TERRITORIES

The U.S. territories operate AFDC programs as do the states. They are required to establish need and payment standards and submit state plans, and they share in the expenses of the program with the federal government.

Financing

The federal government matches 75 percent of benefit costs for AFDC and for cash assistance to persons who are aged, blind, or have disabilities. However, total federal expenditures are capped. Between 1979 and the present, the caps were increased once, by roughly 13 percent (in contrast, federal expenditures for AFDC benefits in the states have more than doubled, and federal SSI payments have nearly tripled).

Differences in Financing Compared to States

- If match rates were determined by formula as they are in the states, the territories would be eligible for higher match rates (except perhaps in Guam).

- The match rate and cap also apply to assistance to people who are aged, blind, or have disabilities. In the states, these people receive SSI, which is 100 percent federally funded.

- The caps may limit the territories' abilities to increase benefits. Benefit payments above the cap are financed 100 percent by the territories. Because of the cap, the effective federal share in Guam is roughly 40 percent.

The territories would like to operate AFDC and SSI programs as if they were states. In the past, two barriers have prevented that from happening: 1) cost, particularly in Puerto Rico; 2) fears that enhancing benefits in Puerto Rico would jeopardize efforts to make Puerto Rico a state. While Puerto Rican statehood is probably no longer a concern, the cost concern still exists.

Option: Increase the Caps

Increase the caps, with a mechanism for regular increases.

Option: Extend SSI

It may be desirable to extend SSI to the territories, with a mechanism for reducing SSI benefits in territories where the income of the general population is much lower than in the states. Extending SSI would alleviate pressure on the entitlement caps, but the cost may be prohibitive.

FACT SHEET ON THE TERRITORIES

Citizens of the territories are U.S. citizens.
Residents of the Northern Mariana Islands can receive SSI.
American Samoa does not receive any federal assistance for cash assistance programs.

Caps:

Puerto Rico:	$82 million
Guam:	$ 3.8 million
Virgin Is.:	$ 2.8 million

AFDC Caseloads, average monthly figures for 1991:

Puerto Rico:	61,000 units;	194,000 recipients
Guam:	1,200 units;	4,400 recipients
Virgin Is.:	1,500 units;	4,000 recipients

Average AFDC payment, 1991:

Puerto Rico:	$102/family;	$32/person
Guam:	$368/family;	$100/person
Virgin Is.:	$183/family;	$69/person
U.S. Avg.:	$388/family;	$135/person

Costs of Living:

There are no good measures of the cost of living that apply to the states and to the territories. In general, food prices in the territories are higher than in the states (territories have limited agricultural production abilities and have high shipping costs).

Attached is a table that shows Fair Market Rents for the largest metropolitan area in each state. The table shows that housing costs in Guam are exceeded only by those in Honolulu, and that housing costs in the Virgin Islands are well above those in the median state.

Tax Issues:

In the past, some policy makers have opposed enhancing the federal role in providing cash assistance to U.S. citizens in the territories on the grounds that federal taxes collected in the territories are returned to the territories. However, there are two good counter arguments to this: 1) It is inappropriate to hold up one facet of the complex relationship between the federal government and the territories as justification for limiting assistance to the poor; and, 2) Many low-income U.S. citizens in the territories do not pay federal taxes, just like low-income U.S. citizens in the states -- what happens to the taxes of higher income residents may not be relevant.

