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Now invited to testify: former beneficiaries appraise the SSI drug addiction and alcoholism program

BY SHARON R. HUNT
AND JIM BAUMOHL¹

The only thing that I do want to tell you is I just thank God that they did have this SSI. And I'm glad they didn't just throw me down the shitter, man, because I think I've come a long way, you know? I mean, a real long way.

A 45-year-old San Francisco methadone patient

As part of the larger SSI Study, we conducted detailed semistructured interviews with 156 respondents in four sites. They spoke at length about matters of legislative concern during the reform and subsequent abolition of the drug addiction and alcoholism (DA&A) program. Respondents were quite aware of the problems considered by Congress. Some acknowledged using SSI payments to buy alcohol and other drugs, and a few claimed to have squandered large retroactive payments. Most insisted that they spent their checks wisely, however, and discussed how they did so. With a remarkable degree of consensus, respondents favored the DA&A program's paternalistic features of representative payment and mandatory treatment, and while less in agreement about time limits, they approved in theory of benchmarks to measure progress.

A substantial majority believed the DA&A program had been an unalloyed good, and only 12 judged it to have been wholly harmful.

KEY WORDS: *Supplemental Security Income, disability benefits, mandatory drug treatment, representative payment, earmarking of money, views of welfare recipients.*

Earlier in this issue we (Hunt and Baumohl) described the drug addiction and alcoholism (DA&A) provisions of the Supplemental Security Income (SSI) program, the controversy leading to their reform in 1994, and the program's elimination in 1996. In February 1994, subcommittees of the House Committee on Ways and Means heard about the DA&A program from 27 witnesses—but none were beneficiaries. In a limited way and long after the fact, we seek to rectify that. In this paper, we are particularly interested in what former DA&A recipients told us about matters of legislative concern.

To this end, the paper proceeds as follows. First, we take up briefly how our respondents came to receive SSI benefits as drug addicts or alcoholics. Next, we consider the matter of “dangerous cash,” looking at respondents' accounts of their relationships with their representative payees, particularly the rationing of money and its earmarking for specific uses. We consider as well the issue of “back pay,” the controversial distribution of retroactive benefits in lump sums, a practice that was discontinued only for DA&A recipients early in 1995. We look next at respondents' views of the requirement that they participate in substance abuse treatment. We then sum up their appraisal of how the DA&A program affected their lives and relay their views about constructive policy. Our concluding discussion revisits issues raised in our earlier paper and foreshadows the policy paper that ends this issue.

Methods

As Swartz, Tonkin, and Baumohl (this issue) describe in more detail, 15–17 months after the end of the DA&A program we conducted semistructured interviews in Portland, San Francisco, Stockton, and Chicago with 156 participants in the larger SSI Study. For this supplemental study we deliberately oversampled people who reported earnings from work at the one-year follow-up of the SSI Study. For the purposes of this paper, it isn't clear what bias this introduced. Except for a few explicit claims of racial bias in the application of the DA&A label, or concerns about the cultural sensitivity of some treatment personnel, we found no systematic differences in respondents' views that we could attribute to demographic characteristics, current employment, or SSI status. On the whole, we were impressed by the substantial agreement among respondents about the strengths and weaknesses of the DA&A program.

In terms of demographic characteristics and SSI status, at least, our respondents resemble others in the four site samples from which they were drawn. Overall, 58% were male, almost half (45%) were in their 40s, and roughly a quarter (23%) were 50 or above. Twenty-nine percent were white, 48% black, 15% Hispanic, and a small group (8%) was composed mostly of Asians and American Indians. Some respondents had been on SSI for less than a year when the DA&A program ended (9%) or had received benefits for 10 years or more (5%). Almost two-thirds (64%) had been on SSI for at least one year but less than five, and another 17% had collected benefits for at least five years but less than 10. We interviewed 103 individuals who did not retain SSI after the DA&A program ended (66%) and 53 (34%) who did. At the time we interviewed them, 24% claimed not to be drinking or using, 17% reported drinking or using very little, 28% were moderate users of alcohol and/or other drugs, and 31% were heavy users.²

The interviews were organized as short life histories and ranged widely. A few respondents were taciturn, but most were anxious to tell their stories, especially when warmed up, and spoke with striking candor about very private matters. Many reveled in detail and the illustrative anecdote, and it was sometimes difficult for the interviewer to cover every point in the interview guide. Even so, we discussed with most respondents what was good or bad about SSI and what they thought about the representative-payee provision and retroactive payment. Our data on respondents' views of the treatment mandate are rich, but they come from only 80 cases.³

We analyzed the voluminous data with the help of software called QSR NUD*IST, version 4 (N4). In its most basic application, N4 is an infinitely flexible electronic filing system that permits multiple-category coding of bits of text that can be viewed categorically and in original context. However, N4 also can execute complicated sequences of logical exercises (called "operators" in N4 lingo) that organize coded text to permit the identification of patterns and the testing of hypotheses with an efficiency that manual qualitative analysis cannot achieve. For present purposes, our analytic aims were to illuminate the range of respondents' ideas about the DA&A program and how they were related. Put another way, we were interested in points of view and the logic supporting them. Although we inevitably invoke words like "some," "many," and "most" to characterize the extent to which ideas appeared regularly, and do provide some percentages, we are mainly interested in how respondents thought through their experience with the DA&A program and how they reasoned about changes they would have made.

Getting on SSI for drug addiction or alcoholism

A welfare claim is not undertaken lightly. While programs vary in their administrative particulars, application processes

are by design invasive and often protracted, particularly in the case of disability claims. The modest benefits to be won at such a cost reinforce the greater desirability of wage earning (see Soss, 2000). As even a young Portland woman with very little work experience told us, "After I was working, I realized how much money I make more than waiting once a month for a lousy check." Almost without exception, respondents told us that people should work for a living and said they would do so if they could.

When they applied, respondents typically saw the benefits of SSI and associated Medicaid coverage as potential help with pressing problems for which they had no other ready solution. As a 37-year-old Chicago woman put it:

I really didn't believe in it [disability benefits for addicts and alcoholics], but I knew that I was sickly . . . that I had asthma real bad. And I knew that I was tired of hustling mens to pay the other half of my rent . . . that I was sick of public aid cutting me off and putting me on and cutting me off. And I knew that soon, one day, I'm not gonna be able to work, and then what the hell am I gonna do?

Like this woman, most respondents initially were attracted to SSI because the benefits were more certain and the payment level much higher than state or county General Assistance (where it was available) or the adult part of an Aid to Families with Dependent Children grant, programs with which most had some experience.

Simply put, SSI represented additional money each month for people who needed it enough to put up with the long and complex application procedure described in our earlier paper (Hunt and Baumohl, this issue). Sometimes they needed a way to be less burdensome or beholden to their families. Asked what prompted her to apply, the young Portland woman quoted above answered, "Because I didn't want to live off my mom. I had to get some kind of money." A middle-aged Chicagoan "really didn't want nothing." He had avoided the dole all his life, but then "I was back at home

with momma. . . . I had to contribute something, you know.”

In addition to the money, some respondents knew about the treatment provision of the DA&A program and saw this as part of the help offered. The observations of a Portland man (the first speaker) and a Stockton woman (the second) are typical in this respect:

I just couldn't do anything. I couldn't hold a job. I didn't want to. I couldn't manage using and drinking [and] at the same time, working. I didn't want to hurt nobody else or hurt me. And so I finally come to the point, after doing this all my life, I gotta have somebody help me out.

My mom said that I should go down there and file for SSI. This was after I had quit working. I was already using and everything. And she said, maybe it will help you. Maybe you can go into treatment, get yourself together or something. And I said, okay. And I filed for it.

Respondents heard about SSI from friends, family, medical or psychiatric personnel, substance abuse treatment providers, social service agencies, welfare workers, parole officers, lawyers—one person read about it in a newspaper. Many heard about SSI from other beneficiaries. The critical role played by General Assistance (GA) programs was a striking feature of some respondents' stories about how they came to apply for benefits. Of 143 respondents who remembered how they first heard about SSI, 19 (13%) learned of it from a GA caseworker. The many respondents who received state or county benefits immediately before applying for SSI commonly observed that to continue on the state or county rolls, they were expected to apply for SSI.

All but a few respondents described periods of heavy drinking and substance use that sometimes encompassed long stretches of their lives. However, quite a few insisted that impairments other than drug addiction or alcoholism were the real causes of their disability, and that their designation as DA&A beneficiaries resulted from the need to portray them-

selves strategically. We do not want to imply, as did some members of Congress, that legions of unqualified poor people got SSI by virtue of DA&A claims. Rather, respondents often resorted to sophisticated help in dealing with a complex, rule-bound system on its own terms. They were helped to amass (not falsify) evidence recognizable to disability evaluators trained to think in terms of impairment categories and their attendant rules of inclusion and severity.

