THE IMPACT OF WELFARE REFORM ON DUAL-DIAGNOSIS DISABILITY CLAIMANTS AND THEIR REPRESENTATIVES: LESSONS FROM THE DISABILITY DENIALS PROJECT AT GREATER BOSTON LEGAL SERVICES

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I. INTRODUCTION

Medical views of addiction have long been complex, and the United States welfare system has likewise taken inconsistent steps toward recognizing substance use disorders (SUDs,[1] alternately referred to herein as Drug and Alcohol Abuse, DAA,[2] or

[1] According to the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), substance-related disorders encompass ten separate classes of drugs as well as gambling disorder. "The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems." AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 483 (5th ed. 2013).
[2] "Drug addiction or alcoholism" is the collective term for substance use disorders that appears in Social Security regulations. *See, e.g.*, 20

addiction) as medical disabilities in their own right. Following a period of more inclusive policies in the 1970s and 1980s, Congress took a step back from the disease-view of addiction in 1996 in the context of sweeping welfare reforms, terminating benefits and creating stricter standards for Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)[3] claimants whose primary disability was addiction. Because an estimated 50% to 70% of individuals with a SUD also have a co-occurring mental health condition,[4] it is perhaps unsurprising that the policy changes had an

C.F.R. § 416.935 (1995). The term originated with an administrative reform act in 1994 that changed the Social Security eligibility rules for substance abuse disorders. Social Security Administrative Reform Act of 1994, Pub. L. No. 103-296, 108 Stat. 1464, 1502; Linda Landry, *Handling Social Security and Supplemental Security Income Disability Cases Involving Alcohol or Drug Use: An Update*, CLEARINGHOUSE REV., Mar.-Apr. 1999, 545. The evolution of the pre-1996 eligibility rules is addressed generally in Part II.A, *infra*.

[3] *Disability Benefits*, Social Security, https://www.ssa.gov/benefits/disability/ (last visited Dec. 29, 2020). The Social Security Administration's SSDI program pays benefits to disabled individuals and certain family members based on the individual's being "insured," meaning that they have worked long enough and recently enough to qualify, and have paid Social Security taxes on their earnings. *Id.* The SSI program offers benefits to adults and children with limited income and financial resources. *Id.*

[4] Max Selver, Note, *Disability Benefits and Addiction: Resolving an Uncertain Burden*, 91 NYU L. REV. 954, 960 (2016).

immediate impact on more than 100,000 beneficiaries,[5] and that they continue to pose challenges for DAA claimants and their representatives today.

Dual-diagnosis claimants—individuals suffering from co-occurring substance use and mental health disorders—make up about one-tenth of Social Security disability clients in the Elder, Health, and Disability Unit (EHDU) at Greater Boston Legal Services (GBLS), a non-profit organization that provides civil legal aid services to low-income residents of Greater Boston. During 2019 and 2020, the EHDU undertook an analysis of 126 randomly sampled decisions among its past SSDI/SSI cases as part of the Disability Denials Project (DDP) in order to identify potential factors contributing to wins or losses. Already in the initial data collection phase, client substance abuse became a standout factor, with the EHDU losing around 80% of cases where the

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[5] Dru Stevenson, *Should Addicts Get Welfare? Addiction & SSI/SSDI*, 68 BROOK. L. REV. 185, 196 (2002).

client had an explicitly documented addiction history.[6]

Although disability cases involving substance abuse had proven difficult to win for more than a decade, the EHDU had continued to take them on, potentially highlighting an important conflict that legal aid practitioners face in their work. Although the intuitive response to a 20% win-rate might be to focus Unit resources elsewhere, when SUD clients walk through the door with case histories comprising 1,000-3,000 pages of medical records, the intuitive response to the individual case and client is often the opposite. These individuals have clear and persistent medical disabilities preventing substantial gainful employment,[7] and legal aid has an important role to

[6] The DDP and its methodology and results are discussed in detail in Part III, *infra*. For each client, the most recent medical eligibility decision resulting in payment or non-payment of benefits, at any level of appeal, and with available electronic data on GBLS's shared drive and/or case management system, was included. Financial cases (e.g., overpayment cases corresponding to claims approved prior to and without GBLS's representation, cases relating only to financial eligibility for SSI) were excluded. *See id*.

[7] To be eligible for disability benefits, an individual must be unable to engage in substantial gainful activity (SGA). Ordinarily monthly earnings above or below an amount set each year by federal regulations indicate whether a person is engaged in SGA. For

play in securing government assistance, as well as the stable income, housing, and health insurance it often entails.[8]

Closer examination of GBLS's addiction cases ultimately revealed four potential areas for further study. These included a circuit split over burden of proof in cases involving addiction, the parallel evolution of the Social Security Administration's (SSA's) and medical community's views on addiction, the 1996 reforms' underlying assumption that disability payments incentivize addiction, and the impact of Welfare Reform on practitioner decision making in cases involving substance abuse. The purpose of this Article is to address each of these themes in turn, while placing them in the broader context of the SSA's evolving approach to disability claims involving DAA.

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example, the monthly SGA amount for 2021 is $1,310. *Substantial Gainful Activity*, SOC. SEC., https://www.ssa.gov/oact/cola/sga.html (last visited Dec. 29, 2020).

[8] "[T]hese impairment cases remain winnable, and handling them remains an important challenge because of the stable income and access to health insurance they generate." Landry, *supra* note 2 (opining two years after the 1996 rule change came into effect).

This Article summarizes the DDP's findings with respect to substance abuse, places them in historical context, and identifies opportunities for further study. Part II traces the origins of today's DAA materiality standard[9] back to Welfare Reform in the 1990s. Part III reviews what studies have shown about the systemic, practical consequences of the 1996 reforms for SUD claimants across the United States. Part IV provides an overview of the DDP, illustrating the practical consequences of Welfare Reform for DAA clients and their representatives at one legal aid office in the Northeastern United States. Finally, Part V presents four areas for further research or reform, informed by the experiences of legal aid practitioners and other stakeholders including the courts, the federal government, the medical community, and, most importantly, the SSDI/SSI beneficiary. Part VI concludes.

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[9] In making eligibility determinations for SSDI and SSI in cases involving substance abuse, the Social Security Administration considers whether the claimant would still be disabled if not for the influence of drugs or alcohol (whether substance use is "material" to the finding of disability). *See infra* Part II.C.

II. DUAL-DIAGNOSIS DISABILITY BEFORE AND AFTER WELFARE REFORM

The coverage of substance use disorders by American work disability benefits programs has a complex history. Despite evolving medical views that increasingly frame addiction as a brain disease,[10] the idea of providing sustained income supports for individuals with SUDs has "never sat well with many legislators and some members of the substance abuse treatment community," given an impression—often fueled by anecdote and heavily circulated media coverage—that benefits might somehow incentivize or "enable" addiction.[11]

Against a backdrop of decades-long policy debates, the rules have changed repeatedly, taking steps first toward inclusion in the 1960s and 1970s, and then notably back again, to arrive at the current system via Welfare Reform in the 1990s. Part II.A traces the evolution of disability benefits programs

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[10] *See infra* Part V.B.
[11] Sharon R. Hunt & Jim Baumohl, *Drink, Drugs and Disability: An Introduction to the Controversy*, 30 CONTEMP. DRUG PROBS. 9, 10-11 (2003) (borrowing a term that became popular in the 1980s).

covering addiction prior to the 1990s. Part II.B provides an overview of Welfare Reform and the March 1996 Contract with America Advancement Act (CAAA) as it pertained to these programs. Finally, Part II.C sets out the rules that went into effect in 1997 and continue to apply to dual-diagnosis SSDI and SSI claims today.

A. Disability Benefits for Addiction from 1972 to 1996

The United States government has offered income support for occupational disabilities since the 1950s.[12] Social Security Disability Insurance and Supplemental Security Income were not features of the original Social Security Act of 1935[13] but first appeared as Title II in 1956 and Title XVI in 1972,

[12] *Id.* at 10. The eligibility of individuals suffering from addiction has long been controversial. *Id*. "Although alcoholism's legitimacy as a disabling impairment was subject to Congressional debate much earlier, neither alcoholism nor drug addiction was specifically mentioned in [SSDI] regulations until 1961." *Id.* at 17.
[13] Christopher Wright, *SSI: The Black Hole of the Welfare State*, CATO INST. (Apr. 27, 1995), https://www.cato.org/sites/cato.org/files/pubs/pdf/pa224.pdf.

respectively.[14] Addiction first appeared in the SSDI regulations under a personality disorders listing in 1961 and had to be associated with psychosis or neurosis in order to qualify for disability benefits.[15] When the SSA's detailed Listing of Impairments premiered in 1968,[16] SUDs were still included as personality disorders—"life-long, habitual, and inappropriate patterns of behavior" that manifested themselves as addiction—and had to be

[14] SSI's forerunner starting in the 1950s was Aid to the Permanently and Totally Disabled (later termed Aid to the Disabled, or "ATD"), which required states to share the costs of benefits and program administration. In 1969, New York was alone in adopting a liberal standard that made heroin addicts eligible for benefits. Hunt & Baumohl, *supra* note 11, at 17-18.