		FMR-2BR		
		1991	1992	1993
HAWAII	Honolulu	851	920	1069
Guam	Guam	739	909	909
CALIFOR	Los Angles	804	829	864
DISTRICT	Washington DC	830	854	844
NEW YO	New York	659	681	819
MASSAC	Boston	902	809	809
NEW JER	Newark	740	765	765
CONNEC	Hartford	698	713	709
ILLINOIS	Chicago	663	692	692
PENNSYL	Philadelpia	610	634	688
NEW HA	Portsmouth	683	697	676
MAINE	Portland	716	731	676
ALASKA	Anchorage	680	656	656
WASHIN	Seattle	632	630	653
RHODE I	Providence	640	653	649
VERMON	Burlington	670	684	644
MINNES	Minneapolis	619	630	630
Virgin Isla	St. Thomas	669	694	629
DELAWA	Wilminton	622	646	626
NEVADA	Las Vegas	663	687	618
MARYLA	Baltimore	571	593	603
GEORGIA	Atlanta	576	580	589
MICHIGA	Detroit	516	522	562
NEW ME	Albuquerque	546	562	562
TEXAS	Houston	455	488	553
WISCON	Milwaukee	494	513	551
COLORA	Denver	506	522	544
WYOMIN	Cheyenne	518	537	537
VIRGINIA	Richmond	465	482	529
OREGON	Portland	516	512	522
ARIZONA	Phoenix	544	505	512
IOWA	Des Moines	492	509	509
INDIANA	Indianapolis	495	508	508
NORTH C	Charlotte	441	453	508
OHIO	Cleveland	480	505	503
FLORIDA	Jacksonville	484	497	498
SOUTH C	Columbia	455	467	496
NEBRAS	Omaha	449	464	491
MISSISSI	Jackson	492	505	491
IDAHO	Boise City	566	594	485
KANSAS	Wichita	486	503	481
NORTH D	Fargo	461	478	478
MISSOUR	St. Louis	498	503	468
TENNESS	Memphis	439	451	462
Puerto Ri	San Juan	460	460	460
LOUISIAN	New Orleans	528	451	460
SOUTH D	Sioux Falls	443	459	459
ARKANS	Little Rock	454	467	452
ALABAM	Birmingham	417	428	440
OKLAHO	Oklahoma City	428	440	430
UTAH	Salt Lake City	429	429	429
KENTUC	Louisville	397	408	420
WEST VIR	Charleston	538	558	408
MONTAN	Great Falls	470	487	395

OPTIONS REGARDING AFDC POLICIES ON SUBSTANCE ABUSE

Background

Some AFDC recipients are substance abusers. According to the 1991 National Household Survey on Drug Abuse, among mothers who report AFDC receipt:

- 12.6% report having used an illicit drug in the past month (Note that this includes marijuana and the use of prescription drugs for non-medical reasons as well as cocaine, heroin, etc.)
- 3.8% report daily marijuana use over the past year
- 1.2% report weekly cocaine use over the past year
- 9.1% report binge alcohol use in the past month (5 or more drinks on at least 3 occasions)

Some of these individuals are addicted or are otherwise severely enough impaired that they need rigorous alcohol or drug treatment and are unlikely to become self sufficient without it. Others are not as impaired and may recover through self help groups or other less intensive measures. The figures above measure use only and do not necessarily indicate serious functional impairment.

The anecdotal experience of states under the JOBS program also indicates that substance abuse is an issue for many beneficiaries.

In the context of welfare reform there are several reasons why we might be concerned about beneficiaries' substance abuse problems:

- Substance abuse may be a barrier to self-sufficiency for the adult/family.

- The government and the taxpayers object to the possibility that AFDC payments could be used to buy drugs.

- When substance abuse is an issue, the AFDC payment may fail to serve its purpose to strengthen family life and enable parents to better care for their children.

Current Law

The current AFDC law does not mention substance abuse. Regulations under the JOBS program provide that a recipient whose only activity is drug treatment would not be counted toward a state's participation rate. Drug treatment may, however, be provided as a supportive service using JOBS funds should a state choose to do so.

One component of the Oregon JOBS waiver allows the state to require participation in substance abuse diagnostic, counseling and treatment programs if they are determined to be

necessary for self sufficiency. That effort has only recently begun and it is too early to have even preliminary data regarding their experience.

Approaches to Dealing with Substance Abuse in Welfare Reform

Fundamental to developing policy in this area is whether one treats addiction as a disease, or as an issue of misconduct. For the past two decades or more addiction has been defined as a disease in medical and legal contexts. According to standard medical diagnostic criteria, substance abuse is a chronic, relapsing disease characterized by symptoms including:

- tolerance to drug effects;
- withdrawal symptoms;
- pathological use; and
- impairments in social or occupational functioning.

Policies with a treatment emphasis build on this public health notion of addiction. More sanction-oriented policies would instead imply a backing-off from the disease concept and a substitution of the position that addiction is instead a problem of behavior and lack of will.