Conventional wisdom about SSI held that being denied was part of the process. (As a San Franciscan observed, “That’s a part of the thing—everyone gets denied the first time unless you walk in there with a hatchet through your neck or something.”) Failing to qualify the first time they applied, or even the second, respondents often sought or accepted the assistance of lawyers or lay advocates who reshaped their claims to take advantage of the ambiguously defined DA&A category.⁴ Advocates believed it was easier to get SSI on the basis of a DA&A impairment than as the result of most others, and respondents often first heard about the DA&A program (as opposed to SSI more generally) from a lawyer. A Stockton woman recalled: “And he [her lawyer] goes, if you’re a drug addict [she was], I can get your SSI quicker if you just tell me if you’re a drug addict. And I was like, you can? He goes, ‘Yeah’. . . . And so, basically, he just dropped all the other stuff . . . and took it for drug and alcohol.”

Typically, respondents resented this rejection of how they defined their difficulties, but they saw it as characteristic of the proverbial “system,” of which only rough justice, if that, could be expected. They were convinced of their incapacity for steady work and often interpreted the technical barriers thrown up by disability determination as examples of official hypocrisy or even racism. A 52-year-old African-American man in Chicago, with numerous chronic health problems, explained his DA&A classification as follows:

I said my problems don’t have nothing to do with alcohol and drug abuse. Then they try to say that’s what caused you to be in the con-

dition you in, from drinking so many years ago. I say, well, if that's the case, it woulda hit me sooner than it did, 'cause I ain't had nothing to drink for two years, or smoked for two years. Mine was more of a physical dilemma than it was an alcoholic dilemma. That's what I tried to get them to understand. Then they wouldn't write me up for that. They wrote me up for alcoholism, you know, [for] which I had been in a treatment place four or five times, but, you know, one of the persons out there told me, that's how they do black folks. They put you in a program like that [DA&A] instead of giving you a disability because they be trying to save that stuff for white folks.

Shorn of its racial dimension, similar indignation often arose from the eligibility bind caused by the DA&A label when the program ended. Having collaborated in the strategic portrayal of their incapacity for work, many respondents damned in retrospect the attorneys who had helped them. As a Portland woman noted bitterly: "I was trying to get it for my leg. [She had a noticeable limp.] I wasn't trying to get it because of drug and alcohol, but my lousy lawyer pinned it on that, because of my history of drug and alcohol. And I was trying to get it for *disability*." A few people told us that their lawyers or disability evaluators acted independently; that they didn't know they were in the DA&A category until a termination notice came in June 1996.

Although most respondents considered debilitating substance abuse to be a legitimate basis for a disability claim, the same people often believed that addiction was tainted in comparison with visible and presumably blameless impairments. (Note, for example, that the Chicago man and the Portland woman quoted above reserved the term "disability" for an impairment unrelated to alcohol and other drug use.) Some even questioned the priorities of SSI. Both speakers below are Chicago women in their late 30s who made no attempt to minimize or excuse their alcohol and other drug involvement. The second speaker had been abstinent for four years and

remained on SSI, probably for the constellation of impairments she named:

If you want SSI, do dope. 'Cause, as they said, back then it was easier to get on [for] drugs. . . . I think that's why I even told them I used drugs, because I couldn't get on SSI with just going in there and telling them I have a bullet in my—they kept denying me, they kept denying me. The minute I mentioned drugs, boom, I got it. . . . If you're a drug addict or alcoholic, you can get it faster than if you're blind, crippled, or crazy, you know. That's messed up. They say that somebody who uses drugs and alcohol can get it better than somebody walking in there blind, or somebody with one leg, they give them a hassle, telling them but we got so many jobs where you can work with one leg or you don't need to see. That's how it was down there.

I had proof from records from hospitals where I was sick at—how come they gonna give me some money when I actually doing drugs and alcohol? That's the craziest shit I ever heard. Why would you give somebody money to do drugs and alcohol? Why don't you give me money when I'm impoverished and I'm sick with asthma? Why I got to go do a joint and do some, you know, that, to get some money? That's the craziest shit . . . because I knew that I had carpal tunnel syndrome. I knew that I had a back problem from an accident in a taxicab. I knew that I have asthma so bad, sometime you—I can't breathe completely out of my nose or mouth. And why would they give me something [for] something that you shouldn't be doing in the first place? That's what made me think that SSI was something of the devil.

The women quoted above, and others with similar views, questioned the legitimacy of substance abuse as a disabling impairment and thought they should have qualified on other grounds, as the second woman finally did. They also addressed obliquely one of the most troubling dilemmas of disability determination: the commensurability of impairments. How should asthma, carpal tunnel syndrome, or the loss of a limb be compared with an addiction to crack? Recourse to some subjective norm of perseverance would effectively award disability benefits to anyone willing to claim them. This would defeat the first function of the disability boundary, which is to ensure that everyone who can

work does so (Stone, 1984; Liebman, 1976). Otherwise, disparate impairments are compared only with great difficulty and questionable validity. The women speaking above were troubled by the apparent absence of moral substance in a medical system of disability determination, but the devil also resides in technical details that they had little or no knowledge of—but that their advocates could exploit.

Dangerous cash

The political vulnerability of the DA&A program was a result of its rapid growth and addiction's ambiguous legitimacy as a disabling impairment (Hunt and Baumohl, this issue). However, even sympathetic legislators worried that the benefits did more harm than good, that the program's paternalistic features—the requirements of representative payment and participation in treatment—failed to mitigate the hazards inherent in providing cash assistance to people apt to spend it in ways that were foolish at best, and personally and socially destructive at worst. They worried that the benefit was “dangerous cash” (Zelizer, 1994:126). As Representative (now Senator) Jim Bunning (R-KY) saw it, “[I]n many cases we are directly subsidizing the addiction of people. We might as well be giving money directly to the drug dealers” (*Exploring Means*, 1994:10).

The problem of dangerous cash is an old one and central to the history of American welfare policy. Until well into the 20th century, public-policy makers, officials of private charities, and social workers dealing directly with poor folk took as axiomatic the danger of cash relief. Poor people, so the argument went, were given to vice and irrational extravagance; or they were incompetent consumers who needed the protection of in-kind transfers in the form of fuel, food orders, rent vouchers, transportation chits, and so forth. The result, as a Depression-era critic of such practices opined,

was that in-kind relief extended the “regulation of other people’s lives” to include “what they should eat, what they should wear, and where and how they should live” (Brown, 1940:223).

The Great Depression greatly hastened the spread of cash relief. The millions of “new poor” overwhelmed their would-be supervisors. Moreover, they had spent their lives as wage earners and bridled at the indignity of in-kind aid. As a sympathetic Philadelphia welfare official put it: “Money for them means the exercise of intelligence and discretion. . . . Around money there is a kind of aura of responsibility which does not attach to *things*” (Kahn, 1933:273, emphasis in original). In this spirit, the federal Social Security Act of 1935 required that the benefits of its programs be paid in cash. (This became known as the “cash payment principle.”) By 1944 the federal Bureau of Public Assistance had outlawed “conditioned tender,” which is to say, the use of federal relief dollars in programs that specified and oversaw clients’ purchases (Zelizer, 1994:190).

The cash-payment principle notwithstanding, federal, state, and local aid programs still regard some beneficiaries as incompetent or disinclined to manage cash in acceptable ways. Policy makers continue to accept the necessity to limit “the right of an individual or a family to fail” (Thurow, 1977:98), thus conditioning public aid to limit the choices of welfare-aided people. For example, recipients of food stamps may not use them to purchase non-food items, including alcohol or tobacco products. In two of the SSI Study sites (Stockton and San Jose), GA was available mainly as a housing voucher.

The representative-payee provision in the SSI law of 1972 was in this vein. The SSI representative payee was to be an authoritative advisor on sensible spending who had both a fiduciary responsibility and a commitment to the beneficiary’s overall well-being. Ideally the payee would be the sort

of prudent “decision aider” that only the well-to-do and savvy could otherwise afford or competently engage (see Thurow, 1977:96-97).

There is little evidence about how well representative payment works, particularly if the aim is to discourage substance use (but see Rosenheck, Lam and Randolph, 1997). Many of our respondents acknowledged that during some periods of time, at least, they spent part of their SSI check getting high or drunk. A long-recovered Stockton alcoholic and heroin addict observed that she “bought a lot of dope with it. It wasn’t about meeting my needs of normal, everyday living.” A Portland man recalled: “Shoot, I’d get it [his check] on the first and I’d be broke by the third or fourth. And that was [spent on] me, not—I wasn’t paying no rent or nothing.” However, most respondents emphasized that even when drinking or using heavily, they took care of basic needs first. Put another way, they earmarked money for particular purposes. Although economists often speak of money as an undifferentiated tool of exchange, in reality there are “multiple monies” designated for appropriate uses in different social contexts (Zelizer, 1994:18–19). Below, we turn to what our respondents thought about having their money controlled, and how they retained some financial autonomy.

