Date: 11/15/94 Time: 18:50

Study: Few Addicts on Welfare Get Treatment and Recover

WASHINGTON (AP) Just 1 percent of the low-income drug addicts and alcoholics who collect disability benefits ever recover or get jobs. Most are dropped from the rolls only when they die or go to jail, according to a federal study.

The report, by the inspector general at the Department of Health and Human Services, also documents government failure to make sure substance abusers are in treatment as a condition of collecting monthly disability checks of $446.

More than 80,000 drug addicts and alcoholics receive benefits under Supplemental Security Income, a welfare program run by the Social Security Administration for the elderly and disabled.

Fewer than 10 percent of SSI substance abusers are in treatment, and Social Security does not know the treatment status of most of the rest, said the federal report released Monday.

Earlier studies by the General Accounting Office and the Republican staff of the Senate Special Committee on Aging found that addicts were spending their checks on drugs and alcohol, sometimes to the point of overdose and death, because of inadequate supervision.

This month's look at the problem finds that death is the most common reason addicts and alcoholics are crossed off the SSI rolls and that many substance abusers collect benefits for years. Investigators identified 510 who have been receiving benefits since the program was begun in 1974.

Sen. William Cohen, whose Senate Aging Committee investigation prompted Congress to end unsupervised cash payments to addicts earlier this year, said the study underscores how Social Security's disability programs are vulnerable to abuse.

``Taxpayer dollars are flowing into the veins of drug addicts, and the government is rarely taking steps to shut off the payments,'' said Cohen, R-Maine.

For their study, the investigators tracked 20,101 recipients who were on the rolls in June 1990. Nearly four years later, as of February 1994, 76 percent a total of 15,271 were still on SSI. On average, they had been collecting benefits for 7.4 years.

Of the remaining 4,830 who were not receiving benefits, half had died.

An additional 399 were dropped because they refused treatment, 370 were in jail or another public institution and 197, just 1 percent of the overall total, had recovered their health or found jobs. The rest had obtained other benefits or been removed for other reasons.

Sen. Cohen, who is in line to become chairman of the Senate Aging Committee next year, said he is hopeful that the new restrictions on SSI payments to addicts, including a three-year limit on benefits, ``will go a long way toward curbing these abuses.''

Under current law, substance abusers on SSI are supposed to be in treatment but only if it is available and are only suspended if they refuse treatment when it is offered.

Under the new law, which takes effect in March, drug addicts and alcoholics on SSI will be kicked off the rolls after three years, regardless of whether they receive treatment.

Social Security Commissioner Shirley Chater said the agency intends to be aggressive about making sure these recipients are referred to treatment facilities where they will be given ``ample opportunity to overcome their addictions.''

``The public has a right to expect substance abusers will not simply continue to collect cash benefits without making an attempt to overcome their addictions and seek productive work,'' Chater said.
APNP-11-15-94 1850EST

DD&A

OMB is clearing a rule by COB today that implements sections of the Social Security Independence and Program Improvements Act of 1994. SSA is under a statutory deadline of February 11th to publish the rule.

Background:

In short, beginning March 1995, the Act:

- Imposes a 36-month limitation on payments to DA&A recipients, effective March 1995. For DI recipients, the limitation only applies if treatment has been available for 36 months. For SSI recipients, the limitation applies whether treatment is available or not.

- Requires all DA&A recipients to undergo appropriate substance abuse treatment, if available.

- Imposes new requires on recipient participation in appropriate treatment. Individuals must comply with treatment requirements, including demonstrating progress. Failure to comply is grounds for suspension of benefits.

- Requires each state to establish at least one referral and monitoring agency to identify appropriate treatment placements and monitor compliance. These agencies are funded by SSA.

Process for developing rule:

The rule follows the legislation very closely. SSA worked closely with OMB and HHS to develop the rule, following a public comment period.

Politics:

The legislation itself, as you know, is controversial, pleasing few because it falls in the middle of a heated debate.

Congress' and advocates' reaction to the rule, therefore, will be all over the map:

- Republicans are pushing to entirely eliminate benefits for DA&A recipients, period. They won't be happy with something that continues benefits for 3 years.

- Others will be unhappy with it because it makes benefits for SSI recipients contingent on treatment and there aren't enough treatment slots available (and no funding in the legislation to increase them).

Some states have raised the specter of unfunded mandates, although OMB believes that the legislation avoids this by making treatment mandatory only "if available".

SSA is going to frame this in terms of individual responsibility. They recognize the political delicacy of the legislation and possible administrative glitches that may arise. (It may lead to an increase in appeals under due process.)

