed with Antisocial Personality Disorder. Affective Disorder, and a long history of alcohol and drug addiction. STARTED DRINKING AT AGE 6, and HEROIN USE AT 19. Incarcerated off and on for 14 years due to drug related crimes. Involved unsuccessfully with several drug treatment programs prior to RMA involvement.

The Michigan RMA initiated monitoring in October, 1991. He was referred to INTENSIVE OUTPATIENT TREATMENT, but recovery was a struggle. Gaddis relapsed three times during the first year of monitoring. The last relapse resulted in a NON-COMPLIANCE SUSPENSION in November, 1992. Gaddis continued to use, and while in suspension, he suffered several cardiac arrests due to an embolism caused by the use of Heroin. After four months in suspension, he returned to addiction treatment, with a better commitment to recovery.

The RMA referred Gaddis to ADULT BASIC EDUCATION and he completed his GED, while remaining compliant with his treatment plan. A referral to MICHIGAN REHABILITATION SERVICES (MRS) resulted in his enrollment in truck driving school. Job placement is currently imminent.

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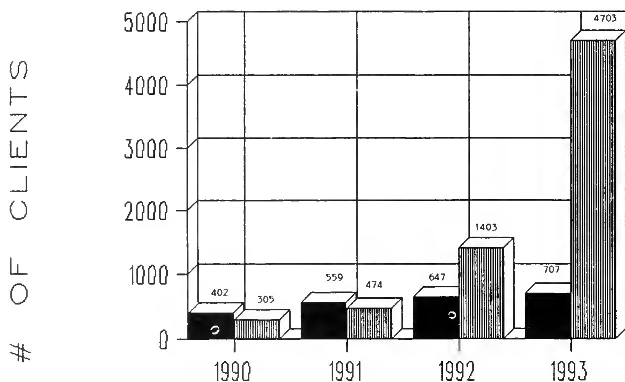
ROBERT, 45-year old male, veteran, high school graduate, raised in home with several generations of alcoholic males, was found to be disabled due to ALCOHOL DEPENDENCE, CHRONIC AND SEVERE.

The Michigan RMA initiated monitoring in July, 1991. His local Veterans Administration (VA) Inpatient unit refused the RMA referral, due to the many times Robert had used their system without recovery. RMA's intervention resulted in admission to a VA HOSPITAL INPATIENT UNIT outside of Robert's local area for a period of thirty (30) days. Due to the severity of his addiction, the next step was a referral to a LONG TERM RESIDENTIAL FACILITY, where he remained for six (6) months. After this period, a new attempt to place him in his hometown VA Hospital for aftercare resulted in enrollment in an IN-HOUSE WORK THERAPY PROGRAM, while awaiting admission to a state vocational training program. The RMA closed the case in March, 1993, when Robert received a VA pension that made him ineligible to receive SSI benefits. At that time, Robert had remained compliant and sober for fourteen (14) months, was working at the VA Hospital, and was looking forward to attending the state training school.

(EXHIBIT D)



Chairman FORD. Thank you very much.
Dr. Dan Flavin.

STATEMENT OF DANIEL K. FLAVIN, M.D., MEDICAL/SCIENTIFIC DIRECTOR, NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, INC., AND ASSOCIATE PROFESSOR OF PSYCHIATRY, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES, DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Dr. FLAVIN. Thank you, Mr. Chairman. My name is Daniel Flavin and I am the medical/scientific director of the National Council on Alcoholism and Drug Dependence. On behalf of NCADD, I thank the subcommittees for this opportunity to testify.

We are the Nation's largest voluntary not-for-profit health organization representing a national and local affiliate partnership serving communities throughout the United States. Its mission is to reduce the incidence and prevalence of the disease of alcoholism, other drug addiction, and related problems, support scientific research and combat the stigma associated with these conditions.

We regard alcoholism as a prototype of other drug addiction, to be a primary chronic disease with genetic, psychosocial, and environmental factors that influences its development and manifestations. It is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic. Alcohol- and drug-related problems cost this country an estimated $166 billion annually; approximately one quarter of all hospitalized patients have alcohol-related problems. In one 1992 Gallup survey, fully one-third of homeless respondents cited alcohol and/or other drugs as the primary reason for their homelessness.

Alcoholism and other addictions do not discriminate in that they affect individuals from all walks of life and with different means.

Because of escalating health care costs, changes in patterns of reimbursement and evolving scientific knowledge about the heterogeneity of alcoholism and other addictions, the approach to treatment for these disease states is undergoing major change. It is no longer felt that a single rigidly applied form of treatment based primarily on the location of service meets the needs of all individuals who require such intervention. A recent report from the Institute of Medicine examining alcoholism treatment concluded that treatment for alcoholism, and by extension to the addictions, is effective and that: one, primary targets of treatment need to be expanded to include the wide and continuous spectrum of alcohol- and drug-related problems; and, two, there should be an emphasis on an expanded multidimensional treatment system in which matching to an expanded array of cost-effective interventions is contingent on community and specialist assessment and refined by outcome determination in reaching a continuity of care.

Core features of treatment include: Facilitating detoxification; abstinence from the drug of dependence; confrontation of denial mechanisms; changes in lifestyle and education about the nature of the disorder. Individual medical, psychiatric, social, occupational, and legal considerations impact on the nature of treatment ren-

dered. There exists a substantial body of literature attesting to the cost effectiveness of treatment services. Nonetheless, a minority of individuals in need of treatment receive it, and there exists significant comorbidity between serious medical disorders and various psychiatric and psychoactive substance use disorders.

There are two important points to consider when we talk about increasing the efficiency of addiction treatment through patient matching. These are ongoing outcomes research documenting treatment effectiveness and the evolution of ever-increasing levels of sophistication in patient placement criteria based on this research.

For several years the National Institute on Alcohol Abuse and Alcoholism has conducted a large scale randomized control study involving nine clinical research centers around the United States to test the effectiveness of treatments matched to patients based on their individual clinical needs. The first report describing this has been recently published in the Journal of Alcoholism, Clinical and Experimental Research. Coupled with this significant advance in research is the development of patient placement criteria focusing on levels of care, independent of location, as developed and refined according to outcomes research. Prototype criteria have been developed by the American Society of Addiction Medicine. Thus, the improvement of existing treatment efforts rests on the redefinition of our perspective and must be guided by the development of objective criteria for placement and the research which validates it.

In conclusion, alcoholism and other drug addictions represent diseases for which there exist effective treatment. A key to the understanding of treatment is the fact that there is no one universally effective intervention appropriate to all individuals suffering from addiction, but rather a continuum of levels of care offering different treatment modalities in various settings. This model underscores the fact that in all fields of medicine, improving the delivery of treatment is dependent on our struggle to identify our successes, learn from our mistakes, and to aggressively seek to improve our knowledge base and capabilities for treating disease. And if I might also say, reflecting back to some of the comments that I heard this morning, it comes to mind that when the founder of NCADD was asked what are the three primary missions of our organization, her response was, No. 1, stigma, No. 2, stigma, and No. 3, stigma.

I would urge all of us to keep in mind that the enemy here is not the addicted person, but the addiction itself. We do not know the extent of the benefits abuse problem that you are beginning to investigate. However, it is our feeling that compassion and strict accountability can definitely coexist. I can tell you anecdotally from my clinical experience of over 11 years in this field, working with a wide range of individuals that I have treated, that they have taught me the most about alcoholism and the addictions. These are wonderful, valuable members of our society who have been on Social Security disability benefits, who have been in a wide variety of disadvantaged situations throughout their addictions and were able to achieve recovery and make valuable contributions to our society.

Thank you.

[The prepared statement follows:]

Summary of Comments to the House Ways and Means Committee
Social Security Subcommittee
Hearing on Social Security Disability Benefits for Alcoholism
and Other Psychoactive Drug Use Disorders
Wednesday, February 9, 1994

Witness: Daniel K. Flavin, M.D. Medical/Scientific Director, The National Council on Alcoholism and Drug Dependence, Inc.; Associate Professor of Psychiatry, The George Washington University School of Medicine and Health Sciences, Department of Psychiatry and Behavioral Sciences.

I. Introductory Statement- The National Council on Alcoholism and Drug Dependence is the nation's largest voluntary, not-for-profit health organization representing a national and local affiliate partnership serving communities throughout the United States. Its mission is to reduce the incidence and prevalence of the disease of alcoholism, other drug addictions, and related problems through efforts targeted at prevention and education; it encourages scientific research in the prevention, diagnosis, and treatment of these disease states; and, it seeks to combat the stigma associated with these conditions.

II. Alcoholism/Drug Dependence as Disease and its Impact- Alcoholism is a primary, chronic disease with genetic,

psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. each of these symptoms may be continuous or periodic (Morse RM, Flavin DK, et al: The definition of alcoholism. Journal of the American Medical Association 268(8):1012-1014, 1992). It is estimated that 15.3 million persons 18 years of age or older in the United States can be classified as alcoholic or as problem drinkers; of these 11.2 million are male and 4.1 million are female (NIAAA, Epidemiologic Report, January 1992). Alcohol and drug-related problems are directly related to, or complicate the medical problems of a significant proportion of those individuals hospitalized in general hospital settings. Alcohol-related family problems alone strike one in four families (Gallup Organization, 1987). Alcohol and drug-related problems cost this country an estimated $166 billion dollars, including reduced productivity and costs associated with mortality (Rice et al: The economic costs of alcohol and drug abuse and mental illness, Institute for Health and Aging of the University of California, 1990). In one 1992 Gallup Survey, fully one-third of homeless respondents cited alcohol and/or other drugs as the primary reason for their homelessness (Gallup Organization, Survey of Homeless Persons in Los Angeles, 1992). Alcoholism and other addictions do not discriminate in that they affect individuals from all walks of life and with different means.

III. Treatment Philosophy- Because of escalating health care costs, changes in patterns of reimbursement, and evolving scientific knowledge about the heterogeneity of alcoholism/addictions, the approach to treatment for these disease states is undergoing major change. It is no longer felt that a single, rigidly applied form of treatment based primarily on location of service meets the needs of all individuals who require such intervention. A recent report from the Institute of Medicine examining alcoholism treatment concluded that treatment for alcoholism is effective and that: (1) primary targets of treatment need to be expanded to include the wide and continuous spectrum of alcohol-related problems; and (2) there should be an emphasis on an expanded, multidimensional treatment system in which matching to an expanded array of cost-effective interventions is contingent on community and specialist assessment and refined by outcome determination in reaching a continuity of care. Treatment was defined by the authors of that study as the broad range of services, including identification, brief intervention, assessment, diagnosis, counseling, medical services, psychiatric services, psychological services, social services, and follow-up for persons with alcohol problems. The overall goal of treatment is to reduce or eliminate the use of alcohol as a contributing factor to physical, psychological, and social dysfunction and to arrest, retard, or reverse the progress of any associated problems (Institute of Medicine, National Academy of Sciences: Broadening the Base of Treatment for Alcohol Problems; National Academy Press, Washington, D.C., 1990). Core features of treatment include facilitating detoxification,

abstinence from the drug of dependence, confrontation of denial mechanisms, changes in lifestyle, and education about the nature of the disorder; individual medical psychiatric, social, occupational, and legal considerations impact on the nature of treatment rendered (Flavin D.K., Morse RM: What is Alcoholism? Current definitions and diagnostic criteria and their implications for treatment. Alcoholism Health and Research World 15(4): 266-271, 1994). There exists a substantial body of literature attesting to the cost-effectiveness of treatment services (Flavin DK: Cost-effectiveness and cost-offset studies in alcoholism and other drug use disorders treatment. NCADD Medical/Scientific Quarterly Public Policy Literature Review 1(4): 51-56, 1991). Less than 10% of individuals in need of treatment receive it. Comorbidity of psychiatric and substance abuse disorders has been well appreciated in the literature, as exemplified in a recent article by Kessler et al (Kessler RC, et al: Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the U.S. Archives of General Psychiatry, 5: 8-19, 1994).

IV. Matching Patients to Appropriate Levels of Treatment- There are two important, practical points to underscore in the area of treatment matching: ongoing outcomes research documenting treatment effectiveness and evolving criteria in the field dealing with patient placement vis-a-vis levels of care and the refinement of such based on outcomes research. For several years the National Institute on Alcohol Abuse and Alcoholism has conducted a national, multi-site study examining the success of community-based treatment

matching paradigms. Coupled with the significant advance in research is the development of patient placement criteria focusing on levels of care independent of location, as developed and refined according to outcomes research by the American Society of Addiction Medicine (American Society of Addiction Medicine: Patient Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders. ASAM, 1992). The improvement of existing treatment efforts rests on the redefinition of our perspective and is guided by the development of objective criteria for placement and the research which validates it.

V. Conclusions- Alcoholism and other drug addictions represent diseases for which there exists effective treatment. A key to the understanding of treatment is the fact that there is no one universally effective intervention appropriate to all individuals suffering from addiction, but rather a continuum of levels of care offering different treatment modalities in various settings. This evolving model underscores the fact that in evolving successful modalities of treatment we struggle to identify our successes, learn from our failures, and aggressively seek to improve our knowledge base and capabilities for treating these conditions.

Chairman FORD. Thank you.
Ms. Jones.

STATEMENT OF LINDA R. WOLF JONES, D.S.W., EXECUTIVE DIRECTOR, THERAPEUTIC COMMUNITIES OF AMERICA, PRESENTING THE STATEMENT OF DANIEL S. HEIT, PRESIDENT, BOARD OF DIRECTORS

Ms. JONES. Good afternoon Mr. Chairman and members of the subcommittee. My name is Linda Wolf Jones, and I am the executive director of Therapeutic Communities of America, a nonprofit association representing over 400 drug free self-help substance abuse treatment and rehabilitation programs nationwide.

TCA and the therapeutic community world share a profound concern that opportunities must increase for addicts to receive treatment and rehabilitation services.

There are an estimated 250,000 disabled substance abusers on the SSDI and SSI rolls. Disabled recipients in these programs receive benefits for such time as their disability, and in the case of SSI, their financial need persists. The average monthly benefit under SSDI is $625 or $7,500 annually. The average federally administered monthly payment for a disabled SSI recipient is $402 or $4,824 annually.

It is clearly in the Federal Government's interest to do everything possible to restore recipients to a state of self-sufficiency if their disability allows for that possibility.

TCA believes that the best way to reduce the growth in the substance abusing SSDI and SSI populations is to reduce the number of substance abusers. The organizational members of TCA are committed to a self-help philosophy and to the provision of drug free residential and other treatment services in line with that philosophy.

Therapeutic communities have been in existence as a treatment modality for substance abuse since the mid-1960s. They operate on the premise that drug abuse is a disease accompanied by deviant behavior and that far greater change is required on the part of the drug abusing individual than simply a cessation of drug use. Drug abusers need to accomplish a change in lifestyle that includes staying away from drugs, staying out of criminal activity, supporting themselves without recourse to antisocial behavior and engaging them productively in the life of the larger community. Only then can the individual truly be considered rehabilitated.

Since change of the magnitude which I am describing doesn't happen quickly or easily, successful completion of a therapeutic community treatment program can take from a few months to 1 year or longer. During that time, the client is immersed around the clock in a highly structured regimen that includes self help, peer pressure, individual and group counseling, confrontation therapy, and gradually increased responsibility in the life and operations of the TC.

Treatment success is measured by such indicators as abstention from drug use and criminal activity and gainful employment subsequent to treatment. Many research studies have shown that the longer someone stays in treatment, even if that person leaves the program before graduation, the greater the likelihood for success in

terms of a reduction in antisocial behavior, such as drug use or criminal activity, and an increase in productive behavior such as employment.

I would like to address briefly the SSI treatment requirement and representative payee issues that have been discussed throughout the hearing today. TCA believes that addicts need and ought to be in treatment. The primary goal of a TC is to foster personal growth focused on the integration of the individual into the larger society.

At the outset, the addicted individual may not be strong enough to want that growth for him- or herself. Therefore, we strongly believe that stringent requirements are appropriate and should be enforced vis-a-vis the participation of drug-addicted recipients in treatment as a condition of SSI eligibility.

We also agree with those critics who believe that family members or friends may not be the most appropriate representative payees for drug-addicted SSI recipients. The opportunities for coercion or pressure on the part of the addict and/or enabling behavior on the part of friend or family member may put the money right back in the hands of the addict who could not be trusted to use it correctly.

Ideally, for the addict in residential treatment, the treatment provider should be the representative payee, thereby ensuring both that the recipient is meeting the treatment requirement and that the funds are being used appropriately for his or her maintenance, and they are not going to be used to buy drugs or alcohol.

Finally, on substance abuse treatment and fiscal issues that go beyond the specifics of the SSDI and SSI programs, we believe there are several administrative barriers that hinder the opportunities for addicts to receive the treatment and rehabilitation services that they would require in order to leave the disability rolls and return to the community as productive citizens.

First and foremost, there must be adequate Federal funding of treatment slots, including TC slots for addicts for whom long-term residential drug free treatment represents the preferred modality. We are grateful to the President for recognizing this need in his fiscal year 1995 budget proposals.

Many of our members have been providing drug treatment services for 20 years or more, so it is with considerable experience that we assert that there is a real shortage of long-term residential treatment beds throughout the country. We know, and surveys have shown, that there are far more drug abusers in need of treatment than there are slots to accommodate them.

For many of these addicts, especially the hardcore and those whose families and/or community structures do not offer the necessary support systems, long-term residential treatment is the indicated modality.

It is essential that any comprehensive health care reform package include coverage for short- and long-term residential treatment as well as outpatient and posttreatment services.

We would also recommend that the Medicaid exclusion of residential treatment in institutions for mental disease be lifted. Currently, no reimbursement can be claimed under the Medicaid program for such services.

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We strongly believe that restrictions on funding for drug treatment and related services, regardless of whether that funding comes from a block grant, Medicaid, or a new national health care plan, is a shortsighted and counterproductive approach to dealing with the drug abuse problem.

Casual drug use has declined, but hardcore drug use has grown. The SSDI and SSI substance abusing populations will continue to grow unless potential applicants and current recipients can be successfully treated and rehabilitated. If the larger society will not pay for 1 year of treatment, it will, in too many cases, pay instead for a lifetime of dependency.

Thank you for this opportunity to express our views. We look forward to working with you on drug abuse and other related issues on which the committee may be working.

We would also like to extend an open invitation to you to visit a local or home State therapeutic community. We stand ready to work with you in any way possible in the coming months.

[The prepared statement of Daniel S. Heit follows:]

TESTIMONY OF DANIEL S. HEIT
PRESIDENT, BOARD OF DIRECTORS, THERAPEUTIC COMMUNITIES OF AMERICA

Good afternoon, Mr. Chairmen and Members of the Committee. I would like to thank you for the opportunity to testify today on the subject of achieving higher rates of treatment and rehabilitation among alcoholics and drug addicts receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits.

