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ALCOHOLISM AND ADDICTION

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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ALCOHOLISM AND ADDICTION

I. Present Law

Federal law and legislative history are silent in terms of specific reference to the classification of alcoholics and drug addicts as eligible, on account of those diseases, under the program of Aid to the Permanently and Totally Disabled (APTD).

While APTD was enacted in 1950, available information indicates that it was not until 1969 that drug addicts were determined as eligible for welfare as disabled persons. New York initiated that interpretation with the concurrence of the Department of Health, Education, and Welfare.

There is no specific information available indicating the point-in-time at which alcoholics first began to receive welfare payments as disabled persons. It seems reasonable to assume, however, that some States have long determined alcoholics as disabled—probably on a case-by-case basis rather than as a matter of statewide formal policy.

Undoubtedly, many individuals determined as disabled on the basis of alcoholism or addiction are otherwise eligible under another welfare category—such as Aid to Families With Dependent Children where the tests of eligibility relate to income, resources and the presence of children in the family. In many instances where the alcoholic mother of young children is rather severely incapacitated, she would be classified as disabled rather than AFDC because disability payment levels under welfare are generally higher than those applicable to AFDC.

According to information supplied by the Department of HEW, every State, in varying degree, has classified persons with a primary diagnosis of alcoholism as disabled (see table 1). Of the 865,894 disabled recipients in June 1970, 11,917 had primary diagnoses of alcoholism and an additional 15,042 had secondary diagnoses of alcoholism. Those with primary or secondary diagnoses of alcoholism constituted some 3 percent of the total recipients on the disabled rolls at that time.

TABLE 1.—*Estimated APTD caseload, by State, with a diagnosis of alcoholism and alcoholic psychosis or drug dependence as primary or secondary disabling conditions, June 1970*

State	Total recipients	Drug dependence			Alcoholism		
		Primary	Secondary	Total	Primary	Secondary	Total
Alabama	18, 367	0	0	0	13	41	54
Alaska	730	4	4	8	6	14	20
Arizona	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Arkansas	11, 271	0	0	0	20	10	30
California	173, 948	0	176	176	1, 080	2, 777	3, 857
Colorado	9, 562	7	21	28	480	277	757
Connecticut	6, 916	0	0	0	124	91	215
Delaware	1, 335	5	0	5	17	28	45
District of Columbia	6, 417	24	0	24	147	245	392
Florida	20, 836	19	0	19	136	227	363
Georgia	33, 194	0	0	0	233	389	622
Guam	(1)	(1)	(1)	(1)	(1)	(1)	(1)
Hawaii	1, 774	2	2	4	10	25	35
Idaho	2, 739	0	0	0	92	53	145
Illinois	41, 400	0	28	28	469	1, 032	1, 501
Indiana	5, 217	0	0	0	29	64	93
Iowa	3, 078	0	3	3	17	34	51
Kansas	5, 410	0	13	13	56	111	167
Kentucky	16, 764	0	0	0	14	43	57
Louisiana	21, 382	0	0	0	166	83	249
Maine	4, 233	0	0	0	24	18	42
Maryland	15, 984	0	0	0	261	434	695
Massachusetts	16, 686	0	0	0	259	190	449
Michigan	26, 820	0	0	0	227	499	726
Minnesota	11, 281	0	10	10	113	226	339