Next steps: HHS and SSA are developing Q&As jointly. They will brief Congress next week. They will also brief the NGA and state organizations either next week or the following week.

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503

SPECIAL

February 7, 1994

LEGISLATIVE REFERRAL MEMORANDUM

LRM #M-1081

TO: Legislative Liaison Officer -

ONDCP - Rabette Hankey - (202)395-6739 - 257
NEC - Sonyia Matthews - (202)456-6722 - 429
ICH - George Ferguson - (202)708-1480 - 399

FROM: JANET R. FORSGREN (for) Janet R. Forsgren
Assistant Director for Legislative Reference

OMB CONTACT: Chris MUSTAIN (395-3923)
Secretary's line (for simple responses): 395-7362

SUBJECT: HHS Proposed Testimony on SSI benefits for drug and alcohol addicts

DEADLINE: 11:00 am February 8, 1994

COMMENTS: The attached two pieces of testimony will be given before the House Social Security Subcommittee and the House Human Resources Subcommittee on Wednesday, February 9th.

OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President, in accordance with OMB Circular A-19.

Please advise us if this item will affect direct spending or receipts for purposes of the the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

CC:
Barbara Selfridge
Keith Fontenot
Richard Popper
Bill Dorotinsky (2)
Shannah Koss
Jim Duke
Cookie Walden
Steve Ricchetti
Janet Forsgren
Doug Steiger

LRM #M-1081

RESPONSE TO LEGISLATIVE REFERRAL MEMORANDUM

If your response to this request for views is simple (e.g., concur/no comment) we prefer that you respond by faxing us this response sheet. If the response is simple and you prefer to call, please call the branch-wide line shown below (NOT the analyst's line) to leave a message with a secretary.

You may also respond by (1) calling the analyst/attorney's direct line (you will be connected to voice mail if the analyst does not answer); (2) sending us a memo or letter; or (3) if you are an OASIS user in the Executive Office of the President, sending an E-mail message. Please include the LRM number shown above, and the subject shown below.

TO: Chris MUSTAIN (395-3923)
Office of Management and Budget
Fax Number: (202) 395-6148
Analyst/Attorney's Direct Number: (202) 395-3923
Branch-Wide Line (to reach secretary): (202) 395-7362

FROM: _____ _____ (Date)

_____ _____ (Name)

_____ (Agency)

_____ (Telephone)

SUBJECT: HHS Proposed Testimony on SSI benefits for drug and alcohol addicts

The following is the response of our agency to your request for views on the above-captioned subject:

_____ Concur

_____ No objection

_____ No comment

_____ See proposed edits on pages _____

_____ Other: _____ _____

_____ FAX RETURN of _____ pages, attached to this response sheet

DRAFT

Mr. Chairmen and Members of the Subcommittees, I am pleased to be here today to testify at your hearing 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 on alternative approaches to assisting this population.

Over the years, the 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 what SSA has been doing to improve administration of the SSI program in cases involving drug addiction and alcoholism (DA&A), what we are doing to explore reasonable modifications to the program, and other issues that your Subcommittees has expressed interest in.

Let me begin by briefly mentioning some background information 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 early discussions which preceded SSI legislation, 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. Seeking to address all concerns,

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.

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 population) at the beginning of fiscal year (FY) 1991 to over 78,000 (or 2.6 percent of the total SSI 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 78,000 DA&A recipients on the SSI rolls, about 64,000 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).

Eligibility Requirements

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

- 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

- 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.

By law, 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.

Increase in SSI DA&A Rolls

As you outlined in the press release for this hearing, 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. At the present time, 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.

Another factor is our increased emphasis to the State Disability Determination Services (DDSs) on the importance of accurately identifying cases involving DA&A impairments. In April 1991 we issued an extensive program circular 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 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.

While there is no data available, recent cut backs 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 and the District of Columbia, include provisions requiring RMAs to:

- o 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, and 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. Chairman, 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 slots was a significant factor in preventing treatment. I would, therefore, defer to SAMHSA to provide information about the overall availability of treatment. I would call to the Subcommittees' attention, however, the major new investment in treatment in the President's FY 1995 budget, as well as his proposed health reform legislation, which SAMHSA will discuss.

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, which they can then use to support their addiction.

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 this provision 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

I recognize that in past years SSA did not administer the DA&A program as effectively as it could have. Recently though we have made great strides, and we want to continue to improve the program.