My name is Daniel S. Heit and I am the President of the Board of Directors of Therapeutic Communities of America (TCA), a nonprofit association representing over 400 drug-free, self-help substance abuse treatment and rehabilitation programs nationwide. I am also President of Abraxas Group, Inc., a treatment provider based in Pittsburgh, Pennsylvania. The therapeutic community world shares a profound concern that opportunities must increase for addicts to receive treatment and rehabilitation services. It is this concern that brings me before the Subcommittees today.

The disability insurance component of Social Security (SSDI) was added to the program in 1956 for workers at least 50 years of age; that minimum age limitation on the availability of benefits was eliminated in 1960. The Supplemental Security Income (SSI) program was designed and implemented in the early 1970s to replace a haphazard system of state programs for the aged, blind and disabled poor. Currently, more than nine million disabled people receive monthly federal payments from the SSDI and SSI programs, of which about 120 thousand are estimated to be substance abusers. Although these substance abusers represent only a small percentage of beneficiaries, their numbers are growing. Further, as you noted in the hearing announcement, the rate of growth of substance abusers in the SSDI and SSI program populations in recent years has outpaced the general rate of growth in both the SSDI and SSI overall program populations.

Disabled recipients of Social Security or Supplemental Security Income benefits receive those benefits for such time as their disability (and, in the case of SSI, their financial need) persists. The average monthly benefit under SSDI is $625 ($7,500 annually); the average federally administered monthly payment for a disabled SSI recipient is $402 ($4,824 annually). Clearly, it is in the federal government's interest to do everything possible to restore recipients to a state of self-sufficiency if their disability allows for that possibility.

TCA believes that the best way to reduce the growth in the substance abusing SSDI and SSI populations is to reduce the number of substance abusers. The organizational members of TCA are committed to a self-help philosophy and to the provision of drug-free, residential and other treatment services in line with that philosophy. Therapeutic communities have been in existence as a treatment modality for substance abuse since the mid 1960s. They operate on the premise that drug abuse is a disease accompanied by deviant behavior and that far greater change is required on the

part of the drug abusing individual than simply a cessation of drug use. Drug abusers need to accomplish a change in lifestyle that includes staying away from drugs, staying out of criminal activity, supporting oneself without recourse to antisocial behavior, and engaging oneself productively in the life of the larger community. Only then can the individual truly be considered rehabilitated.

Since change of the magnitude which I am describing does not happen quickly or easily, successful completion of a therapeutic community treatment program can take from a few months to a year or longer. During that time, the client is immersed around the clock in a highly structured regimen that includes self-help, peer pressure, individual and group counseling sessions, confrontation therapy, and gradually increased responsibility in the life and operations of the therapeutic community. Treatment success is measured by such indicators as abstention from drug use, abstention from criminal activity, and gainful employment subsequent to treatment. Many research studies have shown that the longer someone stays in treatment, even if that person leaves the program before graduation, the greater the likelihood for success in terms of a reduction in antisocial behavior (e.g., drug use, criminal activity) and an increase in productive behavior (e.g., employment) on his or her part.

I would like to address briefly the SSI treatment requirement and representative payee issues that were mentioned in the hearing announcement. TCA believes that addicts need and ought to be in treatment. The primary goal of a therapeutic community is to foster personal growth, focused on the integration of the individual into the larger society. At the outset, the addicted individual may not be strong enough to want that growth for him or herself. Therefore, we strongly believe that stringent requirements are appropriate and should be enforced vis-a-vis the participation of drug-addicted recipients in treatment as a condition of SSI eligibility.

We also agree with those critics who believe that family members or friends may not be the most appropriate representative payees for drug-addicted SSI recipients. The opportunities for coercion or pressure on the part of the addict and/or enabling behavior on the part of the friend or family member may put the money right back in the hands of the addict who cannot be trusted to use it correctly. Ideally, for an addict in residential treatment, the treatment provider should be the representative payee, thereby ensuring both that the recipient is meeting the treatment requirement and that the funds are being used appropriately for his or her maintenance; i.e., that they are not going to be used to buy drugs or alcohol.

Finally, on substance abuse treatment and fiscal issues that go beyond the specifics of the SSDI and SSI programs, we believe that there are several administrative barriers that hinder the

opportunities for addicts to receive the treatment and rehabilitation services that they would require in order to leave the disability rolls and to return to the community as productive citizens. First and foremost, there must be adequate federal funding of treatment slots, including therapeutic community slots for addicts for whom long-term residential drug-free treatment represents the preferred modality. Many of our members have been providing drug treatment services for twenty years or more, so it is with considerable experience that we assert that there is a real shortage of long-term residential treatment beds throughout the country. We know that there are far, far more drug abusers in need of treatment than there are slots to accommodate them. A 1988 Institute of Medicine Report, for example, indicated that approximately two to three million individuals who needed drug treatment at that time were not receiving it. That was six years ago; it has been estimated that the population in need of drug treatment has increased by 20 percent since then. For many of these addicts - especially the hard-core addicted and those whose family and/or community structures do not offer the necessary support systems - long-term residential treatment is the indicated modality. <u>It is essential that any comprehensive health care reform package include coverage for short- and long-term residential treatment of substance abuse, as well as outpatient and post treatment services.</u> We would also recommend that the Medicaid exclusion of residential treatment in institutions for mental disease (IMDs) be lifted. Currently, no reimbursement can be claimed under the Medicaid program for such services.

We strongly believe that restrictions on funding for drug treatment and related services - regardless of whether the funding source is a block grant, Medicaid or a new national health care plan - is a short-sighted and counterproductive approach to dealing with the drug abuse problem. Casual drug use has declined in this country, but hard-core drug abuse has grown. The SSDI and SSI substance abusing populations will continue to grow unless potential applicants and current recipients can be successfully treated and rehabilitated. If the larger society will not pay for a year of treatment, it will - in too many cases - pay instead for a lifetime of dependency.

Thank you for this opportunity to express our views. We look forward to working with you on drug abuse and related issues as they impact on the work of your committee. We would also like to extend an open invitation to you to visit a local or home state therapeutic community. The TCA National Office stands ready to work with you in any way possible in the coming months.

Chairman FORD. Thank you very much, Ms. Jones.
Mr. Anderman.

STATEMENT OF THOMAS A. ANDERMAN, C.S.W., MOUNT PLEASANT, MICH.

Mr. ANDERMAN. Mr. Ford, thank you very much for this opportunity.

In regards to the title of this meeting and hearing on the means of achieving higher rates of treatment and rehabilitation among alcoholics and drug addicts receiving Federal disability benefits, it is a mouthful, so I would like to go directly to the issue at hand.

The Federal Register, volume 20, chapter 3, subpart Q and specifically the 1989 April 1 edition, describes who Social Security will or not will refer to treatment.

Under section 416.1720, part D, if alcoholism or drug addiction is a contributing factor to your disability, that will constitute a referral for treatment and also a referral for monitoring.

The problem I have run into when I started writing about this in 1990 trying to get Health and Human Services to hear me, that there were millions and millions of dollars going down the drain. I received a letter responding to my initial inquiry regarding this and I was told that, first, what was happening wasn't happening, and second, that in effect even if the person did have a drug problem, if it was secondary to the primary diagnosis, they weren't going to be referred for monitoring.

That left my job in an impossible position because I was a dual diagnosis therapist in the Saginaw County mental health office specializing in the treatment of the chemically dependent, mentally ill or vice versa, the mentally ill who are chemically dependent.

I was surrounded by literally hundreds of cases that I had no way of intervening on. That is why I am asking today that changes be made and that all individuals receiving both SSDI and SSA become eligible not for merely treatment by referral from Social Security to the monitoring agency, but by putting this at the grassroots level where information can be gathered at its source and an accurate count can be had. Any agency working with this population should be able to immediately refer these individuals for monitoring as soon as they are identified.

Had I been able to do this when I first started my job, perhaps 12 individuals I have worked with at this time in my life would be alive now. As an unfortunate consequence, nothing being available to them or not being acknowledged as being eligible, they are dead and gone.

This is indeed a very messy situation. I have been treated like perhaps I was in need of disability back in 1990 when I first brought this topic up and pointed these issues out. I am, at this point, resigned to make a lifelong mission of this as needed.

It is a matter of life and death, and I think that every recipient of the U.S. Government's disability programming at least deserves, if they are going to get the benefits in the money, that they can understand that we care enough to make sure it is spent well.

My experience shows me that once a case is referred to monitoring, some significant changes occur in the individual's attitude toward treatment. To start with, 90 percent of the people I would

say, well, we are going to lock you into treatment here inasmuch as saying we are going to refer you, we are going to monitor you, you are going to drop urine, you are going to comply.

Ninety percent of the respondents that I have come in contact with immediately resign or become noncompliant with treatment. That alone would provide substantial savings to pay for the monitoring agencies across the country that are so vitally needed and that have been ignored for years as well as continuing to pay for treatment needed for individuals that are compliant as Ms. Rojas-Dedenbach has pointed out.

Treatment for these individuals has a high probability of success. We have people coming here saying give us your clients because we know they work well. They are interested. We want to treat your people.

So it will clear up a whole range of issues and problems for these people. The answer really lies in making an intervention possible, and that boils down to immediate referral into these monitoring agencies from the grassroots level. I am not now nor will I ever be in the future comfortable or safe to let Social Security have the responsibility of making these people the recipients of a referral for continued treatment. I was told it wasn't happening in 1990.

I have been blessed and honored by the opportunity to sit here today and inform you that, as I knew then and as I know now, it is happening. I am also disturbed to say that I believe once the full extent of this testimony is investigated, as Mr. Santorum has found out, that this indeed is only the initial detonation of a very large problem.

My investigation for the State of Michigan based on the U.S. census data indicates, if the demographics apply nationally, it is not 250,000, it is 1 million of both SSDI and SSA claimants.

So, to close, I would like to say, please give the treatment providers the ability to refer these individuals into treatment and, as a result, folks will be able to get treatment and there will also be substantial savings and immediate clarification of who wants treatment and who doesn't want treatment.

Thank you very much.

[The prepared statement follows:]

Special Joint Sub-Committee Hearing Testimony
Thomas A. Anderman, M.A., C.S.W., L.P.C.
February 9, 1994

During the past five years of my employment at Saginaw County Mental Health I have had the unfortunate experience of watching the SSI program enable the addiction of close to one thousand people. My initial shock lead me to write Congress and the Senate in April of 1990. Since then the problem has only grown worse.

On the streets of Saginaw and other cities across America the phrase "get with the program" has taken on new meaning. The word on the street is "get on SSI and get money for drugs". This has been the word on the street for years.

When the State of Michigan eliminated its General Assistance Program, a new wave of applicants appeared and got on SSI. People who use upwards of $40,000.00 of cocaine a year were now considered disabled, allegedly incapable of "Substantial Gainful Activity" to quote SSA. They suddenly became eligible for retroactive disability claims which granted them checks for thousands of dollars which immediately were spent on their drugs of choice.

My job was to work with the chemically dependent and mentally ill. Here was a Federally subsidized drug purchasing program which not only paid for the drugs at tax-payers expense, but also asked the tax-payers to pay for the needed treatment. This frustration lead me to research The Federal Register because I couldn't believe there wasn't a law which would make non-compliant drug addicts ineligible for benefits. As I had hoped, I found the law which states benefits for addicts/alcoholics who refused treatment became ineligible for their next check.

The resulting concern for this lead to a meeting with SSA representatives from Chicago and Saginaw's SSA offices. In that meeting I was told that enforcement of that clause only pertained to SSI recipients who received disability benefits for a primary diagnosis of Drug abuse/alcoholism (DDA) and that recipients who had a mental illness diagnosis were not covered. In effect, their payments would continue, despite their addictions which <u>caused</u> their mental illness.

At this point I was left with hundreds of cases which no practical intervention could take place. These cases were untreatable becouse either they were their own payee, or the payee they had let them continue to use drugs and drink.

Consulting with workers at the local SSA office confirmed my worst fears. Recipients were able to change representative payees upon formal request. In fact, were doing so in some cases so frequently as to make verification of the representative payees worthiness impossible.

This explained why at the first of the month the prostitutes literally lined up at the Eddy Building downtown Saginaw. Why pushers showed up at Adult Foster Care homes and rooming houses just prior to the arrival of the U.S. Mail. Why there was such a lull in <u>requests</u> for treatment the first week of every month.

It also explained the regular appearance of drug induced psychosis at the end of, or during, the first week. To check on this apparent predictable phenomenon I spoke with treatment centers in Michigan from Detroit to the Upper Penlnsula, and admission workers confirmed the pattern.

There is an obvious problem, and Michigan is addressing it, as are other states, with monitoring agencies. However diligently these agencies work, the number of recipients still out-number the agencies ability to track the cases. Michigan has approximately 6000 cases which are currently awaiting the monitoring process. Nationally Michigan is acknowledged by SSA as "doing a pretty good job". The fact remains, I don't feel right about over five battalions worth of addicts/alcoholics

roaming Michigan exemplified by the attitude of one who told me "you can't touch me. I'm a federally subsidized addict".

The real issue at hand is should drug addicts and alcoholics receive disability without monitoring? In other words should the Federal Government continue to enable these addictions? The clear answer is no. No one can argue this. As an example, I would invite anyone to ask President Clinton if he would have given his brother Roger a check for $500.00 at the beginning of every month and to check with him occasionally? Would he have let Roger pick the payee? President Clinton as Governor of Arkansas jailed his brother in an act of tough love. He knew he couldn't stand by and enable a destructive addiction to ruin his family.

Beyond this, why is the SSA considering alcoholism a disability which lasts for a year or more when the American Psychiatric Association states that clinical remission is reached in six months. Why is it that when any fortune 500 E.A.P. puts an employee who is alcoholic or addicted into treatment, they return to work in less than two months. Yet other people with addictions no worse go through Federal channels and are looked upon as being disabled for a year or more. This is preposterous.

My experience in Michigan has shown me this is a nationwide problem and immediate actions are needed:

1. When an individual with a drug or alcohol problem applies for disability, both the applicant and agencies should be held accountable for the information gathered. Any intentional omissions of information should negate a claim. Likewise, treatment providers who fluff, or intentionally misdiagnose for the purpose of financial gain should be charged with defrauding the Federal Government and should receive stiff fines and felony charges.

   It is a current practice for hospitals et. al. to diagnose someone with a drug induced psychosis as being mentally ill. The reimbursement rate is higher, and for some drug induced psychoses medicaid will not pay, so the diagnosis shifts to mental illness, even when staff knows otherwise.

   This clearly is fraud, and money saved from not paying for this should go into funding Continuing Disability Reviews. The state of Michigan is on record for acknowledging that every dollar spent investigating welfare fraud saved eleven. Likewise there should be astronomical saving investigating claims made to SSA/SSI. I see no need for further expansion in SSA/budgets until this is rectified.

   SSI continues to pay out with cash and medicaid without realistic review procedure. I have witnessed claimants by the hundred who have continued to receive benefits while shunning every available form of treatment. Missing appointment after appointment, evading workers who make house calls, selling their medication, yet the checks continue to arrive. Claimants should have to show SSI why they should continue to be eligible, with proof of attendance, completed treatment, medication compliance, etc.. That despite all best efforts they are still ill, not the reverse. Non-compliance should equal non-eligibility.

2. The entire notion of making addicts of illegal substances eligible for disability payments is completely irrational. Laws against the use of these substances exist because of the known harm that comes both personally and socially from the drug use. Why then do we reward an addict, a crack addict for example, who by definition of his behavior is a habitual felon, an ongoing line of credit for cash and healthcare.

   It is somewhat understandable to offer temporary benefits to an alcoholic who by way of a legal and accepted part of culture finds himself dependent on a legal and federally approved drug. The person did not know they were alcoholic until they were. But for crack? It's illegal because by definition anyone who uses it can, or will become addicted. It doesn't matter what your background is or who you are, you for the virtue of being a human being are vulnerable to its ruinous properties. No one can argue this. There are no predisposing factors for crack addiction other

than being alive. Laboratory animals that become addicted and dysfunctional as any human testify to this. As pointed out in the Journal of Hospital and Community Psychiatry, these animals don't come from bad homes, or social trauma, they just get addicted.

3. Clear diagnosis is not now, nor has it been much of a concern to SSA, unless it is for establishing a disability. SSA is apparently very willing to look at every imaginable combination of maladies to establish the claim. Yet when it comes to cutting people off benefits, or monitoring benefits, SSA will only look at the "Primary diagnosis". It is time for SSA to join the real world in the field of diagnostics. In a letter sent to my Senator, the past Secretary of Health and Human Services told me that HHS/SSA is aware that some of the SSI recipients are abusing drugs but are not identified as such in SSA's record. "The reason for this is that their substance abuse is not considered to be material to a finding of disability; that is, their impairment would be disabling even in the absence of the substance abuse". That is a direct quote. It is also incredibly naive clinically speaking, and could only come from someone who is not involved with this problem on a personal day to day basis. The idea that someone could be poisoning their brain on a regular basis and not have it contribute to the existing disability - especially when the drug history is present years before the "disability", is again, preposterous.

   SSA needs to apply the same standards across the board. All recipients who abuse or are dependent on drugs need to be monitored or else what could be a thirteen month disability will turn into a thirteen year disability. Again, the savings here more than cover the cost of the Continuing Disability Review (CDR).

4. The service providers who gain the most from these clients should have to justify why they are continuously eligible for reimbursement at CDR's. Otherwise, you will have the scenarios of one person running up a two million dollar treatment bill (inflation included) because his addiction was never addressed. Multiply that fiasco by ten thousand people and the resulting ten billion dollars will be as my eight year old son Thomas stated "poured down the drain".

   As a nation we can not afford the waste of human potential nor the financial burden. Either the Federal Government recognizes it has made a mistake or it will set precedence to bankrupt the health care system. Limits which are strictly enforced must be made. Why should an addict stop using drugs when he knows he can always get taken care of? Medicaid in Michigan no longer pays for inpatient substance abuse treatment for that exact reason. This wasn't a safety net. It was more of a hammock. Giving alcoholics and addicts Carte Blanche lines of health care was a disaster here. Now the Federal Government needs to see that its program or safety net is more of a gill net which tens of thousands of people languish in.

   Establishing parameters for the amount of treatment a certain disability is due is only prudent. I am not asking to deny treatment, only to focus it diagnostically. The rest of the health care field lives within standards of treatment regarding specific Diagnosis Related Groups. The medical field has responded by creating specialist in those fields, to function with those standards. Ironically it has created a rather large niche where the poor souls suffering from organic mental disorders from drugs don't get treated for their problems. The symptomology is acknowledged by The American Psychiatric Disorder as being identical to many mental illness which are chronic. The following scenario is occurring as the reader follows the text.