Mississippi	21, 930	0	0	0	13	40	53
Missouri	18, 844	0	96	96	170	341	511
Montana	2, 147	3	8	11	132	76	208
Nebraska	4, 546	0	4	4	54	108	162
Nevada	[2]	[2]	[2]	[2]	[2]	[2]	[2]
New Hampshire	812	0	0	0	10	7	17
New Jersey	12, 388	22	3	25	269	219	488
New Mexico	8, 274	8	26	34	291	168	459
New York	76, 970	5, 353	653	6, 006	3, 194	2, 690	5, 884
North Carolina	27, 515	79	0	79	258	430	688
North Dakota	2, 076	0	2	2	32	64	96
Ohio	30, 823	0	78	78	335	736	1, 071
Oklahoma	24, 958	0	0	0	248	124	372
Oregon	7, 536	3	3	6	79	202	281
Pennsylvania	43, 045	54	7	61	1, 435	1, 164	2, 599
Puerto Rico	15, 501	31	0	31	246	246	492
Rhode Island	3, 983	0	0	0	88	64	152
South Carolina	10, 435	0	0	0	37	62	99
South Dakota	1, 482	0	0	0	25	50	75
Tennessee	25, 110	0	0	0	41	123	164
Texas	23, 702	0	0	0	55	27	82
Utah	5, 186	11	33	44	461	266	727
Vermont	1, 878	0	0	0	13	10	23
Virginia	7, 734	7	0	7	65	108	173
Virgin Islands	62	0	0	0	3	3	6
Washington	16, 352	18	18	36	229	588	817
West Virginia	9, 397	0	0	0	44	74	118
Wisconsin	6, 933	0	5	5	52	115	167
Wyoming	931	0	0	0	45	26	71
National total	865, 894	5, 650	1, 193	6, 843	11, 917	15, 042	26, 959

[1] Not available.

[2] No specific program.

While some 12,000 APTD recipients were classified in June 1970 as disabled with primary diagnoses of alcholism, the Department of HEW estimates, in general terms, that, nationwide, approximately 200,000 alcholics are potentially eligible for APTD as disabled and because of their low assets and incomes.

States exhibit considerably more variation and circumspection in their classification of drug addicion as the basis of eligibility for APTD. As table 1 indicates, in June 1970, 31 States did not have anyone on their APTD rolls who had a primary diagnosis of drug dependence. Several of those States did, however, include on APTD persons with secondary diagnoses of drug addiction. Of the 865,894 APTD recipients in June 1970, a total of 5,650 had primary diagnoses of drug dependence and another 1,193 had secondary diagnoses of addiction.

Based upon Department of HEW data, there are probably some 75,000 to 100,000 addicts eligible or potentially eligible for APTD because of low income and assets.

It should be noted, that there has been a substantial increase in the APTD rolls since June 1970. In November 1971, there were 1,056,000 recipients of APTD—an increase of almost 200,000 over the June 1970 figure. Undoubtedly, a substantial proportion of that increase represents addicts and alcoholics—particularly addicts—coming onto the rolls. For example, in June 1970, New York had some 6,000 addicts on APTD—in calendar 1971, New York reported almost 21,000 addicts on the rolls. (For fiscal 1973 New York estimates it will have 32,000 addicts on APTD.)

These disabled recipients are eligible for cash maintenance payments, Medicaid and social services. A recent HEW agreement with the State of New York resulted in the definition of social services for addicts being broadened to include many medical services. This agreement resulted in increased Federal funds for New York since social services are matched with 75 percent Federal dollars, whereas medical services under Medicaid in New York are matched at only 50 percent. In addition, some services provided addicts and alcoholics probably were not eligible for any Federal matching before the New York agreement.

Under social security disability insurance, however, alcoholics and addicts are eligible for benefits only if they have another disabling condition, such as cirrhosis of the liver. There are currently an estimated 10,000—of a total of 1,650,000 disabled workers—whose disability is based upon impairments directly related to alcoholism or drug dependency. This number does not include those with nonrelated disabilities who also abuse drugs or alcohol.

II. Problem

Under H.R. 1, alcoholics and addicts would be defined as disabled (applying the general social security definition of disability) for purposes of welfare eligibility. However, alcoholics and addicts would not receive cash assistance if treatment were available which they refused.

The Finance Committee expressed concern earlier that this H.R. 1 provision might result, in many cases, in alcoholics and addicts receiving cash payments without being involved—or only nominally involved—in treatment programs. Related to this is the obvious

potential problem of alcoholics and addicts using welfare payments to support their addiction or alcoholism.

