Do Public Support Payments Encourage Substance Abuse?

This study of homeless veterans contradicts some of the anecdotal evidence driving public policy on support payments to persons with substance abuse problems.

BY ROBERT ROSENHECK AND LINDA FRISMAN

Substantial concern has been expressed that public support, in particular Social Security disability payments, may stimulate increased substance use among beneficiaries who suffer from addictive disorders. It has been estimated that as many as 250,000 Social Security beneficiaries suffer from substance abuse disorders and that they receive almost $1.4 billion in public support payments each year. Although most of these beneficiaries have other disabling conditions, the number of claimants for whom substance abuse is the primary disabling condition doubled from 1989 to 1994, finally reaching 90,000.

In 1994 Public Law (P.L.) 103-296 imposed new regulations for beneficiaries of both the Social Security Disability Income (SSDI) and the Supplemental Security Income (SSI) programs when an addictive disorder contributes to the disability. Under these regulations, disability benefits related to addictive disorders were subject to a three-year time limit, and SSDI recipients, like current SSI recipients, were required to participate in substance abuse treatment and to have a representative payee to manage their funds. In March 1996, before these provisions could be fully implemented, P.L. 104-121 prohibited all new awards of SSI and SSDI benefits for disability related to substance abuse and terminated current beneficiaries after January 1997.

This aggressive legislative action was based on anecdotal clinical descriptions and ethnographic accounts, not on empirical studies of the relationship between receipt of public support payments and substance abuse. The few studies that do exist avoid the central

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policy question, whether receipt of public support payments is generally associated with active abuse of alcohol and drugs among recipients who have a diagnosis of substance abuse.

To shed light on this question, we examine admission assessment data gathered on homeless veterans with substance abuse problems who were contacted through a Department of Veterans Affairs (VA) community outreach program. Our goal is to discern the relationship between substance use and both amount and source of income (employment versus public support payments versus other sources such as criminal activity and gifts) and thereby test the assumptions that are driving policy in this area.

Methods

In 1987 the VA established a program, now called the Health Care for Homeless Veterans (HCHV) program, at forty-three VA medical centers in twenty-six states and the District of Columbia. Through this program, clinicians identify homeless veterans in shelters, missions, and soup kitchens and on the streets and link them with needed health care and social services.

Study sample. Nine of the forty-three sites participated in an intensive evaluation of this program. Details of site selection and sample recruitment are presented elsewhere. Analyses for this study were conducted on the subgroup of veterans who were identified as having a current or past problem with alcohol or drug use and who had not resided in an institution (which might have artificially curtailed their use of substances) during the prior month (N = 655). Current or past substance abuse was determined by (1) a clinical diagnosis of alcohol or drug abuse/dependence upon admission to the program, or at clinical reassessment three months after program entry; or (2) a history of hospitalization for alcohol or drug abuse. The sample thus includes homeless veterans who, by virtue of their past or current behavior, are at risk for substance abuse.

Measures and analysis. Current substance use was evaluated with (1) the number of days that alcohol had been consumed, (2) the number of days that alcohol had been consumed to the point of intoxication, (3) the number of days that various controlled substances (marijuana, cocaine, amphetamines, barbiturates, heroin, “downers,” and hallucinogenic drugs) had been used, and (4) the amount of money spent on alcohol and on drugs. Participants were asked to report on each of these measures in the past thirty days, as well as on their source of monthly income.

To identify factors that might confound analysis of the relationship between income and substance use, we conducted a series of correlation analyses: first between substance use and various so-
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ciodemographic characteristics, health status, and social adjustment measures; then between these measures and receipt of public support payments. Characteristics associated with either substance use or receipt of public support then were included as covariates in subsequent analyses. The principal analyses for this study were multiple regression analyses that examined the relationship between income and substance use, controlling for potentially confounding factors. Analysis of covariance (ANCOVA) was then used to disentangle the relationship of public/private income source and substance use from the relationship between total monthly income (less than $100; $100-$500; more than $500) and substance use.

Results

- Sample characteristics. Veterans in the study sample were overwhelmingly male (98 percent), with an average age of 41.1 years. The majority were white (55.3 percent). At the time of program entry 23.1 percent had been homeless for less than one month and 26.5 percent, for more than one year. At the time of assessment 675 percent were given an initial diagnosis of substance abuse (52.4 percent alcohol abuse and 33.1 percent drug abuse), and 57.7 percent had a psychiatric diagnosis other than substance abuse. Patients also were included in the sample if they had been hospitalized for an alcohol (574 percent) or drug (30.0 percent) problem in the past, or if upon clinical reassessment they were identified as having an alcohol (82.2 percent) or drug (50.1 percent) problem. During the month prior to assessment alcohol had been used an average of 7.8 days; alcohol was used to the point of intoxication an average of 5.1 days; drugs were used 5.4 days; and an average of $46 had been spent on alcohol, and $37 on drugs.