[15] *Id*. at 17.

The Social Security Administration's Listing of Impairments "describes, for each major body system, impairments considered severe enough to prevent an individual from doing any gainful activity," or, for applicants under age 18, "severe enough to cause marked and severe functional limitations." *Disability Evaluation Under Social Security*, Social Security, https://www.ssa.gov/disability/professionals/bluebook/listing-impairments.htm (last visited Dec. 29, 2020).

[16] The Social Security Administration developed the original Listing of Impairments with the aid of its Medical Advisory Committee when its disability program began. The Listing of Impairments is subject to continuous review and updated based on program experience and medical advances. *History of SSA During the Johnson Administration 1963-1968*, Social Security, https://www.ssa.gov/history/ssa/lbjdib1.html (last visited Dec. 29, 2020).

accompanied by "evidence of irreversible organ damage" to qualify for coverage.[17]

At the beginning of the 1970s, Congress debated the creation of a new federal benefits program (SSI) to cover individuals living in poverty and ineligible for SSDI.[18] In that context, the Senate Finance Committee was "greatly influenced by" Senator Harold Hughes, a Democrat from Iowa who was also a recovering alcoholic, chairman of the Senate's Subcommittee on Alcohol and Narcotics, the author of the 1970 Comprehensive Alcoholism Prevention and Treatment Act, and a believer that alcoholics

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[17] Hunt & Baumohl, *supra* note 11, at 17. This came to be known as the "end-organ damage criterion." *Id*. "Originally, the Social Security Administration did not treat alcoholism as a disease that could independently qualify an individual for benefits." Stevenson, *supra* note 5, at n.15. Instead, benefits were granted only when "alcohol abuse manifested itself in physical symptoms of an independently recognized medical disorder of sufficient severity to constitute an 'impairment' precluding employment" under the listing for that disorder. *Id*. According to Warnecke Miller and Rebecca Griffin, the adoption of a listing accounting for "addictive dependence on alcohol or drugs, with evidence of irreversible organ damage" was based on a contemporaneous change in social views, as public perception shifted away from the "formerly prevailing social and legal view that an alcoholic is simply an individual who lacks the will or moral fiber to curb his self-indulgence." Warnecke Miller & Rebecca Griffin, *Adjudicating Addicts: Social Security Disability, the Failure to Adequately Address Substance Abuse, and Proposals for Change*, 64 ADMIN. L. REV. 967, 974 (2012).

[18] Stevenson, *supra* note 5, at 188.

should be denied eligibility for the new SSI program. Both Senator Hughes and the committee expressed concern that recipients' treatment compliance would not be ensured under the new law, and that cash benefits would be used to purchase drugs and alcohol.[19]

Along with the eventual creation of the SSI program came specific provisions for SUDs, though at that time addiction was not yet treated as an independent basis for eligibility.[20] With the program's implementation in January 1974, the rules governing SSI removed SUDs from the category of personality disorders, instead characterizing them as "functional nonpsychotic disorders," and eliminated the end-organ damage requirement. The following year, the SSDI program adopted the same standard. Nevertheless, a *de facto* end-organ damage criterion remained in place amidst a "whirlwind of litigation,"

[19] Hunt & Baumohl, *supra* note 11, at 18. The committee favored compelling participating states to "refer all alcoholics and drug addicts on SSI or Aid to Families with Dependent Children to certified treatment programs, monitor their progress, and make 'protective payments' for food, shelter, and clothing." *Id*. at 18-19.
[20] Stevenson, *supra* note 5, at 188.

as a statement accompanying the 1975 Listing of Impairments caused confusion by noting that addiction was not "in itself" a qualifying condition.[21] Then, in the 1980s, coming out of the Benefits Reform Act and its requirement that the SSA draft more "realistic" regulations addressing mental impairments, amendments in 1989 recognized SUDs as independently qualifying disabilities.[22]

Approximately 34,000 recipients of (SSI forerunner) Aid to the Disabled (ATD) had considered SUDs a primary or secondary diagnosis in June 1970. Upon the inception of the SSI DAA program, only ATD recipients with a primary SUD

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[21] Hunt & Baumohl, *supra* note 11, at 19. The SSA's statement was "intended to remind adjudicators that as with any impairment, addiction had to be supported by evidence sufficient to substantiate disability." *Id.* The deletion of the end-organ damage requirement came in response to "growing consensus in the medical profession that alcoholism was a "disease" in its own right. Stevenson, *supra* note 5, at 188.

[22] Stevenson, *supra* note 5, at 188-89.
In 1982, the Social Security Administration adopted a definition indicating that substance addiction disorders were "[b]ehavioral changes or physical changes associated with the regular use of substances that affect the central nervous system." *Id.* at n.18. Prompted by numerous court decisions, the SSA issued a Social Security Ruling (SSR 82-60) in 1982 indicating that alcoholism and drug addiction could be disabling conditions. Dean Spade, *Undeserving Addicts: SSI/SSD and the Penalties of Poverty*, 5 HOW. SCROLL: SOC. JUST. L. REV. 89, 98 (2002).

diagnosis were transferred into this new category. These individuals made up about 97% of SSI's initial 10,000 DAA beneficiaries. Over the next few years, as many of these individuals "died, went to prison, or were dropped from the rolls after [Continuing Disability Reviews][23] conducted in 1976 and 1977," the total number of SSI DAA beneficiaries declined to 4,000.[24] During this time, the DAA program generally remained small and thus unnoticed by Congress and the public into the 1980s.[25]

Then, unexpectedly in the late 1980s, SSA staff found their DAA workload growing rapidly,[26] while

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[23] The SSA periodically reviews beneficiaries' medical impairments (in the form of a Continuing Disability Review) to determine whether they continue to have a disabling condition. *Continuing Disability Reviews*, SOC. SEC., https://www.ssa.gov/ssi/text-cdrs-ussi.htm (last visited Dec. 29, 2020).
[24] Hunt & Baumohl, *supra* note 11, at 20-21.
[25] *Id*. at 24.
Even by 1989, DAA beneficiaries represented only 0.7% of all SSI blind or disabled recipients between 18 and 64 years old. *Id*.
[26] "[An] increasing number of disability claims and hearing requests, combined with agency downsizing, were creating significant problems in the administration of the disability program" in the early 1990s. "By 1993, disability program administration accounted for over half of the [SSA's] administrative expenses," and "the time it took to process an initial claim had increased from 80 days in 1988 to 100 days in 1993," while the processing time for a hearing "increased from 212 days to 265 days over the same period." John R. Kearney, *Social Security and the "D" in OASDI: The History of a Federal*

per a 1991 report from the Office of the Inspector General, "unclear SSA guidelines and DA&A regulations...created inconsistent program implementation across the states."[27] According to a Congressional Research Service Report, in October 1994, around 97,000 individuals with SUDs were on the SSI rolls. The General Accounting Office estimated that an additional 153,000 recipients of SSDI or SSI had a SUD, and that individuals suffering from addiction were receiving $1.4 billion each year in benefits.[28]

In this context, due to the rising number of DAA beneficiaries,[29] in 1994 the 103rd Congress passed legislation called the Social Security Independence and Program Improvements Act of 1994 (P.L. 103-

Program Insuring Earners Against Disability, 66 SEC. BULL. 1, 18-19 (2005), *available at* https://www.ssa.gov/policy/docs/ssb/v66n3/v66n3p1.pdf.

[27] *Id*. at 24.

[28] Carmen D. Solomon, *Substance Abusers: New Rules for Disability Benefits from Supplemental Security Income and Social Security Disability Insurance*, CONG. RES. SERV. (Feb. 16, 1995), https://www.everycrsreport.com/files/19950216_95-291_c6363ad781471c1d27e0a51f14c4f9bd5301ddd8.pdf.

[29] Mikki D. Waid & Sherry L. Barber, *Follow-up of Former Drug Addict and Alcohol Beneficiaries*, Social Security Office of Policy (Oct. 2001), https://www.ssa.gov/policy/docs/rsnotes/rsn2001-02.pdf.