The role of the representative payee

The Department of Health and Human Services’ Office of the Inspector General (OIG) investigated the DA&A program in 1991 and 1994. Its 1994 report concluded that most payees (88%) actively managed beneficiaries’ funds, but in different ways: 68% paid bills and gradually dispersed funds; 15% paid no bills but doled funds over time; 5% paid bills but gave out remaining money in a lump sum; and 12% merely turned over all the money at once. The few organizational payees in the study were the least likely to release the whole check at one time; and overall, family members and other individuals were somewhat less likely than organizations to assume tight control of the money. However, the report noted that family members and other individuals were more

involved than organizations in beneficiaries' lives, mainly because they saw them more often and had known them longer. The report did not assess how well payees kept beneficiaries away from alcohol and other drugs (OIG, 1994).

The use of family members or friends as payees was officially discouraged after 1994. Even so, most of our respondents received their first check and chose a payee prior to that time, and the majority (82) had a family member as payee or had different family members serve in that capacity over their whole time on SSI. Fourteen used a friend or a series of friends. Eight others used a combination of family members and friends, and two more switched from an agency payee to a family member. In sum, 106 (68%) relied mainly on family and friends to receive their checks and oversee their expenditures. Thirty respondents used an agency payee of some kind for the whole of their SSI career, and 12 others switched from a family member or friend to an agency. Thus 42 (27%) relied mainly on organizational payees. The remaining few used store owners, a doctor, a landlord—people who might have been friends but were identified by role.

Consistent with the 1991 OIG report, which found that just over half of a sample of DA&A recipients approved of the payee requirement (OIG, 1991), two-thirds of our respondents approved, even if they chafed a bit under the rule, and even if they had initial objections to it. While we can't be sure, we don't think this represents mere acceptance of the inevitable. Typically, respondents readily allowed that spending money wisely was not a long suit. When asked if a payee was useful, a 50-year-old Stockton methadone patient responded as though only a fool would ask the question: "Why certainly," he deadpanned. "I mean, how many responsible addicts do you know?" A San Francisco man in his late 40s, who remained on SSI for a psychiatric impairment, had his own nice analogy for representative payees: "It's like, what do they call it? Designated driver. Same sort of principle." Another San Franciscan, a recovering heroin addict in

his mid-40s, explained that he needed a payee “to learn how to adjust my money and learn how to spend it. . . . You know, it’s something that I never did. I mean, I’ve been in prison all my life. You understand what I’m saying? And then when I got out and I got money, . . . I just splurged, man, and spent it.”

Very few respondents judged the payee provision to be unfair in principle, although more thought that having a payee was an unfair requirement of *them*. This objection assumed two forms. Some respondents disagreed with the blanket application of the requirement. A Portland woman in her mid-40s explained that “as bad off as I’ve been with drugs, I’ve always paid my rent and my utilities. And so I couldn’t understand why they’d give me a payee when they could see that I could do these things.” Others felt diminished by comparison with people whom they judged to be far less competent but who were not required to have a payee. A San Francisco man said:

Some people who are totally mental cases, mere basket cases, can get their own money and do their own financing. And somebody who has that “alcoholic or drug problem” can’t take care of his own finances? Somebody who walks around the street, you know, all dazed, and his money’s taken out of his pocket, and looks like he needs a bath for the past five years—oh sure, they can go pick up a check in an office. . . . To me, those are the people who need a payee. Those are the people who need somebody to handle their resources.

At the SSI Study’s baseline data collection at the end of 1996, all of our 156 respondents had been in a payee relationship during the previous six months. Half (49%) had a relative as payee during that time, 27% an agency, 22% a friend, and two respondents indicated another category of person. When queried systematically about what their payees did, respondents gave reports similar to the OIG findings summarized above. As the following table illustrates, agencies and relatives were more likely than friends to pay a respondent’s

rent or to provide an allowance, but both practices were typical. Overall, 71% of payees paid rent and 74% administered allowances. On the other hand, families and friends were much more involved in the time-consuming activities of grocery shopping, housing searches, tracking down substance-abuse and medical treatment, and helping people get to care. They were also more likely to extend financial assistance beyond the SSI check. Many of our respondents lived with or near the relative or friend who served as payee.

Activities of representative payees by payee type

| | Payee Type | | | | |
|---|----------------|------------------|----------------|---------------|----------------|
| | Friend N=35 | Relative N=77 | Agency N=42 | Other N=2 | Total N=156 |
| Pays Rent | 19 (54.3%) | 60 (77.9%) | 31 (73.8%) | 1 (50.0%) | 111 (71.2%) |
| Gives Allowance | 22 (62.9%) | 58 (75.3%) | 35 (83.3%) | 1 (50.0%) | 116 (74.4%) |
| Buys Groceries, Other Necessities | 17 (48.6%) | 50 (64.9%) | 16 (38.1%) | 1 (50.0%) | 84 (53.8%) |
| Provides Transportation to Substance Abuse Treatment | 12 (34.3%) | 35 (45.5%) | 3 (7.1%) | 1 (50.0%) | 51 (32.7%) |
| Helped Find Substance Abuse Treatment | 7 (20.0%) | 27 (35.1%) | 5 (11.9%) | 0 (0.0%) | 39 (25.0%) |
| Gave Financial Support While in Treatment | 11 (31.4%) | 30 (39.0%) | 6 (14.3%) | 1 (50.0%) | 48 (30.8%) |
| Helped Find Medical/Dental Treatment | 7 (20.0%) | 30 (39.0%) | 4 (9.5%) | 2 (100.0%) | 43 (27.6%) |
| Helped Find Housing | 12 (34.3%) | 35 (45.5%) | 2 (4.8%) | 1 (50.0%) | 50 (32.1%) |

Overwhelmingly, respondents were happy with their payee: At the SSI Study baseline, 84% were “very satisfied” or “satisfied” with the relationship. A recovering Portland heroin addict in her mid-40s confessed that “if my daughter wouldn’t been getting my check, I probably been homeless the whole time, waiting . . . to get my checks to spend on dope.” A recovering Chicago alcoholic and crack addict in his early 50s observed: “If I had got that whole check, if I had to take it up there and cash it, I knew what was gonna happen. Shoot, I probably wouldn’t even have that thing not even for, it’d be gone that same night.” We heard many comments of this sort, from abstinent people and heavy users alike.

Still, some respondents (7%) were “unsatisfied” or “very unsatisfied” with their payee, and another 8% were “neither satisfied nor unsatisfied.” Agency payees had a low satisfaction rating (60%) compared with ratings for friends (94%) and relatives (91%). Even those who were happy with an agency payee sometimes objected to certain features of the arrangement. The fee permitted to organizational payees was a particular sore spot, and a few respondents referred to themselves as “robbed” by this requirement.⁵ Others found an agency payee to be “a hassle” because they had to appear at certain times to get money, or wait to see their worker, or because phone calls were not returned. A Stockton man summarized as follows his problematic relationship:

Yeah, it was hell with her. Not to the point where she acted like it was her money, but it was the lack of contact, it was no—you could not call her on the phone and explain—you had to leave a message and she said she’ll get back to you. Then you see her that one day a week, and then she’s always in a hurry. “I’ve got an appointment. Here, take this check and go.”

By and large, respondents wanted and appreciated a personal touch, and this is what they often found organizational payees to lack. To be sure, family members could patronize, but usually they cared about their kinsperson’s welfare. A 46-year-old Chicago man, a recovering alcoholic and heroin addict who retained SSI, said about his younger brother: “I didn’t have a mind to cover no money. He had a mind, you know what I mean? . . . He paid my bills, he made sure I ate, he got me shoes, pantses. When he got through and he had some change left, he said, ‘Here’s a little something for you.’ He . . . always let me know where all my money went to.” A San Francisco man in his mid-40s, an alcoholic who said he now drank much less than formerly, developed a similar relationship with a local storekeeper:

I used to give away my money. And when I ran into this payee there, everything got a whole lot better. He only gives me a certain amount. And if he knows I been drinking or whatever, he won’t give me a cent. And we go shopping every week. And he tries to

involve me, you know, having me do things with him sometimes. Like clean the storeroom up or something.