Across the entire sample, average earned income was $71 per month, average public support payments were $105 per month, and the average of other sources of income was $57 per month. Altogether, 202 veterans (32 percent) reported receipt of public support payments. Among veterans in this subgroup, public support averaged $333, earned income averaged $24, and other income averaged $12, for a total income of $369 per month. Among the 445 veterans who did not receive public support payments (68 percent), earned income averaged $93, and other income averaged $78, for a total of $171 per month. Recipients of public support payments were older, were more likely to be black, and had more severe psychiatric and medical problems than other veterans in the sample.

- Income and use of addictive substances. Standardized regression coefficients showed significant relationships between employment income and all of the measures of substance abuse and...
related expenditures. However, the 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 or alcohol than did public support recipients who received lower levels of public funding. Also, although the findings suggest that higher total incomes were associated with higher levels of substance abuse for the study group as a whole, on average, public support recipients reported significantly lower levels of substance use and spending than did those who did not receive any form of public support, even though the former group had higher total income (Exhibit 1).

Although the subjects of this study are desperately poor, average spending on alcohol and drugs was substantial, averaging 18 percent of total income among public support recipients and 55 percent of total income among other veterans. Thus, public support recipients with substance abuse disorders do appear to use some portion of their public support payments to purchase alcohol and drugs. However, while substance use may be substantial among public support recipients, neither reliance on public support nor the size of the

<table>
<thead>
<tr>
<th>EXHIBIT 1</th>
<th>Average Expenditures On And Use Of Substances, By Source And Amount Of Income</th>
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<tbody>
<tr>
<td><strong>Substance abuse measure</strong></td>
<td>Number of days alcohol was used in previous month</td>
</tr>
<tr>
<td><strong>Income category</strong></td>
<td></td>
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<tr>
<td>Source of income</td>
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<tr>
<td>Receives public support</td>
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<tr>
<td>(n = 202)</td>
<td>6.79 (9.48)</td>
</tr>
<tr>
<td>Other veterans</td>
<td></td>
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<tr>
<td>(n = 445)</td>
<td>8.19 (9.78)</td>
</tr>
<tr>
<td>F statistic</td>
<td>7.70*</td>
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<tr>
<td>Monthly income</td>
<td></td>
</tr>
<tr>
<td>Less than $100</td>
<td></td>
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<tr>
<td>(n = 304)</td>
<td>7.44 (9.67)</td>
</tr>
<tr>
<td>$100-$500</td>
<td></td>
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<tr>
<td>(n = 249)</td>
<td>7.95 (9.49)</td>
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<tr>
<td>More than $500</td>
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<tr>
<td>(n = 94)</td>
<td>8.63 (10.42)</td>
</tr>
<tr>
<td>F statistic</td>
<td>2.25</td>
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</tbody>
</table>

**SOURCE:** Authors' analysis.

**NOTES:** Standard deviations are in parentheses. Additional statistical details are available from the authors.

* Statistically significant variation (p < 0.05).
public support payment appears to be associated with higher levels of self-reported substance use.

**Caveats.** Before we further consider the meaning and implications of these findings, we raise several methodological limitations. First, since this is a cross-sectional sample, we cannot rule out the possibility that these findings can be explained by other unmeasured differences between the groups or the individuals. One possible explanation is that recipients who received disability benefits were less prone to heavy substance abuse than were others with substance abuse disorders because the former were sicker, mentally or physically, and as a result exhibited lower demand for addictive substances than did those who received no public monies. If this were the case, then our findings might not hold for other cohorts. Unfortunately, even a statistically controlled study such as ours cannot rule out this possibility.

However, it is just as likely that the severity of addictive disorders drives substance use, not simply the availability of one or another type of funds. There is ample evidence from the ethnographic literature that persons who crave substances, even if they lack employment, have ways other than public support to obtain funds (such as theft, burglary, panhandling, and selling blood plasma) and are driven to these sources by their craving for alcohol and/or drugs. The results of this study suggest that veterans have ready access to funds other than employment earnings and disability payments.

A longitudinal design in which patients could act as their own controls would reduce some of the problems associated with this study. Indeed, an eight-month longitudinal outcomes study of a subgroup of HCHV participants found no significant relationship between increased public support payments and changes in either alcohol or drug abuse. It was notable, however, that these increased payments were associated with improved housing.