There are several possible approaches to addressing the problem of substance abuse among AFDC beneficiaries. These are:

1. Do nothing

As in the current AFDC program, one could ignore the issue of substance abuse. If no provisions regarding substance abuse are included in the welfare reform bill, there are several possible outcomes for substance abusing beneficiaries. At least some of these individuals are likely to drop out of training programs and be subject to penalties and eventual expulsion, without having addressed their substance abuse problems. Without income, they and their families are likely either to end up on the streets or seek income through prostitution, drug dealing, or other criminal activity. Alternatively, unless explicitly prohibited, some states might choose to classify substance abusers as disabled and not require their participation. Neither scenario would result in satisfactory outcomes for these families.

2. Encourage or mandate treatment participation

One could instead decide that because substance abuse disorders are a serious barrier to family self sufficiency, efforts should be made to encourage or require substance abusers to participate in alcohol and drug treatment programs. The more emphasis the AFDC program places on treatment, however, the more burden would be placed on welfare agencies to assure beneficiaries have access to treatment programs. This may or may not require direct payment through the AFDC program depending on other factors which are discussed below. Paying for substance abuse treatment could be a costly endeavor. Identifying substance

abusers and monitoring their treatment participation would also require resources. For more information see the sections below on identification, treatment, and monitoring.

3. Reduce or eliminate payments to substance abusers

Finally, one could decide that substance abusers should not be entitled to AFDC, whether or not they seek treatment. While resources would be required to identify substance abusers, reducing or eliminating payments to these individuals would reduce welfare costs. Doing so could prove harmful to these individuals and their children, however. It could also prompt those expelled from the program to seek income through criminal activity, or could cause their children to be placed in foster care. It should also be recognized that in past congressional efforts to eliminate benefits to substance abusers (during the 1980's) benefits (such as guaranteed student loans and other programs) were denied only to individuals convicted of drug related criminal offenses and not for drug use itself. In addition, at that time entitlement benefits were explicitly excluded from the list of programs to which drug offenders were denied access.

Implementation of an Approach to Address Substance Abuse

There will be implementation choices to be made for any approach except "do nothing," particularly if encouraging or mandating treatment is considered. Options for setting up an intervention system to deal with substance abusing AFDC recipients involve alternatives in four areas:

A. A way of identifying substance abusers
B. An intervention (alcohol or drug treatment)
C. Monitoring to assure compliance
D. Sanctions for noncompliance and/or incentives for compliance

Combinations of different alternatives within each of these four items are possible. In some cases (e.g. sanctions) these items could parallel those planned in other parts of the welfare reform plan or could be different for this population. If reducing or eliminating benefits is chosen, only identification and sanctions would be necessary.

A. Options for Identification

- Conduct a substance abuse assessment uniformly as part of a job readiness assessment.

- Require a substance abuse assessment if an individual fails to participate or succeed in other mandated activities, or there are other indications that give the caseworker reasonable cause to suspect substance abuse.

- Remain silent on the issue and leave it to the states to decide what they want to do in terms of identification. (This option is chosen in the Republican proposal).

Issues to consider:

Substance abuse assessments cost money, and the more you look for substance abuse the more cases you are likely to find. On the other hand, the more passive the system the more likely it is that individuals who are in fact in need of treatment services will not be identified. A passive system may also be biased toward looking for and finding substance abuse disproportionately among certain groups (e.g. inner city residents). Leaving the decision to the states would provide flexibility, but could lead to situations the Department might not be comfortable with (although these could be moderated either through regulation or in law). For instance, a state might choose not to conduct any identification of substance abusers (equivalent, in effect, to the "do nothing" approach above) or, conversely, might choose a potentially unconstitutional method of identification such as the universal drug testing of AFDC applicants.

B. Options for Intervention

- Mandate alcohol or drug treatment for those determined in need of it.

- Mandate alcohol or drug treatment, with an exception if treatment is unavailable. (This is the option chosen in the Republican plan.)

- Make referrals to treatment programs but do not mandate treatment or take other follow-up measures.