III. Committee Action

A. EXECUTIVE HEARING

On April 19 the Committee held a special executive hearing with Administration officials in order to obtain further information on the relationship between alcoholism, addiction and the welfare system. Among those present at the hearing were the Assistant Secretary for Legislation, Mr. Stephen Kurzman; the Deputy Commissioner of Social Security, Mr. Arthur Hess; the Director of the National Institute on Alcoholism, Dr. Morris Chafetz; the Director of the National Institute of Mental Health, Dr. Bertram Brown, and HEW's New York Regional Welfare Commissioner, Mr. Elmer Smith.

During the hearing, Committee members asked questions concerning the extent to which alcoholics and addicts are presently on the welfare rolls; the potential increase in this number if alcoholics and addicts were more generally added to welfare programs; costs of treatment; potential effects of treatment; and the extent to which Federal programs are generally available to deal with problems of alcoholism and addiction.

B. HEW RESPONSES

At the executive session and in correspondence which followed, the Department attempted to answer the Committee questions. The Department's best estimates were that some 35,000 addicts and alcoholics were on the welfare rolls in 1970 in those States which then specifically covered such persons as disabled (see table 1). This number does not include possible alcoholics or addicts who are covered under another category such as AFDC or old age assistance, nor does it include those who are otherwise disabled who are also alcoholics or addicts.

In terms of potential eligibles, Department officials estimated, at the executive session, that, of approximately 10 million citizens with drinking problems, 5 percent or 500,000 are totally disabled. As previously indicated, the Department estimates that somewhat less than half of these, or 200,000, are needy. The balance have resources of their own, family resources or public programs such as Veterans Administration care available to them. The Department estimated the total number of addicts at 250,000. No specific estimate was given as to those who are both disabled and needy, but the figure might be on the order of 75,000.

Department witnesses indicated that the success of treatment varied with alcoholics and addicts. On average, they estimated that one-third of addicts could be cured, one-third could be significantly improved and another one-third would not improve. With respect to alcoholism, the Department estimated that 75 percent could be significantly improved. However, they indicated that the potential improvement figure would be lower than 75 percent with respect to those alcoholics determined as disabled.

The Department supplied tables 2 and 3 identifying presently available Federal treatment programs and the total Federal expendi-

tures for alcoholism and drug addiction. The cumulative total of Federal expenditures in the area of alcoholism and addiction is projected at some $600 million in 1973. Estimates by Department witnesses on the costs of treatment were as follows: Intensive outpatient care of an alcoholic, approximately $2,000 per year; intensive outpatient treatment of drug addiction, including methadone maintenance, at about $2,000 per year. Good institutional care of a severe alcoholic might run $5,000 a year; and intensive institutional group therapy for an addict could cost $10,000 a year.

From this information, it is possible to at least attempt to project the total costs of treating and maintaining needy, disabled alcoholics and addicts. The costs of the average case for maintenance and therapy might run $3,000 a year. Multiplying this by the estimated number of potential and presently eligible alcoholics and addicts—275,000— develops a potential total cost of $800 million. This figure should be reduced by current Federal treatment expenditures and by current State and local payments for State hospital care and general assistance. As tables 2 and 3 show, current Federal treatment expenditures amount to approximately $300 million.

C. COMMITTEE REQUEST

The Committee asked the Department of Health, Education and Welfare to work with the staff in developing approaches to the problems of alcoholism and addiction in relation to the welfare system and other governmental programs. The Committee indicated that the effort should be directed toward developing a treatment program rather than a cash assistance program and that any program developed should not duplicate other Federal programs.

D. HEW RECOMMENDATION

In a letter to the Committee signed by Mr. James Edwards, Deputy Assistant Secretary for Welfare Legislation, the Department recommended the following:

> "We are agreeable to the present provision in H.R. 1, but are also willing to see these provisions eliminated. We recommend this course to the Committee because we simply do not believe that now is the time, nor H.R. 1 the place, to establish a large new program for drug addicts and alcoholics under public assistance programs."

IV. Alternative Proposals

A. INSTITUTE NEW PROGRAM

Despite the lack of constructive specific suggestions from the Department, the staff has attempted to develop a plan for dealing with needy and disabled alcoholics and addicts. Below is a brief outline of the program, followed by a description of the individual problems that we faced in developing the proposal and the specific proposals developed to deal with each problem.