   I. Emergency room admission due to drug related psychosis.

   II. Patient is transferred to a psychiatric unit (patient has no insurance).

   III. Hospital social worker facilitates a disability claim to cover the cost of the psychiatric treatment. The hospital is forced to "taylor diagnosis" to obtain a reimbursable DRG.

IV. Client receives SSI and Medicaid retroactive to cover hospitalization. Client/patient uses SSI money for drugs which reestablishes the psychoactive substance disorder and related organic mental syndromes which mimic mental illness which causes additional hospitalization for "mental illneos".

V. Claimants continuing to receive SSI remain isolated against any efforts of intervention to treat drug problem. Federal tax monies are used to continue drug/alcohol addiction. This leads to a repeat of the above cycle and continues for tens of thousands until they have chronic disabilities due to substance abuse/dependence.

I have been powerless to stop this cycle with both addicts and alcoholics who should not be on SSI and those with what were at that time acute organic mental disorders, which are now chronic organic disorders.

Specialization in the medical fields has produced few who want to specialize in the treatment of these agonized souls. Generally speaking, by the time they are in mental health centers few have anyone in their life who want or love them. They have burned most family ties and the families that remain with them are at tortured ends having experienced the living decay of their child or sibling. They are ready to accept any help that comes along and desperately cling to what appears to be an answer. Unfortunately they rarely get it.

I therefor ask that we respond with appropriate and responsible action by adopting the following:

1. All subcontractors of disability determination services for SSA adopt, at their expense (since they, the states, benefit form the Federal monies in the long run), a uniform means of determining disability which thoroughly investigates chemical abuse/dependence no matter the disability, and that Federal regulations regarding DA & A apply to all recipients.

2. That Social Security Administration monies stay at established levels or less for SSI budgeting. That HHS/SSA acquire monies from existing budgets by stopping payments to fraudulent providers and ceasing benefits to those non-compliant cases which are pending, until they receive a thorough review with regards to DA & A.

3. That under "dram shop laws" of certain states HHS/SSA could possibly be held liable for the inadvertent contribution to individuals deaths, or injury to others.

4. That only licensed physicians (M.D. or D.O.), with specialized training make determinations of disability for over one year in regards to substance abuse.

5. That HHS/SSA create, adapt existing forms so any worker will report existing drug abuse/dependance, under newly adopted law. That in doing so the unnecessary permanent disabilities that occur will be prevented.

6. Any falsification of intentional omissions on paperwork for applicants can result in charges of fraud with fines.

7. That policy be created to identify realistic treatment limits for DA & A recipients, and that the recipient be held responsible for use of such treatment.

8. That when <u>applying</u> for benefits it should be recognized by all parties that all monies involved are for treatment and rehabilitation, and abuse of such, reportable by any involved party, can be grounds for legal charges, discontinuance, and/or fines.

Over the past five years I have seen abuses which have resulted in death and permanent disability. I've consoled parents who've watched as their children become more and more ill. I've also seen people who have been diagnosed as schizophrenic, stop all drug and alcohol abuse, and resume normal lives. I've seen every imaginable combination of mental illness and drug abuse significantly improve when drug abuse stops.

For the love of God, as long as HHS/SSA allows, or turns a blind eye to this, a conservative fifteen percent of SSI recipients will without a doubt continue to become more ill, more dependent, more disabled. Mr. Gambino states that 1.5 percent of SSI recipients are strictly DA & A. I know of no one who works with this SSI population and understands substance abuse that will dispute the figure of 15%.

My investigation shows that one in every 250 Americans is affected by this nightmare. That's approximately one million people. There is an increasing amount of cocaine and drug abuse emergency room admissions across the country since the crack epidemic started. Concurrently, during this time there is a parallel increase in psychiatric admissions. This is not a coincidence.

Laws that directly effect one million people need to be enacted for their own protection. Projections of SSI recipients for the end of 1995 are close to 7 million people. The 15% I speak of are the close to one million people out there now suffering on the street, in the jails, in the institutions, who have no one to intervene on their behalf. Please, if you've ever suffered from the affliction or endured someone else's suffering from addictions, adopt these changes.

Chairman FORD. Thank you very much.

Dr. Flavin, there are some who have testified here today about the effectiveness of treatment. Can you elaborate? There is little agreement about the treatment. You have said it is effective.

Dr. FLAVIN. It is effective, but we have not considered the full range of services. We have considered treatment to be 28 days of inpatient interventions, whether that be in a general hospital setting or in a freestanding facility.

Generally, this 28 days of inpatient treatment was considered to be the gold standard for many, many years in our field. People then spoke of inpatient treatment and aftercare. And personally I do not use the term aftercare, although it is used frequently in our field, because it implies that there is a treatment and something that comes afterward. Treatment is a continuous, ongoing process.

Inpatient treatment for some is not necessary and for others it is. But it is only a first step in the process of recovery. I think people in the field are beginning to appreciate that. Some people may recover through attendance at AA alone. Other people will need to be in an inpatient program followed by some type of ongoing outpatient intervention. Others need to be in therapeutic communities, as we have heard today.

I have worked extensively in both inpatient and outpatient settings. I can tell you that there is a woeful inadequacy of therapeutic communities and residential treatment facilities, for example, in the New York area where I am most familiar with. It makes it very difficult and seriously limits our overall effectiveness if there are not adequate facilities that people can be referred to. Thus, we need to broaden our perspective. For too long that perspective has been too narrow. The accumulated research published in the literature prior to 1985 or 1987 is really analogous to apples and oranges.

Methodology is different and treatment populations are different and definitions of what people are treating is different. More recently (and that is why I quoted the NIAAA study), research is turning out to be very, very interesting and it holds a great deal of promise for the future.

Chairman FORD. They say that the first step to recovery is admission of the problem. In the cases that we are talking about with SSI recipients, if there is an admission of the problem and also treatment to solve the problem, or to try to get to the root of the problem, are we faced with obstacles to recovery if drug addicts and alcoholics fear loss of benefits upon recovery from their addiction?

Is that a problem for us as it relates to the treatment of addicts?

Dr. FLAVIN. That is a very good question. I have always thought about motivation for treatment, not in terms of what the patient thinks about on first entering treatment, for example, in a coerced situation where someone is remanded to treatment——

Chairman FORD. I am not speaking of the provider. I understand that. I am talking about the recipient.

Dr. FLAVIN. The recipient and their attitudes as time goes on. I believe that effective treatment includes and the component of the effective treatment that you were asking about before is encouraging personal independence.

Certainly the thrust of all of our efforts as a multidisciplinary team working, for example, in my treatment program or other similar treatment programs, lies in getting the person back into as much of an independent a position as possible. In the treatment program that I worked in previously, we had a very active occupational therapy program in an outpatient setting in which all the people coming into the program received an occupational therapy evaluation; this was made an integral part of their treatment.

Beyond this, I don't know that the data exists at the present time to really—to answer your question specifically. But it is something that I think treatment providers need to be aware of.

Ms. ROJAS-DEDENBACH. May I address that issue?

Chairman FORD. All right.

Ms. ROJAS-DEDENBACH. We do have experience, we have experience in this so I can talk to you from experience in dealing with the SSI drug addict. Yes, if we were to only put the person through treatment and then do a continuing disability review, and cease their benefits, it is a disincentive. We realized that from the get-go.

The important thing, however, is what you do in order to assure that that doesn't happen, that it is not a disincentive. And what we have done in Michigan is to assure that that person knows from the very beginning this is a rehabilitation course they are setting themselves into, and that includes using the Social Security work incentives.

If you are familiar with the Social Security work incentives as the person is recovering, they can start incorporating into their treatment plan a rehabilitation plan, a referral to vocational rehab, a referral to job training programs. It is critical at that point because that person then, by the time they are suspended benefits, you know, or by the time they go through a continuing disability review, then they will have the vocational plan in place and they may be eligible for continuing benefits while they are getting back on their feet, and that is part of the system now, Social Security work incentives under Social Security procedures.

By utilizing those, then we are not telling people that, yes, if you do get better, if you do recover, you are going to lose your benefits. By the time you get—your disability is reviewed, we want you to be in a rehabilitation program, we want you to be as close to employment and being self-sufficient as possible.

Ms. JONES. May I jump in on that for a second, also? Because, Congressman, you know in the welfare world we have said that most recipients don't want to be on welfare. They would rather be working and self-sufficient.

In the TC world, we believe that once a client has gone through the kind of behavioral change treatment program that we have put them through, their own desire and their goal at the end of it would be to be employed, to be self-sufficient, to be an independent and functioning member of the community, and not to be considered as eternally disabled.

So, at that point, I think it becomes a moot point. Yes, on both of these beneficiary rolls, welfare and disability, you will always have a few people who want to cling to the benefit, but optimally,

the majority of recipients would rather be out there making it on their own.

Chairman FORD. Well, I am not sure I am ready to place it in the same category, because if we go back and listen to Dr. Flavin, when we see what has led to the addiction in many of the cases that we are talking about, oftentimes, I think you will find joblessness. The same is true with the welfare population.

But when you look at Aid to Families with Dependent Children, in most cases, it is a woman who is head of a household and we are talking about alcohol being, I guess, the biggest addiction problem, probably way over the drug addiction. In many cases the effects of that addiction brings on a lot of the problems that we see in the welfare population, whether it is divorce, child abuse or other problems that we see.

This is not an area in which I have enough evidence to say the direction that Congress and this committee ought to be headed in. That is why we have the great panelists here today and we will hear from many more people throughout this country to try to get a hold on the issue.

But I am not ready to place SSI in the same category as AFDC. Over an 11-year period of looking at the welfare population of this country, I hear many people and voices throughout this country talking about people on welfare are lazy and don't want to work, but I don't find that to be the case.

I find in a vast majority of the cases people do want to work. But I am concerned about those who are addicted knowing that if there is a recovery, there are no jobs out here in America. There is not only a welfare jobless population, but there is a population of males in this country, that cross color lines, and they cannot find jobs. They have been addicted and it will be very difficult for them to move back into the labor market.

They know right away that health care benefits and a monthly stipend is a greater amount of money than any welfare check. I don't think any State anywhere in this country pays welfare benefits of $445 for one individual. And that is sort of strange.

I know SSI payments are received by both males and females, but if you look at the category that we are making reference to—drug addicts and alcoholics—I think you will find more males in this category than you will find females. These female head of households who take care of the babies in this country receive far less in benefits and oftentimes don't receive $445 for a family of four or five people.

I don't want to lump them together. There are a lot of similarities. We will be considering these similarities as we decide whether or not we should incorporate SSI reforms in the overhaul of the welfare reform package.

Ms. JONES. I hear you and I agree with you, and I think you have just made a point that I wish had been more addressed today across the board, because whether it is a welfare reform hearing, an SSI hearing or a UI hearing, it always seems to come down to the same question of whether there are enough jobs to support people, and if there aren't, how are they going to live.

Chairman FORD. That is what I am afraid of with this population. There are probably more stigmas with this population than

the welfare population—oftentimes this population can't go to the other side of town and knock on the door to get a job.

They are rejected before they walk in and if there is any sign of recovery, they know what will happen.

Eventually, we will have a health care package that that will eliminate part of the problem, but this is the beginning. We are incorporating this into the overall strategy of a welfare policy debate in the country.

My time is up. Mr. Camp, I am sorry.

Mr. CAMP. Thank you, Mr. Chairman. And I want to thank the witnesses for coming today.

I am not an expert in this area so I have particularly enjoyed learning from each of you and your testimony. Dr. Flavin, I have a question. Some of the people here showed me a study by the Institute of Medicine, I am sure you are familiar with them, on treating drug problems.

They indicate that the attrition from therapeutic drug communities is very high. They show that typically only 15 percent of admissions graduate after continuous stays in treatment. And in fact when readmissions are calculated, it is only between 20 and 25 percent, which means 75 to 80 percent of the people don't complete the program.

Could you comment on that, please?

Dr. FLAVIN. Actually on that particular study, I am not sure that I can, but I can comment on the phenomenon in general from a clinical standpoint. I would say that in my clinical experience, there are three particular areas that we need to address here.

The first is letting them know that treatment is out there and that help is available. Second, and this is at the point you refer to, is getting them to at least come in through the front door which is a major step for many of them because of denial; often they are not ready to stop using.

The third is in "capturing" them into treatment and retaining them in treatment, which is to a large extent very challenging. In the treatment program that I was involved with, we took a look at this. I kept informal statistics and approximately 20 to 30 percent of people that walked through the front door stayed for only one or two visits.

We looked at the reasons for that and one of the primary reasons was that we were expecting the alcoholic or addict to display a certain degree of motivation to get into treatment and to show us that first before we would then reach out and offer our treatment services.

And we learned from that experience, that indeed, at the point of entry, one must be very aggressive in terms of getting the person into treatment. If they don't show up for a treatment appointment, call them, make yourself available to them.

And as we did that, we found that our capture rate began to increase.

So, it is a very important point that you raise in terms of getting—attracting people into treatment and then keeping them in treatment once they are there.

Mr. CAMP. Thank you. I appreciate that. It seems that they don't stay. My time is going to go very quickly, so I wanted to ask a couple of other questions.

Ms. Dedenbach, you indicate in your testimony, you refer to weak noncompliance procedures. Would you favor random drug testing?

Ms. ROJAS-DEDENBACH. No.

Mr. CAMP. Tell me why.

Ms. ROJAS-DEDENBACH. I think you would be wasting your resources if you are doing random, because I would like to—and this gives me an opportunity to tell you that the clients—52 percent of the clients that we service do not comply at least once. But 72 percent go back to treatment and stay in treatment. And like the doctor was saying, sometimes it takes several attempts before the final "capture" is made, OK?

Now, when you do random testing, you are maybe testing people that don't really need testing. But if you test people that are potential noncompliers or potential relapsers—and some of us that are working with them day in and day out know that, then we can selectively test only those that are potentially noncompliant.

Mr. CAMP. I see. You would like some sort of targeted drug testing?

Ms. ROJAS-DEDENBACH. Exactly.

Mr. CAMP. And you talk about proof of abstinence, and that is the only way you can prove that, is through a drug test?

Ms. ROJAS-DEDENBACH. Exactly.

Mr. CAMP. You would not like to have it random, but more directed.

Mr. Anderman, I want to thank you for your testimony as well. You mentioned a couple of concerns, and one is, in your testimony, you would like to see us change the whole representative payee system. Is that my understanding of what you said in your written testimony or what your written testimony indicates?

Mr. ANDERMAN. Yes, sir.

Mr. CAMP. Also, you mentioned that no one should be allowed to receive disability payments for either drug addiction or alcohol without some form of monitoring; is that correct?

Mr. ANDERMAN. Absolutely.

Mr. CAMP. And if I understood your written testimony, you draw a difference between alcohol and illegal substances.

Mr. ANDERMAN. I do. It is very apparent to me we are giving a message that is mixed, as mixed can be. On the one hand, we jail people for years at a time, and on the other hand we say, have a check for $400, $500, have some free treatment.

Mr. CAMP. So you are saying, for illegal substances, no disability payments at all?

Mr. ANDERMAN. No disability payments in cash. I am not saying some type of treatment shouldn't be available for them. I am certainly saying absolutely under no conditions on earth should you give them cash.

Mr. CAMP. You say here the entire notion of making addicts to illegal substances eligible for disability payments is completely irrational, and by that, you mean cash payments?

Mr. ANDERMAN. Cash payments, correct. One has to understand that the primary symptom that a drug addict is going to exhibit is denial. That is a nice way of saying they are dishonest. And expecting a drug addict to take sums of cash when they are not monitored and to just do the right thing with it, it won't happen. It is just as assured that it can happen for 99 out of 100 people.

Mr. CAMP. So you are recommending drug testing for those who have illegal substance disabilities, or how would you determine if those receiving a benefit from the government are in compliance?

Mr. ANDERMAN. Urine screening is part of every standardized treatment format that doesn't have a restrictive setting. If the treatment center in one way can't, first, limit visitors, or second, keep the people inside, and you get a baseline on their behavior, then if they can't do that, then they go to the urine screening, either on a random or continuous basis.

The population that I work with that is also chemically dependent, medically ill, we demand that we have urine screens, because our chief psychiatrist is very concerned about them mixing prescription pharmacology drugs with whatever street variety they get ahold of. We don't want to take the liability for that, nor do the—the primary reason is, we don't want to help people die. If we find out they are using street drugs, our psychiatrist will put it in a choice "your drugs or my drugs, but not both."

Mr. CAMP. Of your caseload, how much of it is outpatient?

Mr. ANDERMAN. All of my caseload at present. What I am doing right now is that I would be arranging treatment, getting them in or I would be arranging their aftercare when they are getting out.

Mr. CAMP. Thank you, Mr. Chairman.

Chairman FORD. Thank you very much.

Let me thank the panelists for your testimony today. I thank all of you for coming out. Let me apologize for the length of the hearing. I know we had 45 minutes of vote on the House floor, but it was really out of our control here.

As we get ready to close, there are two questions here that were for the previous panelists from the minority side. I would like for these questions to be submitted to the witnesses, and sent back to be made a part of the record.

[The question to Mr. Schatz from Mr. Bunning and the response appears on page 137. Questions for the record for Mr. Anderman from Mr. Bunning and Mr. Anderman's responses follow:]

Q. What is the worst case scenario you have ever seen in the SSI program?

A. The worst case I have seen is a man who was a drug addict from age 16 until his death at the age of 42. During that time he was placed on SSI from the inception of the program until his death in 1992. He was hospitalized 72 times, resuming his alcoholism and addictions upon each release. During this time he also received over 30 medical hospitalizations in ER and medical floors along with countless hours of outpatient sessions and services from other social agencies.

The man's body was found in his apartment approximately 3 days after he drank himself to death.

In today's dollars he received treatment at a cost of over $1.5 million while his drinking and drug use never ceased. He personally scoffed at those offering help, knowing that no one could cut off his money. He continually abused the privilege of treatment, manipulating the SSI system in order to sustain his way of life and escape responsibility for his actions.

Q. How can SSI work? Aren't there guidelines in the Federal Register which outline how best to address abuses within the program?

A. SSI can work if we in the field can directly identify noncompliant recipients to SSA who could then begin monitoring procedures. Those who are noncompliant can and should be cut off. The savings generated from this would more than pay for the costs of monitoring.

There should also be a distinction between the benefits afforded those who use alcohol and those who use illegal drugs.

There should be mandatory reviews in which the recipient must demonstrate why they should be allowed to continue receiving SSI. Continuance of SSI should be contingent on the recipient's effort to overcome their disability during the preceding year—if the recipient displays no effort then their SSI should be discontinued.

There are too many thousands of people who do nothing to assure that eligibility for SSI is met.

Chairman FORD. Let me again thank you very much. That will conclude the business of the joint subcommittees of Ways and Means today. Thank you very much for coming down and being with us.