Issues to consider:

Many substance abusing individuals are unlikely to recover without treatment, and even with treatment many are unable to remain drug free. Other programs give us some experience with mandatory treatment. Under SSI, the Social Security Administration requires that some of its beneficiaries participate in treatment, if available. In practice, SSA has found that in the absence of aggressive referral and monitoring systems they have been unable to enforce the provisions. The criminal justice system has had relatively good experience with mandatory treatment under its Treatment Alternatives to Street Crime (TASC) program. They have found that individuals coerced into treatment are no less likely to be successfully rehabilitated than individuals who enter treatment voluntarily, provided in each case that the individual remains in treatment at least three months. The TASC program has an aggressive monitoring system in place.

A further issue is that treatment would need to be provided/paid for somehow. The following are among the possibilities:

- The proposed benefit plan under Health Care Reform includes limited substance abuse treatment. If enacted as proposed, most treatment for AFDC recipients could be provided through this mechanism.

- In the absence of Health Care Reform, Medicaid policies apply. State Medicaid programs currently vary widely in their reimbursement policies for alcohol in drug treatment, and in many cases would not cover appropriate services. One could require states to provide more extensive coverage through Medicaid for these services, but this option would be strenuously resisted by states. In some states Medicaid does provide adequate coverage for the treatment likely to be required by many substance abusing AFDC recipients.

- One could require states to give first priority to AFDC beneficiaries in treatment programs paid for through the federal drug treatment block grant or through other public funding mechanisms.

- The AFDC program could pay for drug treatment directly as it does for employment and training programs. (Under current regulation, substance abuse treatment can be paid for as a supportive service if a state so chooses, but cannot be considered the individual's primary activity.)

Finally, it should be recognized that because substance abuse is a chronic and relapsing disorder, individuals may need multiple treatment opportunities. Typically abusers are not able to remain clean immediately and even those for whom treatment is effective may have multiple relapses before entering a stable recovery. A proposal which does not provide for the possibility of relapse would be unrealistic.

The Republican welfare reform proposal remains silent about whether or how treatment services would be assured for those required to participate in them.

C. Options for Monitoring

- Conduct periodic or random drug screens on recipients identified as alcohol or drug abusers. (This is the option chosen in the Republican plan.)

- Require that the treatment program in which the beneficiary is participating certify periodically that the individual is making satisfactory progress. A treatment program that provides aftercare (follow-up services) could continue this function even after intensive services end.

Issues to consider:

Drug testing has been used in the past (primarily by employers) in order to provide treatment services and to discourage casual use of drugs. Neither is the case here where testing is instead used to impose sanctions. Such a policy would almost certainly be challenged

legally. In addition, these screens are not good indicators of alcohol use and so could only be used to monitor whether a recipient was using illicit drugs. The implementation of drug testing by local welfare agencies would be administratively difficult and expensive as well.

D. Options for Sanctions/Incentives

- Expel from the program (either permanently or for some time period) individuals who either refuse treatment or fail to make satisfactory progress. (This is the option chosen in the Republican plan.)

- Use the same series of sanctions for unsatisfactory participation in drug treatment as would be used for individuals failing to participate in other activities required in their employability plans.

- In addition to one of the above, one might allow a substance abuser who satisfactorily completes treatment additional time (e.g. 6 - 12 months) beyond the two year time limit so that they can have both treatment and opportunities for education and training. (This approach was included at state option in an early draft of the Republican plan but was subsequently dropped.)

Issues to consider:

Under the SSI program, SSA requires the termination of benefits to beneficiaries who refuse treatment. In practice, because treatment has been unavailable, the agency rarely moves to terminate benefits. It should be considered whether sanctions should be imposed for continued use of drugs even if the beneficiary is not provided with the opportunity for treatment.