1. Outline

- Medically determined (as described below) alcoholics and addicts would not be eligible for welfare benefits under the APTD category.

- Alcoholics and addicts who meet the income and resources test for welfare and who meet a definition of disability parallel to the social security definition, that is who are unable to engage in any substantial gainful activity by reason of a medically determinable addictive dependence on alcohol or drugs which has lasted or can be expected to last for a period of 12 months—would be eligible for an alcoholism or addiction treatment program which would be established under Title XV. A State would have the option of instituting such a program. Once enrolled in the treatment program, the alcoholic or addict would be referred to a local treatment organization or agency certified by the appropriate State agency designated under the Comprehensive Alcohol Abuse and Treatment Act of 1970 or the Drug Abuse and Treatment Act of 1972.
- In a State which provides welfare payments under categories other than APTD to persons medically determined (as described above) to be alcoholics or addicts (for example, an alcoholic mother or an addicted child on AFDC) the person must be referred for care and treatment to the appropriate agency as a condition of continued eligibility for Federal matching. Refusal of care and treatment by an addict or alcoholic would result in termination of assistance payments for that individual.
- The local treatment agency would be reimbursed with Title XV funds for the treatment of enrolled alcoholics and addicts, but only after all other funds available under any other Federal treatment program had been utilized to the extent available. To assure maintenance of expenditure levels in the primary Federal programs directed toward treatment and rehabilitation of alcoholics and addicts and to avoid any shifting of the bulk of those expenditures to Title XV, it is recommended that:

  (*a*) Title XV expenditures for care and treatment (including social services) not exceed amounts appropriated, allocated, and actually available in States for care and treatment of alcoholics and addicts.

  (*b*) If a reduction in other Federal expenditures is made, either through reduction in appropriations or expenditure levels (including impounding of appropriated funds), then the Federal matching funds available under Title XV should be reduced proportionate to such decreases.

  (*c*) (*a*) and (*b*) would not apply to the extent that any reductions occur as a consequence of actual decrease in need for care and treatment as determined by the Secretary (subject to verification by the Inspector General).
- To be eligible for reimbursement under Title XV, the individual treatment program must be carried out under a professionally developed plan of rehabilitation designed to terminate dysfunctional dependency on alcohol or drugs and which must be renewed at three-month intervals. Additionally, the plan must include to the maximum extent feasible a program of work rehabilitation.
- If proper treatment or rehabilitation would be thwarted by the lack of maintenance funds for the enrolled alcoholic or addict, maintenance payments to the patient or protective payments could be made with Title XV funds. Maintenance payments may not exceed comparable welfare payments and the question of maintenance

versus protective payments must be specifically reviewed at least every three months.

- Matching under Title XV would be at the rates otherwise provided for the types of payments made. For example, medical care and treatment would be matched at Medicaid rates and cash payments would be matched at the rates applicable to the category under which the person would otherwise be aided.

2. Not Eligible for Welfare

Problem

Alcoholics and addicts, by the nature of their illness, might use cash assistance payments inappropriately—specifically to support their alcholoism or addiction with little thought given to the solution to their problem.

Proposal

As outlined above, the staff would recommend that alcoholics and addicts not be eligible for the regular welfare program, but that they be enrolled in a separate treatment program for their condition.

3. Eligibility for Treatment

Problem

Specific determinations of alcoholism and addiction can be difficult to make and under loose definitions a vast number of people conceivably could be eligible for any treatment program.

Proposal

The staff would recommend limiting eligibility in the new Title XV program to those alcoholics and addicts who are:

A. Needy by the State income and resource standards, and
B. Disabled under the following definition—"Unable to engage in any substantial gainful activity by reason of a medically determinable addictive dependence upon alcohol or drugs which has lasted or can be expected to last 12 months."