[Whereupon, at 4:05 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

ALTERNATIVE PROGRAMS, INC.

425 GOLDEN STATE AVENUE
BAKERSFIELD, CA 93301
(805) 326-0411

February 21, 1994

Janice Mays, Chief Counsel and Staff Director,
Committee on Ways and Means
U.S House of Representatives
1102 Longworth House Office Bldg.
Washington, D.C. 20515

Dear Ms. Mays;

This letter is in response to your request (Press Release dated January 26, 1994 announcing the Joint Hearing which was held on February 9, 1994) for statements concerning "exploring means of achieving higher rates of treatment and rehabilitation among alcoholics and drug addicts receiving Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) benefits".

From our point of view, as a contractor of a 240 bed, minimum security community corrections facility for the California Department of Corrections, the problem is glaring. Inmates are exchanging information for "the quick fix" of collecting SSI instead of conscientiously taking the steps to legal independent employment. It is no secret that alcoholics and addicts can file for and receive SSI benefits more readily than people with physical disabilities such as arthritis, heart conditions, emphysema etc. Inmates raise questions every day concerning " how to apply for SSI benefits before their release or how they can become eligible".

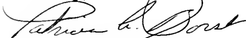
Last week an inmate asked how quickly he could file charges against SSA because they did not take action on his request last year. He was only out of prison a month or two last year, but he feels that the SSA "owes him six or seven thousand dollars". This is the first time that this inmate has ever been in a minimum security prison - he has always been a level 4.

Our company, Alternative Programs, Inc. has seen the need for alternative remedies for the traditional way of dispensing SSI and/or SSDI benefits to alcoholics and addicts for some time. We have been in contact with Gil Watson, District Manager of our local SSA offices for well over a year proposing solutions to this out of control problem.

I am enclosing the Idea Proposal that we sent to Mr. Watson in July of 1993. He subsequently sent it on to the State Office, who I was told, forwarded it to the Bethesda Office.

We are available and interested to asist in providing a solution to this critical issue. Not only are we wasting money, we are wasting lives. In effect, by supplementing a person's addiction without insisting on recovery treatment, we are sending a message to all people who are chemically dependent that he/she can continue the addiction and that the taxpayers will pay for it. We are reenforcing the problem not solving it. We are promoting the abuse and misuse of addictive substances as well as millions of government dollars.

Sincerely,



Patricia A. Borst,
Director of Program Development

API

ALTERNATIVE PROGRAMS, INC.

425 GOLDEN STATE AVENUE
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(805) 326-0411

July 8, 1993

Mr. Gil Watson, District Manager
Social Security Administration
5300 Office Park Drive, Suite 100
Bakersfield, CA 93309

Dear Mr. Watson:

This letter is a follow-up to our recent meeting in which we discussed the possibility of Alternative Programs Inc. developing a specifically targeted substance abuse treatment program locally. As we discussed, a program of this nature is much needed in this community as it is in many communities throughout the country.

There is a very concentrated segment of our society that is responsible for a significant percentage of the drug/alcohol problem. That segment is the public offender on felony parole who continues his or her substance abuse. Identifying chemical and/or alcohol addiction as a disability should, in theory, have a positive effect in assisting those individuals with this disability toward recovery. However, in the majority of the cases of Parolees, it has had a very negative effect. In many instances federal money has become a part of the problem rather than a part of the solution.

As you are well aware, California State parolees have learned how to manipulate the system and many are using their SSI funds to subsidize their addiction. This is accomplished through an arrangement with their designated "Payee" to give the money directly back to them (the addict/alcoholic) who in turn uses the money to buy drugs or alcohol instead of food and shelter.

Public awareness and outcry has not had an effect on curbing this situation! Even during those times when this problem was publicized, there was a dramatic increase in both applications and enrollment for SSI benefits by parolees.

The numbers are staggering! It has been reported that there are in excess of 20,800 chemically addicted individuals currently on the SSI roles in the State of California. More than 1,380 of these addicts/alcoholics are located in the Kern County area alone! Identifying exactly how many of these individuals are on State parole is difficult, however, according to California Department of Corrections and other sources, an informal estimate places more than 50% of them on parole. (We feel that identifying and keeping track of these parolees might be another area where we might be able to be of assistance.)

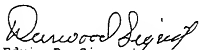
Given these outrageous numbers and the fact that each individual receives approximately $620.00 every month, there are millions of tax dollars which flow from the U.S. government through the hands of "illicit payees" into the coffers of drug suppliers through the addicts or alcoholics who spend their SSI money to buy drugs or alcohol which is being injected, inhaled or ingested.

Even though alcohol abuse is not usually associated with criminal involvement, it is the #1 cause of death in the U.S. today. Not only does it claim the lives of the alcoholic, it also kills millions of innocent victims through violent crimes or drinking drivers.

This is obviously a deplorable situation, but it is not the fault of any of the government agencies involved. A general lack of any mechanism for coordinating between levels of government and their agencies has allowed the manipulative minds of some to take advantage of the system. We would like for you to consider our "idea" proposal that you will find enclosed. We feel that our proposed program and services would have the capability to effectively provide a solution to these aforementioned problems while it saves lives and taxpayer dollars.

We will appreciate your thoughts about our summary proposal and any suggestions that you have as to how we might implement it as expeditiously as possible. We will submit a full proposal with a completed budget upon request. Thank you for your interest and consideration.

Sincerely,



Edwin D. Sigrest
Alternative Programs Inc.

ALTERNATIVE PROGRAMS INC.
425 GOLDEN STATE AVENUE
BAKERSFIELD, CALIFORNIA

SUMMARY PROPOSAL

FOR

SUBSTANCE ABUSE TREATMENT PROGRAM
TO SERVE SSI RECIPIENTS BEING SENTENCED
OR PAROLEES APPLYING FOR SSI

I. PROGRAM SUMMARY:

Program would provide RECOVERY TREATMENT; LIFE SKILLS and EMPLOYABILITY TRAINING, as well as FOLLOW UP and AFTERCARE SERVICES for: 1.) new or repeat offenders (who are receiving SSI benefits for chemical addiction) as an alternative to longer term prison sentencing; or 2.) to parolees applying for SSI benefits as a voluntary detox and recovery treatment program before they are officially enrolled for SSI payments.

This program would solve most major causes of fraud and misuse of SSI benefits by: 1) assigning an impartial payee; 2) initiating an intensive program which would focus on recovery and responsibility; 3) teaching money management and other life skills that are crucial to survival without drugs, alcohol and crime; 4) establishing ongoing support systems after release; 5) and encouraging self-sufficiency through education and employment.

By using a combination of SSI funds and supplemental funds from California Department of Corrections, both departments would realize a substantial savings. Tapping into Job Training Partnership Act money could help defray expenses, provide job readiness/retention training and other employment assistance. The objective of the program would be to successfully rehabilitate and transition as many of these individuals as possible from tax receivers to taxpayers.

II. STATEMENT OF PROBLEM/NEED
(Causal Factors, Target Population, Resources Needed)

Inmates, particularly in California, have become aware that SSI benefits are available based upon their substance abuse disability. They have been encouraged to apply for these funds by both public and private organizations, as well as the inmate "grapevine". This inmate rumor mill has been the single most effective recruiting system at work. Most inmates apply immediately upon their parole and some even try before they are released. The numbers of these recipients has increased dramatically over the past several years.

The first facet of the problem develops when the "Payee" is selected. If the client is allowed to have input into the selection, he/she will most certainly favor someone who will be amenable to releasing his benefits back to him/her. This of course results in the SSI benefits being used to purchase drugs or alcohol. If the Payee is selected for him/her and the Payee refuses to cooperate with the client/parolee, problems begin to develop with the relationship. This happens very frequently and the client/parolee then returns to SSA demanding that someone else be designated as his/her payee. Some clients return numerous times to change payees. SSA is forced to use a great deal of time and resources as it is forced to take on the role of "Enforcer" while trying to resolve these reoccurring problems. This is valuable time and money that could be spent in much more productive ways serving the legitimately disabled instead of those who are taking advantage of the system.

Another problem is that there is no correlation between the client's success in overcoming his/her addiction and the termination of his/her SSI benefits. There may even be a reverse result. If a client/parolee successfully becomes drugfree/sober, his/her $620.00 per month is terminated. This gives the recovering person no incentive to get transitioned from addict/alcoholic to reputable taxpayer in the world of work and self-sufficiency. These individuals need an adjustment period with a significant support system to ease them into independence.

Although there is a monitoring agency assigned to oversee chemically addicted SSI recipients and refer them to programs, this agency has little power to expressly deal with parolees or offenders. As a matter of fact, nowhere is there a tabulation of just how many of these recipients have been incarcerated or have been involved with unlawful behavior. Although these clients may be referred to a traditional recovery program, no one follows through with aftercare to assist the client through the steps to self-sufficiency.

Our target population then, needs to be those individuals diagnosed as having a chemical addiction disability who have a criminal background -- either with new or repeat offenses. It is realistic to assume that most of these individuals have a history of not only substance abuse, but also family abuse or violence, insufficient education, poverty and of course, a criminal history. Within contemporary society, individuals coming from these backgrounds are traditionally relegated to and thought of as "the underclass". They are set apart from the class structure that characterizes social status. (In many analyses, social class status is defined in terms of employment and income potential). Factors that promote achievement are neither operative or available to the underclass.

Within the barrier or wall of the "underclass", alternatives to success are almost non existent and most of these individuals are forced to wait for assistance from beyond the "wall" or to turn to drugs/alcohol, crime and welfare. Their efforts are focused on resolving immediate crisis situations as best they can.

Crisis management and problem-solving skills are constantly practiced although frequently through patterns of ineffective solutions, self destructive behavior (substance abuse) or other maladaptive patterns (crime). When this happens, the addiction becomes just another symptom of the problem and not the whole problem. Because these individuals have used only survival skills and have no real "life skills", these problems compound and hopelessness, helplessness and desperation erode any last bits of self esteem and confidence that might have been present. The individual no longer knows how to function in normal settings. He/she has been programmed for failure --- frequently this means a lifetime of social dependence.

If there is any hope for him/her to overcome this dependence, he/she must be "reprogrammed". This kind of "reprogramming" can not be achieved through traditional recovery programs alone and certainly not through "warehousing" in a prison.

What type of services can best address all these needs? The answer is to utilize the effective resources of an efficient organization to provide alternative programs which could be supported through the coordination of funding from SSA and CDC, with perhaps other grant or J.T.P.A. sources.

III. PROPOSED SOLUTION/PLAN
(Desired Impact, Beneficiaries)

Clearly, a program needs to be put in place that will answer the multitude of needs both for the clients and society as a whole. This program must address the problems of addiction - both to drugs/alcohol and to social dependence, as well as the tremendous waste of federal and state dollars.

API proposes to establish a substance abuse treatment program for those public offenders who are on the SSI roles or to those who are on parole who are applying for benefits. The program will have both in-patient and out-patient phases. The California Department of Corrections (CDC) could serve as the Payee for those cases under it's jurisdiction. API will serve as CDC's agent and administer the SSA payee program for those offenders or parolees assigned to it.

API will use the SSI funds to pay rent, buy food and other allowable items. None of the funds would be given directly to the addict/alcoholic client.

Each CDC parolee (in Kern County) who applies for SSI benefits for chemical addiction disability, will be referred to API immediately and be placed on the monitoring program. API will provide case management to other services such as employment referrals, agency referrals, community resource brokerage, drug testing, substance abuse program (SAP) counseling etc., as needed by the client.

In the event that drug use is detected, CDC will determine whether the public and client's best interests would be better served by a more intensified substance abuse treatment program. The client will then be offered the opportunity to voluntarily enter API's in-patient program.

New or repeat offenders who are currently receiving SSI benefits and are being sentenced for offenses that involve drug or alcohol abuse could also be referred by the courts for entry into the alternative program in lieu of traditional sentencing. The program will be voluntary, so SSI benefits would not stop, but instead be diverted toward the cost of board and care during an inpatient treatment program. The SSI funds would help to reduce the actual cost of board and care. CDC would then pay the balance.

After the inpatient treatment of thirty to eighty-nine days, the client would transfer to the second phase of the program - monitoring and aftercare. During the inpatient phase and continuing throughout the outpatient phase of the program, the client will receive basic life skills training that will teach and encourage responsibility and independence.

Learning to manage their money and priorities will instill self-esteem and confidence. Referrals to further SAP counseling, literacy, vocational or educational training, assistance with job procurement and other resources will assure personal empowerment for all clients. Empowerment includes the recognition that change ultimately requires acceptance of personal responsibility for one's own life by taking charge, developing self confidence, setting goals and recognizing that he/she is in control of his/her own destiny - successes or failures. Clients will be given the opportunity to acquire life skill competencies necessary to "play the game of life" outside "the wall", where the rules are different. Different skills, strategies, orientations, values and approaches must be learned and applied. Each SSI client will be assisted in developing a PASS plan.

The API program is unique in that its' program becomes part of the recovery process. It does not replace other programs, but enhances them by dealing with the real life issues of responsible work ethics, staying on the job and dealing with the day to day problem of relapse prevention. Our program enhances the efficiency and success of SSA, CDC and other agencies by becoming partners with them to assist and monitor client progress and to intercept potential problems and eliminate wasted benefits.

Although this is a tremendous undertaking, API believes that it is possible and even necessary for this type of program to be put in place. Realisticly, everyone can not be saved, however a program such as the one we propose will allow this target group the opportunity to transition from the ranks of the "underclass" to the status of a productive taxpaying member of society. The choice is theirs. In the meantime, society will have benefitted by saving millions of federal and state dollars which could be used better for education or medical care.

ADVANTAGES/OBJECTIVES OF THIS SOLUTION:

1. This program will provide a much needed substance abuse treatment program for a segment of the community who could not otherwise afford one and who would go untreated. API, in the coordination of resources role, will be able to refer/provide the client assistance with a wide range of needs through a planned, integrated and monitored delivery system which would include continued random drug testing.

2. This program will create an environment where it will reduce the number of SSI applicants who are unmotivated to rehabilitate. New strings attached to SSI benefits for substance abuse disability will discourage application from those who are seeking another method to support their addiction.

3. The API monitoring program will save considerable federal tax money by insuring that those on SSI roles who are arrested or abscond will be removed from SSI roles quickly.

4. The program will save considerable state tax money by appropriately providing a place for detoxification and treatment for individuals in lieu of returning them to prison.

5. API, as designated payee, will insure that the SSI funds awarded will provide the needs for which they are intended.

6. API, as designated payee, will relieve SSA from considerable cost, time and misdirected energy in assigning and reassigning payees.

7. This program will give the public renewed confidence that the inequity has been corrected and that their tax dollars are being spent wisely. SSI BENEFITS WILL THEN BECOME PART OF THE SOLUTION RATHER THAN PART OF THE PROBLEM!

8. By combining federal and state resources in the in-patient phases of this program, both CDC and SSA will realize options here-to-fore not available for the care and treatment of their mutual clients. This in turn will make more efficient use of existing tax dollars and IT WILL NOT REQUIRE ANY NEW DOLLARS!

9. Although the out-patient phase will be more directly advantageous to SSA in providing efficient use of tax dollars, there will be major advantages to CDC in reduced numbers of arrests for new crimes and returns to prison which in turn will reduce prison overcrowding and free up state beds. These areas require considerable time, money and manpower to process and operate.

10. Each client will be assisted to develop a PASS plan and receive monitoring services until he/she has transitioned into an independent lifestyle. Ideally the program would be for a period of twelve months, however this could be less or more (with the benefit of support groups) depending upon the individual client.

IV. BUDGET/COST
(Complete Breakdown of Costs, Other Support will be provided with submission of complete proposal upon request)

The cost of the API program would be no more and perhaps substantially less per individual than traditional incarceration.

SSI benefits could be used as a base payment for board and care during the inpatient phase. This is exactly the same amount that would be spent for unsupervised/untreated clients. CDC could pick up the balance of approximately $1,000.00 to $1,250.00 per month per client. This represents not only board and care, but also a complete substance treatment program. This is a savings of $500.00 or more per month if the individual were housed in a traditional prison setting. The CDC's commitment to each individual client would also be for just a few months instead of years of traditional sentencing.

The Aftercare/Monitoring phase would be contracted with SSI for a nominal monthly charge per client. Auxiliary funding (such as Job Training Partnership Act money) could be applied for to assist in educational/vocational training and job procurement. Existing community resources would be utilized to defray other expenses.

Feb. 10, 1994

Janice Mays, Chief Counsel & Staff Director
U.S. House of Representatives
1102 Longworth House office Building
Washington, D.C. 20515-6348

RE: Social Security
(This is a written statement for the Ways and Means Committee meeting on the issue of Social Security)

My name is Vicki Berchtold. I have (until Dec. '93) worked for 7 years at a homeless shelter for women and children in Peoria, IL.

I am writing in regards to people who have an alcohol or drug problem and are receiving Social Security. I have seen a major increase in homeless residents who are receiving SSI or SSD because of their substance problem. I am alarmed at this increase. What I typically see is a resident receiving their check and then going out and blowing it on their drug of choice in 24 to 48 hours. Many have no payee and are not even required to get into treatment. The government is ENABLING the substance abuser to continue their addiction.

Explanation of Social Security:

A) SSI: A person who has a primary diagnosis of a substance abuse problem must have a payee and be seeking treatment. A person who has a substance abuse problem as their secondary diagnosis is not required a payee or to be in treatment.

B) SSD: A person who has a primary diagnosis of a substance abuse problem does not need a payee or need to be seeking treatment.

Observed problems with the Social Security Program:

A) Payee's: A payee could be a relative or friend. I have seen payee's who have a substance abuse problem, and when the check comes they both go out and use.

Social Security requires that the payee be accountable and to keep track of how the money is spent by saving receipts, but this is not enforced.

It is very difficult to find a responsible person who would be willing to be a payee. Very few social service agencies allow their employees to be payee's because of the responsibility, amount of time and the frustration level of not allowing an addict to use their money on drugs.

Some payee's use the money for their own benefit and the recipient does not receive their full amount.

B) No payee: I have seen homeless resident receive their SSI or SSD check and within 24-48 hours they have blown their money on their drug of choice.

C) <u>Treatment:</u> Though treatment is a requirement for SSI, I have never seen anyone checking if a person is looking into or going to treatment. I have never seen a person cut off because they are not going to treatment.

Treatment is very difficult to get into because of the past government cuts. In the Peoria area several treatment programs have closed or have had to cut back in personnel and occupancy. There is a major lack of treatment space/programs that a person could get into if they so desire.

<u>Suggested Changes:</u>

A) Whether substance abuse is a primary or secondary diagnosis for SSI or SSD, a payee should be required. A better monitoring system regarding payee's needs to be instituted.

Some suggestions are:

1) Payee should not be another substance abuser, bar owner or another SSI/SSD person who is suppose to have their own payee.