At bottom, however, the representative payee is not there to provide a convenience. The payee is not a designated shopper for the rich and busy. Rather, the payee oversees how people of suspect judgment spend money; the payee imposes priorities on a beneficiary's consumption. Most payee relationships involve negotiation about rationing money and dedicating it for particular uses. Indeed, respondents' reported satisfaction with their payees probably reflects their satisfaction with the style and course of such negotiations. While many heavy drinkers and drug users were quite satisfied because the payee relationship curbed their consumption, others were satisfied because their payee was permissive. We turn to these issues next.

Rationing and earmarking

A Chicago man, a heavy user of alcohol and crack, told us about being the client of an agency payee:

It was okay because they saved you a lot of money, because . . . they wouldn't let me spend it all at one time. They just give me enough just to survive with. You know, . . . pay your rent and . . . give you groceries. They give you, like your allowance, stuff for like, you know, washing powder . . . personal things. And it was okay in a way, [but] . . . I like to control my own stuff, be my own man. . . . They controlled my money and everything, so I didn't like that.

As the Depression-era revolt against in-kind assistance underscored, being responsible for one's own consumption is a mark of full maturity, of "being one's own man." To be on a financial leash is to "feel like a dummy," as a San Francisco woman put it. At best, it is to be in a tutelage relationship; at worst, it is to be treated like an incompetent. While most respondents conceded that they had benefited from such a relationship, they also found ways to assert themselves within it.

Respondents' payees exercised varying degrees of control. For the most part, agency payees were stricter. Established hours, queuing routines, and customary role distance insulated staff from hectoring and requests for loans. They were better equipped than family members or friends to enforce strict budgets. While observing that it could be an aggravation, most respondents appreciated having their benefits rationed, whether by an agency or by a diligent, thick-skinned relative. A 56-year-old San Francisco man who was switched to an agency payee following the 1994 DA&A program reform said: "I didn't accept it at first but I thought it was a lot better than the way I was when I was with my friend because I did manage to start saving a little money. Because I did stop drinking a lot, too, because I didn't have the money that I did have when I had it all at one time." "Sometimes," observed a Chicago man in his mid-40s, whose father was his payee, "when it's in somebody else's hand you get a time . . . to think about what you gonna do with it (laughs). . . . Instead of doing some impulsive thing like spending on this and that and that and this." Often the "impulsive thing" was alcohol and other drug-related socialization. Another middle-aged Chicagoan, a heavy user of crack and alcohol, noted that it was a good thing his godmother was a conscientious payee, because "I could be on my way to pay my rent, and . . . I'd meet a friend, drink or whatever. Next thing I know, it's the next day and I still ain't went and paid my rent and I'm broke."

Not every agency payee was always vigilant, however. A recovering Portland methamphetamine addict told us, perhaps with some hyperbole: "I'd go down there and say, I need to buy a color TV set. Can I have \$200? . . . I need to buy an air conditioner, can I have \$200? One time I ran out of stuff to buy and one day I said, man, I want to turn gay. I want to go entertain this man. Can I have \$200? She'd just write the checks, man. I thought, man, how can this motherfucker be that stupid. But, I just want a fix, I don't care." Still, even

when payees took seriously their responsibility to earmark money, they could be defeated easily enough. Many of our respondents were seasoned hustlers who, having decided to claim their spending authority, found plenty of ways to convert earmarked relief into personal money. “I got a lot of clothing,” a San Francisco man explained about manipulating his agency payee, “boots and stuff like that, that I was getting and then reselling.”⁶

Some respondents generated personal money through spot work or hustling (see Campbell et al., this issue). The moral obligations of the dole or the intent of a family benefactor did not encumber this “earned” income. Semiretired prostitutes often told us that while SSI allowed them to leave the full-time trade, they still went on occasional “dates,” particularly if they needed money for a special purpose, legal or otherwise. Some respondents maintained small drug businesses in order to pay for their use without “wasting” their SSI money, which they put to respectable use. Indeed, in cases where respondents continued to drink or use substantially in spite of a diligent payee, they could avoid conflict with their payee by earmarking an alternative source of cash for disreputable consumption while reserving SSI money for its “official” purpose. A 51-year-old Portland man, a heavy drinker on SSI for three years, explained his system of private accounting:

I didn't really spend any of the SSI money except on my necessities, a roof over my head. None of that money I spent on boozing. That's all catalogued. I got proof of that, you know, clothing. You know, it took care of all my needs, like a TV for myself and a radio, a clock, you know, things that I need for my own sanity. I still knew how to hustle money, so I didn't have to worry about money. I could borrow from Peter to pay Paul, so I'd steal from my own monies. But the money I made [hustling], I put back in there. . . . But when I'd hit a big one, that was my drinking money.

We can't tell from our data how effective such earmarking schemes would have been in the absence of representative payees. However, given their comments about the value of

representative payees, we think that, for the most part, respondents believed that *for people drinking or using heavily*, private earmarking alone was unlikely to keep the rent and the bills paid consistently.

“Back pay” Those found eligible for federal disability benefits are entitled to retroactive payments, or what recipients call “back pay.” SSI beneficiaries are entitled to benefits from the date they applied, or, if later, the date on which their impairment was judged to have become medically eligible. Retroactive benefits are paid in a lump sum unless the Social Security Administration determines that harm would be done by paying benefits this way.⁷ Recipients have a specified amount of time (usually six months) to “spend down” their back pay to within SSI’s resource limit (\$2,000 at the time of our study).

In the early 1990s, the print and electronic media repeatedly highlighted the stories of two DA&A beneficiaries who misused their retroactive SSI benefits. In January 1992, William Whiting, of Bakersfield, California, was found dead in a motel room after purchasing large amounts of drugs and alcohol with his retroactive check (Otten, 1992). Linda Torrez, also from Bakersfield, was arrested for heroin possession, and while searching her apartment, police found thousands of dollars in cash from a retroactive check (Irvine and Goulden, 1992). Congress responded to such concerns by enacting in 1994 a provision that called for back pay to be doled out in smaller increments (Benefit Reforms, 1995).

Two studies published after the elimination of the DA&A program examined the impact of retroactive payments on addicted individuals. Satel et al. (1997) found that among 43 people who received back pay while in long-term residential substance-abuse treatment, unplanned (“precipitous”) discharges rose relative to those in a comparison group—although it was not clear that these discharges were due to substance use. A related study (Herbst et al., 1996) examined the program attendance of 26 methadone maintenance

patients who received back pay while in treatment. The median number of days missed from treatment in the 90 days before and after receipt of the check went from three before to six after.

Of our 156 respondents, one-quarter either did not get back pay, didn't know (or couldn't remember) how much it was, or received double monthly payments in lieu of a lump sum, a common practice after 1994. Among the rest, 51% received less than \$3,000 (though most got more than \$1,000); 27% got \$3,000 but less than \$5,000; 16% got from \$5,000 to less than \$11,000; and seven people received \$11,000 or more.⁸ We asked respondents how they spent this money.⁹ Almost two-thirds reported buying "useful things" like cars, furniture, electronics, and washers and dryers, with no mention of using any of it for alcohol or other drugs.¹⁰ A San Francisco woman noted with satisfaction: "I bought my furniture. I bought a brand new bed, like I never had before (laughs). A brand new bed, queen size." A number of people spoke about paying off debts and bills, or giving money to family members or buying them things in appreciation of past support. If the check came around Christmas or a birthday, respondents sometimes gave gifts as never before, particularly to their children, nieces, and nephews. Listen to a Stockton mother of three:

I went and bought clothes, clothes, clothes, clothes. That's what I did. . . . I went and bought all kinds of good stuff. You know, when I get a lot of money I don't think about drugs. I think about what I want. Because there's a lot of things I sit back and say damn, I wish I could have that. That Playstation for my son, or they need Starter jackets. . . . But if I get a lot of money, that's the first thing I do, I go out and buy all kinds of stuff. And give my mom money, because she's always been there for me. If the house needs something, I'll go and get that for her.

The use of back pay to express their gratitude likely constituted for many the reestablishment of credit in severely tried relationships. As anthropologists have observed for genera-

tions, gift-giving creates or renews a recipient's obligation (Stack, 1974). As well, back pay gave people a rare stake for other sorts of investments, permitting, for example, moves that required first and last months' rent and a security deposit. A Stockton woman bought a mobile home with some of the \$44,000 she received (a residence is exempt from the resource limit). A Portland man who had spent a number of years homeless recalled, "Yeah, I bought [a van] right away, because I figured, I didn't know how my life was going to go. . . . But I didn't want to go back to the old life, sleeping under bridges and sleeping out. So I bought me a van, in case anything would happen, at least I could stay in it."