4. Coordination With Other Programs

Problem

Recent Federal legislation, particularly the Alcohol Abuse and Treatment Act of 1970, and the Drug Abuse and Treatment Act of 1972, defined a broad new Federal role in dealing with alcoholism and addiction. Any new program should coordinate with the activities of these programs and should not duplicate their efforts.

Proposal

The staff would recommend that in order to coordinate the new Title XV program with the recently established Drug and Alcohol Abuse treatment programs, Title XV funds be made available only to local treatment agencies or organizations which are certified as appropriate and qualified to provide care and treatment by the designated State Drug or Alcohol Agency established under the recent Federal legislation.

Similarly, to prevent a duplication of activities, no Title XV funds would be made available unless the local agency had first utilized all

other funds available under any other Federal or State treatment program. If any of those funds should be withheld by Federal or State budget agencies, Title XV funds should be cut back proportionately, by statute.

5. Plan of Treatment

Problem

In the past, Federal treatment funds have often gone to support programs which were primarily token or pro forma in nature.

Proposal

It is recommended that in order for Title XV funds to be available, care and treatment be provided under a professionally developed plan which must be reviewed and renewed at not longer than three-month intervals.

Further, the Secretary and the Inspector-General would be required to regularly determine whether pro forma compliance was being undertaken. Federal funds would be terminated in the absence of an active program.

6. Maintenance

Problem

Treatment and rehabilitation for needy disabled alcoholics and addicts cannot be pursued if the person does not have any source of maintenance assistance for food and shelter. The alcoholic or addict might have to turn to illegal efforts to secure necessary funds for basic necessities in the absence of cash or supportive payments.

Proposal

In those cases where it is determined that proper treatment or rehabilitation would be thwarted by the lack of maintenance funds for the enrolled alcoholic or addict, maintenance or protective payments could be made. Such payments could be no greater than comparable welfare payments. The question of protective payments versus direct payments must be specifically evaluated at least every three months.

B. EXCLUSION AND STUDY

However, if the Committee wishes to follow the Department's recommendation that this is not the time and H.R. 1 is not the place to establish a new program for treatment of needy and disabled alcoholics and addicts, then alcoholics and addicts could be designated as ineligible for welfare payments effective six months after enactment. The Committee, at the same time, could instruct the Department to report back within 12 months as to HEW's recommendations concerning possible alternative approaches relating to care, treatment and maintenance of needy, disabled alcoholics and addicts in the context of the welfare system.

TABLE 2.—*Estimated total Federal obligations for alcoholism programs*

[In millions of dollars]

	1969	1971	1972	1973
Treatment and rehabilitation:				
Health, Education, and Welfare:				
National Institute of Mental Health		8.3	68.3	78.2
Social and Rehabilitation Service	14.1	26.7	37.4	31.7
Veterans' Administration		8.1	12.5	14.5
Office of Economic Opportunity		11.0	2.0	
Subtotal	14.1	54.1	120.2	124.4
Education and training: Health, Education, and Welfare	.7	1.8	4.8	4.8
Research:				
Health, Education, and Welfare	6.2	6.6	8.4	8.9
Transportation		7.4	29.4	31.7
Subtotal	6.2	14.0	37.8	40.6
Total, Federal	21.0	69.9	162.8	169.8
Total, DHEW	21.0	43.4	118.9	123.6

TABLE 3.—*Estimated funding for Federal drug abuse treatment programs by agency and legislative authorization*

[Fiscal years, millions of dollars]

Agency and authorization	Obligations			Additional authorizations above 1973 requested obligations		
	1971	1972	1973	1972	1973	1974
SAODAP: Sec. 223, Public Law 92-255					$40	$40
HEW (NIMH):						
CMHC; NARA	$38.4	$80.0	$92.2			
Sec. 401(a), Public Law 92-255 (amends sec. 221 CMHCA)					60	60
Sec. 401(c), Public Law 92-255 (amends sec. 256(e) CMHCA)					25	75
Sec. 409(a), Public Law 92-255				$15	30	40
Sec. 410(b), Public Law 92-255				25	65	100
HEW (SRS): VRA;[1] JDPCA	2.3	3.6	5.2			
DOD; all services	.4	48.2	62.6			
OEC: EOA	12.1	13.0	20.0			
JUSTICE (LEAA): OCCSSA	16.6	16.3	14.9			
JUSTICE (BOP): NARA	2.3	2.8	3.4			
HUD (Model Cities): DCMDA	6.0	9.3	9.3			
DOL (Manpower Administration): EOA; MDTA			1.0			
VA: 38 U.S.C.[1]	.7	16.4	21.6			
Total	78.8	189.6	230.2	40	220	315

[1] Indefinite continuing authorization.