OPTIONS SUMMARY

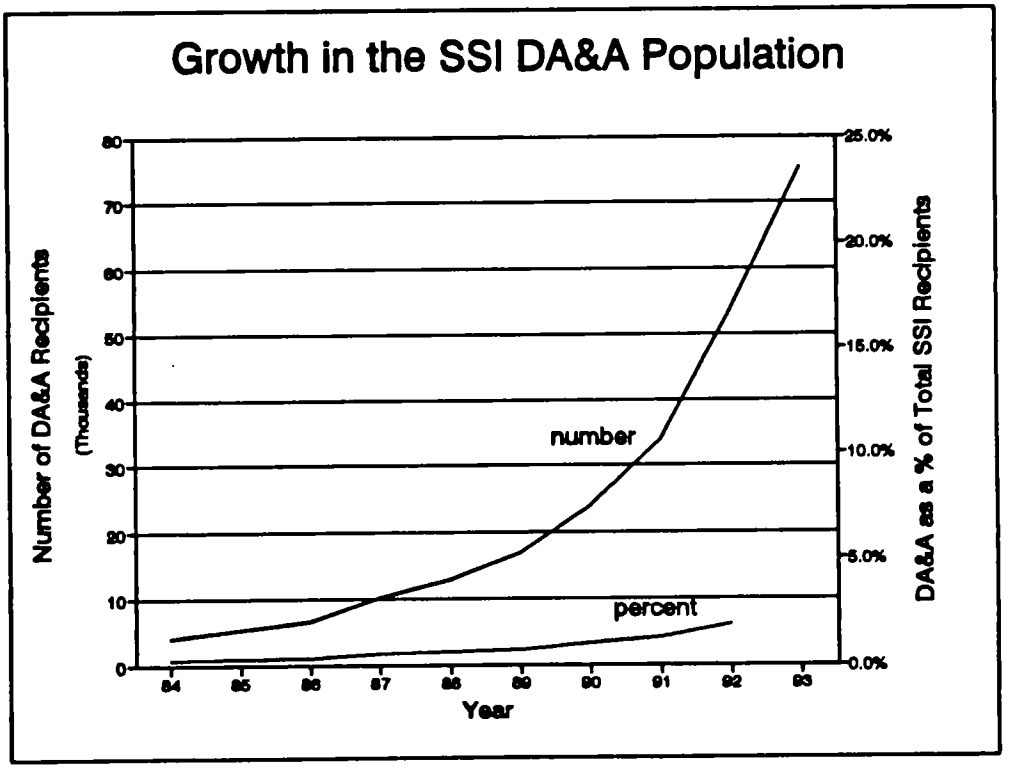
	OPTION	Staff[1] Recommendation	Republican Proposal
ASSESSMENT	Universal assessment		
	Assess if there is cause to suspect abuse	✓	
	Let states choose if/when/how to assess		✓
INTERVENTION	Mandatory alcohol and drug treatment		
	Mandatory treatment with exception if unavailable	✓	✓
	Provide treatment referrals without follow-up		
MONITORING	Periodic or random drug testing		✓
	Assurance of progress from treatment facility	✓	
SANCTIONS/ INCENTIVES	Expel from program for refusal or failure		✓
	Use same sanctions as for non-participation in other activities	✓	
	Provide time extension for substance abusers who remain in treatment	✓	

1. "Staff" recommendations represent the opinions of ASPE analysts only and may differ from those of other agencies.

SSI AND ADDICTION

Background

The policy of making Supplemental Security Income (SSI) cash payments to drug addicts and alcoholics (DA&A) recently has come under scrutiny. Some concerns center around anecdotes about the ease with which DA&A claimants are able to establish disability. Other questions focus on the growth in the numbers of DA&A beneficiaries: 72,137 in September 1993, compared to 4,021 in December 1984. As a percentage of the total SSI disabled population, DA&A beneficiaries have grown proportionately from 0.2 percent in December 1984 to 1.9 percent in December 1992. The following graph reflects this growth.



However, an issue receiving equal attention is whether it is appropriate to make cash payments under SSI, which might be used to purchase drugs and alcohol, to drug addicts and alcoholics. It has been suggested that DA&As should instead receive services, including treatment.

Most SSI DA&A beneficiaries (67.5 percent) are between the ages of 30 - 49. Where race of DA&A beneficiaries is known, the number who are black and white is roughly equal, 40.3 and 39.2 percent respectively. Most (68.4 percent) have no income other than SSI.

However, 19.7 percent of SSI DA&A beneficiaries receive Social Security checks as well as SSI.