2) Enforcement of turning in receipts from payee of how the money was spent. Example: rent, food, and phone.

3) Designate specific person(s) at each Social Security office to be payee's for people who can not find an appropriate payee.

B) Enforce the policy that they are to be in treatment. This should also include SSD recipients.

1) More federal money is needed to increase the number of substance abuse programs.

2) A voucher system could be used to pay for treatment.

3) Drug testing (drops) should be required of substance abusers and if they are found using then they should be cut off.

4) A person should be required to enter a treatment program within 30 days and then complete the program or be cut off. There needs to be much stronger enforcement and follow through regarding this issue.

Thank you for reading and considering these concerns.

Sincerely,

Vicki Berchtold MSW

Vicki Berchtold MSW

CALIFORNIA STATE DEPARTMENT OF SOCIAL SERVICES TESTIMONY FOR HEARING TO EXPLORE MEANS OF ACHIEVING HIGHER RATES OF TREATMENT AND REHABILITATION AMONG ALCOHOLICS AND DRUG ADDICTS RECEIVING FEDERAL DISABILITY BENEFITS

My name is Eloise Anderson and I am the Director of the California Department of Social Services (CDSS). The CDSS wishes to express its appreciation for the level of Congressional interest being shown for problems and issues in the administration of the SSI/SSP program as it relates to alcoholics and drug addicts. Given California's extensive and continuing experience with adjudicating the disability claims of alcoholics and drug addicts, plus the significant adverse publicity that has been given to the program, your interest and concern are welcome and shared by the CDSS. Following are suggestions for legislative and other reforms that we feel would cause significant improvement to the program. We either have or will be advocating these changes in federal law and administrative practice to improve the integrity of the program.

ALCOHOL & DRUG ADDICTS SSI/SSP CASELOAD INCREASES

The increase in the SSI/SSP disabled drug addicts and alcoholic (DA/A) population should not be characterized as resulting from "efforts by States to shift their welfare caseloads to the federal government." First, under federal law a state must refer a drug addict or alcoholic who appears to meet current Federal disability standards to the SSI/SSP program. This referral is not a matter of discretionary "shifting." Second, in states like California, the "shifting" of disabled drug addicts and alcoholics from county welfare caseloads to SSI/SSP, to the extent that this occurs, often results in significant new state costs rather than federal ones. This is because: 1) California adds a substantial supplement to the federal SSI payment, and having persons added to the SSP caseload adds to state costs, and 2) the federal government uses any income an SSI/SSP receipient has to first offset the federal portion of the grant: if any income remains after the federal benefit has been reduced to $0, only then is it used to offset the state portion of the grant. In California, a majority of recipients have other income, such as Social Security or a pension, and as a result many recipients receive an "SSI check" that contains little or no federal money. In summary, while SSI/SSP certainly reduces a county's welfare costs, the cost of doing so is often borne by the state.

THE IMPACT OF OUTREACH AND THE CDR MORATORIUM

The Social Security Administration's (SSA) increased outreach efforts are undoubtedly one cause of the growth of the DA/A caseload. We understand that these efforts are the result of directives from Congress to SSA and that Congress substantially increased appropriations to SSA for this purpose.

We believe that another, and more significant, cause of DA/A caseload growth is the moratorium on continuing disability reviews (CDRs) that has existed for the last three years. CDRs are supposed to be done periodically on all disability cases to determine if the recipients remain disabled. The CDR moratorium was imposed by SSA due to the workload pressures on the State Disability Determination Services to process new claims. The current limited ability to perform CDRs means that recipients who are no longer disabled (including DA/As) can continue to receive SSI/SSP benefits indefinitely. States like California that are experiencing difficult economic times cannot afford to bear these unnecessary costs, and neither should the federal government. Further, we suggest that the integrity of the SSI/SSP program will be impugned over time by the provision of benefits to persons who are no longer disabled. We urge the Congress to adequately fund the Disability Determination Services to conduct CPRs to assure that only those who are eligible for the benefits have access to them.

REPRESENTATIVE PAYEES

We agree with those critics who contend that there are problems with family members and friends serving as representative payees for drug addicts and alcoholics. This is particularly a problem where the recipient is abusive of the representative payee, which often leads to subsequent misuse of SSI/SSP benefits. To address this, California urges Congress to consider requiring institutional representative payees for SSI/SSP recipients who are drug addicts or alcoholics. Such institutions could include the drug treatment centers that would treat these recipients' addictions, nonprofit community based organizations (CBOs), County Welfare Departments, and the like. As indicated in the announcement for these hearings,

family or friends who truly want to use the benefit for the DA/A recipient's basic needs, instead may be intimidated or abused into giving the money to the recipient for drugs and alcohol. It should be noted that the existing federal law, which allows certain nonprofit CBOs to act as representative payees for SSI/SSP recipients, is working effectively for many DA/A recipients. This additional effort is funded at a cost of $25 per month from the recipient's SSI/SSP grant. Unfortunately the number of CBOs that can qualify to act as payee is limited by some restrictive provisions of federal law, including one which limits participation to CBOs that existed on October 1, 1988.

It should also be noted that if institutional payees were exclusively in control of DA/A recipients' funds, the administratively costly option of a voucher system would not have to be considered.

RETROACTIVE PAYMENTS

There has been considerable negative publicity about alcoholics and drug addicts using retroactive payments to pay for alcohol or drugs. Using this sometimes large, albeit temporary financial resource, some of these recipients become so involved with their addiction that they sever contact with their families and social service agencies, in some cases permanently.

To counter this problem, California urges the Congress to consider holding retroactive benefits for recipients in a special treatment account which would be used to defray the costs of alcohol or drug rehabilitation treatment for these recipients. We do not propose that this provision supplant the Interim Assistance Reimbursement plan in place. Rather, it should be implemented with retroactive benefits remaining after local assistance costs have been reimbursed.

MANDATORY TREATMENT

In California, SSA contracts with an outside Referral and Monitoring Agency (RMA) to oversee DA/A recipients' treatment plans and to monitor recipients'attendance. As part of the RMAs responsibilities, it is also required to report treatment non-compliance on a timely basis to SSA.

The actual provision of treatment can be problematic, since it is easy for recipients to avoid treatment. According to federal regulations, treatment must be both available and appropriate. Any treatment facility whose access requires the use of public transportation may be deemed "unavailable" because the recipient has to pay for transportation. If the appropriate treatment is determined to be in-patient treatment and there is no bed available without fee, the treatment is considered to be "unavailable". If the facility requests a nominal fee or co-pay for any type of treatment, it may be deemed inappropriate because recipients cannot be required to pay for treatment. In such cases, the recipient states that it is "too difficult" to attend a treatment program and SSA will waive that provision without suspension of benefits. As a result, it is probable that these recipients are using public funds to continue their abusive habits while successfully avoiding all treatment, with no detrimental consequences. Purposeful avoidance of treatment will be eliminated by enacting the requirements below.

California recommends that before SSI/SSP payments could begin for a DA/A recipient, the DA/A recipient would be required to be registered into and regularly attending an approved treatment program for a period of thirty days prior to benefits being paid. The RMA would have a greater responsibility for screening applicants, enrolling them in an appropriate treatment program, and monitoring them to assure their required attendance. The RMA would also be responsible for immediate action should it determine that the recipient is not meeting his/her required treatment program.

California also urges that monitoring requirements be tightened and strengthened to ensure compliance with requirements for treatment. Current monitoring requirements include consequences for non-compliance which can be avoided by a recipient's claiming of hardship. The RMA may or may not report such non-compliance on a timely basis and SSA may or may not react on a timely basis. While recent budget cuts and resulting work backlogs have affected this aspect of the SSI/SSP program, we have received complaints that the RMA seldom responds to non-compliance reports. Although suspension of the DA/A recipient from the SSI/SSP program for non-compliance with treatment requirement is currently required, this is not always done. California urges the Committee to require the

RMA to submit a monthly report on each DA/A recipient, indicating their compliance or non-compliance for that month, rather than a cumulative statistical report.

In the event of continued non-compliance, current regulations require a recipient's permanent suspension from the program. As this is not always done on a timely basis, California requests closer supervision by SSA to ensure compliance with existing regulations.

BENEFIT TIME LIMIT

A reasonable time limit should be imposed for a drug addict or alcoholic recipients's successful completion of treatment. This can be determined by the case worker or professional assigned to the individual's treatment program and would allow recipients to progress at their own pace. While we agree that society has an obligation to help alcoholics and addicts regain productive lives, there ought to be limits on that obligation. Further, we must assure that there is an individual obligation as well. It is inappropriate to expend United States government resources to continue to support alcohol or drug addiction. As a result we recommend that SSI/SSP benefits be made contingent upon a recipient's continued progress in treatment, up to a lifetime maximum of 24 months when the disability is based on alcohol or drug addicition.

SUMMARY

California urges Congress to support the proposals detailed in this statement of testimony. In summary we are proposing the following:

- Require that alcoholics and drug addicts have institutions or community based organizations as their representative payees.
- Use retroactive SSI/SSP benefit payments to fund the treatment costs of alcoholics and drug addicts.
- Require 30 days participation in an approved treatment program before SSI/SSP benefits could be paid to alcoholics or drug addicts.
- Review and strengthen treatment monitoring practices.
- Establish a 24-month lifetime limit on the receipt of SSI/SSP disability benefits where alcohol or drug abuse are causative factors to the disability.

FOREVER FREE/CATHOLIC CHARITIES

4539 S. Wells
Chicago, Illinois 60609
(312) 548-9500
Betty McDaniel, Founder/Program Administrator

Date: February 21, 1994

AVAILABILITY OF TREATMENT:

It is Forever Free's postition that we concur with the sentiments of practically everyone from both professional and non-professional perspectives with regards to the fact that the effects of drug use/abuse has and continues to devestate our families and communities at an alarming rate. The insidiousness of this epidemic (drug abuse) increasingly dishevels our moral fabric and appears to critically injure the coping mechanism of the institution of our families.

In framing Forever Frees's response to the Honarable Andy Jacobs, Jr. (D., Ind.), Chairman, subcommittee on Human Resources, committee on Ways and Means, U.S. House of Representatives; and also with equal respects to Janice Mays, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives,--let it be said that this organization (Forever Free) ascribes to the "disease concept" relating to addictions and recovery; which is well documented and supported in the current literature regarding substance abuse.

It has been Forever Free's experience that there continues to not only be a shortage of viable treatment facilities (especially inpatient) --but also, there appears to be a " bottleneck " with regards to the service delivery system. This is especially true for those with marginal insurance coverage or those whom have no insurance at all.

Currently, people seeking treatment may phone an agency to receive assistance, yet, because of the bottleneck in the system -- they may not receive the needed critical attention until 5 or 6 weeks after the initial "outreach" for help. Meanwhile, these individuals may lose their lives, commit crimes, neglect their households, and significantly compound their difficulties because of the waiting period. It must be understood by the reader and by the casual observer of the matter just described , that we cannot afford the hauteur of indifference by believing, "Well, you did it to yourself so you'll just have to wait." It behooves all of those involved in the structuring and the refinement of the rehabilitation service delivery system, that it is necessary to "strike the iron when it's hot" --when responding to individuals afflicted with the menance of addiction. Individuals with drug addictions usually don't clamor for assistance until a crises. It must be understood that this behavior is an inherent pathological characteristic of the disease process itself. Therefore, it seems that it would be prudent for the rehabilitation service delivery system to acknowledge this paradoxical behavioral symptom and provide effective strategies.

Hence, the availability and "timeliness" of treatment must be essential when ascertaining "treatment" to restore individuals afflicted with this seemingly "cursed", yet , all too common ailment.

Ideally, the rehabilitation service delivery sytem should have in its arsenal, an array of emergency drug treatment centers. These emergancy drug treatment centers should be strategically located, whereas, a volume of individuals addicts immediately screened, detoxed and

referred to appropriate treatment facilities and recovery homes.

More Wholistic recovery homes are needed, much like the concept established here at Forever Free. The Forever Free concept provides a safe, structured nuturing family like environment for women and their children. This concept differs from the "traditional" half-way house in that this recovery approach focusses on the spiritual, mental and physical well-being of the individuals involved. The goal is to return the person afflicted with an addiction to a productive and effective citizen on a long-term basis. The recovery home is staffed with professionals 24 hours a day, and case management occurs in-house. Nutritious wholesome meals are served, which does not include pork , red meat, sugar or junk food. Staff provide the guidance and as the residents make progress, they encourage one another and begin to turn their lives around.

With all of the abandoned buildings that blight our inner cities, the reovery home concept is an approach that warrants further review. While this concept is in its infancy, preliminary results appear promising. Members of the Subcommittee are welcome to visit Forever Free to review this concept to determine its merits.

Without question, more funding is desperately needed to increase the array of treatment options including detox units, 28 day treatment programs, outpatient programs, half-way houses and recovery homes. Essential studies and new program inititative are needed to ascertain the viability of "new concepts and approaches" to the treatment of drug addiction.

We must continue to strive to eradicate the scourge of drugs from our children, our friends, co-workers and loved ones to ensure a strong America as we approach the 21st century.

<u>REPRESENTATIVE PAYEE:</u>

Embodied in the background of Press Release #9; Subcommittee on Social Security Committee on Ways and Means, U.S. House of Representatives; the GAO admittedly found little enforcement of the requirement that SSI beneficiaries who are disabled by alcoholism or drug addiction participate in treatment as a condition of eligibility. This was attributed in large to SSA funding limitations to Referral and Monitoring Agencies. Therefore, our legislators should prioritize funding so that the enforcement of the stated requirements are adhered to.

It is Forever Free's position that more institutions and social agencies should serve as representative payees. It is believed that such an arrangement would increase the accountability of the person addicted to drugs. Drug screeenings and the appropriate follow-up could continue, as the addicted person could hopefully progress towards recovery.

As stated in a 1989 hearing, held by the Subcommittee on Social Security and Human Resources, drug-addicts and alcoholic SSI recipients were serving as representative payees for each other. Even with the 1990 reforms enacted by congress to prevent this kind of abuse-- it appears evident that these problems with the representative payee program continue to exist at an alarming rate.

The GAO has acknowledged that of the SSI drug addicts and alcoholic recipients, that only 2% of institutions and 4% of social agencies act as representative payees. It is Forever Fress's position that the abuse of the representative payee system would significantly decrease if organizations and facilities within the treatment arena would serve in this capacity (representative payees).

More studies are recommended to ascertain effective approaches to systematic changes to reduce this difficulty.

81-535 O - 94 - 7

Written Statement to the Subcommittee on Social Security, Committee on Ways and Means

From: Mary Ann Anderson, Executive Director
The Illinois Alcoholism and Drug Dependence Association (IADDA)
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217/528-7335 FAX: 217/528-7340

Submitted in response to press release #9 regarding the hearing scheduled for February 9, 1994.

The SSI Program has an important role to play in health reform. Some alcohol and other drug addicted people are, in fact, disabled by their illness; and they are in need of extended treatment in a community program. SSI can provide the necessary funds for room and board in a safe, drug-free halfway house or apartment, while the individual is treated on an outpatient basis for their addiction. This can enable the SSI recipient to obtain the vocational training or education as well as job placement.

Most of the problems associated with SSI now, are directly linked to the shortage of substance abuse treatment for public-pay clients. ADM block grant monies, state funding, and Medicaid do not pay for enough residential treatment beds or outpatient services. Medicaid prohibits treatment in facilities of 16 beds or more, thus driving up costs and reducing capacity. An estimated 10,000 people are waiting for treatment in public-funded "slots" in Illinois alone.

An expert panel should be convened to examine SSI and its role in support of health reform and welfare reform. These dollars can be spent far more wisely, and will produce a tremendous savings for federal and state governments.

Individuals who receive substance abuse treatment have sharply reduced medical bills. A large number of studies have proven this cost-offset occurs. In Illinois SSI recipients were studied in the mid-1980s and it was found that $2 were saved in medical bills for every $1 that was spent on substance abuse treatment (within the first 12 months following treatment). Over a 22 month period $5 were saved as a result of that $1 investment in treatment. [Copies of these studies are available from the Illinois Alcoholism and Drug Dependence Association (IADDA) office.]

The House Ways & Means Committee is ideally suited for examining and resolving the SSI problem, so that individuals, families, and communities benefit. SSI is an important piece in the puzzles of welfare reform and health reform.

TESTIMONY OF MITCHELL S. ROSENTHAL, M.D.
PRESIDENT, PHOENIX HOUSE

As president of Phoenix House and a treatment professional with some 30 years experience in the treatment of drug abuse, I am grateful for the opportunity to submit testimony, for the record, to the subcommittee about the treatment of substance abusers receiving SSI benefits.

Phoenix House, which is the nation's largest private, non-profit drug abuse services agency, operates 16 treatment centers in three states and provides a full service continuum, from prevention and drug education to long-term residential treatment. The overwhelming majority of our program participants -- more than 1,600 -- come from the "hard core." They have been heavy, high-risk abusers of the most destructive illicit substances and require the demanding and comprehensive long-term residential regimen offered at our adult treatment centers and Phoenix Academies (residential high schools for adolescents in treatment).

As the subcommittee knows, there are more than a quarter million substance abusers of all kinds receiving Disability Insurance and SSI benefits. The great majority of these abusers have been granted benefits for reasons other than substance abuse. A certain number, however, receive SSI benefits solely because of their substance abuse. They are enrolled in a special DA&A (drug addiction and alcoholism) program, the size of which has increased dramatically of late, from 17,000 in 1989 to 70,000 by last August.

Substance abusers in the DA&A program are required to take part in treatment and can receive SSI payments only through a representative payee. However, the General Accounting Office, when examining the program, was able to verify records of treatment for just 20 percent of the DA&A population, and prior testimony to this subcommittee has indicated the inability of many representative payees -- particularly friends and relatives -- to prevent substance abusers from using their benefits to support their addiction.

Too Many DA&A Recipients or Too Few

A major question at these hearings has been the reason for such a rapid rise in DA&A beneficiaries during the past few years. And,

while I can offer no better explanation for the program's recent rate of growth than have other witnesses, I feel obliged to point out that -- from my perspective as a drug abuse treatment professional -- 70,000 recipients seems a relatively modest number.

There are, according to the Institute of Medicine, about 5.5 million to 6 million Americans in need of drug abuse treatment. The Office of National Drug Control Policy estimates that roughly half this number -- 2.7 million -- are "hard core drug users." These are the men, women, and adolescents whose drug abuse drives our most intractable social problems and whose disordered behavior is largely responsible for the rise in adolescent violence, child abuse, homelessness and other manifestations of social disorder, including the spread of AIDS and TB.