However, improving the SSI program for the DA&A population is a multi-step process, 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 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 the best alternatives for providing effective treatment and rehabilitation. 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

DRAFT

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 came into being in October, 1992 as part of the U.S. Public Health Service (PHS) and incorporated the research and service programs of the former Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA). Three centers for prevention and treatment services are now part of SAMHSA: the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services. SAMHSA was established to enable the PHS to more effectively address health problems resulting from addictive and mental 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 have co-occurring mental health problems.

Prevalence

Nationally, the rate of illicit drug use, based on the National Household Survey on Drug Abuse, which is published by PHS, 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 drug users. 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 people.

However, not all trends are favorable. 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.

Estimating the size of the substance abusing population is both controversial and extremely difficult. The White House Office of National Drug Control Policy (ONDCP) is releasing its National Drug Control Strategy today. It 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.

Availability of 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.

To further increase the availability of treatment, the President is proposing for FY 1995 a new initiative of $345 million focused on the treatment of hard core substance abusers (both alcoholics and drug addicts), a population that would include those who are currently receiving SSI benefits. These funds would support treatment for up to 74,000 individuals suffering from addictive disorders. The President is proposing an additional $10 million for the expansion of treatment of hard core substance abusers among the American Indian and native Alaskan populations.

Treatment of Substance Abuse

We know we can successfully intervene with hard core substance abusers. 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:

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

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:

- o Establishing effective Referral and Monitoring Agencies (RMAs) in all States.

- o 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 in March with the recipients of these cooperative agreements.

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 based on real time. 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.

Date: 11/15/94 Time: 08:45

Study: Few Addicts on Welfare Get the Required Treatment and

WASHINGTON (AP) For low-income drug addicts and alcoholics, the surest way to get crossed off the federal disability rolls is to die or go to jail. Only 1 percent ever recover or get a job, according to a government study.

The report, by the inspector general at the Department of Health and Human Services, is a devastating portrait of the government's failure to make sure substance abusers are in treatment as a condition of collecting a monthly disability check.

More than 80,000 drug addicts and alcoholics receive benefits under Supplemental Security Income, a welfare program run by the Social Security Administration for the elderly and disabled that pays a maximum of $446 a month.

Fewer than 10 percent of substance abusers are in treatment, and Social Security does not even know the treatment status of most of the rest, the HHS report said.

Earlier studies by the General Accounting Office and the Republican staff of the Senate Special Committee on Aging found that addicts were squandering their checks on drugs and alcohol, sometimes to the point of overdose and death, because of inadequate supervision.

The latest look at the problem finds that death is the most common reason addicts and alcoholics are dropped from the SSI rolls and that many substance abusers collect benefits for years. Investigators identified 510 who have been receiving SSI since the program was first launched in 1974.

For their study, the investigators tracked 20,101 recipients who were on the rolls in June 1990. Nearly four years later, as of February 1994, 76 percent a total of 15,271 were still on SSI. On average, they had been collecting benefits for 7.4 years.

Of the remaining 4,830 who were no receiving SSI, half had died.

An additional 399 were dropped because the refused treatment, 370 were in jail or another public institution and 197, just 1 percent of the overall total, had recovered their health or found a job. The rest had obtained other benefits or been removed for other reasons, investigators said.

Their study was prompted by a similar analysis earlier this year, which looked at a tiny sample of recipients, and comes amid heightened congressional interest in the program, which as quadrupled in size since 1990.

Sen. William Cohen, whose Senate Aging Committee investigation earlier this year prompted Congress to end unsupervised cash payments to addicts, said the HHS study underscores how Social Security's disability programs are highly vulnerable to abuse.

``It is appalling that the most common reason for terminating benefits to addicts and alcoholics was the recipient's death, according to the IG's findings,'' said Cohen, who is in line become chairman of the committee next year when the GOP takes control of Congress.

``Taxpayer dollars are flowing into the veins of drug addicts, and the government is rarely taking steps to shut off the payments,'' Cohen said.

Cohen said he is hopeful that the new restrictions on SSI payments to addicts, including a three-year limit on benefits, ``will go a long way toward curbing these abuses.''

Under current law, substance abusers on SSI are supposed to be in treatment but only if it is available and are only suspended if they refuse treatment when it is offered.

Under the new law, which takes effect in March 1995, drug addicts and alcoholics on SSI will be kicked off the rolls after three years, regardless of whether they receive treatment.

Social Security Commissioner Shirley Chater said the agency intends to be aggressive about making sure these recipients are referred to treatment facilities where they will be given ``ample opportunity to overcome their addictions.''