296) (SSIPIA). SSIPIA placed a three-year time limit on DAA benefits, emphasized treatment and monitoring requirements, required SSDI recipients with DAA to have a representative payee,[30] and gave preference to qualified organizations and agencies as representative payees.[31] Over the next two years, finding that these changes had not been enough to curb DAA benefits and that the rolls had continued to expand, members of Congress expressed concern that these programs "inappropriately divert[ed] scarce federal resources from severely disabled individuals" and "provid[ed] a perverse incentive, contrary to the long-term interest of addicts and alcoholics, by providing them with case payments so long as they [did] not work," and prepared for further legislative changes.[32]

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[30] Prior to SSIPIA, SSI beneficiaries received benefits through a representative payee, who managed their money on their behalf. The new legislation expanded this requirement to cover the SSDI program, as well. Linda G. Mills & Anthony Arjo, *Disability Benefits, Substance Addiction, and the Undeserving Poor: A Critique of the Social Security Independence and Program Improvements Act of 1994*, 3 GEO. J. FIGHTING POVERTY 125, 131 (1996).
[31] Solomon, *supra* note 28.
[32] Stevenson, *supra* note 5, at 191.

B. Welfare Reform and the Contract with America Advancement Act

As "potent images of welfare queens driving Cadillacs" took hold of the public's imagination in the 1980s[33] and the media promoted a "moral panic" around the issue of drug use that "bled into poverty and disability policy" toward the end of the decade,[34] the tide turned toward more restrictive welfare policies, particularly with regard to disability benefits for addiction. Welfare and its costs had grown dramatically in previous decades. By the early 1990s, a recession had helped increase the number of SSI recipients alone from around 4.4 million in 1988 to 6.3 million in 1994.[35] Against that backdrop, in 1992 the *New York Times* ran a six-part series on "Rethinking Welfare," citing "increasing alarm over the persistence of welfare dependency" and quoting then-President George H. W. Bush vowing to "break

[33] RUCKER C. JOHNSON, ARIEL KALIL & RACHEL E. DUNIFON, MOTHERS' WORK AND CHILDREN'S LIVES: LOW-INCOME FAMILIES AFTER WELFARE REFORM 3 (2010), *available at* https://research.upjohn.org/cgi/viewcontent.cgi?article=1026&context=up_press.
[34] Spade, *supra* note 22, at 89.
[35] Stevenson, *supra* note 5, at 185.

[the] cycle of dependency that destroys dignity and passes down poverty from one generation to the next."[36]

In 1994, a Republican congressional campaign manifesto called the "Contract with America" took aim at a previous liberal welfare regime that, according to Republicans, had made welfare more attractive than work.[37] Meanwhile widely publicized incidents circulated in the media, painting a picture of welfare recipients using their checks to buy illicit substances.[38] Anecdotes supplemented the news

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[36] David Daniels, *Is Our Society Addicted to Welfare?*, SYSTEMS THINKER, https://thesystemsthinker.com/is-our-society-addicted-to-welfare/ (last visited March 3, 2021).

[37] *See* Jeffrey B. Gayner, *The Contract With America: Implementing New Ideas In the U.S.*, The Heritage Foundation (1995), https://s3.amazonaws.com/thf_media/1995/pdf/hl549.pdf ("Never before had so detailed a document become such an integral part of a congressional election campaign; never had so many innovative ideas been drafted into legislation so quickly; and never in the previous six decades had so much legislation been passed by the House of Representatives in less than 100 days after the newly elected Members of Congress took office.").

[38] Dean Spade lists numerous examples of articles published between 1994 and 1995 by news outlets such as the *San Jose Mercury News*, *Wall Street Journal*, *Washington Post*, and *USA Today*. Spade, *supra* note 22, at n.28. Starting in 1992, stories of beneficiaries "found dead of a drug overdose in a...motel room," having "just purchased large amounts of drugs and alcohol with [a] retroactive SSI check," or "arrested for heroin possession" and found with "thousands of dollars in cash from...SSI 'back pay,'" and having "representative payees

stories about beneficiaries using lump sums of government money to buy drugs.[39] In February 1994, NBC's *Dateline* featured a recovering alcoholic and shelter operated who opined that the Social Security Administration was "the largest supplier of drugs and alcohol to addicts in America."[40] In May, as

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[with] drug and alcohol problems" came to be "revisited many times...by daily newspapers and weekly print and television magazines." Sharon R. Hunt & Jim Baumohl, *Drink, Drugs, and Disability: An Introduction to the Controversy* 27-28 (Feb. 2001) (draft manuscript), https://www.researchgate.net/publication/228555279_Drink_Drugs_and_Disability_An_Introduction_to_the_Controversy.

[39] Stevenson, *supra* note 5, at 186; Daniel Dohan, et al., *From Enabling to Bootstrapping: Welfare Workers' Views of Substance Abuse and Welfare Reform*, 32 CONTEMP. DRUG PROBS. 429, 431 (2005) ("[S]ubstance abuse problems...intruded on worker-client relationships, often when workers came to believe that clients were using cash aid to purchase alcohol or drugs."); John Holliman, *Alcoholics, Advocates Wary of New Welfare Law*, CNN (Sept. 30, 1996), http://www.cnn.com/US/9609/30/welfare/.

[40] Hunt & Baumohl, *supra* note 38, at 29; *but see* Holliman, *supra* note 39 ("Since the [CAAA] was passed, the welfare community has been split over whether giving money to alcoholics and drug abusers helps or hurts their efforts to get better.").

According to Robert Rosenheck and Linda Frisman in 1996, the basis for the changes was ultimately mostly anecdotal. *See* Robert Rosenheck & Linda Frisman, *Do Public Support Payments Encourage Substance Abuse?*, 15 HEALTH AFF. 192, 194, *available at* https://www.healthaffairs.org/doi/full/10.1377/hlthaff.15.3.192. Similarly Linda Mills and Anthony Arjo said the 1994 changes were influenced by "an anecdotal hysteria on the misuse of benefits coupled with a misinformed understanding of the nature of addiction," reflected in the congressional report that was influential in the ultimate decision to make the 1994 changes. Spade, *supra* note 22, at 99.

Congress was contemplating legislative changes, *60 Minutes* ran a segment called "Easy Money" with the opening line, "If you're a drug addict or an alcoholic and you are looking for an easy way to make some easy money, the Social Security Administration is more than willing to help you out even when they probably know you are more than likely to use the money to buy more drugs or...booze."[41] Similar attitudes came to be reflected in the statements of politicians in Congress.[42]

In the same year, the Subcommittee of Human Resources of the House Ways and Means Committee held hearings on SSIPIA in response to the media coverage and circulating anecdotes, and proposed excluding drug addicts and alcoholics altogether from Social Security's disability benefits programs.[43] Momentum continued to build toward

[41] Hunt & Baumohl, *supra* note 38, at 28.
[42] "It is highly unlikely that when Congress passed the SSI program in 1972...members realized they would be writing a guaranteed annual income and medical care [program] for addicts." Hunt & Baumohl, *supra* note 11, at 10 (quoting Rep. Rick Santorum). "I think probably most of the American people would be outraged to find...that someone is even receiving disability when they inflict it on themselves." *Id*. (quoting Rep. E. Clay Shaw, Jr.).
[43] Spade, *supra* note 22, at 96.

further reform after SSIPIA, even before the 1994 changes had gone into effect.[44] In 1995, a report by the Cato Institute, a libertarian think tank, concluded that SSI was “one of Washington’s primary fiscal black holes,” as “populations that were once marginal to the primary mission of SSI—such as drug addicts, alcoholics, children, and immigrants—[were] swelling the ranks of SSI, and their numbers [were] expected to increase.”[45] The Cato Institute report pointed to various failings in the system: representative payees had addresses at liquor stores and bars; in 1991, the Social Security Administration did not know the treatment status of 82% of DAA beneficiaries; investigators had determined at one point that as many as 90% of DAA SSI recipients were using their benefits to purchase alcohol and illegal drugs; and many beneficiaries were dying while on the program from overdoses or alcohol poisoning—in fact one of the most common ways to leave the program was by dying.[46]

[44] *Id*. at 97.
[45] Wright, *supra* note 13.
[46] *Id*.