Predictably, back pay sometimes exacerbated problems of rationing and earmarking for both payees and recipients. Twenty percent of respondents reported spending a small amount of their check on substances. Sixteen percent reported spending a large amount of back pay on alcohol and/or other drugs. (Two respondents attributed a relapse directly to receipt of back pay.) A recovering Portland addict in his late 50s recalled: "Twelve hundred dollars lasted me one night. That's the truth. One night and it was gone. I mean, I'm a heroin addict, cocaine addict. You don't put \$1,200 into a man's hand like that." This fellow claimed that the check came directly to him, instead of to his payee (his father), but payees were not always up to managing the sums involved. A Chicago man spent his \$2,200 of back pay on "a lot of partying" because "my brother [his payee] gave me \$500 at a crack. He said, 'How could you be broke? I just gave it to you last week.' Cabs, hotels, women, eating good, drugs. I squandered it." But to reiterate, only a small fraction of respondents told such stories about how they spent back pay.

There was no clear relationship between the amount of back pay and its use. Even relatively large amounts often posed no great problem, given the long deprivation experienced by respondents. As a Chicago man observed, "Three thousand dollars ain't no money for all the things I've missed out on.

Shoot. Had no clothes, had to buy clothes, you know, had to buy everything, shoes, stuff for the hair, stuff for the body.” To others, similar amounts could be frightening. Asked how it felt to get \$2,600 at one time, another Chicago man responded: “Scary. The reason why I said scary is because I still was . . . sick. . . . I still had an addiction problem. . . . So when I got all that money, I was like, ‘damn’— a lot of thoughts was going through my mind.” A San Francisco man who spent “a lot of foolish [money] on drugs back then” said (without intending the humor): “They gave me a radioactive check.”

Eleven percent of respondents had an agency payee when they received back pay, and they were just as likely as others to spend a lot of it on alcohol or other drugs. Many agencies did impose tight rules for access to back pay—but not always with the intended result. As a Stockton man recalled with disgust: “They [his agency payee] said I had to be drug free for six months before I could get a down payment on a car and stuff. Yeah, it was screwed up. They fucked me all around. I had \$10,000 back pay coming and couldn’t use it. And I just pissed it off [because he could only get small allotments] and stuck every bit of it in my arm.” As the vernacular term suggests, respondents saw “back pay” as deferred wages of hardship to which they were entitled, especially if it could give them a stake in something big or beautiful they could afford no other way.

The fairness and helpfulness of the treatment mandate

Social Security Disability Insurance and SSI require that beneficiaries follow recommended treatment when it can restore work capacity. Only DA&A beneficiaries, though, ever were subject to a systematic attempt to enforce this *quid pro quo*. Here, we take up how respondents viewed the requirement to go to treatment.

Just over half (80) of our respondents gave a specific opinion about the fairness and/or helpfulness of the treatment mandate. Of these, two-thirds believed it was fair, helpful, or both—a proportion that closely resembles the findings of the 1991 OIG investigation.¹¹ To our surprise, not one respondent stated that mandated treatment infringed on personal liberty.¹² In fact, many defended the mandate by invoking a citizen's obligation to avoid being a burden to the state or as fair exchange more generally. A 40-year-old Portland woman, a heavy drinker with an extensive treatment history, said the mandate was fair because "you're sitting there and you're getting money for something that you say is wrong with you. The best thing is to be in treatment." A 36-year-old San Francisco man who had never been treated until coerced by the mandate said, similarly, "if you getting money from the government for certain problems, then you should be treated for such. . . . There's certain limits the government has, as far as letting people do what they want. This is a democracy, but it doesn't mean you get to go around sponging to the max, you know." "It's an exchange," explained a 49-year-old Portland man. "You do this for us and we'll do this for you. This is the way it should be."

A Stockton man, a heavy drinker only in his late 20s, gauged his obligation to be like that of a public employee: "I was like getting paid for doing it anyway. It was like another job." More telling, though, he said he "didn't care" about whether the treatment mandate was fair or not. For quite a few respondents, fairness was irrelevant. If you wanted a check, you went to treatment. That was the deal, and most respondents took it. As a Stockton woman explained: "I'm pretty much compliant. If that's what you gotta do, that's what I'll do. . . . I think when you're all strung out on either drugs or alcohol real, real bad . . . you're really not thinking about [what's fair]. You're just doing what's gonna be the thing to do to manipulate the situation to, you know, to get by." A Portland woman explained that going to treatment allowed

her to feel “safe.” As she put it succinctly, “It wasn’t a matter of fair.”

More typically, respondents reasoned pragmatically that the mandate’s fairness was related to treatment’s helpfulness.¹³ In 63 of our interviews, respondents were asked specifically about whether the mandate was fair. (In other cases, respondents raised the issue without being asked.) In nearly half of these, their answers turned immediately toward treatment’s usefulness. A brief and pure example: An interviewer asked a San Francisco woman, “Do you think it was fair that they made you go to [program name]?” The reply: “Yeah, I do, because it helped me a lot.”

A gay Portland man in his 30s distinguished more carefully between fairness in general and helpfulness to him:

Oh, yeah, I totally agree with that [mandated treatment]. And I didn’t have a problem with going, too, *when they’re gonna help you*. But like I said, [program name] was a waste of my time. We weren’t dealing with any problems, and everybody was pointing the finger at everybody. And, well, you’re gay, get away from me. And, oh, my God, he’s HIV positive—don’t want to be in the same room. It was a bunch of crap.

When good general intentions produced specific bad effects, the result was viewed as unjust. As a heavy-drinking Stockton fellow in his mid-40s appraised it, the mandate was “reasonable” but was unfair to him in view of his history:

Maybe [it was] reasonable to ask [me] to do so because under the circumstances, the people that wanted me to do so thought it would help me. . . . Okay, I can understand that. But they didn’t know what I know. They didn’t know that I’d been through [program name] . . . and when I started here I wanted to throw up. It just made me sick listening to the same stuff. It was like getting a beating again. You know, I’ve already been beat. I don’t want to be beat no more.

A few respondents believed the mandate was unfair because it should not have applied to them, either because they were

no longer drinking or using, or because their DA&A classification was inappropriate. Often they resented being made to attend and had little patience with the treatment process or others involved in it. A Stockton woman in her 50s, who neither drank nor used and claimed to be a DA&A designee as the result of her lawyer's strategy, complained:

Sit there and listen to people talk about, oh, I'm fighting alcohol, and they got the damn bottles here right outside in the garbage bucket. And . . . they're sitting there crying all through the meetings. Well, [at] one time I was doing it two or three times a week. Then . . . they got to trusting me and loving me. So I'd go once a week. Then I went once a month. Then, a whole year later, I'm still needing treatment. When am I gonna not need treatment, dammit?

Even so, some abstainers believed the mandate was fairly applied to people like themselves. A recovering San Francisco heroin addict in his mid-50s who had participated in two residential programs and was working in an outpatient clinic explained that "it's an ongoing process. And there's no cure. And, you know, if you're not conscious all the time [about] why you need to not use, you start using again. So it's good for a person to always be going—have some type of involvement in a recovery or meetings or sponsor or something." Similarly, an abstinent San Francisco woman in her 30s "accepted" the mandate because "I'm knowing that they're thinking that there's a possibility of me using."

Commonly, respondents held that for treatment to be effective, participants had to be "ready." A Chicago heroin addict, whose benefits were suspended for three months because he left treatment, explained: "You can't make anyone get something they don't want. . . . I mean, the first time, they told me I had to go or I wouldn't get nothing. I went for a month and quit. The second time, the only reason I went [was] because I wanted it. I wanted it. If you don't want it, it don't do no good."

As this gentleman suggests, treatment motivation changes with time. This was a very common observation. Looking back, a Stockton man, formerly a heroin addict and an alcoholic, abstinent for several months when we spoke with him, said: “God knows I needed it [treatment], probably, but . . . I’m sure [that] at the time I didn’t think it was fair. I’m almost positive [that] at the time [I thought] goddammit, this shit, why I gotta go now? I’m pretty sure I had that kind of attitude.” Many respondents conceded that the mandate promoted their “readiness.” This, in turn, colored their retrospective appraisal of the treatment mandate. We heard many remarks similar to: “I didn’t like it at first, but it was doing me good” (a recovering heroin addict in Chicago) or “At first, I didn’t think it was fair, but like I say, once I got involved, I was saving my life” (a recovering San Francisco crack addict). A Stockton woman, long a heroin addict and alcoholic, who became consistently abstinent after being in a jail-alternative program, observed that mandated treatment is fair because:

I think [a treatment mandate] gives you the opportunity to see that there is a problem and turn your life around. . . . I think that the little nudge to get in—get your foot through the door—would help break that denial. I remember what it was like as the addict thinking that there was nothing wrong with me. How dare you [force me into treatment]? But once I got over into recovery, now I can see it was, oh my God, I’m worth so much more than getting up every morning and having to get well [with the day’s first heroin] and just waiting for that check and being hungry the last two weeks out of the month. And not knowing who, what, when and where. And watching for that mailbox. That’s such a vicious cycle that I think everybody should be able to have the opportunity to break.