As shown in the above graph, the number of reported DA&A cases has grown significantly over the last five years. The number of reported cases, however, varies significantly by state. The following table reflects statistics by selected states as of December 1992.

	SSI disabled recipients age 18 - 64				
	Total blind and disabled (B/D		Alcoholics and drug addicts		
	Number	%	Number	DA&A per State as % of all DA&A	DA&A as % of total State SSI B/D
Total	2,858,800	100.0	53,676	100.0	1.9
California	461,602	16.1	18,696	34.8	4.1
Illinois	136,000	4.8	9,406	17.5	6.9
Minnesota	100,200	3.5	3,764	7.0	3.8
New York	236,500	8.3	2,390	4.5	1.0
Wisconsin	55,300	1.9	2,257	4.2	4.1

Source: December 1992 SSI 10-percent sample file and the December 1992 DA&A file.

Current Law and Practices

The Federal SSI Program was implemented in 1974, replacing the State welfare programs for aid to the aged, blind, and totally and permanently disabled. SSI is a means-tested program that makes cash payments to eligible aged, blind and disabled beneficiaries. The primary purpose of SSI payments is to help meet basic subsistence needs for food, clothing, and shelter. While SSI eligibility may entitle beneficiaries to other benefits and/or services (e.g., Medicaid), SSI itself is not designed as a program of service provision.

Disability under the SSI Program follows the same definition used in Social Security disability insurance (DI) program: having a physical or mental impairment that is so severe that the individual cannot engage in substantial gainful activity anywhere in the economy, and the condition is expected to last at least one year or end in death. However, special restrictions have been placed on SSI beneficiaries who are identified as being DA&A. Unlike Social Security disability insurance (DI) beneficiaries, SSI DA&A beneficiaries were (and continue to be) required to have a representative payee. SSI cash payments should not be made directly to the DA&A beneficiary. Also, SSI DA&A beneficiaries are required to accept treatment for addiction, if available. Failure to comply results in suspension of benefits.

Determining the precise history of how drug addiction and alcoholism has been considered within the context of Social Security disability programs (DI and SSI) is particularly difficult because official policy and actual practice seem to have diverged at different times. It appears that:

- When the SSI Program was originally implemented, regulations permitted consideration of drug addiction and alcoholism in determining whether an individual was disabled.

- However, this policy was not implemented consistently, and actual practice often denied benefits to DA&As who did not have another condition that, in itself, was so severe that benefits could be awarded based on the other condition alone, e.g., benefit claims were approved only if an advanced physical condition resulting in end organ disease (e.g., cirrhosis) supported the award without consideration of alcoholism.

- The 1983 McShea court case, affirmed in the 1989 Wilkerson court case affirmed Social Security policy as stated in the regulations: that alcoholism must be considered in determining whether an individual has a disability within the Social Security definition. As a result, the discrepancy between policy and practice seems to have been reduced, and benefits are no longer denied in the absence of another condition that is disabling in and of itself. Benefits are now awarded when the determination of disability is based on a combination of impairments with DA&A contributing, and even based solely on DA&A if the addiction is so severe that the applicant is unable to work.

The purpose of identifying cases as DA&A is to earmark those beneficiaries who are required to have a representative payee and to accept treatment. Since these requirements do not apply to beneficiaries who still would be found disabled even if substance abuse ceased, cases should only be identified and coded as DA&A if disability would cease if DA&A were to stop. Since DI beneficiaries are not required to have representative payees nor to accept treatment, they are not identified as DA&A.

A key element of the SSI program for substance abusers, referral for treatment and monitoring compliance, is an area that has been neglected in the past. SSA has a program in place to refer substance abusers for available treatment and to monitor compliance with the treatment program. SSA implements this program through agreements or contracts with a referral and monitoring agency (RMA). SSA has had agreements or contracts with RMAs covering 18 states (NY, NJ, MD, PA, TN, IL, MI, MN, OH, WI, MT, WA, MS, NE, NV, CA, HI, and AZ). In close collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Care Financing Administration (HCFA), SSA has developed a standard model aimed at improving the effectiveness of referral and monitoring. SSA is currently negotiating and implementing contracts to establish RMAs in all States; the new standard model is being implemented through the RMA negotiations. However, a primary barrier to dealing effectively with DA&A beneficiaries may continue to

be the lack of available treatment. Treatment must involve no cost to the individual in order to be considered available by SSA.