Here is a population of close to three million, among whom we may conservatively assume that one-to-two million are disabled by drug abuse and in need of long-term treatment. But very few receive SSI benefits, for the GAO reports that most of the 70,000 in the DA&A program are alcoholics. Barely 11,000 are users only of illicit drugs and slightly more than 20,000 use both drugs and alcohol. This means that only about 32,000 of the one-to-two million disabled drug abusers in America are receiving the benefits to which their disability entitles them.

Today, in the New York treatment centers of Phoenix House, there are more than 900 adult residents -- but only 18 receive SSI disability benefits. In California, where we treat some 140 adult residents, only six are on SSI.

It has become all but impossible for drug abusers in treatment -- even long-term and demanding 24-hour-a-day residential treatment -- to qualify for federal disability benefits. And I would urge this subcommittee, in reconsidering the DA&A program, to seek ways of ensuring that those for whom these benefits were designed have access to them.

In New York, long-term residential treatment for drug abusers was first made possible by establishing the eligibility of addicts for benefits under the old federal welfare category of AID to the Disabled. Today, almost all residents at the New York treatment centers of Phoenix House are rejected for SSI but qualify instead for state home relief. This places an unfair burden on New York taxpayers, for a welfare cost that once was shared by the federal government is now borne by state and local government alone.

Subsidizing Substance Abuse

While there is need to re-examine eligibility for the DA&A program -- and, I would hope, make admission easier for drug abusers engaged in appropriate residential treatment -- the failure of most DA&A clients to meet treatment requirements is a more worrisome matter. This is deeply troubling but in no way surprising, for it reflects a broader problem of how social policy and social service agencies have tended to ignore what amounts to the subsidization of substance abuse.

The greatest single failure of social policy in the United States is the growing number of damaged, disruptive, and dysfunctional families. And, for a vast number of these families, dysfunction derives in whole or in part from substance abuse.

This connection between substance abuse and family dysfunction is hard to ignore. Yet that is exactly what social policy and many social service agencies have been doing. And to the degree that they have ignored substance abuse, government can be said to have "enabled" it.

There is today far more awareness than there was just a few years ago of how drug-related disordered behavior has created vast new problems for social service agencies. Nevertheless, continued drug use rarely threatens the ability of most drug abusers on the rolls to secure welfare, housing, food stamps, or any other form of public assistance. The priorities of social service agencies still tend to minimize awareness of drug abuse. Relocating the homeless takes precedence over addressing their drug dependence. Reuniting mothers with their drug exposed infants is often given greater weight than dealing realistically with maternal drug use.

I bring this to the attention of the subcommittee in hopes that, as they consider changes in SSI, they will look more broadly at public benefits and substance abuse. The overriding goal, as I see it, is to bring substance abusers into appropriate treatment. And priority, as set by the Administration's new National Drug Control Strategy, is to get the "hard core" -- the disordered drug abusers --- into treatment first.

Few substance abusers of any kind seek the treatment they need. And the disordered, who are generally deep into denial, rarely enter treatment unless they are compelled to do so -- by their families, their employers, or the courts.

The need for coercion to bring most drug abusers to treatment creates something of a paradox, because drug abusers must play an

active role in their own recovery. And this requires a kind of motivation few bring with them to the treatment site.

Thus, the first task of treatment is to overcome denial and generate the motivation clients must have in order to succeed. Fortunately, treatment methods of today -- and the therapeutic community's residential regimen in particular -- are able to accomplish this, and with clients who are initially unwilling to engage in the treatment process. Moreover, the research shows that abusers who enter therapeutic community programs involuntarily are no less likely to succeed than those who come in on their own.

But disordered drug abusers will not accept the treatment they require if they have less demanding alternatives. And it is rare for any drug abuser to enter treatment when other options are available.

That is why I believe it is important for government and society to employ every available form of suasion that will help bring drug abusers to treatment. Only recently have we begun to explore the many ways in which the criminal justice system can promote treatment. The welfare system too should be used. And I would suggest, as one component of welfare reform, imposing the requirement of treatment on every drug abuser entitled to any public benefit.

Mandating Treatment

What the GAO report makes clear, however, is that treatment requirements are easier to impose than to enforce. And if treatment is to be more broadly mandated by social service agencies -- beyond even its extension to all 250,000 substance abusers receiving SSI and Disability Insurance benefits -- then it is most important for SSA to continue working with the Center for Substance Abuse Treatment in the development of referral and monitoring systems.

Other issues also need be resolved, including the question of representative payees and who best can receive and administer the benefits of substance abusers.

If treatment is a requirement of eligibility, then it seems reasonable for SSI benefits to be received and administered by the licensed agency providing this treatment. This is how home relief payments for drug abusers in residential treatment are handled in New York State. They are paid to the treatment agency, under the "congregate care" provisions of the State's social service regulations.

I would therefore propose that, whenever possible, licensed treatment providers receive benefits for their DA&A clients. Moreover, I would suggest that benefits for DA&A clients end when these clients either quit or complete treatment, as do the home relief benefits of New York drug abusers in treatment.

Treatment Capacity

Finally, there is the question of treatment capacity raised by the subcommittee.

There are today more than half a million treatment slots (565,000) in the United States. But relatively few of these slots are appropriate for the truly disordered -- those one-to-two million drug abusers who display characteristically irresponsible and antisocial behavior, and whose disorder is manifested in ways that make them a burden to society and a danger to themselves and others.

Appropriate treatment for this population goes well beyond arresting compulsive drug use. It must address the psychological basis of addiction. It must achieve changes in self-perception and in the attitudes and values that prompt and sustain not only drug use but <u>all</u> self-destructive and antisocial behavior. And it should, as well, remedy the deficits -- social, educational, and vocational -- that would preclude reasonably productive, positive, and drug-free post-treatment lives.

Most drug abusers do not require treatment so demanding, comprehensive, or prolonged. But for the disordered, this is what is required.

When we talk about treatment that alters basic behavior, we are well past the point of chemically-assisted or acupuncture-aided detoxification. And, although methadone maintenance programs provide a viable intervention for many heroin addicts, it is not generally considered the first or the most desirable option.

The treatment of choice for most disordered drug abusers is the therapeutic community model of long-term, residential treatment. Large-scale, long-term outcome studies have documented both the effectiveness and cost-effectiveness of this regimen. But today, outside of prisons, there are barely 12 thousand therapeutic community beds in the United States -- 12 thousand out of 565 thousand treatment slots.

The President's budget for FY 1995, however, proposes a $345 million initiative specifically to expand treatment capacity for the hard core. And I urge the members of the subcommittee to support this initiative and work to ensure that the number of therapeutic community beds are at least doubled.

Mitchell S. Rosenthal, M.D. is a psychiatrist, chairman of the New York State Advisory Council on Substance Abuse, and president of Phoenix House.

TESTIMONY OF JOSE L. SANCHEZ
SSA CLAIMS REPRESENTATIVE, PORTERVILLE, CALIFORNIA

Mr. Chairman and members of the committee, my name is Jose L. Sanchez and I am an employee of the Social Security Administration. However, this testimony is my own, as a concerned citizen, and not in behalf of the Social Security Administration, nor in my official capacity as an employee of the agency. Yet I wish to have you consider my testimony as coming from an employee who on a daily basis works in the eye of the storm. I also feel that you should learn of the problem faced by the Social Security Administration from the perspective of an employee, and thus get a more balanced view. I know that the agency for some time has shrouded with secrecy the problem of drug addicts, alcoholics, criminals and other social dependents receiving federal disability benefits, and has done its best to keep it from public scrutiny. Members of Congress, the problem has now come to light and it's time we deal with it, for it is imperative that we restore the integrity of the Social Security program and thus regain the much needed confidence in our government. But, before I continue, I wish to thank you for initiating these hearings on this important issue.

Mr. Chairman and members of the committee, who would have imagined the negative results of well-intentioned rules and regulations that allow drug addicts and alcoholics to be considered disabled based on the merits of just having an addiction? It seems to me that we have again created a fairy tale notion that by providing money to these individuals and a chance for rehabilitation, these individuals will change their lifestyles. Not so, Mr. Chairman. Again, I believe that what we have created is a wonderland for these astute individuals that provides a pension for rewarding their criminal past and present. If supporters of these individuals continue with the notion that by doling out money we will somehow tame the viper of drug addition and alcohol abuse, well I believe the viper has struck back and we now find ourselves here discussing the painful effects. But the worst is yet to come, as we begin to see the swelling of anger of public opinion.

The problem we face today at Social Security is of major proportions. Simply put, the agency has lost control and is at a loss for answers to the problem. The multitude of drug addicts and alcoholics applying have now swelled the rolls of this public assistance program. In dollar value to the taxpayers, it is unacceptable. In human terms, the effects are too often tragic. But, as far as the administration of the disability program, the Social Security policy makers have shown no resolve to correct the problem. The disability program is a complete mismanagement. This, sir, is inexcusable.

I thus write to you with the utmost concern. My personal interest is, of course, change in my place of employment, but also, because I care. As a member of this society, I have a stake in the final outcome of any government decision. Ultimately, we all desire successful and productive results. And yes, government should provide for the welfare of the indigent and the disabled.

By all accounts, I consider myself to be a "bleeding-heart liberal." And I am proud to be one. However, it makes sense to have a heart, but not giving it away indiscriminately. And that is

exactly what is occurring at SSA; we are attempting to help these so-called disabled addicts, but with no sense of direction and purpose.

I have also worked in the field of social welfare for the last eighteen years. The last fourteen I have been with the Social Security Administration. Since the beginning, I have been a claims representative in the disability program, SSI. Thus, having worked for so many years in the disability program, I have come to understand the problems we face, first hand. As a former steward of the union (AFGE), I have traveled throughout California, and I have learned that the problem is widespread and similar in nature in every Social Security office. So, with certainty, I believe that my sentiment is shared by the majority of SSA employees in the field offices. I know that the morale is low because the work loads have sky rocketed. The frustration is high because we often feel we should have more time to help the truly disabled, like the terminally ill and the aged.

And on the subject of the drug addicts and alcoholic abusers, well, we pretty much dislike the situation, for these cases take much of our time, perhaps up to 75 percent of our work time. Of every ten applications, seven may be from addicts looking for drug money, casual alcoholics attempting to cash in on the bounty, or ex-convicts just released from jail or prison come in to demand what they think is "due" them. Also, parents who are being forced by the Welfare Department to register for work, immediately come to the Social Security and apply for disability, as the prospect for income is assured and with no strings attached. Each and every one applies under the guise of having a disability or addiction. Yes, drug addiction and alcohol abuse has become the "catch-all" phrase to use for guaranteed results. Consequently, the Social Security is now faced with an overwhelming tide of addicts, criminals and other social dependents flooding its gates. Furthermore, the entire system has become a bottleneck of sorts. Thus, for workers faced with tremendous work loads and no consistent policy from the agency when dealing with this type of case, the general attitude is disgust and anger.

Mr. Chairman, the agency knows there is a problem, but is at a loss for a solution. What happens is this: administrators at the local and regional levels hint at ways to stem the tide by urging the adjudicators to find clever ways to deny the claims, such as finding the applicants ineligible due to excess income, i.e., to charge them with unstated income from monies derived from their drug sales, their "boosting" (shoplifting), etc., or just find them "SGA," (denying them when they show the capacity for substantial gainful activity). However, we, the employees, are equally aware of recent court decisions that have considered the issue of substantial gainful activity and income issues. Thus, the battle for interpretation has become intense and resulting in confusion. In the end, we, the employees, have been left to shoulder the part of assuming what the course of action should be, and thus by defacto set policy on this issue. (See Exhibit #1)

Mr. Chairman and committee members, I want to assure you, however, that despite the difficult task that we employees have, all of us are committed to the job, and we firmly believe in the mission that Congress has set for our agency. We ourselves know fully well the need for the existence of these government programs, for we daily witness the pain and sorrow of the disabled. But what is most rewarding are the joy and sometimes tears of happiness we see

in recipients and family members, when they realize that their government is there with a helping hand.

More About the Problem:

Yes, it is an accepted fact that substance addiction is a disease, and that legislation passed by Congress also included drug addiction and alcoholism as a general disability. But it is equally important that we acknowledge that Congress provided for strict eligibility requirements.

The problem we now face is not the statutes that allow for the disability, but rather the inept system that administers a program, knows that unexpected problems result from the legislation, but does nothing to convey the problem to the law makers for purposes of making proper adjustments. On the contrary, SSA has made excuses, attempted to dimish the problem, and in some cases, covered it up. Instead, SSA has a set of talking points to persuade the critics that there is no problem. But the staff at lower levels know better.

Mr. Chairman, the word is out. Every common criminal, every drug addict, every casual alcohol abuser, every prison inmate, and other social dependents know that the Social Security in crisis and that by overwhelming the system, they will somehow prevail in becoming eligible. You see, Mr. Chairman, in the chaos, and in the overwhelming work loads, in true bureaucratic fashion, back logs are fixed in the most expedient way. In our system, the most expedient method is to say yes rather than litigate. Consider the typical causal addict or others with time on their hands. Even after having been denied one to four times on the same allegation of disability, these individuals consistently appeal each and every denial -- at no cost to them, of course. They know that eventually they may be reviewed by somebody different, a besieged-with-work analyst, or an ALJ who will buy the act, and they eventually prevail. It is not unusual that an applicant who has been denied several times (for unrelated drug or alcohol abuse), is asked "Have you ever drunk alcohol or taken drugs?" Well, who hasn't? Thus, we often see returned cases who originally went for medical review for other than drug or alcohol, come back as DA&A (drug and alcohol) cases. In questionable disabilities, the claimant keeps silent and accepts the favorable allowance. But in many other instances, claimants vehemently deny having a drug or alcohol addiction and get angry and demand we strike out the label of addict and/or alcoholic.

Mr. Chairman, in California, the DDS (Disability Determination Services) which determines disability, have had to streamline their medical review procedure to a one-page (pre-print) determination. (See Exhibit #2) Is this acceptable? When the alleged drug addicts or alcohol abusers have no medical history to support their claims, DDS relies on statements from friends or relatives. Much of the time their relatives have a stake in the outcome, but so do the friends. This, Mr. Chairman, is also not acceptable.

The fact that most of the criminal element has a record about having been caught with drugs or alcohol does not make them addicts. The fact that the criminal element has a history of having been in halfway houses or been in recovery homes, does not mean they were there seeking

help to change their ways. On the contrary; most often these individuals were forced there by the courts in lieu of punishment. Yet DDS(S) throughout use this information as proof of rationale for finding disability.

Prisoners, on the other hand, have their long records of incarceration. This is normally construed as anti-social behavior, and coupled with the allegation of alcohol or drug addiction, usually come back as DA&A cases. Their secondary diagnosis may be affective disorder, post traumatic stress (the shock of having been in jail and suddenly released to society), or anti-social disorder. In the area that they live, the San Joaquin Valley of California, we are surrounded by prisons. As soon as prisoners are released, they do not stop to hold up the local corner store. They directly come to the Social Security to pick up their check, thanks to the successful prison outreach program SSA has for prisoners. If not in the early release program in which we take their application even before they are let out, these parolees or ex-cons apply at what they call, in their lingo, "the money store" (SSA).

Other social dependents have also made use of the catch-all phrase, addiction, in order to flee persecution.

Consider the following actual case scenarios: I recently took an application from an unemployed father who was being asked by the welfare to begin training under the "Gain Program," but refused and came to SSA to apply for disability under the alleged alcoholic addiction. His statement in the application read, "I consume about a twelve pack of beer a day. I recently realized that I was an alcoholic. Beer helps me to relax. I can't do without it. I do not want to stop because I like drinking. I am currently receiving unemployment on my last job and I have been receiving it since at least two years. The employment office does not send me to work and I would not go anyway because I am always drinking."

In my observations written for the benefit of DDS, so they could get a profile of the claimant, I wrote, "Claimant alleges only drinking a twelve pack a day. He just may be a casual drinker. No signs of alcoholism. Receives unemployment."

A month or two later the case returned as an allowance, with alcoholism as the only diagnosis. The decision had been based on the relative's verification and the rationale for allowance was on a one-page pre-print. (See Exhibit #3) In contrast, let me give you another true-to-life story.

Sometime last year, I stopped seeing the lovely girl who always was at the drive-through window of the bank where I bank. I asked about her and was politely told she was ill. A month or two later, while shopping at the local super market, I saw her picture in a flyer. The flyer was asking the community for help in the cost of this girl's chemotherapy. The next day, at work, the first thing I did was to call the phone number I had obtained from the flyer. I proceeded to inform this girl of SSI and SSA disability. The girl was ashamed but with hopes of help, agreed to apply. I then set an appointment on our computer system. I wished her good luck, and she thanked me. Three weeks later, I learned that she had been denied because she intended to return to work soon. Thus she was found "SGA," and denied. Again, I

called the girl and let her know that if circumstances changed, she should call on us, SSA. Well, a month later her mother called me and informed me that her daughter's cancer was now terminal, and she requested help. I immediately set up an appointment and the next day we had the mother in the office. A "Teri case" was set up, and we quickly expedited the process. Two weeks later I received the decision from DDS. It was an allowance. I dropped everything and called the mother to give her the good news. The mother quietly answered that her daughter had passed away. Nonetheless, she thanked us (SSA). I wonder if this family delayed treatment because of no funds. Could we have made a difference?

More recently, I took an application from a lady who also was alleging alcoholism. Upon her allowance, I had to call the local welfare office for verification of the family's AFDC grant, and because the lady was telling me she was not included in the grant. I could not understand why. She was the only parent in the household and there was no explanation why she would be excluded. Well, the welfare worker informed me that this lady was indeed included but that her grant was less because an overpayment was being recovered. The worker also verified that the reason for the overpayment was that the claimant had been caught for welfare fraud. Apparently, she had been working under an assumed name and Social Security number.

Mr. Chairman, the agency would have us believe that guidelines of eligibility requirements are strictly adhered to, such as the requirement of undergoing appropriate treatment for their addiction. And also that these individuals must receive their SSI payment through a representative payee.

Well, please be ready for a "reality check":

In the fourteen years or so I have only once been involved with a report from an RMA (referral monitoring agency). In that particular event, SSA was informed that this claimant was refusing to cooperate. Per the Poms (regulations) I called this man in and explained that he must cooperate or his benefits would be terminated. To my surprise, this claimant was also surprised because he said that nobody had ever contacted him. In short, a statement is all that is needed with the promise from the individual indicating that he/she will cooperate. At no time are payments put in suspense or terminated. This I have never seen. One can argue that the reason we at SSA do not see notices of non-compliance from the RMA(S) is because they do so well in maintaining their cases, or because of a high success rate. No, Mr. Chairman, the fact is that time and time again, we hear from the claimants, "When will they call me?"