A Chicago man, drinking moderately and using small amounts of heroin when we spoke with him, had been sanctioned for not complying with the mandate. Yet he observed:

They did the right thing. They did me good. . . . I would have never stopped. They were using a threat. It was good they threatened. A lot of us had to go. It was a pain in the ass to go. No one felt like it. But you had to clean up your act, and, hey, why not

clean up for six, seven, eight months, a year? You know, you're doing it for 20 years. You can't take a year out of your way?

Because they found treatment to be helpful in the end, many respondents saw the mandate as fair in retrospect. However, at any given point some treatment participants will be "ready" and others will not, even if they had been "ready" at some point in the past. Substance abusers, it need scarcely be said, are often recidivists. And yet, some respondents were reluctant to recognize that others could be seduced by treatment. Indeed, they could be quite indignant about enduring the disruptive presence of the uncommitted. A recovering polysubstance abuser, a Stockton woman in her mid-40s who had many treatment episodes, thought the mandate was unfair because:

It didn't never help anyone. I remember this girl being in treatment, and she was just there so her check wouldn't stop. It didn't do any good. She was getting loaded while she was there, and when she left she got loaded the same night. . . . And just like I explained to her [counselor] one time before, I said, it's not fair to take people in that just has to be here instead of people that want to be here. You know, it makes it hard for the whole program.

From this point of view, treatment should be only for people ready to use it effectively—and yet the logic of mandated treatment is to create readiness by exposure and motivational counseling. This must be accomplished in the face of—or perhaps by making use of—the sort of peevishness expressed immediately above.

Did SSI improve life?

As our discussions of representative payees and the treatment mandate indicate, respondents had many good things to say about SSI. Asked to evaluate the program generally, nearly 60% judged it to have been an unalloyed good; about one-third had mixed (though largely positive) views; and a dozen

thought the benefits were wholly bad for them. Those who retained benefits were somewhat more likely to praise the program than were those who didn't, but the correlation was not statistically significant.

Respondents' views of the program were powerfully shaped by how they gauged its value in helping them improve their lives. Some credited SSI with triggering dramatic changes for the better. A San Francisco man who continued to receive benefits on the basis of a psychiatric impairment after three years as a DA&A recipient said:

Well, it's stopped me from being homeless. Gave me a place to live in this community. It's also made me realize about responsibility of paying my rent and being able to take care of myself, like buying myself clothes and food. And it's done a lot for me. It's made me feel like, you know, gee, I know I can survive now in this world. You know, and understand that I have like, you know, just a regular, normal life like everybody else.

SSI was welcomed unequivocally by respondents like this fellow, who believed himself incapable of self-support. When such respondents criticized the program, it usually was for too meager benefits. Some, however, identified SSI with their immobility and failure. Each check was an insult to self-reliance. A Chicago man, a recovering crack addict and moderate drinker, on SSI for only a year and a half, noted:

You have to stand up on your own, anyway. It's just something they giving you. It's not enough to live on. It's just a rut you get stuck in. When I lost my job, [SSI] was a rut that I got stuck in, and only when I was clean and sober was I able to get out of that rut a little bit. And as long as I—as long as they give me this money, as long as I'm using, I stay in this rut.

A recovering Portland heroin addict, a DA&A beneficiary for three years and usually employed after losing her benefits, recalled:

It helped me while I was getting it. But when they told me I wasn't getting those checks, that was the best thing that could ever [have] happened. Because as long as I was getting that check, I didn't

think about getting up, trying to go to work, trying to go to school, trying to do nothing. Because I knew I had my check coming. It was like I was stuck. You know, as long as I was getting that check, I wasn't gonna put forth no type of effort, which I didn't—to try to do nothing that was different. I was all right with that.

A 47-year-old Chicagoan, a heavy crack smoker, on SSI for over five years before losing his benefits, put it this way: “The good thing was the money; the bad part was the crutch.”

A significant minority of respondents made comments about the demotivation they associated with “waiting on the check.” This much said, we should emphasize that most respondents did not see the program this way.¹⁴ More typically, respondents saw DA&A benefits as a “foundation” or a “springboard,” even if the program wasn't perfect. Respondents often praised the check that permitted them the stability to work on their rehabilitation. An abstinent San Francisco woman in her early 40s, who lost SSI after three years, recalled:

I was needing [SSI] because I was working on myself, actually. And I was needing that help because with that help I was able to go to school, and I was not always worried about . . . who was going to pay my rent. That was a great help for me. And that really pushed me where I am, because when I got [to] the point that I was sober, and my mind cleared up, that I was able to learn. And then I said I want to go to school, get my career, get a license or get something that I can do for myself.

A nearly abstinent Portland man in his mid-50s, who had been classified DA&A for three years and remained on SSI for psychiatric problems, spoke not of a loss of motivation but of therapeutic release from the stress of getting a living:

[SSI is] helpful in the sense that I feel that a lot of my drinking in my life is because I've had to deal with stressful situations that ordinary people should be able to deal with—work situations. . . . I'm so uncomfortable in normal situations that . . . the anxiety builds up when I work, to a point where I'm overwhelmed, I can't stand it and I drink. And so I think that the fact that I'm not under a lot of pressure now has helped me to stay sober.

A similar point was made by a San Francisco woman who received SSI for six years (about the same length of time she had been in recovery) and usually was employed after termination: "If I didn't have money to pay my rent and if I was working, I would have relapsed a long time ago. And I think that goes for a lot of people, because it's harder to maintain your recovery and work when you're trying—you know, just trying to keep that together." A nearly abstinent Stockton man who lost benefits after only two years observed about getting SSI: "I ain't gotta do a lot of strenuous shit, emotionally, physically, to where I can work on myself through AA, get sober, go to school, learn something at the same time, and I'll still have a little income. Where I ain't gotta worry about being broke. And I had my insurance in case I got sick."

For many, SSI opened the door to other services. Respondents highly valued Medicaid, which accompanies SSI in most states. Medicaid provided coverage for health and mental health treatment, and offered more options than public indigent care for substance abuse treatment. Some respondents were able to get on methadone because it was affordable for the first time. A recovering Portland alcoholic and methamphetamine addict, a DA&A beneficiary for two years who requalified for psychiatric impairment, stated flatly that "if I wouldn't have got SSI to pay the rent, I'd still be out there. I'd still never realize that there was a life other than drugs. And by SSI being there and by having a case manager in mental health, and by being on a health plan, has really showed me that there is another life. I mean, I was a hardcore addict for over 20 years."

A few people discussed at length how SSI allowed them to avoid illegal activity. A recovering Portland heroin addict who remained on SSI for psychiatric reasons (she was a DA&A recipient for a little less than three years) remarked: "Yeah, I mean, because it helped get me . . . out of the stores [she was a shoplifter] and out of the dope bag." A Chicago heroin user, on SSI for over 10 years (retaining his benefits

due to a variety of impairments, including mental illness), had a similar experience: “It was good for me for where I really didn’t have any income other than stealing. It allowed me, you know, to be able to maintain a apartment, with some dignity.” Noting that he had stayed out of jail while on SSI, a San Francisco long-time methadone patient, and a heavy user of alcohol and marijuana, offered a classic pragmatic justification for the welfare state:

To me, it’s a money saver. I mean, why wait for somebody to go off and do something, to where you got [to] send them to prison. Spend all that money for the courts, then house him for \$35,000 a year? That’s crazy when you can get \$7,000 a year and let him house himself. I mean, as long as he ain’t causing trouble, and he got his SSI.

How former DA&A beneficiaries would design policy

Very rarely were respondents educated beyond high school (from which fewer than half had graduated), and a substantial majority had been poor all their lives. They were now in middle age, mainly, many with substance abuse problems that began in adolescence. Most thought of themselves as addicts or, less politely, as “drunks” or “dope fiends,” active or not. When asked what they thought should be done for people in their current or recent circumstances, their answers relied heavily on decades of personal experience that had taught them to mistrust themselves (or the selves they had been) and others like them. Their outlooks were provincial and their moral bearings often quite conservative, albeit complicated by a keen sense of necessity honed by years of Hobson’s choices.