The following year, sweeping welfare reforms[47] included the Contract with America Advancement Act (CAAA), which most directly affected benefits for addiction.[48] Section 105 of Public Law 104-121, enacted on March 26, 1996, changed the rules for dual-diagnosis claimants.[49] The legislation mandated the removal of persons from SSDI and SSI rolls for whom DAA was "material" to disability; put a stop to new allowances based on DAA; and terminated benefits for individuals who had previously qualified for benefits on the basis of DAA, unless they

[47] *See, e.g.*, Michael D. Tanner, *Twenty Years after Welfare Reform: The Welfare System Remains in Place*, CATO INST. (May 2, 2016), https://www.cato.org/publications/commentary/twenty-years-after-welfare-reform-welfare-system-remains-place.
[48] Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat. 847 (to be codified at 42 U.S.C. §423(d)(2)(C) (2012)); Selver, *supra* note 4, at 957. Inherent in the reforms was a desire to discourage DAA, or at least not to keep encouraging it through a permanent federal subsidy. Miller & Griffin, *supra* note 17, at 977.
[49] Paul Davies, Howard Iams, & Kalman Rupp, *The Effect of Welfare Reform on SSA's Disability Programs: Design of Policy Evaluation and Early Evidence*, 63 SOC. SEC. BULL. 3, 3 (2000). "Before the Social Security Administration...could fully implement the 1994 Reform Act provisions, Congress passed the [CAAA]...which erased any potential beneficial effect of the benefit restrictions in favor of outright elimination of DAA as a basis for disability benefit eligibility." Landry, *supra* note 2, at 546.

specifically appealed their termination.[50] This marked the first time in the history of the SSDI/SSI programs that Congress had eliminated entire categories of disease or diagnosis as a basis for eligibility.[51]

For the Social Security Administration, these changes took place in the context of exponentially expanding caseloads.[52] In 1996, more than 200,000 people were receiving federal disability payments on the basis of SUDs,[53] and the number of individuals for whom DAA was the primary disabling condition had doubled from 1989 to 1994, reaching 90,000.[54] Predictions varied as to the impact that the CAAA

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[50] An appeal could be based on, for example, the beneficiary's SSA record incorrectly coding DAA, their having an additional disability and needing a new medical evaluation, their turning 62 before January 2, 1997 and becoming eligible for retirement benefits, or their qualification for SSI payments based on age before January 2, 1997. Waid & Barber, *supra* note 29.
[51] Spade, *supra* note 22, at 97-98.
[52] Michael Wiseman, *Welfare Reform in the United States*, 7 HOUSING POL. DEBATE 595, 598 (1996), https://www.innovations.harvard.edu/sites/default/files/hpd_0704_wiseman.pdf.
[53] Rukmalie Jayakody, Sheldon Danziger, Kristin Seefeldt, & Harold Pollack, *Substance Abuse and Welfare Reform*, National Poverty Center (Apr. 2004), http://www.npc.umich.edu/publications/policy_briefs/brief02/brief2.pdf.
[54] Rosenheck & Frisman, *supra* note 40.

would have on beneficiaries. Social workers and advocates for the homeless predicted that "throngs of homeless, helpless addicts [would be] bounced from Medicare-funded treatment programs, driven to desperation by the deprivation of their only safety net."[55] Meanwhile the government estimated that 70-80% of beneficiaries would have another disability to keep them on the program.[56]

As of March 29, 1996, the 1994 DAA provisions were overridden by the CAAA.[57] Nearly 160,000 DAA beneficiaries received termination notices.[58] Although the government had estimated that around 80% of these individuals would ultimately requalify on the basis of another disability, only about 34-40% percent had requalified in 1999.[59]

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[55] Stevenson, *supra* note 5, at 186.
[56] Stevenson, *supra* note 5, at 186-87, 196; Holliman, *supra* note 39.
[57] Hunt & Baumohl, *supra* note 11, at 51.
[58] Waid & Barber, *supra* note 29.
[59] Different sources offer different estimates. *See* Selver, *supra* note 4, at 958; Stevenson, *supra* note 5, at 196.

C. Disability Benefits for Addiction After 1996

The new (and current) standard for SSDI/SSI eligibility for DAA claimants was whether, in the absence of drugs or alcohol, the claimant would still be disabled. The relevant test is a multistep analysis including both an evaluation of disability attributable to all causes, including substance abuse, followed by a materiality analysis that asks whether the claimant would still be disabled if not for the influence of drugs or alcohol; thus whether a SUD is "material" to the claimant's disability.[60]

In total, the analysis is carried out in three overarching parts:[61]

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[60] The 1996 reforms kept the earlier 1994 changes' definition of "materiality," but changed the penalty. Whereas the consequences after 1994 included a representative payee requirement, mandatory treatment, and a three-year limit on eligibility, the 1996 reforms revoked eligibility altogether where a SUD was found to be material. Landry, *supra* note 2, at 545-47. "Consistent application of this hypothetical assessment would prove impossible." Hunt & Baumohl, *supra* note 11, at 20.

[61] Alternatively, the Social Security Administration summarizes the evaluation process as a series of six steps in its Policy Interpretation Ruling on Evaluating Cases Involving Drug Addiction and Alcoholism (DAA). *See generally* SSR 13-2p, 78 Fed. Reg. 11939-47 (Feb. 20, 2013).

Does the claimant meet the disability standard? The first step requires the SSA adjudicator to follow the usual rules for disability case development and the sequential analysis of disability at 20 C.F.R. §§ 404.1520 and 416.920. All of the claimant's impairments, including any DAA impairments, and resulting functional limitations must be considered in making the disability determination. If the claimant meets the disability standard, the decision maker moves to step two. Is there medical evidence of drug addiction of alcoholism? Medical evidence of DAA is defined as evidence that is from acceptable medical sources and is sufficient and appropriate to establish an individual's medically determinable substance use disorder.... DAA is not present in an individual unless evidence from a medically

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The SSA instructs adjudicators to ask:

Does the claimant have *DAA*?
Is the claimant disabled considering all impairments, including *DAA*?
Is *DAA* the only impairment?
Is the other impairment(s) disabling by itself when the claimant is dependent upon or abusing drugs or alcohol?
Does the *DAA* cause or affect the claimant's medically determinable impairment(s)?
Would the other impairment(s) improve to the point of nondisability in the absence of *DAA*?
Id. at 11941.

> acceptable source establishes that the individual has a substance-dependence or a substance-abuse disorder....If the medical evidence establishes the existence of a substance-use disorder, then, and only then, must the adjudicator move to step three and make a materiality determination.
> Is the claimant's substance use disorder 'material' to the disability determination? If the claimant meets the disability standard and if acceptable medical evidence establishes the existence of a substance-use disorder, SSA must determine whether the DAA impairment is a contributing factor material to the disability determination....This materiality determination requires SSA to evaluate which of the claimant's functional limitations would remain without the substance use and whether the claimant still meets the disability standard after SSA considers any remaining limitations.[62]

The party bearing the burden of proof in these cases faces a significant hurdle, as it is often impossible to determine which of a claimant's

[62] Landry, *supra* note 2, at 548-49 (summarizing the new materiality evaluation) (internal citations omitted).

symptoms or impairments are attributable to substance use, as opposed to other causes.[63]

III. THE SYSTEMIC IMPACT OF WELFARE REFORM

Numerous studies have examined the systemic effects of Welfare Reform, and often the empirical results have not aligned with what Congress expected in the 1990s.[64] The Social Security Administration itself carried out three studies to assess the effects of Welfare Reform and the CAAA.[65] According to the SSA, around 138,000 beneficiaries permanently lost their benefits. An estimated 28% never reapplied because they did not think they would qualify, or due to mental inability or misunderstanding. Field offices were unable to reach many claimants, who did not have stable addresses, and commonly reported that claimants "most in need of the benefit [were] also those least able to complete the reapplication (or initial

[63] *See infra* Part V.A.
[64] Stevenson, *supra* note 5, at 196.
[65] Davies, Iams & Rupp, *supra* note 49, at 3.

application) process," and had "limited capacity to comply with the requirements of the relatively complex and time consuming reapplication process."[66] Systemic processes may also have artificially inflated the numbers of DAA recipients on the rolls, so a certain percentage of the individuals whose benefits ended in 1997 may have been misclassified.[67]

According to a report from SSA's Office of Research, Evaluation, and Statistics, the legislative changes had a substantial effect of the targeted recipients who ultimately lost eligibility for payments—but a very small effect on the SSA's disability programs overall, as DAA beneficiaries had accounted for only 2.6 percent of individuals receiving SSDI and SSI at the time.[68] Of the SSI beneficiaries who maintained eligibility after the reforms, most did so on the basis of a psychiatric

[66] Stevenson, *supra* note 5, at 196.
[67] *Id*. at 196-97.
[68] Davies, Iams, & Rupp, *supra* note 49, at 5.

impairment.[69] The primary impairment for DAA SSI beneficiaries who had maintained eligibility shifted from 1996 to 1998, with over half of DAA beneficiaries with a SUD diagnosis being classified instead in the "other mental disorders"[70] category by December 1998. The second and third most common categories were "mental retardation" (8.4%) and "musculoskeletal and connective tissue disorders" (7.7%).[71]

Meanwhile participation in treatment programs "dropped dramatically."[72] A study presented by Kevin M. Campbell, PhD, of the Association of Health Services Research, found that in the year after termination, participation in outpatient programs steadily declined, though individuals in treatment programs whose benefits continued actually showed increased levels of participation.[73] Another study in

[69] *Id*. at 6. Of beneficiaries receiving SSI payments based on DAA in 1996, 75% had a psychiatric impairment. Waid & Barber, *supra* note 29.
[70] Waid & Barber, *supra* note 29.
[71] *Id*.
[72] Stevenson, *supra* note 5, at 197.
[73] *Id*. at 198.