Appendix

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., May 2, 1972.

MR. TOM VAIL,
Chief Counsel, Committee on Finance,
U.S. Senate, Washington, D.C.

DEAR MR. VAIL: As you will recall, when I met with the Committee on April 19, Senator Bennett asked for information with respect to the number of drug and alcohol abusers on social security disability rolls and the number who could be expected to be placed on the disability rolls under title XX.

It is difficult to identify the number of drug and alcohol abusers who are on the social security disability rolls because of the method of adjudicating claims, and because of the method by which statistics are kept on allowed claims.

Statistics on allowed claims are gathered on the basis of the impairment which plays the predominant role in the applicant's disability. Secondary, or contributing, impairments or conditions may not be specifically listed in the decision. These secondary impairments, even when they are listed, do not appear in the statistics from which we would have to extract the requested information.

The abuse of alcohol or drugs does not, in itself, constitute a disabling impairment under the social security disability program. An alcohol or drug abuser may be unemployed, and his past or continued use of alcohol or drugs may present obstacles in securing employment. However, if he retains the capacity to perform substantial gainful activity, he would not be found disabled, regardless of whether he is employed or unemployed. Nor would he be found disabled if a severe impairment resulting from drug or alcohol abuse were amenable to treatment with improvement permitting a return to substantial work within 12 months of the onset of the impairment. An individual will be found disabled only if he has a medically determinable impairment which has lasted or can be expected to last 12 months or more and which is of such severity that he cannot do his previous work and, considering his age, education and work experience, cannot engage in any other kind of substantial work which exists in the national economy.

To establish a disabling impairment resulting directly from alcoholism or drug abuse, appropriate medical evidence must show addictive dependence (i.e., habitual dependence over an extended period of time) resulting in irreversible damage to a body organ such as the liver or brain, with evidence of marked restriction of ordinary daily activities, constriction of interests, deterioration in personal habits, and a seriously impaired ability to relate to other people.

In cases where organic complications of alcohol or drug abuse (cirrhosis, organic brain syndrome, etc.) preclude engaging in sub-

stantial gainful activity, the determination of disability would be based on the severity of the complications and our statistics would list these complications as the primary impairment rather than the drug or alcohol abuse.

Consistent with the above discussion, our records show a very low incidence of allowed cases in which drug or alcohol abuse is identified as the primary disabling impairment. For the period 1964–1969, some 9,750 allowed cases or .5% of the total allowances (1,737,456) were identified as based on impairments which were directly related to alcoholism or drug dependence. However, these data do not reflect the total incidence of allowed cases in which the disability may have been due in part to the abuse of drugs or alcohol, and do not reflect the incidence of drug and alcohol abuse which may exist among beneficiaries whose disabling impairments have little apparent relationship to the use of drugs and alcohol.

With respect to the expected incidence of allowed cases involving drug and alcohol abuse under title XX, new applicants would be subject to the same adjudicative requirements and constraints for establishing disability that are required for claimants under title II, and accordingly we have no basis for expecting a different incidence of allowances where the disabling impairment resulted directly and primarily from the abuse of drugs and alcohol.

Insofar as the APTD conversion cases are concerned, some State programs do not have comparable criteria for determining disability as are found in the title II evaluation criteria. Accordingly, some alcohol and drug abusers who would not otherwise qualify for disability under title XX may be converted to the title XX disability rolls from the State programs.

Sincerely yours,

ARTHUR E. HESS,
Deputy Commissioner.

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