Not surprisingly, then, respondents were alert to many of the same problems in the DA&A program that troubled lawmakers. If they had not done so themselves, most knew people who had blown a check, or a good part of it, on alcohol or other drugs. They saw some people go through the motions in

treatment “just to get that check.” Twenty percent or so thought most drug addicts and alcoholics should not get SSI benefits, though the overwhelming majority believed the DA&A program could work and should be made to work. The 38-year-old San Francisco woman speaking below, a long-recovering crack addict and alcoholic, who spent three years on SSI, had a typical point of view:

I would require them to go to treatment, and I would give them the check, with the representative payee. You know, because I do believe even though they're on drugs, they need some type of financial income. But I do believe it needs to be monitored, because obviously if they're on drugs they're not gonna spend it correctly. So, yeah, I would give them a check, and I just would have the representative payee, to make sure they're getting their food, their clothing, their shelter, and maybe a few dollars in their pocket, to make them feel like they're somebody. Gives them some self-worth.

The position outlined in the quote above begs a powerful question, however: What should such a program expect in the way of rehabilitation? And as a corollary, how should expectations be encouraged and enforced? Should the program tolerate chronic use in cases where recipients “ain't causing trouble”? Or should it demand more? Another San Francisco woman, a long-recovering alcoholic, illustrated the quandary quite clearly. Opining that she would give checks only to people “willing to go to a program . . . work the program and really be willing to be sober,” she added quickly: “But I would not cut it off when they're still sick and using, because they need it, too.”

Time limits and sanctions

The 1994 DA&A program reform imposed a controversial three-year lifetime limit on benefits based on substance abuse and required recipients to make progress in treatment or face progressively stiffer restrictions on benefits. A few respondents had strong reservations about time limits and penalties. They took seriously their counselors' insistence that addiction is a “chronic, relapsing disease,” and they worried that time limits, in particular, made little sense under such circum-

stances. A 50-year-old Stockton man, who retained SSI and drank moderately while on methadone, explained:

I view it like this, and I could be wrong—[give the benefits] indefinitely. However long it takes, because I really see this as a disease, a debilitating disease. . . . The American Medical Association realizes it is a disease. And from my experience with drugs and alcohol, I realize that it is a disease just the same as cancer, sickle cell, diabetes, etc. . . . and I think people are incapacitated by this debilitating disease.

While most respondents would have agreed about addiction's disease status, most also favored clear benchmarks, sanctions, and even time limits. A recovering Stockton polysubstance user in her mid-40s said: "I mean, five years, come on, you can get a damn near—well, you can almost get a Master's. I mean, you could come out of it with a degree. You know, [it should be] just enough help to get you on your feet. Not a lifetime thing." She thought recipients should be in treatment before a check was issued. A 45-year-old Stockton heroin addict, on SSI for only a year, favored "two to three years," but with immediate treatment. Absent this: "Well, I'm gonna stay loaded for the rest of my life. Hell, why should I quit? I'm getting paid to stay loaded. That's the way they look at it. Just a milk train." Said a recovering alcoholic and crack addict in his mid-30s:

If I was the mayor of Chicago and I had people that was on drugs and alcohol, I would give them a certain time limit. And I would try to work with these people to get them off of drugs into the work field, which means they would get like two or three strikes. I would leave them on, but they would have to go into a program to try to straighten up. They fail, that's one. Fail again, that's twice. Fail again, completely cut off; you're out there on your own.

A 38-year-old Stockton woman, an infrequent user of heroin who retained SSI, also favored clear benchmarks and tough sanctions:

If you didn't have a home and [weren't] showing that you [had] some kind of skills, in six months your check should be taken away. I believe they should do that from the beginning. Because a lot of

us—and I'm not trying to [be] mean or anything because I'm the same way—if you put my back against the wall, I'm gonna do what I have to do. But if you keep patting me on the back and telling me it's okay, next time I'm gonna push it as far as I can. And a lot of people are like that, especially drug addicts. They're gonna push it as far as they can, until you got their back against the wall. And you might as well just put their back against the wall right from the beginning and make them do what they gotta do.

Some respondents thought drug testing would be an effective monitoring tool. The first statement below is from a 40-year-old recovering alcoholic and methamphetamine addict from Portland who remained on SSI for psychiatric impairment; the second is from a recovering heroin addict in his mid-50s from San Francisco:

I think that [a] payee, man, should make sure you ain't using no drugs and should make sure that you're doing honest stuff. . . . I tell you, it wasn't until people started calling me on mine that I realized that I had a problem. As long as I thought I was skating and scamming, and as long as I thought I was getting away, man, I was cool. And then when I realized that they were hip to me . . . I finally said whew, I got to change this.

I would set it up that they can get on it, but I would have mandatory drug testing, you know, and maybe—I don't know about the chances, how many chances. One, maybe one chance, or maybe no chances; but there definitely have to be mandatory drug testing because I think that's the only way that it's possible to manage a person that's receiving SSI and he is an addict or an alcoholic. You know, because then he'd have to report before he'd get his check. And be clean before he get his check, you know? I think that would be a deterrent for him to go back out and use. . . . And should it be cut off permanently if he test dirty, I don't know. Maybe they should have a penalty period. Maybe he can't get it for 60 days or 90 days or something.

Treatment and beyond

As our previous discussion made clear, most respondents favored mandatory treatment. Those who didn't usually invoked the "readiness" argument or, in a few cases, had worked out alternatives to formal treatment and the Anonymous fellowships—often Bible study and church attendance—that seemed preferable and not amenable to coercion. Most respondents had few qualms about demanding accountability.

At the same time, some respondents emphasized that for poor folks, conventional treatment was insufficient. As they saw it, DA&A recipients needed transportation, child care, and especially job skills and employment placement. A Stockton woman suggested a military-style program to give hands-on training. A Chicago woman, a recovering alcoholic and crack addict who retained SSI, would

set up a government program that would help see a person through . . . to five years, to get them back in college, whatever, to the day when they got a good job, they own place, they paying they own bills and everything. And that's what kind of program we need, because just giving a person a little money, that don't do nothing, if a person already depressed and they life messed up, that do nothing but make them—they just saying, well, I might as well go ahead and use. I don't got nothing no way, or whatever like that. They take that little money and they run with it because they done waited 30 days for that money. . . . You want to give a person something to look forward to.

Another Chicago woman, still on SSI and a daily polysubstance user, stressed that treatment didn't end in the clinic, but that to be successful it must lead to "something to do":

Treatment would be nice. And then where, after that you can find them a little something to do every day, once they go to their treatment. When you come back out you ain't got nothing to do still. That's why you go back to originally what you was doing when you did go. Because you ain't got nothing else to do. Before you know it, you'll be around the same people all over again.

A number of people emphasized that drug addicts and alcoholics should be taken out of their environment as part of any

rehabilitative plan, whether hospitalization or enrollment in a quasi-military training program. A Portland methadone patient still on SSI said:

I'd make sure that they were stable where they're at, or where they want to be. That they had a good meal and that they had housing, and then I would design treatments for them, like mental health. And if they had serious problems, like heroin, to go get on a methadone program. And to go to groups. It would be just like what I'm doing. And to keep away from drugs and alcohol with their environment. Try to have an environment where they're—you know, people ain't knocking on your door to give you drugs, you know, like [it is in] a motel room and stuff. To find a better and different place, away. To maybe join something religiously. Go to church maybe. Something that just keeps you away from the street. I would design this so that they could have this. But they would have to give in a little bit, too. You know, nothing's for nothing. So, anyway, they would have to give in and do these—do what they're supposed to do. And that would be keeping clean.

Conclusion

The vast majority of respondents approved of the SSI DA&A program or something close to it. Many were angry about its sudden demise, particularly those who had been “promised” three years to clean up but received benefits and treatment for a considerably shorter period. Still, respondents were aware of the program's problems, and by and large they approved of the congressional application of benchmarks, sanctions, and time limits in the service of reform. They believed, in short, that public assistance for drug addicts and alcoholics should be conditional. At the same time, however, they believed that some form of public assistance should keep the unregenerate from becoming homeless and hungry.

Despite their endorsement of stricter rules, respondents wanted recognition of their individual needs. When asked about constructive policy, a few emphasized this point, but for the most part we infer it from negative examples others

gave of official stubbornness or caprice. We think respondents—experienced clients of the welfare state and the criminal justice apparatus—grasped intuitively the importance of worker discretion in the application of rules, the enforcement of conditions. While very few objected to the formal authority of treatment personnel or payees, some were adamant critics of how power was used.