Chicago found that individuals were more likely to drop out of treatment after losing benefits.[74]

To study the CAAA's effect on labor force participation,[75] in 2010 Pinka Chatterji and Ellen Meara at the University of Albany and Harvard Medical School used repeated cross-sections from national household surveys to estimate how termination of SSI affected labor market outcomes for individuals with DAA. That authors found that, in the short run (1997-1998), declines in SSI came with increases in current employment and labor force participation. However, in later years (1999-2002), SSI receipt increased and the short-term labor market outcomes diminished.[76] Meanwhile, "across all states and agencies," a study by the Lewin Group found "very few reports of former beneficiaries returning to employment."[77]

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[74] *Id*. at 200.
[75] "[O]ne purpose of the 1996 legislation was to change the incentive structure for addicts and encourage them to re-enter the workforce. This did not occur." Stevenson, *supra* note 5, at 198.
[76] Pinka Chatterji & Ellen Meara, *Consequences of Eliminating Federal Disability Benefits for Substance Abusers*, 29 J. HEALTH ECON. 226 (2010), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2842468/.
[77] Stevenson, *supra* note 5, at 198.

At the same time, the income level of former beneficiaries and their households decreased substantially, and a predicted shift to other state-run welfare programs failed to materialize.[78] The legislative changes also had an impact on housing for affected beneficiaries. The Lewin Group study noted reports that most individuals who lost their benefits in 1997 were "unable to remain in their prior housing arrangements, and some were thought to have become homeless."[79] In addition, an Urban Health Study of the University of California-San Francisco examined data pertaining to 1,224 subjects in six San Francisco Bay Area communities and found that, prior to the CAAA, individuals receiving SSI benefits were less likely to be homeless. The study also concluded that loss of benefits for individuals with DAA "increased the severity of social ills such as homelessness, illegal activity and increased unsafe

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[78] *Id*. at 197.
[79] *Id*. at 198. "[A]ddicts who did not requalify for SSI were twice as likely to report experiencing hunger and homelessness as those who continued to receive SSI in the years following the enactment of the CAAA." Selver, *supra* note 4, at 958.

drug use."[80] Another study by the National Health Care for the Homeless Council, surveying 3,648 individuals, reported that more than half of former SSI/SSDI recipients who had previously paid for housing were in emergency shelters within two years of losing their benefits. An additional 26.4% were living with friends or relatives, in treatment beds, or in transitional housing.[81]

In terms of mental health, four different treatment agencies surveyed by the Lewin Group reported "deaths from suicide attributable, at least in part, to the termination of SSI/SSDI benefits."[82] Finally, with regard to crime, a study focused on former recipients in Chicago found, in a random sample of 276 individuals, that at least 70% had been arrested at least once. The authors concluded that "the relationship between criminal activity and SSI status was more complex than originally thought,"[83] as

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[80] Stevenson, *supra* note 5, at 198-99.
[81] *Id*. at 200-01.
[82] *Id*. at 198.
[83] *Id*. at 199 (citing Arthur Lurigio, et al., The Criminality of Former Supplemental Security Income Recipients for Drug and Alcohol Addiction Pre and Post-Benefit Termination, Presentation before the

crime seemed to be tied more strongly to income level regardless of source (e.g., government or employment). "Thus," they wrote, "individuals who are employed, but at substandard wages, may be more likely to commit crimes to supplement their incomes than individuals who are supported by their families or the government at higher levels."[84]

IV. THE DDP AT GREATER BOSTON LEGAL SERVICES

In Massachusetts specifically, the Lewin Group study found a 42.9% decrease from December 1996 to December 1998 in the number of individuals receiving SSI payments based on DAA.[85] Massachusetts beneficiaries still feel the impact of Welfare Reform today, as suggested by the results of a recent data analysis project at one Boston-based legal aid office. Greater Boston Legal Services is a

Academy for Health Services 16th Annual Meeting (July 31, 1999) (abstract available at http://www.academyhealth.org/abstracts/1999/lurigio.htm) (last visited June 20, 2002)).

[84] *Id.*

[85] Waid & Barber, *supra* note 29.

non-profit organization that provides civil legal aid services to low-income residents of Greater Boston. Within GBLS, the Elder, Health, and Disability Unit handles a variety of health insurance, income supports, elder law, and disability cases, including Social Security disability (SSDI/SSI) appeals. In a sample of 126 Social Security cases handled by the EHDU from 2007 to 2020,[86] 15 (12%) involved a past or current substance abuse component.[87]

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[86] Data for the DDP was drawn from cases with available electronic records including at least information on an SSDI/SSI eligibility decision that the client obtained, at any level of appeal, while represented by GBLS. The EHDU started collecting this type of case data for the first time in 2019, for the purposes of the denials project. Ultimately whether a case was included in the sample depended on whether or not its handler had kept copies of, for example, administrative law judge decisions, closing letters, or other relevant documents in an electronic file format, and whether the author could be granted access to the file's corresponding record in GBLS's case management system.
Due to the limitation of the search to electronic records, the oldest cases identified appear to date back to 2007. Addition of new, incoming decisions to the sample ended on December 23, 2020. The relatively unstructured nature of the search is acknowledged as a limitation of this project. Not all SSDI/SSI cases handled by GBLS between 2007 and 2020 were included in the DDP sample, as many records, especially for older cases, had been maintained partly or fully in paper form and been moved to storage prior to 2019. In these instances the author made a best effort to reconcile all available information from different sources.
[87] This was defined as substance abuse explicitly mentioned in the most recent available decision resulting in payment or non-payment of benefits. In a limited number of cases substance use or abuse

In order to identify factors potentially contributing to wins or losses among the EHDU's cases, the DDP compiled data on this sample of 126 cases comprising a list of 18 different factors (listed *infra*), plus the most recent documented outcome (i.e., the claimant's approval or denial for SSDI or SSI) at any level of appeal.[88] The sample included cases both handled locally by the Massachusetts hearing office and outsourced to hearing offices in other states,[89] as well as decisions most recently affirmed, overturned, or remanded by the Appeals

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appeared in passing in a client's record but was not acknowledged in the most recent decision in their case. This happened where, for example, the client had disclosed substance abuse fully resolved decades earlier, or a suspicion of substance use was mentioned in passing in the client's record. If no decision text was available, then available medical records were searched for a diagnosis of substance abuse. If no medical records were available, then the representative's brief was searched for mention of substance abuse.

[88] The most recent documented outcome was defined as the most recent medical eligibility decision resulting in payment or non-payment of benefits. In cases where the most recent documented outcome was a remand for a new hearing, without a new decision with respect to medical eligibility, the most recent determination with respect to medical eligibility (e.g., the overturned decision) was taken instead to be the most recent documented outcome.

[89] Ordinarily the disability hearings attended by GBLS representatives are held at the Boston Office of Hearings Operations. The Social Security Administration has occasionally transferred cases to hearings offices outside of the state. For example but without limitation, GBLS representatives have participated remotely in hearings held in Albany, New York and Providence, Rhode Island.

Council[90] or a federal court.[91] Because the sample was not limited to any particular level of appeal or U.S. state, it reflected the Unit's case handling or features of the Social Security system as a whole, as opposed to reflecting trends within a particular court or limited subset of courts or SSA offices.

Based on Disability Benefits practice group discussions over the summer of 2019, the factors ultimately included in the DDP analysis were:

- The claimant's age at intake;
- The claimant's gender;
- The claimant's ethnicity;
- The claimant's primary spoken language;
- Whether an interpreter was needed;
- The claimant's relationship status;

[90] The Social Security Administration's Appeals Council headquartered in Falls Church, Virginia offers review at the final administrative decisional level in SSDI and SSI cases. The Appeals Council was created in 1940 as a three-member body established to oversee hearings and appeals, and to promote national consistency in local administrative decisions. *Brief History and Current Information about the Appeals Council*, SOC. SEC., https://www.ssa.gov/appeals/about_ac.html (last visited Dec. 29, 2020).

[91] In cases where a claimant disagrees with a decision of the Appeals Council, or where the Appeals Council decides not to review the case, federal district courts offer a final level of appeal. *Federal Court Review Process*, SOC. SEC., https://www.ssa.gov/appeals/court_process.html (last visited Dec. 29, 2020).