``The public has a right to expect substance abusers will not simply continue to collect cash benefits without making an attempt to overcome their addictions and seek productive work,'' Chater said. ``We are committed to helping those entitled to the assistance of their government while also protecting the interests of the taxpayer who must pay the bill.''

APNP-11-15-94 0844EST

FACT SHEET: SSI BENEFITS FOR ALCOHOLICS/DRUG ADDICTS

On Tuesday night, February 8, 1994, the NBC program Dateline ran a segment about benefits being paid to alcoholics and drug abusers through the Social Security Administration's disability program. The Washington Post ran a story on this topic on February 7, 1994. Below are some key facts regarding this issue.

THE PROBLEM:

* **Supplemental Security Income (SSI) benefits for drug addicts and alcoholics are mandated by statute.**

  Since Congressional enactment in 1972, individuals have received SSI benefits for disabling conditions that will last at least 12 months and will keep them from working. Drug addiction and alcoholism are included.

* Current law requires substance-addicted SSI recipients to accept treatment and that their benefit be paid to a legal guardian or "representative payee." However, it it often difficult to find decent representatives, or any representatives at all, for some SSI recipients.

* Recent reports have indicated that some SSI recipients addicted to drugs and alcohol may use benefits to sustain their habits. **This is a serious concern.**

THE RESPONSE:

* The Social Security Administration (SSA) **has already improved** its referrals to treatment programs and its monitoring systems.

  In October, 1993, SSA had referral and monitoring contracts in only 18 states. Today, such systems are in place in 33 states and the District of Columbia. By the end of FY 1995, all states will be involved. These new contracts will require recipients to undergo regular substance abuse testing.

  SSA is also working aggressively to find more and better representative payees.

* **The FY 1995 Budget reflects a determination to solve this problem.**

  The FY 1995 budget requests $36 million for referral and monitoring activities, an 80% increase from the FY 1994 level, and **an 800% increase over the Bush Administration figure** of $4 million in FY 1993.

* The FY 1995 budget also requests $345 million for the treatment of hard-core drug abusers.

* The Administration will work with Congress to make appropriate changes to the program. The public has a right to expect those disabled by substance addiction to take responsibility for themselves, seek treatment and do all they can to cure themselves of their addiction.

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THE WHITE HOUSE

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(Including cover)

PRIORITY: (Y) N

FROM: Jen O'Connor

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MESSAGE: HHS sent talking points on the SSI/drug abuse issue. They were dense, so I reformatted them. Both versions are attached.

DRAFT TALKING POINTS
SSI BENEFITS FOR ALCOHOLICS/DRUG ADDICTS

Supplemental Security Income (SSI) benefits to drug addicts and alcoholics are mandated by law, and are based on a medical determination that substance addiction is a disease. The statutorily mandated eligibility requirements are the same as that for other disabling conditions - a medically determinable impairment expected to last for at least 12 months, and an inability to perform substantial gainful activity.

However, the American public has a right to expect that those disabled by substance addiction should seek to take responsibility for themselves. The Administration therefore supports provisions in current law requiring that SSI recipients accept treatment, and that their benefits be paid to a legal guardian or other representative payee. (NOTE: these provisions do not apply to addicted SSI recipients disabled by a related impairment, such as cirrhosis of the liver.)

The Administration is concerned about reports that those addicted to drugs and alcohol may be using cash benefits to sustain their habits, and that many SSI recipients are not receiving drug treatment. HHS has already taken steps to improve the program's administration and is considering others.

SSA, for example, is working to improve both referrals to drug and alcohol treatment services and the monitoring of recipients' treatment. As of October 1993, SSA had referral and monitoring contracts in place in only 18 states, and only 45 percent of recipients were being monitored. Today, new, stronger referral and monitoring systems are in place in 33 states and the District of Columbia, and SSA is continuing its efforts to expand the program. These new contracts will require recipients to undergo regular testing for signs of substance abuse. SSA is also aggressively working with the Substance Abuse and Mental Health Services Administration (SAMHSA) and non-profit organizations to recruit more and better representative payees for drug and alcohol addicted SSI recipients.

The Administration's budget request also reflects a determination to solve existing problems. We are asking Congress for $36 million for SSA referral and monitoring activities, an 80 percent increase from the FY 1994 level of $20 million. The Bush Administration allocated just $4 million in FY 1993.

In addition, the budget request asks for $346 million for SAMHSA to conduct a new initiative focused on the treatment of hard core substance abusers. And the Health Security Act would make residential and outpatient treatment, counseling and case management available to all Americans.

The Administration is interested in working with Congress to make whatever changes are necessary to improve this program, and move drug and alcohol-addicted Americans toward self-sufficiency.