Possible Approaches and Issues

An underlying premise in developing policy related to drug addiction and alcoholism is whether these conditions are characterized as disease or as misconduct. For the past two decades, addiction has been defined as a disease in medical and legal contexts, both in the U.S. and internationally (by organizations such as the World Health Organization). A number of court cases have held that addiction should be considered as a disease in benefit determinations and as a handicapping condition under the Americans with Disabilities Act.

Viewed as disease, addiction to alcohol or other drugs is a chronic, relapsing condition characterized by an individual's impaired ability to limit his or her use of the substance despite negative consequences. Social Security disability policy currently supports treatment of drug addiction and alcoholism as disease. Recognition of drug addiction and alcoholism as diseases is inherent in determining that disability exists in these cases.

The following is a range of options for consideration in developing an approach for addressing criticisms of and/or deficiencies in current SSI policy with respect to DA&As.

1. Exclude all individuals who are determined to be DA&As from eligibility for SSI disability payments. Many of the recent allegations about abuse of the SSI program by DA&As criticize the practice of making cash payments to this group of people. The publicity in this regard has suggested that vouchers for services are more appropriate. Since SSI is a program of cash assistance instead of services, another vehicle may be more appropriate for this population.

Issues to consider:

This approach directly responds to criticism that federal dollars are being used to purchase drugs and alcohol. However, since Social Security disability programs employ very strict eligibility criteria, and since by definition, beneficiaries of this program are unable to work, this approach may be seen more as treating the symptom instead of the core problem. Since 68.4 percent of SSI DA&A beneficiaries have no source of income other than SSI checks, and since the availability of treatment is limited, it is not immediately obvious that other vehicles exist to serve this population, and excluding them from eligibility may cause spill-over into other problem areas such as homelessness and/or crime.

Excluding DA&As from eligibility for disability payments may be inconsistent with treatment of these conditions as diseases. This would be inconsistent with the Public Health Service position, conventional medical practice, and a number of court cases.

However, this position is supported by the Veterans' Administration which treats drug addiction and alcoholism as willful misconduct.

This approach would create different definitions of disability for the DI and SSI programs, and would ignore the fact that substance abusers may have other severe physical and/or mental conditions that would support a finding of disability even in the absence of substance abuse; an unknown number in this category are currently receiving benefits.

2. **Limit eligibility for SSI disability payments only to those individuals who have another physical or mental impairment which is disabling in and of itself.** Under current policy, these individuals are not required to have a representative payee nor to undergo treatment. One could continue to exempt these individuals from the representative payee and treatment requirements, or extend these special requirements to this group.

Issues to consider:

The issues are the same as with the first approach, except that benefits would be paid to those individuals who are determined to be eligible for benefits without consideration of current substance abuse. If this population, which by definition has such severe disability, were required to accept available treatment as a condition of payment, limited treatment slots may be taken away from individuals who are more likely to become employed.

3. **Improve implementation of current policy.** Current SSI policy concerning DA&As is more restrictive than any other Federal program concerned with this population, although the policy has not been aggressively implemented. One might decide that the current policies are appropriate, but should be implemented more effectively. Current efforts are underway in SSA to establish referral and monitoring agreements in all States using improved treatment models, and to make other changes to improve practice in this area. SSA's current efforts could also be supplemented with demonstration projects seeking improvements in the representative payee system, and to design treatment specifically for the SSI population. Possibilities include:

- **Permit payments to social service agencies to act as representative payee for DA&A beneficiaries.** Family members and friends (generally the first choice as representative payees) may experience difficulty in properly disbursing funds because of pressure from the beneficiary. Social service agencies may be better able to properly exercise control over funds. Allowing SSA to purchase this service could make more payees available.

- **Conduct a waiver demonstration using SSA and HCFA funds.** A waiver demonstration could combine a structured residential setting paid for with SSI funds,

with a treatment program paid for with Medicaid funds. The program director would be representative payee, using the SSI cash assistance to pay for food & shelter. This should be a long term residential program. Waivers would be needed by HCFA and SSA to be able to conduct such a demonstration.