- The claimant's housing status;[92]
- The claimant's disability or disabilities;[93]
- Whether the claimant's record included substance abuse (past or current);[94]
- Whether the claimant's disabilities were only mental;[95]
- Whether a hearing was held by videoconference (or teleconference);[96]
- Whether a treating source had provided an opinion supporting disability;[97]

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[92] Many clients represented by the EHDU are minors under age 18. In these cases the parents' or other responsible parties' housing status was noted, if available.
[93] All physical and mental disabilities alleged by the client were included, as opposed to, for example, the set of severe impairments ultimately acknowledged by a factfinder. *See, e.g.*, 20 C.F.R. § 404.1520(a)(4)(ii) (2012) (referring to the identification of "severe" impairments in the disability evaluation process).
[94] This was defined as substance abuse explicitly mentioned in the most recent available decision resulting in payment or non-payment of benefits. "Past substance abuse" included references to a "history of" substance abuse and SUDs "in remission" or in treatment.
[95] The Social Security categorizes claimants' functional limitations as exertional (e.g., relating to the strength demands of activities such as lifting and walking) or non-exertional (e.g., relating to psychiatric symptoms or sensory functions). The disability evaluation differs based on whether a claimant's limitations are only exertional. *See, e.g.*, 20 C.F.R. § 404.1569a (2003).
[96] Claimants can consent to remote participation in disability hearings by videoconference.
[97] Various categories of healthcare providers (e.g., physicians, physician assistants) may provide opinion evidence in support of a claimant's case. *Revisions to Rules Regarding the Evaluation of*

- Whether the case concerned an application, continuing disability review, or age 18 review;[98]
- Whether the case had previously been remanded;
- Whether the claimant was the sole caretaker of minor children;
- The claimant's source of income at the time of their hearing;
- The claimant's employment status;[99] and
- The claimant's education level.

Already in the data collection phase, substance abuse was a standout factor, as 80% of the EHDU's sampled SSDI/SSI cases involving a past or present SUD had resulted in a loss, in contrast with an approximately 34% loss rate on average across all

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Medical Evidence, Social Security, https://www.ssa.gov/disability/professionals/bluebook/revisions-rules.html (last visited Dec. 29, 2020). Medical opinion evidence may include an assessment of residual functional capacity, or the most an individual can do in an occupational setting given their functional impairments and limitations. *See, e.g.*, 20 C.F.R. § 416.945 (2012).

[98] When a beneficiary is approved before age 18, the Social Security Administration must redetermine their eligibility for SSI based on the adult program criteria in an Age-18 Redetermination Procedure. Jeffrey Hemmeter & Elaine Gilby, *The Age-18 Redetermination and Postredetermination Participation in SSI*, 69 SOC. SECURITY BULL. 1 (2009), *available at* https://www.ssa.gov/policy/docs/ssb/v69n4/v69n4p1.pdf.

[99] For example, whether the claimant was unemployed, employed part-time, a student, or actively seeking employment.

cases.[100] In the set of 126 cases, 15 involved past or current substance abuse,[101] and only three of these cases had resulted in favorable outcomes for the claimant. In one of these cases, the claimant had been able to provide medical evidence of disabilities originating at birth or in childhood. The claimant had also undergone numerous inpatient hospitalizations for psychiatric evaluation or treatment unrelated to substance abuse, and had clear communication impairments. In a second case where the EHDU secured an approval, the claimant had well-documented physical impairments necessitating an

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[100] To place these rates in context, statistics from the Massachusetts disability advocacy firm Citizens Disability indicate the following success rates for applications at different stages of appeal in Massachusetts: 45.4% at the initial stage (54.6% loss rate), 20.2% at the reconsideration stage (79.8% loss rate), and 46.8% at the hearing stage (53.2% loss rate). Citizens Disability also reports the following success rates for applications nationwide: 38.4% at the initial stage (61.6% loss rate), 13.7% at the reconsideration stage (86.3% loss rate), and 51.1% at the hearing stage (48.9% loss rate). *Massachusetts and Social Security Disability Benefits*, Citizens Disability, https://www.citizensdisability.com/state-by-state-information/massachusetts-and-social-security-disability-benefits/ (last visited Mar. 2, 2021). It is important to note that these statistics differentiate between claims approved at different levels of appeal, whereas the DDP did not distinguish between levels of appeal. *See supra* note 86.

[101] Addictive substances frequently appearing in the relevant medical records included alcohol, cocaine, heroin, and opioid medication.

assistive device in order to walk, and an opioid use disorder "in remission." In the third case, no decision text was available for review, but the presence of substance abuse for DDP purposes was determined based on available medical records. In that case, the claimant had been approved for SSI as a child and was seeking GBLS's representation in order to obtain SSDI.

In more than one case, a factfinder or treatment provider had remarked explicitly on the possibility that at least some of the claimant's mental symptoms were attributable to substance use. Often, distinguishing between symptoms arising from an "organic" mental disorder and those due to drugs or alcohol, can be challenging, if not medically impossible. As detailed in Part V.A, *infra*, this can potentially lead to a lack of uniformity in the Social Security system, with different outcomes arising from similar sets of facts depending on where the case is heard.

V. OPPORTUNITIES FOR FURTHER STUDY

Examining statistics across cases and more closely examining individual case histories provided an opportunity to uncover potential areas for further research or reform. First (Part V.A), a question of burden of proof in SUD cases remains unresolved among the federal courts, potentially affecting cases where claimants cannot point to a period of sobriety, or where it is otherwise impossible to determine which of a claimant's impairments may be attributable to substance use. In these cases, the SSA has at least twice issued guidance indicating that a "tie"[102] in the evidence should go to the claimant. Nevertheless, a circuit split has emerged, with some circuits following the SSA's guidance, and others diverging and treating the SSA's guidance as only persuasive.[103]

Second (Part V.B), the SSA's history of taking one step forward, one step back with respect to inclusion of SUDs among eligible disabilities

[102] Selver, supra note 4, at 970.
[103] *Id*. at 969.

reflects the medical community's own inconsistent treatment of substance abuse—though increasing scientific evidence supports the notion of addiction as a brain disease. Third (Part V.C), driving the legislative changes to the Social Security's DAA rules in the 1990s was an assumption that government benefits incentivize addiction for individuals with a SUD. Proponents of this view found support in anecdotes and media coverage leading up to the 1996 reforms. Twenty-five years later, questions remain as to whether empirical evidence aligns with the anecdotes and supports this assumption. Fourth (Part V.D), how did representatives—for example, practitioners working with clients in the legal aid setting—adjust their practice based on the new rules after 1996? As DAA cases became more challenging to win, how did practitioners determine which claims to take on and which strategies to employ? Each of these issues is addressed here in turn.

A. A Circuit Split over Burden of Proof in Addiction Cases

The CAAA revoked SSDI/SSI eligibility from two groups of individuals with SUDs: those for whom the SUD was the primary disability, and those for whom SUD contributed to a different, additional disability, such as a mental health condition. For the latter group, disentangling SUD-related limitations from limitations related to a co-occurring condition can be virtually impossible, and this poses a dilemma for courts and claimants. Where the evidence is in equipoise and materiality of the SUD cannot be clearly established, does the tie go to the claimant or the government? While the SSA itself has handed down guidance suggesting that the tie should go to the claimant, circuit courts have split on this question.[104]

Immediately following the 1996 reforms, the SSA issued Emergency Teletype EM-96200, an internal agency guideline instructing administrative hearing offices that "[w]hen it is not possible to

[104] *See generally* Selver, *supra* note 4.

separate mental restrictions and limitations imposed by DAA and the various other mental disorders shown by the evidence, a finding of 'not material' would be appropriate."[105] Subsequently in 2013, the SSA issued Social Security Policy Interpretation Ruling 13-2p, and an Order of the Appeals Council subsequently cited this Ruling in endorsing a tie-goes-to-the-claimant approach.[106] Meanwhile circuit courts diverged, with the Fifth, Eleventh, Ninth, and Second Circuits placing the burden of proof on the claimant, and the Tenth and Eighth Circuits taking the opposite approach, placing the burden on the government.[107]

The party with the burden of proof in DAA claims faces a significant hurdle, and the adjudicator is forced to speculate with respect to the effects of substance abuse cessation.[108] The SSA itself, in its Emergency Teletype, instructed, "We know of no research data upon which to reliably predict the

[105] *Id*. at 966.
[106] *Id*. at 973.
[107] *Id*. at 966-73.
[108] *Id*. at 964; Stevenson, *supra* note 5, at 194.

expected improvement in a coexisting mental impairment(s) should drug/alcohol use stop," and suggested looking to evidence of a period of abstinence in claimant records.[109] Thus DAA claimants are put in a position to abstain long enough to provide medical evidence showing lack of improvement, and adjudicators are subject to "overreact[ing] to any mention" of substance abuse in the medical records, which can create "a negative psychological effect."[110]

The *status quo* also leaves a lack of uniformity across the Social Security system. Ultimately, "the allocation of the burden will determine whether a large number of dual-diagnosis claimants receive benefits," as "similar fact patterns can yield opposite results based on the allocation of the burden of proof."[111]

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[109] Stevenson, *supra* note 5, at n.47. "Medical evidence...often leads to the conclusion that the causes and effects of a claimant's addiction and co-occurring disorder cannot be separated." Selver, *supra* note 4, at 975.
[110] Stevenson, *supra* note 5, at 194-95 ("But-for causation could function as a proxy, a way to punish drug use itself.").
[111] Selver, *supra* note 4, at 974-76 (citing Parra v. Astrue, 481 F.3d 742, 749–50 (9th Cir. 2007) (affirming ALJ's finding of DAA

Writing about this circuit split in a 2016 Note, Max Selver at New York University Law School argued that placing the burden on the government is the correct approach based on the text of the CAAA and its implementing regulations, as well as public policy considerations, as the Social Security Administration has "vastly superior resources and expertise to litigate this complex issue," compared to the claimant.[112]

B. Evolving Medical Views of Substance Abuse

Over recent decades, the SSA has taken steps forward and back with respect to inclusion of DAA in the set of disabling conditions eligible for government support. According to Linda Mills and

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materiality where physician testified that there was insufficient evidence in the record to support a conclusion one way or the other regarding DAA materiality); Bayer v. Astrue, No. 08–cv–02389–WYD, 2010 WL 1348416, at *6–7 (D. Colo. Mar. 31, 2010) (reversing DAA materiality finding because ALJ improperly interpreted doctor's opinion that he "could only 'guess' as to how the bipolar disorder, without the effects of alcohol, would limit [p]laintiff's mental health" to mean that claimant's bipolar disorder would not be severe absent substance abuse)).