In all fairness, I must admit that on several occasions I have seen a counselor from one of the RMA(S) in our office interviewing these addicts. Of course, they come in drunk and/or high on cloud nine. Who wouldn't, if quitting the habit would make them rehabilitated and presumably no longer having a disability. Well, one day I happened to ask the counselor if he had lately had any success stories in which he had helped them become rehabilitated. He answered stoically, "Our job is not to rehabilitate them, only to help them cope with their illness." And he was serious.

Mr. Chairman and members of the committee,on March 22, 1989, I appeared before your committee and gave testimony of the problems of the payee system. Because of the rampant abuse by payees, you made changes in the law to curtail fraud and abuse. Let the record show that I made some suggestions for ways in which the payee system could be improved. However, in spite of the changes you prescribed, the payee system continues to be riddled with abuse. I can assure you there has been no tangible change other than procedural change.

I continue to believe that what I had suggested is the answer: criminal penalties and actual punishment, frequent accountability, activate an investigative unit within each office, and (the only alternative to solve the problem) is have a payee unit within each office handling the claimant's funds. Currently, friends of the addicts and alcoholics who themselves are questionable, are routinely assigned as payees. Family members, of course, can also have an interest in the monies, and thus lie to the system with an honest smile. In contrast, the caring relatives usually don't last too long, as they realize that the cause is futile. And, in many cases, it is the relatives who condemn our system of doling out money with little restrictions, for they know that the monies will ultimately be used to further the addiction. In some cases, the results are tragic, as was the death of William Harold, an addict who after receiving SSI benefits, the next day overdosed. In that incident, Social Security funds were cited in the newspaper as the cause. (See Exhibit #4)

Recommendations for Solutions:

It would be desirable to scrap altogether the rules that allow drug addicts, alcohol abusers, the criminals and the other social dependents. However, it is also unrealistic to expect such a miracle. Nonetheless, we all recognize that needed changes must take place, if we are to regain control of the vast number of undeserving recipients filtering into the system.

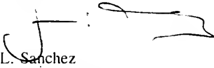
It is a joke around the Social Security offices that a solution to the problem is not to give them money, but to offer them a chance to rehabilitate -- in boot camp. Jokingly enough, this concept holds promise. And why not? Since every addict purports to want to rehabilitate, let it be in a controlled atmosphere. Provide them with food and shelter, plus counseling at a government facility. Stop their addiction "cold turkey," and thus we could see who is truthfully trying to rehabilitate. Six months in a boot camp atmosphere, plus the next six months in a classroom training to help them achieve self support. No participation, no money.

Mr. Chairman, band aid approaches to problems do not work. Since 1989 the payee problem has not changed, in spite of changes Congress initiated. Thus, I argue, only drastic changes must take place.

One more thing. Whenever a problem is brought to your attention concerning SSA, please consider the advice of the soldiers in the battlefield. The captains and generals look only through self-serving binoculars.

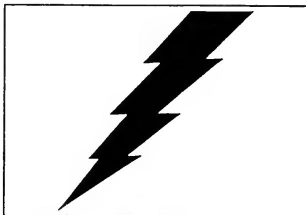
In closing, thank you for lending an ear and spending time to consider this statement, for I hope that real change may take place. I, thus, wish you luck; I hope that you be strong in your wisdom, valiant in your resolve, and that you clean up this mess.

Sincerely,



Jose L. Sanchez
549 N. Christopher Dr.
Porterville, CA 93257
Phone: (209) 784-1765

Exhibit 1



Copies to all CRs

ATTN: [redacted]

FROM: [redacted]

SUB: SGA and Drug Addicted Applicants

DATE: September 3, 1993

NO. OF PAGES: 10 (includes cover sheet)

MESSAGE:

Attached is a recent ALJ decision on a case taken to the hearing level. We had originally denied the case based on excess unstated income. The applicant is a drug addict with a current drug addiction. He supports the addiction with illegal activities. These illegal activities generate the monies he uses to buy drugs. It is these same monies that we used as a basis for charging "unstated income" and denying the case.

What is significant about this decision is that the ALJ not only affirmed our decision on the unstated income but went on to rule on SGA. He determined that the applicant's daily activities in hustling for money equated to SGA. There is a case already on the books with a specific ruling on the SGA issue. The case is Bell vs. Sullivan. It is cited in the decision.

This SGA ruling has impact on the T2 side of the operation. A person could be denied disability benefits based on SGA performed in support of illegal pursuits. The ALJ made it clear that the law does not distinguish between legal and illegal activity when defining SGA.

I have attached a copy of the decision.

(209) 734-6751 *** FAX (209) 734-6978

INFORMAL

	ACTION	P/C
CR		
/60	6/9/93	

Date: May 19, 1993

To: [redacted]

Re: Unstated Income in DA/A Cases

At your suggestion, I checked with [redacted] in Visalia on their use of unstated income in DA/A cases. They have had one case go to the ALJ on this issue. The judge's decision included the following analysis:

> As to the issue of unstated income caused by his drug habit, the claimant has previously stated he uses $80.00 to $100.00 a day in drugs....It is my determination the claimant has unstated income of at least $80.00 per day either in terms of drugs supplied to him or obtaining money in this amount by theft or whatever means necessary to satisfy his drug habit. This unstated income continues to the present time.

Information on amount of drug use should be available on all awards based on drug abuse. The California DDS uses a drug and alcohol questionnaire that asks, "What kinds of drugs are you using? How much?" If this questionnaire was reviewed on each DA/A allowance, field offices could find heavy drug users ineligible based on unstated income.

I discussed this with Maureen in SSI Programs and her staff will include an example of unstated income in their next monthly program circular (subject to clearance from CO).

Exhibit 2

REPORT OF CONTACT
(Use ink or typewriter)

TO: NE MAT SE GL WN MA
ODO DIO ODS

PERSON(S) CONTACTED AND ADDRESSES ☐ WE OR SE PERSON ☐ OTHER *(Specify)*

CONTACT MADE ☐ DO ☐ BO ☐ CS ☐ HOME ☐ PHONE ☐ OTHER

DATE OF CONTACT

SUBJECT

Medical evidence indicates that the claimant has a history of disordered behavior, which has been exacerbated by abuse of alcohol and/or drugs. The claimant's substance abuse is a significant contributing factor to the finding of disability. It has been concluded that without this element, the claimant's condition would not be expected to prevent engaging in substantial gainful activity.

Therefore, treatment for substance addiction is imposed as a condition of receiving benefits, as required by Social Security regulations.

SIGNATURE

DISTRICT OFFICE *(Name, Address & Code)*

☐ CR ☐ FR ☐ SR ☐ CLAIMS CLERICAL
☒ OTHER *(Specify)*

DATE OF REPORT

PAGE OF

*U.S. Government Printing Office: 1992 — 312-183/60068

Exhibit 4

The Bakersfield Californian

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...e 106 / No. 102 — Serving the southern San Joaquin Valley since 1866 — 47 cents — SATURDAY, APRIL 11, 1992

Social Security funds cited in man's death

Payee program under attack

By LOIS HENRY
Californian staff writer

One day William Harold Whiting was a man addicted to heroin, trying to get along with a part-time job, a wife and 2-year-old daughter.

The next day he was a corpse on the coroner's table.

The difference between those two days was $7,303.

That was the amount paid to Whiting as a lump sum in Social Security benefits for his disability — determined by Social Security evaluators to be alcoholism.

He was 36.

"We begged them not to give him that lump sum payment," said Whiting's brother-in-law, Robert Moser.

"They promised us Hal's money would go to Catholic Social Services and they would be his assigned payee. But instead Hal got his hands on it. Now he's dead."

Whiting received the money Jan. 29. On Jan. 30 he was brought to San Joaquin Hospital at 1:55 p.m. in full cardiac arrest. He died 10 hours later.

The coroner's report shows Whiting's blood was little more than a mixture of alcohol, morphine and cocaine.

Whiting's case is an extreme example of problems of the Social Security payee program.

A payee is someone who is supposed to look out for money given to substance abusers or those who are too mentally incapacitated to watch funds themselves.

But Social Security doesn't conduct criminal background checks on payees, or employment status checks. So addicts many times have other junkies act as payees. Unscrupulous people sometimes offer to act as payees and then take the money for themselves.

William Harold Whiting, mother Billie Whiting and niece in a family snapshot

The problem is so bad and so widespread, some Social Security workers have estimated millions of dollars are being lost each year.

"The representative payee situation is scandalous," said Chapin Wilson, a union official of the Association of Federal Government Employees, or AFGE, which represents Social Security workers.

"The government has a responsibility to maintain the integrity of this program, and they aren't doing it. Literally millions of dollars are being lost every year."

Please turn to JUNKIE / A2

1) A couple of months before you parole, write to:

Dept. of Health and Human Services
Social Security Administration
P O BOX 19001
Olympia Washington 98507

Ask for information about benefits for:
Prisoners under Public Law 93:365:92:60 (rule R.C.W. 72.02.040) and ask for the address of the Regional Director of the S.S. office in your area paroling to.

2) Write the Regional Director after turning in your parole plans, tell them you want to apply for $980.00 per month in S.S.I. benefits. Ask that the application be sent to an address that you're paroling to. These details are covered in R.C.W. 72.02.040 Keep a copy of your letter.

3) Once released, go to the local S.S.I. office and apply for benefits under R.C.W. 74.2[illegible]. Take a copy of the letter you wrote to the Regional Director.

4) Being incarcerated also qualifies you for disability benefits. However these benefits are in a different category from the disadvantaged minority. Benefits require a separate application at the SS office

You have to be persistant with this one and may have to file the application 3 or 4 tim but once you're approved, you're eligible for $310.00 a month for every month you've been down.

5) Contact the U.S. Dept. of Social Health Services and apply for vouchers for food, housing, and clothing, plus an immediate $150.00 in food stamps.

) Local U.S. Housing & Urban development (HUD) office - You may be eligible for low cost housing.

7) If you know a trade, the Division of Vocational Rehabilitation can help you get started under R.C.W. 72.02.100. Go to various stores to check prices and give VocRehab a list of clothes and tools you need. You could get up to $1,500 and even an extra $100.— gate money.

8) Need a job? The target job tax credit program will pay half your wages that gives your employers a $3,000 tax write off, during your first year of employment and $1,500 the second year you work and $1,500 the 3rd year your jobs consititutes "training".

THE DEFICIT LETTER from Wright Publishing Co.
1800 Diagonal Road - Suite 600 * Alexandria, VA 22314
Christopher M. Wright, Publisher * Compuserve 73514,1217
703-684-4470

STATEMENT OF CHRISTOPHER M. WRIGHT
for the
Subcommittee on Human Resources
Subcommittee on Social Security
House Ways & Means Committee
Joint Hearing on SSI-DA&A
February 9, 1994

Introduction. Imagine trying to explain to the average person that the federal government hands out free money to drug addicts and alcoholics. When the SSI-DA&A story first hit the news in 1992, my parents and I, along with many other Americans, were outraged at this indefensible use of taxpayer money. I have followed SSI since that time and I have come to the conclusion that SSI-DA&A should be scrapped in favor of the limited substance abuse treatment program I describe below. Short of a complete overhaul, I support the concepts contained in the House Republican Welfare Reform Bill for having government agencies serve as representative payees and for disqualifying DA&A's for positive drug tests.

All factual representations in this Statement are documented. Sources available upon request.

Program Growth. SSI-DA&A is exploding. Just look at these numbers:

Beginning of:	DA&A Recipients in Current Pay
1984	3,493
1985	3,938
1986	4,657
1987	6,413
1988	10,076
1989	12,694
1990	16,569
1991	23,455
1992	33,773
1993	53,464
1993 (Sept.)	72,137

Source: Social Security Administration,
Response to FOIA Request
November 8, 1993

These numbers are stunning - the number of recipients is doubling every 2 or 3 years. My sources at the Social Security Administration tell me the number is still going up. At the present rate, all 22 million drug addicts and alcoholics in the country could be on this program by the year 2015. Moreover, the numbers above are undoubtedly understated for several reasons. First, they include only those recipients for whom DA&A is the primary diagnosis but exclude those for whom DA&A is the secondary diagnosis. This means, for example, there are drug-addicted AIDS victims receiving SSI that are not counted as DA&A. Secondly, my sources tell me that field personnel deliberately misclassify recipients because a DA&A coding entails extra work. Thus, addicts get on SSI after being labeled "sociopathic" or "manic-depressive", or as having "organic brain syndrome".

How much is all of this costing? Federal benefit payments in FY 1992 for all of SSI totalled $17.24 billion. By comparison, federal benefit payments for AFDC in FY 1992 were

only $12.202 billion. Ways & Means 1993 Green Book, pp. 679, 867. Here we have a combination of exponential program growth, a virtually unlimited pool of possible new recipients, and an expense which is already taking on gargantuan proportions. The mentality from the beginning of SSI has been 'Grow This Program'. We have had 20 years of unbridled growth in SSI and no one has yet stopped to ask how it is working.

<u>Pernicious Effects</u>. The wake-up call came in the Bakersfield <u>Californian</u> on February 28, 1992:

"Linda Torrez said she was paid $8,585.82 by taxpayers for being a junkie.

Torrez was arrested last week on charges of possession and use of heroin. During the raid, Bakersfield police found a paper sack with more than $5,000 in it.... Torrez ... produced documentation showing the money was hers via a lump sum payment from ... Supplemental Security Income. She said she is disabled and due to start receiving monthly benefits.

Her disability: She is a heroin addict....

[A]ddicts or alcoholics must ... present the Social Security Administration with a ... payee who is responsible for the benefits.

Torrez told police her monitor was Samuel Mendez.... Mendez was arrested the same day as Torrez, also on charges of heroin use and possession...."

Since that time, other reports have proliferated of DA&A's receiving lump sum payments of $5,000, $10,000, $25,000 and even $39,000 from SSI. The lump sums consist of SSI benefits paid retroactively after a DA&A whose initial claim was denied wins on appeal and gets on the program. Fully 40 percent of DA&A's get on the program only after appeal.

The representative payees in these and other reports have turned out to be other drug addicts and even drug dealers. Other representative payees turned out to have addresses in liquor stores, bars, and check cashing establishments in high drug areas.

Thus, it should be no surprise to learn that substantial numbers of DA&A's use their benefits to buy illicit drugs and alcohol, as many as 90 percent according to one study cited by the HHS Office of Inspector General. There are numerous drug counselors and at least one homeless shelter worker who have stepped forward and said that their DA&A clients spend SSI benefits on drugs or alcohol. Floyd Brown, a drug counselor in Stockton, California, said he hears nearly every day another story where a DA&A spent SSI benefits on drugs. Mr. Brown appeared on local TV with two addicts who admitted on camera to using their SSI benefits to buy drugs. In San Francisco, Rick Libhart said he used his monthly SSI benefits to buy "speed" in bulk, which he then repackaged and sold on the street at a profit.

The consequences? Ruinous for some addicts who go on binges or disappear from treatment and never return. For others, death from overdose, acute alcohol poisoning or suicide. This program has blood on its hands.

SSI-DA&A is pumping money directly into the drug economy. "Social security, unknowingly, unwittingly, provides more money to drug dealers and bars than any other organization in the whole world," said Francis J. O'Byrne, an SSA administrative law judge in Chicago. SSI-DA&A is helping to increase demand for drugs at a time the government is supposedly waging a 'War on Drugs'. As the drug economy grows, SSI money is undoubtedly fueling gang violence in America and drug cartels in other countries. Those who believe that government is the unfailing agent of moral

progress in society should have their heads examined.

The fatal flaw in SSI-DA&A is that the program purports to require people to conquer their addiction through treatment but in fact rewards them for remaining addicted. DA&A's are reluctant to leave their addictions behind because they will lose their SSI benefits. Drug counselor Floyd Brown said that addicts on SSI resist treatment. A judge in Illinois, a state legislator in California and others have called the government an "enabler" of addiction. Giving money to addicts plays into the psychology of addiction by reinforcing dependency instead of self-reliance. Not only are DA&A's addicted to chemical substances, they are also addicted to SSI.

This is enough to give the welfare state a bad name. But the pernicious effects of SSI-DA&A do not stop here. First among SSI-DA&A's casualties must be counted the rule of law. As many as 90 percent of the addicts spend their benefits on illicit drugs. Plainly stated, the government is helping these people break the law. By aiding and abetting criminal activity, SSI-DA&A is engendering and directly funding a profound disrespect and a callous disregard for law. Not just on the part of the addicts themselves, but also on the part of SSA which knows all about this illegal activity but has done next to nothing to stop it.

Second, it is entirely possible that SSI-DA&A in and of itself is creating more drug addiction and alcoholism. There is a respectable school of thought which holds that, if you subsidize something, you will get more of it. Causation is impossible to prove or disprove, but this kind of speculation about social service programs has persisted through the ages, starting in ancient times. In the Netherlands, which has had socialized disability programs longer than the U.S., a mind-boggling 15 percent of the work force is considered "disabled". That very well may be the future of SSI-DA&A and other socialized disability programs in America.

Third, SSI-DA&A feeds a growing and ever-more militant Welfare-Industrial Complex. This Compassion Industry is comprised of lawyers who handle individual Social Security claims for a 25 percent cut; class-action lawyers; advocacy groups who lobby for program expansion; doctors; psychiatrists; bureaucrats; social workers; and others who now make their living from government benefit programs. They all have a vested interest in building up a system which brings them work. Many fine minds have been diverted into essentially unproductive activity. The understanding that wealth must be created before it can be redistributed grows ever more dim. We are headed for an upside-down world where most people will make their living from the government. Total government spending at all levels is currently about 43 percent of GDP.

Last, but not least, this expanding "industry" and the change in the character of American life it has wrought has only been made possible by the prevailing deficit-spending mentality. SSI-DA&A is an open-ended entitlement program funded from general revenues and borrowings, not payroll taxes. Open-ended entitlements are a prime cause of the mounting national debt. We are using borrowed money to create socialist paradise on earth. For every hundred dollars we borrow today, those who follow us must pay back not only the hundred but in addition an extra $6 or $7 in interest every year until the debt is repaid. We have taken to chronic borrowing to cover garden variety social spending. This is a particularly poor use of borrowed funds. Nothing is being created with this money that will pay back this debt. In Clintonian terms, there will be no "return" on this "investment". Moreover, permanent social programs do not match

in urgency critical, one-time national investments we periodically make, like debt-financing World War II. It is not "compassion" to throw borrowed money at social problems and run up the national debt for the next generation. We need to decide how much "compassion" we can afford and then say, 'No more, that's all there is.'

Mismanagement. SSI opened for business in 1974 and basically federalized the previous state adult assistance programs for the aged, blind and disabled. It was thought at the time that the federal government could do a better job than the states of administering these programs. We were going to save money.