- **Adapt planned demonstration program for hard core addicts.** New funds will be requested in the FY95 budget to treat hard core drug addicts. This will include $310 million in funds that will be distributed to states through the drug treatment block grant, and $35 million in demonstration funding within the Center for Substance Abuse Treatment. One could make SSI beneficiaries a target population within this demonstration and encourage grantees to propose services designed for this population. States could be encouraged to use block grant funds for this purpose as well.

Issues to consider:

Issues around the effectiveness of alcohol and drug treatment arise because single, short term treatment episodes do not necessarily result in the complete cessation of drug use. Because alcohol and drug addiction are chronic, relapsing disorders, a single episode of treatment may not result in abstinence. Treatment research shows that treatment effectiveness improves with length of stay in treatment and that treatment reduces drug use, functional impairment, criminal activity and increases employment.

4. Support the Republican plan which adds the requirement for random drug testing to current policies. The Republican welfare reform proposal would require SSA to implement random drug testing for DA&A beneficiaries, and to suspend permanently beneficiaries found to be using drugs.

Issues to consider:

Alcohol and drug addiction are chronic, relapsing disorders. Being permanently terminated from the SSI program due to the nature of the disability for which you received benefits seems inconsistent with the award of benefits in the first place. Further, since by definition DA&A beneficiaries would not be disabled in the absence of alcohol or drug use, DA&A's found testing negative for drug use could also be suspended from the program.

It is also unclear what this is designed to accomplish. Current policy already requires an individual to be in treatment, if available. Congress is understandably frustrated by reports of untreated addicts receiving benefits. Yet suspending benefits without regard to treatment seems contrary to the program's purposes.

This approach would be very difficult to administer. Drug testing has been used in the past (primarily by employers) in order to provide treatment services and to discourage the casual use of drugs. Neither is the case here where testing would be used instead to impose sanctions. Such a policy would almost certainly be challenged legally. In addition, such testing, particularly on a random basis, would be difficult to administer.

5. Maintain the status quo in terms of entitlement, but enact provisions to time-limit benefits to this beneficiary population. Another way to address DA&A cases might be through emphasis of a temporary/short-term aspect of the existing disability program. As discussed earlier, part of the definition of disability is that the condition is expected to last at least one year. As part of the decision to allow claims, assessments are made concerning whether or not the individual is expected to improve, and these cases are flagged for an early continuing disability review (CDR). Under one concept of temporary disability, notification could be given along with award of benefits that payments will be terminated at the end of a specified time when the condition is expected to have improved. Many DA&A cases might be among those that could be handled in this manner. Time- limited benefits could be implemented in various degrees.

- Time limits when appropriate treatment is offered with provisions for relapse.
- Time limits for drug addicts only.
- Time limits for drug addicts and alcoholics.
- Strict time limits and then termination of entitlement.
- Reassessment after a given time period based on a determination of whether the individual may be reasonably expected to recover, or whether the individual is so disabled, either by their addiction or a combination of addiction and other impairments (e.g. a psychiatric disorder) that recovery is unlikely.

Issues to consider:

Assuring that treatment is available would be critical to the success of this approach; in the absence of viable treatment, many of the issues surrounding the first approach, deny benefits, would also apply here. Without a serious treatment component, time-limited benefits could also create a conflict by awarding benefits on the basis of the disease of addiction, but terminating them quickly on the basis of a behavioral characteristic of the disease.

Related considerations:

Policy development should also recognize existing discrepancies in treatment of DA&As between the DI and SSI programs. Are the "insurance" aspects of DI sufficient to justify less stringent treatment of beneficiaries who are substance abusers?

If the decision is made to place more weight on behavioral aspects of addiction, how far is one willing to go in addressing behavioral aspects of other medical conditions which are the basis of awarding disability benefits, e.g, the roles of eating in obesity (an automatic award of disability benefits when certain prescribed thresholds are exceeded), of smoking in lung and heart disease, and of diet and exercise in cancer and heart disease?