[112] *Id.* at 960-61.

Anthony Arjo, writing in 1996, the SSA's more inclusive, pre-1994 policy had correctly fit the then-current medical understandings of addiction as a disabling disease.[113] In contrast, as later suggested by Dru Stevenson, then at Greater Hartford Legal Aid in Hartford, Connecticut, the 1990s' driving concerns about "the perverse incentives of encouraging substance abuse" seemed to assume that individuals suffering from addiction have a "choice" with respect to their behavior.[114] Stevenson addressed at length the debate in different fields over the extent to which engaging in substance abuse is a voluntary or involuntary act.[115]

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[113] Mills & Arjo, *supra* note 30, at 139; *see also* Spade, *supra* note 22, at 103-04 (placing 1980s' and 1990s' drug policy in the context of "widespread moral and social panics" resulting from "complex political contexts").
[114] Stevenson, *supra* note 5, at 202-03 (contrasting "moral hazard" and "rehabilitation" perspectives on providing benefits to individuals with SUDs).
[115] *Id*. at 203-11; *see also* Wright, *supra* note 13 ("At present [1995], SSI operates on the philosophy that addiction is an illness and not a result of individual behavior and choices. However, the view that addiction is a disease remains disputed."). "Many observers saw the attack on the DA&A program as an assault on the 'concept of addiction as a disease,'" while "[m]any congressmen troubled by the program emphasized that addiction is a 'self-inflicted condition.'" Hunt & Baumohl, *supra* note 38, at 47-48.

The medical field itself increasingly characterizes addiction as a medical condition, rather than a choice or a moral failing—though mirroring the welfare system, the consensus in medicine has not continuously evolved in this direction.[116] Today the American Psychiatric Association, the main psychiatrists' organization in the United States and largest psychiatric association in the world, defines addiction as "a complex condition, a brain disease that is manifested by compulsive substance use despite harmful consequences."[117] However, historically, this view found mainstream acceptance only relatively recently.

> In his [1816] book, *An Inquiry Into the Effects of Ardent Spirits Upon the Human*

[116] Writing in 2011, one physician described the study and treatment of addiction as "com[ing] of age by way of a long and winding road." David E. Smith, *The Evolution of Addiction Medicine as a Medical Specialty*, 13 VIRTUAL MENTOR 900 (2011).
[117] *What Is a Substance Use Disorder?*, AM. PSYCHIATRIC ASS'N, https://www.psychiatry.org/patients-families/addiction/what-is-addiction (last visited Dec. 29, 2020). Addiction has been linked medically to desensitization of reward circuits, increased strength of conditioned responses and stress reactivity, and weakening of brain regions involved in executive functions such as decision making and self-regulation. Nora D. Volkow, George F. Koob, & A. Thomas McLellan, *Neurobiologic Advances from the Brain Disease Model of Addiction*, 374 NEW ENG. J. MED. 363 (2016), *available at* https://www.nejm.org/doi/full/10.1056/NEJMra1511480.

> *Body and Mind: With an Account of the Remedies for Curing Them*, [America's first surgeon general Benjamin] Rush described the symptoms of tolerance and alcohol withdrawal, encouraging physicians of the time to consider substance abuse a disease entity. Concern about the widespread abuse of other drugs began following the Civil War through recognition of addiction as a result of indiscriminate prescription of opiates for pain relief. Not until the 1950s did the American Medical Association formally acknowledge alcoholism as a medical illness, and not until the 1960s, as a disease.[118]

In the 1970s, changes to the Social Security rules followed a contemporaneous "growing consensus in the medical profession that alcoholism was a 'disease' in its own right," removing the physical organ damage requirement for SUD-based eligibility for benefits.[119] Then, in 1989, following the passage

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[118] Karen Egenes, *Addiction Treatment: A Historical Nursing Perspective*, 7 ADDICTIONS NURSING 2, 2 (1995). In an echo of Civil War-era history, in recent years the opioid epidemic has again drawn attention to addiction as a public health crisis, prompting calls for research on addiction and pain. *See* "Surgeon General Priority: Opioids and Addiction," Health & Human Services, https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/index.html (last visited Jan. 3, 2021).
[119] Stevenson, *supra* note 5, at 188.

of a Benefits Reform Act that required the SSA to draft more "realistic" regulations pertaining to mental impairments, the agency recognized alcoholism and addiction as independently qualifying conditions.[120]

> Nevertheless, both policy and medicine continued to take steps forward—toward a disease model of addiction—and back again over the following decades. Authors in the medical community observed, regarding medical views of addiction, as recently as 2016.
> Although the brain disease model of addiction has yielded effective preventive measures, treatment interventions, and public health policies to address substance-use disorders, the underlying concept of substance abuse as a brain disease continues to be questioned, perhaps because the aberrant, impulsive, and compulsive behaviors that are characteristic of addiction have not been clearly tied to neurobiology.[121]

[120] *Id*. at 188-89.
[121] Volkow, Koob, & McLellan, *supra* note 117. As a result, authors have noted a limited focus on substance abuse in U.S. medical schools and relatively low levels of expertise in addiction medicine. Norman S. Miller, Lorinda M. Sheppard, Christopher C. Colenda, & Jed Magen, *Why Physicians Are Unprepared to Treat Patients Who*

It remains to be seen how subsequent evolution of the medical view of addiction will influence DAA eligibility rules in the coming years.

C. Theory Revisited: Do Disability Payments Incentivize Addiction?

The systemic impact of the CAAA on outcomes such as employment, homelessness, and suicide is addressed *supra* in Part III. Here, the focus is on the essential question on which the 1990s' new policy depended: *Do disability payments incentivize addiction?* Frequently the justifications driving the 1996 rule-change were based on the idea that disability payments somehow either enabled addiction or failed to promote recovery.[122]

Have Alcohol- and Drug-related Disorders, 76 ACAD. MED. 410 (2001), *available at* https://journals.lww.com/academicmedicine/Fulltext/2001/05000/Why_Physicians_Are_Unprepared_to_Treat_Patients.7.aspx; Anita Ram & Margaret Chisolm, *The Time Is Now: Improving Substance Abuse Training in Medical Schools*, 40 ACAD. PSYCHIATRY 454 (2016); Ernest Rasyidi, Jeffrey N. Wilkins, & Itai Danovitch, *Training the Next Generation of Providers in Addiction Medicine*, 35 PSYCHIATRIC CLINICS N. AM. 461 (2012).

[122] *See, e.g.*, Wright, *supra* note 13 ("Even with a 36-month cap, SSI pays substance abusers to stay addicted because cash assistance during those 36 months will be cut off should they recover and return

Numerous studies since the 1990s have evaluated this assumption.

In 1995, Andrew Shaner and colleagues at the West Los Angeles Veterans Affairs Medical Center evaluated 105 male patients with schizophrenia and cocaine dependence, and found that the patients' "cyclic pattern of drug use strongly suggest[ed] that it [was] influenced by the monthly receipt of disability payments," where the cycle included "depletion of funds needed for housing and food, exacerbation of psychiatric symptoms, more frequent psychiatric hospitalization, and a high rate of homelessness."[123] Shaner, et al. remarked on the "troubling irony" that "income intended to compensate for the disabling effects of severe mental

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to work. Only those addicts who have the strongest motivation to help themselves will ever recover. Therefore, SSI is unlikely ever to produce many recoveries because it encourages addicts to show up for treatment to get the cash, not be cured.").