How did the story turn out? In 1991, after more than 15 years of federal administration, the HHS Office of Inspector General issued a scathing report on SSI-DA&A. The OIG found:

* the exact number of DA&A's was unknown.
* only 8% of DA&A's were in treatment (required where available and appropriate and can consist of NA/AA meetings).
* 10% of DA&A's were not in treatment
* the treatment status of 82% of DA&A's was unknown, but they continued in current pay.
* the records were unreliable because of widespread diagnostic miscoding.
* 4,439 SSI recipients had a primary diagnostic code of DA&A but were not coded for DA&A status
* 1% of DA&A's did not have representative payees
* there were no referral monitoring agencies (RMA's) in 35 states. SSA is required to monitor recipients' attendance in treatment and SSA contracts with state agencies for this function.
* the eligibility criteria varied in practice from state to state.
* what constitutes treatment had not been defined.
* what constitutes success in treatment had also not been defined. Treatment centers must be approved by law but some had never even been visited.

Overall, the OIG concluded that many DA&A's were "receiving benefits without any real effort at rehabilitation which is directly in conflict with Congressional intent." In other words, the program controls exist largely on paper but not in reality.

There have been some improvements claimed since 1991. SSA now states that 30 percent of DA&A's are in treatment (22,000 out of 72,000). However, RMA's still do not exist in all states and the treatment status of 25 percent of DA&A's is still unknown. The OIG told me that SSA considers its record-keeping to be adequate in this respect. The OIG does not. Neither do I. In 1991, SSA could not account for the treatment status of 82 percent of 19,760 DA&A's, or 16,203 recipients. Now, SSA cannot account for at least 25 percent of 72,137 recipients (18,034), which is more than before. This is improvement?

An SSA work group has been convened to study the question of fuzzy eligibility criteria, and the definitions of treatment and success in treatment. With respect to eligibility criteria, the people in the field are completely at sea. An ALJ in San Francisco said it comes down to varying subjective assessments by individual judges. An ALJ in San Diego said the regulations require disability findings where he would not ordinarily make them. "All they have to do is go to some doctor or psychologist and say they are addicted. They don't even have to have needle marks. All they have to say is, 'I hear voices.

I think someone's coming after me,'" ALJ Albert Tom told the Orange County Register. Gregg Bender, a police detective in Bakersfield, California told me that his local SSA office told him they have never turned an addict down.

The disability determination process, one in which the people who make the initial decisions never even see the applicant, is in obvious disarray. SSA has admitted that errors are made and a court has noted that guaranteeing the correct disposition of every claim would be cost prohibitive. Moreover, I asked SSA for the DA&A pass rate (the number of people who get on versus the number who apply). The answer came back: SSA keeps no records responsive to my request. Thus, SSA cannot tell us the pass rate, how it may have changed from year to year, or how it may vary from office to office.

There are other types of mismanagement of SSI-DA&A not flagged in the 1991 Inspector General report. I described above how there are drug addicts and alcoholics receiving SSI benefits who are not coded DA&A. This results from deliberate misclassification by field personnel and from substance abuse being a secondary diagnosis for some recipients. This means that there are drug addicts and alcoholics getting lump sums and monthly checks who do not have representative payees. SSA has known for a long time that there are addicts and alcoholics getting wads of cash in these cases but, as far as I am aware, SSA has not sought legislation to keep the money from being injected, smoked, snorted or imbibed. Similarly, Title II SSDI DA&A's also are not subject to representative payee requirements. There are no controls on any of these people.

DA&A's are supposed to be suspended from the program if they are incarcerated, and disqualified if they remain incarcerated for more than a year. Computer cross-checking enables SSI to suspend inmates in state and federal prisons. The problem is, no systematic checking occurs with respect to local jails. Moreover, there are people who are supposed to be incarcerated but are not. These include fugitives, as well as parole and probation violators. These people can still collect AFDC, Food Stamps and Medicaid benefits. Query: Can they also collect SSI benefits?

The stories above about liquor store and drug addict representative payees points up the fact that SSA has until recently not checked the background for those who serve in this capacity. There was a pilot program to do so in Bakersfield, California and it has also been reported that SSA is doing something about this nationwide. If true, why did it take SSA 20 years to think of it?

I have heard the notion that SSA field workers have stopped requiring treatment in hard cases. If true, DA&A's are being kept on the rolls even though SSA knows they are not in treatment. A drug counselor in Michigan reports that some of his SSI addicts are refusing treatment but not being kicked off SSI. The program has evolved beyond recognition into something completely at odds with the original program design, but SSA has never thrown a flag on the play or initiated a reform effort.

Connect the dots and you will discern a pattern in SSA's administration: `Grow this program'. Nowhere can this be seen more clearly than in the question of Continuing Disability Reviews (CDR's). This story begins with the fact that there are "unprecedented increases in applications for benefits under the DI and SSI programs. Initial claims for disability benefits reached an all-time high of 2.4 million for fiscal year 1992, a 50-percent increase over the 1.6 million applications received in fiscal year 1989." GAO, Social Security Disability - SSA Needs to Improve Continuing Disability Review Program, July 1993, p. 3.

Undoubtedly, SSA has a legal duty to process new claims. That would be in keeping with the nature of an entitlement -- anyone who meets the program criteria gets on. SSA has no duty to perform CDR's for SSI but it has authority to do so. Id. p. 2. The number of CDR's conducted on the SSI program dropped precipitously from 86,364 in FY1989 to 14,715 in FY1992. Id. p. 10. SSA does have a duty to perform CDR's with respect to SSDI, but the GAO found that SSA performed only about half the number required from 1987 to 1992. Instead, SSA has shifted resources into processing new claims. Id. p.1. SSA has a legal duty to process new claims and a legal duty to conduct CDR's. SSA made an election, a conscious choice, to downgrade its legal duty to conduct CDR's in favor of processing new claims. Now SSA wants a 1,000 additional workers, not to conduct CDR's, but to process new claims! The pattern holds true: 'Grow this program'. Get more people on this bus. It does not matter where the bus is going or whether SSA even has its hands on the wheel. SSI-DA&A is careening down an embankment and SSA is still punching tickets as if nothing was wrong. 'Grow this program'. Success is measured by how much money is flying out the door. Maybe it is time to put the brakes on.

Why are CDR's important? A critical assumption underlying the original program design was that DA&A's would be treated successfully and leave the rolls when they were no longer addicted or disabled. See 1991 Inspector General report, p. 2. A standard course of drug treatment lasts about 2 years, but DA&A's typically stay on SSI four years or more. Id. p. 8. Of those DA&A's the Inspector General interviewed, "many revealed that they have not had acute problems with their disabling addiction in years." Id. p. 8. But they get to stay on the program and draw benefits into perpetuity because CDR's are so few in number!

SSA has known about this finding since 1991. What have they done about it in the last 3 years? Nothing. You would think that SSA would begin to keep tabs on how long DA&A's remain in the program. Unbelievably, SSA still has no idea what the facts are. I put in a FOIA request asking for a breakdown of how many DA&A's have been on the program 0-1 years, 1-2 years, 2-5 years, 5-10 years, and 10-20 years. The answer came back November 8, 1993: "We do not maintain records responsive to ... your request."

SSA's priorities are elsewhere. In response to a another FOIA request, SSA sent me a table showing that they intend to increase through FY 1995 the total number of new disability claims processed while the total number of CDR's conducted will fall and remain below the FY 1992 level. I was also informed that SSA "does not allocate resources to the State specifically for CDR cases, but for the overall disability workload." (SSA's emphasis). Despite the Inspector General's finding in 1991, SSA has not directed the States to make CDR's a priority. Instead, SSA has in effect told the States to bring more people on board. The mentality has always been and continues to be: 'Grow this program'. The time has come to stop and ask why. Floyd Brown, the drug counselor in Stockton, told me that he has yet to see the case where SSI worked as intended, where the person got off drugs and then off SSI.

Fraud. I have no hard evidence that there is outright fraud associated with SSI-DA&A. However, the HHS Inspector General recently cited an "extraordinary increase in Social Security fraud." OIG Semi-Annual Report, March 31, 1993, p. 36. Drawing on actual case scenarios involving other types of SSI recipients, some intriguing possibilities for DA&A fraud present themselves:

* One addict obtains several Social Security Numbers and files multiple claims for SSI-DA&A.

* A representative payee conceals the death of a DA&A recipient and continues to receive payments. n.b. - The 1991 Inspector General report found one dead DA&A still in current pay.

* An alcoholic conceals the fact of having returned to work.

We might never know whether these scenarios have actually occurred with respect to SSI-DA&A. Records pertaining to SSI fraud are not maintained by SSA but by the HHS Office of Inspector General. Surprisingly, the OIG does not keep track of the number of SSI fraud convictions, much less the number of SSI-DA&A fraud convictions. OIG simply has no idea how many SSI convictions there are, what their dollar value might be, or what the trend-line is. My FOIA request for general statistics drew a complete blank. Moreover, I also requested records detailing the methodology used to identify suspicious SSI claims. No records were produced in response to my request. Therefore, it is entirely possible that no methodology has ever been developed. Clearly, the whole question of SSI fraud is in its infancy. My sources tell me it is about to grow up. Fast.

<u>A Failed Program</u>. SSI-DA&A is a failed program, cut loose from its moorings, warped beyond recognition, having a sorry record of bureaucratic bungling and evil consequences:

* Instead of graduating from treatment, beneficiaries leave the program in coffins.

* Instead of food, clothing and shelter, program dollars buy heroin, cocaine and whiskey. The Medellin Cartel thanks you, the distillers of America thank you, and gang leaders everywhere would like to invite you down for a party.

* Instead of the federal government improving program administration, we have rampant mismanagement. Program controls exist on paper but not in reality. And we have an agency whose resistance to reform is virulent, an agency determined to 'Grow this program', no matter what. The growth in SSI-DA&A outstrips growth in SSI as a whole and is not explained by demographic factors. Some people believe that the baby boom accounts for the overall surge in federal disability claims, but this explanation does not explain the exploding number of DA&A's who are of all ages. Outreach on the part of SSA and word getting around prisons are much more cogent explanations for SSI-DA&A's spectacular growth. It has been reported and government sources have confirmed for me that some states send personnel to homeless shelters and elsewhere to switch recipients out of state programs and into SSI.

* Instead of fixing the problem of substance abuse and addiction in this country as originally touted, SSI-DA&A cannot demonstrate any palpable results toward solving this problem. Indeed, SSI-DA&A may itself be creating more addiction by giving addicts a soft pillow on which to land and doing nothing to instill individual responsibility in the addict population.

* Instead of remaining a supplement to Social Security and other income, SSI-DA&A has become an entire livelihood and a way of life for its beneficiaries. You know a program has failed when the first word in its title - "Supplemental" - no longer has any meaning. It is time to take the fig leaf off. What was envisioned as a brief stop on the road to recovery is now nothing but another federal welfare program for a new class of permanent beneficiaries. Let's rename it 'TSI' - Total Security Income.

* Can it get any more warped than this? An addict and a state parole worker independently offered up the same explanation

for why SSI-DA&A is a good thing: 'We have to give these people money so they will not steal from us.' (Here, take my house and I'll go live in the homeless shelter.) Cut loose from its moorings and drifting out to sea....

What to do with a failed program? Here is what not to do: The SSI Modernization Project recommended in 1992 that we spend an additional $105.5 billion over 5 years on SSI. Among the Project's recommendations were raising monthly benefits to 120 percent of the poverty level and adding 3.6 million new beneficiaries to the rolls. The Project's recommendations are now embodied in H.R. 2676, introduced by Rep. Carrie Meek (D.-Fla.), whom the National Taxpayers Union lists as the third-biggest spender in the House of Representatives. The Modernization panel said finding the money was not their problem. According to Rep. Meek, a commission that was supposed to look into financing the Modernization panel recommendations was never appointed. The day has long since passed that we can just open the spigot and be as irresponsible as the Modernization panel suggests. It may be that any reform of SSI is subject to PAYGO requirements. Even if not, any proposal should be expected to explain how much it will cost and where the money can be found.

Here is what else not to do: Try to turn the original program design into reality. It would be enormously expensive to fix all the problems with the current design. The cost of fully funding drug treatment for a mushrooming clientele by itself is likely to be prohibitive.

Here is where to begin: SSI-DA&A needs to be examined with a gimlet eye in the light of 20 years of experience.

Is more intensive case management the answer? The results of an intensive case management pilot now underway should be studied before going in that direction.

Does it make sense that the average monthly benefit is higher for SSI than it is for AFDC?

Is addiction a disability? Authorities remain sharply divided over whether alcoholism is a disease. Traynor v. Turnage, 485 U.S. 535, 552 (1988), cited in Schoolcraft v. Sullivan, 753 F.Supp. 1478, 1488 n.10 (D.Minn. 1991). In Traynor, most forms of alcoholism were deemed to be "willful misconduct". A recent study found that alcoholism is not hereditary.

What is a disability? If a guy who is paralyzed from the chest down can start a computer services company and generate a million dollars in annual revenue as reported in the Wall Street Journal, then what does it mean to be "disabled"? How expansive a definition of disability can we afford? Does it make any sense that employers have to make "reasonable accommodations" under the Americans With Disabilities Act, but we still have burgeoning numbers of people who say they "cannot" work and must remain dependent?

How do you determine that someone cannot work? Is it best to rely on medical evidence, a doctor's say-so? When one court has commented negatively on the credibility of doctors who do a lot of this work? Or is it fair to put applicants through work simulation tests? Are they disabled if they can actually file papers or answer phones? Does government have anything to learn from private workers' compensation insurers in terms of spotting bogus claims and containing costs? Is there any resolution to the age-old question: How do you separate the deserving from the undeserving?

Recommendations and Funding. Here are my proposals and funding mechanisms, subject to further study.

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We should end SSI-DA&A as we know it. In its place, we should institute the limited drug treatment program described below.

If SSI-DA&A is to be retained, then I advocate the adoption of two features found in the House Republican Welfare Reform bill, H.R. 3500. The number one problem to be solved is keeping the money out of the hands of the recipients, so that they do not end up dead and so that the money does not end up in the drug economy. H.R. 3500 would allow certain government agencies to serve as representative payees. I would change it to require an agency payee because family and friends can be intimidated. H.R. 3500 tacks on up to 10 percent of the benefit amount as the agency's fee for serving in this capacity. With agency payees, I would relax the rule that lump sums must be spent within 6 months to retain eligibility. Using drug treatment centers as payees would be consistent with the agency payee concept. There is a pilot underway with a treatment center as a representative payee and the results should be studied before moving in this direction.

H.R. 3500 would also subject DA&A's to random drug testing and terminate recipients if they test positive. This would instill new respect for the rule of law and be a strong incentive for recipients to take responsibility for themselves. SSI-DA&A has a therapeutic rationale and drug testing would be rationally related to the purpose of seeing that people are using federal money to get better, not worse.

I would find the money for these 2 proposals in 2 places:

1) Representative payees already get an allowance and this could be redirected to agency payees;

2) I would stop all outreach efforts ($8 million in FY 1992) and devote the money to drug testing and the representative payee function.

Ending SSI-DA&A as We Know It -- When SSI was instituted in 1972, the Senate initially wanted to put DA&A's into a separate program. Instead, DA&A's were put in SSI and the supposed treatment and payee controls were instituted.

The Senate had it right the first time. I advocate splitting off DA&A's and starting a limited drug treatment program along the following lines:

* It would start with a pilot project and end with a sunset provision -- top-to-bottom review after 6 years.

* It would not be an entitlement. The first section of the new law would explicitly state: "This is not an entitlement." Instead, it would be a system of rationing. The budget would be set and translated into a finite number of treatment vouchers to be issued. The number of people getting into the program would equal the number of people getting off, and no more.

* Presumably, the budget for the program would be pegged at some amount far lower than what we are currently spending on SSI-DA&A. Otherwise, I would not be proposing it.

* Rationing of social services is not a crazy, right wing idea. It is a Democrat idea. It is how the Democratic city government of Washington, D.C. ended the right-to-shelter entitlement program for homeless people in 1990. Entitlements are fiscally irresponsible and give people a bad attitude. The recipients become more demanding and angry. Entitlement advocates are reinforced in their mistaken belief that the well is bottomless. In a system of rationing, we get to know exactly what we are going to spend, right down to the penny.

* In a system of rationing, who gets on and who does not? The best candidates for successful rehabilitation get on. The ones who represent the best possibility for a "return" on our

"investment".

* Treatment would consist of 6-12 months of inpatient treatment, followed by 18 months of outpatient treatment. Recipients would receive no cash benefits during the inpatient phase. They would receive a living allowance, with the treatment center as representative payee, during the outpatient phase. The living allowance would decline each month, reaching zero in the last month, to remind recipients that compassion has limits and that they must take responsibility for themselves. Knowing that the clock is winding down will help focus the mind.

* One positive drug/alcohol test and you are out, unless the state of the art in treatment calls for something different.

* Administration would become easier in some respects. Means-testing could be simplified and CDR's would not be needed.

* An objective performance measure would be selected, but carefully so as to minimize program distortion. Positive tests or arrests during or within 3 years of treatment, for example. A performance measure would make the treatment center accountable to the program and the program accountable to the public for results. The best would be retained. The worst would wash out. And we would see exactly what we were getting for our money.

* No sneaky end runs. No deliberate misclassification would be allowed. If a person has a primary or secondary diagnosis of DA&A, or if they test positive for drugs/alcohol, they would not be eligible for SSI but would go into the pool of applicants for this program.

* There is a rationale for treating DA&A's differently. The program's therapeutic aims would be rationally related to the purpose of seeing that people are using federal money to get better, not worse. D.C.'s repeal of the right-to-shelter law successfully withstood court challenge.

* Such a program would be more faithful to SSI-DA&A's original goal of fostering rehabilitation. Limiting opportunity to the best candidates would strike the right balance between those who believe addiction is a treatable condition and those who do not. I myself am a skeptic. My experience as a criminal defense attorney tells me that only a handful of highly motivated individuals ever make it back. I had one case, Victoria B., an addict on SSI, who was considered one of the best participants in her Washington, D.C. drug program. Her counselor spoke highly of her. But she tested positive for heroin the day of her arrest. Treatment can be successful, but motivation is the key. Currently, some DA&A's go to treatment just to collect SSI. My experience tells me that their prognosis is not good.

* One of the goals of SSI was to remove the stigma of being on welfare. We need a new kind of stigma, one that says, 'Don't get on this program unless you really need it. Because it is not an entitlement program, space in this program is limited. If you are on here when you really don't need it or want it, you are taking it away from someone else who really wants and needs to be here. You have a responsibility to the community.'

* It strikes the right balance between those who say that welfare spending in and of itself creates more dependent people and those who say that it does not. With the number coming in equalling the number going out, the chances that the program will act as a magnet and create more addiction will be minimized.

* The money is not directly pumped into the drug economy as it is now.

* Not socialist paradise on earth. Not a shining city on the hill. No exuberant talk about eradicating poverty for all time. Modest. Sustainable. Sensible. And far more constructive than what we are doing now.

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