When asked how *they* would design a program for people like themselves, respondents spoke more about categories of activities (employment and so forth) than about how programs should be conducted. Not surprisingly, the few who ventured to think out loud about program dynamics often ran aground on the problem of when to invoke what rules and how to make crucial distinctions. They wanted limits but knew the importance of toleration; they wanted toughness *and* sympathy. A few laughed at a just-uttered contradiction or retreated into a shrug, an “I don’t know,” or in one instance declared simply that “it’s complicated.” Had we probed more deeply for constructive alternatives to the styles of help they encountered, we think most respondents would have told us that a good program would be flexible and forbearing, but that its staff—wise, discriminating, and honest—would know where to draw lines. We think this is what was meant when admired treatment staff, in particular, were described as “good people” who had “been there,” while others were criticized for having too little experience with life and addiction, no matter how well intentioned. Respondents were looking for helpers of nice judgment whom they could trust to hold them accountable without beating them down or leaving them stranded.

Of course, to exalt judgment and discretion is to mount the horns of a famous dilemma: Discretion may be used fairly or tyrannically, wisely or foolishly; and an accumulation of individual considerations often amounts to substantial inequity (Lipsky, 1980). Moreover, official discretion invites manipulation, as we saw in our discussion of rationing and earmark-

ing. Paradoxically, powerful workers may incite their clients to resist by deceitfully manipulating the situation (Gordon, 1988; Segal et al., 1977; Wiseman, 1970) or, more rarely, by challenging authority outright by recourse to law (Davis, 1993) or to direct collective action (Piven and Cloward, 1977). Ironically, it was for these reasons that the cash once considered dangerous only to clients became a threat to caseworkers as well. By the 1970s, the use of relief as a "therapeutic tool" had been replaced by the separation of services from eligibility determination and budgeting so that caseworkers might avoid the corrosive "entanglements of public assistance administration" (Burns, 1972:171). The 1972 amalgamation into SSI of Old Age Assistance, Aid to the Disabled, and Aid to the Blind was a watershed event in this history.

In the DA&A program, however, the use of representative payees, a treatment mandate, and financial sanctions to change client behavior imported the old supervisory sensibility into the new cash-transfer regime. Moreover, the cumbersome procedural requirements involved in enforcing sanctions—procedures invented to protect clients from the abuse of discretion—pulled many of the program's teeth, frequently resulting in the worst of both worlds: client resistance and bureaucratic futility (see Hunt and Baumohl, this issue). Even so, like many of today's welfare reformers, respondents favored paternalistic interventions and surveillance techniques that inevitably draw caseworkers into troubled relationships with clients.¹⁵

There are no clear administrative solutions to these problems. To echo the respondent quoted earlier, "it's complicated." As a federal disability program, SSI is geographically far-flung and administratively fragmented. The Social Security Administration does not provide services; the monitoring and rehabilitative functions of the DA&A program were carried out entirely by contractors, who often had sub-contractors (Hunt and Baumohl, this issue). Under such circumstances, different

definitions of fairness and different applications of discretion co-exist uneasily among bureaucrats and a variety of professionals with different training (Mashaw, 1983). But such problems are not peculiar to SSI or to its former DA&A program. Throughout the human services, professional discretion and bureaucratic proceduralism exist in inevitable tension, and equity is an ideal on the horizon, not a reality close to hand.

Given such quandaries, welfare programs that aim to influence people, rather than punish them or merely process information and checks, probably must rely on powerful incentives and sure rewards. Forthright control must be balanced with certain commitment to human welfare. People need something to “look forward to,” as we were told. Workers should rely on encouragement, persuasion, and reinforcement, and should not abandon clients when they screw up (see Shaner et al., 1997; Hasenfeld and Weaver, 1996; Riccio and Hasenfeld, 1996). Sanctions should be brought to bear carefully, and losses should be recoupable. Workers’ caseloads should be small enough to permit frequent, unhurried contact. Earnest effort, measured by treatment participation that may run in fits and starts over long periods, might be the best criterion for good program standing under such a dispensation.

At bottom, we think this is both what respondents wanted and what they thought would be most effective in transforming self-admitted problem people into reasonably sober and responsible citizens who would at least do no harm. “Maybe,” said an abstinent San Francisco man, “explain it to the people this way: You really want a new kidney, right? You really want to get on dialysis, right? Well, we only have so many machines. We only have so many dollars. And there’s a lot of people who really do want to get clean and sober and really want to get their families back together. And yes, we’d like to help you, if you will help yourself. Yeah, definitely.”

Notes

1. The authors contributed equally to this paper.
2. We classified respondents as not drinking or using if they reported at least six months of no alcohol or other drug use when we interviewed them. (However, they could be in methadone maintenance.) We considered respondents to be drinking or using very little if they were abstinent one to five months or used cannabis or alcohol (no drunkenness) three or fewer times per month. We defined “heavy use” as the consumption of one or more substances to intoxication for five or more days per week or evidence of regular use throughout the day. “Moderate” use is a residual category that includes all others.
3. Some respondents were not asked for their opinions about the mandate as the result of time constraints or other difficulties with an interview; but others were not asked because they were permitted to attend Alcoholics Anonymous or Narcotics Anonymous meetings rather than formal treatment, or claimed never to have been subject to mandated treatment because they were already being treated on a voluntary basis, or were notified of the mandate only shortly before the DA&A program was dismantled.
4. See Hunt and Baumohl (this issue) for a lengthy discussion of the historical development of the DA&A category and its ambiguous boundaries.
5. From 1985 through 1988 the Social Security Administration allowed representative payees to be reimbursed for actual out-of-pocket expenses incurred on behalf of beneficiaries. This practice was terminated because it was inequitable and subject to abuse. The Omnibus Budget Reconciliation Act of 1990 created a three-year program, beginning in July 1991, to allow certain non-profit organizations to collect a fee that could be the lesser of 10% of the beneficiary’s total monthly benefits or \$25 (GAO, 1992). These provisions expired in July 1994, but they were reestablished to permit the lesser of 10% or a \$50 fee in DA&A cases, indexed to the Consumer Price Index. Fees for other beneficiaries remained the lesser of 10% or \$25, to be adjusted each year by the same formula used to adjust benefit amounts (Social Security Independence and Program Improvements Act of 1994; C. Rep. No. 670, 1994).
6. Freedom comes at a price, of course, because such commodities—food stamps, for example—lose considerable value in resale. We were told that on the street food stamps got only 50 cents on the dollar.
7. Prior to the 1994 DA&A program legislation, retroactive benefits of less than \$4,000 (for any recipient) were paid without an evaluation of the payee. When the amount exceeded \$4,000, field office staff were required to evaluate the payee’s ability to handle the accumu-

lated funds unless the payee was a parent, spouse, or child with custody of the beneficiary; the legal guardian; a financial trustee; a social service agency; or a nonprofit institution or organization. Retroactive benefits could be held for a few months to allow for an evaluation period. If the payee was deemed incapable of handling the funds, installment payments were made in addition to the monthly benefit.

8. Some of these amounts may be underestimates, because respondents reported the back pay remaining after state and county welfare departments deducted the value of GA collected during the waiting period.
9. Here we use data from both the structured and the semistructured interviews, resulting in responses from 111 people. In 11 cases, survey data were missing and the semistructured interview could not supply them; in 34 cases, respondents did not get a check or, rarely, said that a treatment program kept the money without revealing the amount.
10. However, interviewers administering the structured instrument did not probe explicitly for whether respondents used any of the money to purchase alcohol or other drugs, and those doing the semistructured interviews did not always do so.
11. In the 1991 OIG study, 72% of DA&A recipients reported that treatment helped them, and 78% agreed that it should be required (OIG, 1991). Responses in our study varied by current alcohol and other drug use, with those at the extremes of abstinence (80%) and heavy use (73%) more likely than others (50%) to believe the mandate was fair or helpful.
12. The closest anyone came to this position was a San Francisco man who, when asked if it was fair that he had to go to treatment, said: "Absolutely not. I thought it was the worst thing in the world. I mean, let someone put a gun to your head, so you cannot have a roof over your head or food to eat or your money to drink or anything like that, to party, unless you do what they say. Like a dictator, you know. You know, like Mommy and Daddy telling you to do what they say." In the next sentence, however, he took it all back, making clear that while he felt this way at first, he came to appreciate the value of treatment. We discuss this commonly expressed change of heart below.
13. This may have reflected how case managers reasoned with their clients about the necessity of treatment. As a Stockton man responded to a direct question about whether the mandate was fair: "Yeah [it was fair], because it was something that they [his case manager] said was gonna help. . . . I was looking for all the help I could get."

14. Consistent with other studies of welfare recipients, we found respondents to see such disincentives mainly as a problem for people other than themselves. See Soss (2000) and Rank (1994).
15. The most tough-minded of our respondents would have been surprised to learn that much of what they proposed by way of “cutting them off” or forcing beneficiaries to “show some accountability”—drug testing, for example—would be difficult to apply widely without violating due-process considerations installed to protect people like themselves.

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