[123] Andrew Shaner, Thad A. Eckman, Lisa J. Roberts, Jeffrey N. Wilkins, Douglas E. Tucker, John W. Tsuang, & Jim Mintz, *Disability Income, Cocaine Use, and Repeated Hospitalization among Schizophrenic Cocaine Abusers—A Government-Sponsored Revolving Door?*, 333 NEW ENG. J. MED. 777 (1995), *available at* https://www.nejm.org/doi/10.1056/NEJM199509213331207?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0www.ncbi.nlm.nih.gov.

illness may have the opposite effect."[124] They found that cocaine use, psychiatric symptoms, and hospital admissions all peaked shortly after the arrival of patients' disability payments on the first of the month, and that the "average patient spent nearly half his total income on illegal drugs."[125]

The following year, Robert Rosenheck and Linda Frisman at the Department of Veterans Affairs Northeast Program Evaluation Center and Yale Medical School again considered whether public support payments incentivize substance abuse, in a nine-site study involving 655 subjects.[126] Although the results showed a significant relationship between overall income level and substance abuse, the authors concluded the following:

> [T]he coefficients revealed no statistically significant relationships between public support payments and any of the substance abuse measures. In other words, in this study those who received high levels of public funding had no greater tendency to use or purchase drugs

[124] *Id*.
[125] *Id*.
[126] Rosenheck & Frisman, *supra* note 40, at 193-94.

> or alcohol than did public support recipients who received lower levels of funding. Also, although the findings suggest higher levels of substance abuse for the study group as a whole [i.e., veterans], on average, public support recipients reported significantly lower levels of substance abuse and spending than did those who did not receive any form of public support, even though the former group had higher total income.[127]

Another, nine-site study followed 1,764 randomly selected SSI beneficiaries over two years, examining how loss of SSI benefits affected their use of alcohol and illegal drugs.[128] The authors reported in 2003 that "termination of the [SSI] program had no effect on levels of substance use" among beneficiaries, whereas higher levels of substance use were "significantly and substantially associated with younger age (under 44 years), psychiatric and legal programs, and family or social conflict," and concluded that "subsets of the DA&A population

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[127] *Id.*
[128] Richard Speiglman, Jean Norris, Shanthi Kappagoda, Rex S. Green & Zoran Martinovich, *SSI Receipt and Alcohol and Other Drug Use among Former SSI DA&A Beneficiaries*, 30 CONTEMP. DRUG PROBS. 291, 291 (2003).

need individualized services beyond income support."[129]

In 2000, James Swartz and co-authors at Illinois Treatment Alternatives for Safe Communities, Incorporated, Loyola University, and the University of Illinois at Chicago conducted follow-up interviews with 204 randomly selected DAA beneficiaries in Chicago, who had initially been interviewed between January and March 1997, immediately following termination of their SSI benefits.[130] The authors reported that beneficiaries "who ha[d] lost DA&A disability benefits and who continue[d] to be unemployed or underemployed ha[d] elevated rates of drug dependence and psychiatric comorbidities," and so "helping these cases make the transition from government assistance to sustained employment is increasingly difficult."[131]

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[129] *Id*. at 291-92.
[130] James A. Swartz, Arthur J. Lurigio, & Paul Goldstein, *Severe Mental Illness and Substance Use Disorders Among Former Supplemental Security Income Beneficiaries for Drug Addiction and Alcoholism*, 57 JAMA PSYCHIATRY 701 (2000), *available at* https://jamanetwork.com/journals/jamapsychiatry/fullarticle/481633.
[131] *Id*.

In 2003, James Swartz and co-authors at the University of Illinois at Chicago performed a prospective, two-year study with follow-up interviews conducted every six months, and urine samples collected at the final three follow-up interviews, with 740 former SSI recipients who had received disability benefits for DAA in 1996. The authors found that participants were "28% more likely to test positive for cocaine use in the first 10 days of the month," and that this effect was "general across all subjects and...not restricted to those receiving SSI benefits," and that receipt of SSI "did not increase cocaine or opiate use generally, nor did having a representative payee suppress use."[132] The authors concluded that the "check effect" for cocaine use was "general and not confined to [beneficiaries] receiving federal cash benefits." They further noted that lack of any check effect for opiate use was "probably the result of the difference between a

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[132] James A. Swartz, Chang-ming Hsieh & Jim Baumohl, *Disability payments, drug use and representative payees: an analysis of the relationships*, 98 ADDICTION 965 (2003), *available at* https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1360-0443.2003.00414.x.

relatively steady state of opiate use associated with addiction and a binge pattern of cocaine use triggered by suddenly flush resources."[133]

In 2006, Marc Rosen and co-authors at Yale Medical School, the West Haven Mental Health Center, the Yale School of Public Health, and the Department of Veterans Affairs Northeast Program Evaluation Center performed a secondary analysis of data from 6,199 participants in a cohort study completed over four years. The authors found that participants who did not receive benefits "significantly reduced their substance use over time."[134] Adjusting for potentially confounding covariates, the authors found that participants who started receiving benefits "showed no greater drug use than those without benefits but had significantly more days housed and fewer days employed."[135]

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[133] *Id.*
[134] Marc I. Rosen, Thomas J. McMahon, HaiQun Lin, & Robert A. Rosenheck, *Effect of Social Security Payments on Substance Abuse in a Homeless Mentally Ill Cohort*, 41 HEALTH SERV. RES. 173, 173 (2006), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1681526/pdf/hesr041-0173.pdf.
[135] *Id.*

Participants whose benefits preceded the study and continued had "more clinician-rated drug use over time than those without benefits."[136] Overall, the authors concluded that the "hypothesis that Social Security benefits facilitate drug use was not supported by longitudinal data in this high-risk population."[137] Thus the empirical evidence diverges with respect to the central question of whether disability benefits incentivize substance use. Further study, including a more comprehensive review of the literature on the topic, could shed added light on this issue.

D. Practitioner Decision Making in Dual-Diagnosis Disability Cases

The 80% loss-rate revealed by the DDP raises another question: How did the 1996 reforms influence practitioner decision making, when considering representation of clients suffering from addiction? One EHDU attorney familiar with the

[136] *Id.*
[137] *Id.*

Unit's SSDI/SSI practice pre- and post-Welfare Reform recalled that, before 1996, practitioners were still making arguments that, for example, a client was disabled due to inability to control drinking. However, already then, some clients hesitated to seek approval for benefits based on drug use, predicting that their eligibility on that basis might not last. Judges also occasionally seemed wary of making decisions on the basis of a SUD, instead approving clients on the basis of other, concurrent disabling conditions (e.g., back pain).

The EHDU attorney also noted that the Unit may have considered eliminating SUD cases from its SSDI/SSI caseload a decade ago, eliciting vehement opposition within the Unit at the time. The prevailing opinion may have been that disability payments should not be used to incentivize behaviors—abstinence, employment—but instead to ensure that individuals who cannot work due to a medical disability are able to obtain the food and housing

needed to survive.[138] The decision to continue representing clients with SUDs may also have been driven by the belief that DAA clients were generally abusing substances due to mental illness—and not that their mental conditions were due to substance abuse.

VI. CONCLUSION

It may be unsurprising for seasoned advocates that the DDP uncovered a high loss rate for disability benefits eligibility cases involving substance abuse. Already in 1999, a few short years after Welfare Reform, Linda Landry at the Disability Law Center in Boston remarked that DAA cases were some of the

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[138] *See, e.g.*, Selver, *supra* note 4, at n.20. Writing for the *New York Times* in 1996, former United States Secretary of Health, Education, and Welfare and founder and chairman of the National Center on Addiction and Substance Abuse at Columbia University, Joseph Califano, Jr., opined that the 1996 Welfare Reform package denied "basic life supports to children in households headed by caretakers struggling with addiction." *Id.* (citing Joseph A. Califano, Jr., *Welfare's Drug Connection*, N.Y. TIMES (Aug. 24, 1996)). Another homelessness rights advocate opined that "the idea that addicts need a 'swift kick' to get on their feet is divorced from the reality of living in extreme poverty and homelessness." *Id.* (citing John Holliman, *Alcoholics, Advocates Wary of New Welfare Law*, CNN (Sept. 30, 1996), http://www.cnn.com/US/9609/30/welfare/).

most difficult to win.[139] More than 20 years later, the DDP data suggest that this is still true—but that advocates continue to feel it is important to take these cases.

In addition to showing that DAA cases remain an uphill battle for dual-diagnosis clients and their representatives, the DDP also brought attention to a number of opportunities for further research and possible reform. It highlighted a stark divergence between circuits on the question of burden of proof in DAA cases; a longstanding question of whether empirical evidence supports the CAAA's driving assumption that disability benefits incentivize[140] substance abuse; a question of how further evolution in the medical community's treatment of substance abuse will come to be reflected in disability law; and a question of why practitioners continue to accept the uphill battle in these cases—despite understanding

[139] Landry, *supra* note 2, at 545.
[140] *See, e.g.*, Stevenson, *supra* note 5, at 196 (referring to an "incentives-based approach" with respect to disability benefits for substance abuse).

for years that the data suggest a low likelihood of success.