A second limitation is that recipients of public support payments may have been less likely than other veterans to report the full extent of their substance use, perhaps because they were afraid that such reports would jeopardize their benefits or would result in their being forced to have someone else manage their funds. We believe that the possibility of such underreporting is minimal because study participants were never at risk of losing public benefits as a result of substance use. However, we do not have evidence that study participants understood this, and we recognize that underreporting must be regarded as a potential threat to validity in the absence of consistent biochemical validation.

A third limitation concerns the representativeness and timeliness of the sample. Subjects were drawn from a sample of homeless...
veterans who had expressed interest in receiving clinical services from the VA. This sample thus may not represent the population that faces the greatest risk of adverse consequences from public support payments: persons who have no interest in treatment. However, HCHV outreach efforts were targeted at underserved veterans, primarily through community outreach, who were minimally involved in treatment if they were involved at all. This sample may not be representative of all beneficiaries of public support programs at risk for active substance abuse, but it does reflect an especially poor, currently untreated, and therefore highly vulnerable population. It also should be noted that although the data were gathered between 1987 and 1988, continuing evaluation of the HCHV program suggests few changes between the populations served in the late 1980s and those served in the mid-1990s.

A final limitation is that data on many specifics of the public support payments and on the current management of patient funds are not available. In the VA compensation and pension program, for example, substance abuse in and of itself is not a compensable disorder. In contrast, until recently SSI and SSDI could be awarded when substance abuse materially contributed to the disability. It thus is possible that VA recipients are more likely to have substance abuse disorders that are secondary to psychiatric illnesses, while SSI recipients have primary substance abuse disorders. In spite of this potential difference, we doubt that the specific source of funds, or the duration of beneficiary status, had a major effect on our results.

Our results must be regarded as suggestive rather than definitive. They are a useful first attempt at an empirical examination of the impact of public support payments on substance use in a community population with substance abuse problems that are not now being treated.

**Policy Implications**

Concern about the destructive effects of alcohol and drug use on any population is justifiable, but especially in regard to vulnerable populations such as homeless or disabled persons. Addictive disorders have been shown in virtually every community survey to be a major risk factor for homelessness, as well as for other health, social, and economic consequences. It is clear that veterans in this study used some portion of their public support payments to purchase alcohol and drugs. Any therapeutic effort or public policy that is effective in reducing substance use and its harmful consequences among these or other patients deserves serious attention. It is especially important to distinguish the public health goal of protecting a vulnerable population from moralistic concerns that public funds
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should not be spent on certain activities, especially when such funds have been shown to help remove homeless persons from the street.¹²

To the extent that policymakers wish to minimize the adverse public health consequences of monetary support through benefit reduction or control of funds, they should be informed by answers to two questions: (1) Do public support payments increase substance abuse in vulnerable populations, and (2) does having another party involved to manage a disabled person’s finances (known in the field as a “representative payee”) reduce substance use? Data presented in this study raise questions about the assumption that public support funds increase substance abuse among recipients.

If public support payments do not appear to contribute to overall levels of substance abuse, then one might not expect programs that control such funds to be associated with reduced use. There has been only one published study on representative payee services for mentally ill persons: a presentation of successfully treated cases that did not include systematic outcomes data or information on a suitable comparison group.¹³ An unpublished report on an eighteen-month longitudinal study of 606 participants in the Social Security Administration’s Drug Abuse and Alcoholism (DA&A) program concluded that “representative payee services did not appear to make a difference in outcome. . . . 90 percent of the alcoholics reported using alcohol. . . . 53 percent of the drug addicts reported using illegal drugs . . . [and] only one-fifth of the respondents reported a reduced number of times they were detoxified in a year.”¹⁴

These findings are consistent with the results of other studies of efforts to direct the way in which low-income persons use public support funds. In two studies, for example, housing vouchers and food stamps were substituted for cash payments.¹⁵ Both studies found that beneficiaries did not use categorical benefits primarily to increase the quality of their housing or food consumption, but rather to subsidize current housing and nutritional patterns, thus freeing funds for more elective consumer expenditures. Although leading scholars have suggested using categorical or in-kind benefits as a way of channeling consumer spending among homeless persons, and among substance abusers more generally, evidence of the effectiveness of such approaches is still lacking.¹⁶

Well-qualified institutional representative payees and mandatory treatment often are difficult to find and costly to maintain. Estimates provided to us by several agencies that operate representative payee programs suggest that effective money management services may cost as much as $2,000 per beneficiary per year. The cost of requiring representative payees for all substance abuse cases would thus range from $180 million to $500 million per year. If
representative payees and mandatory treatment were required for all substance abusers, scarce resources would be used to provide services to some beneficiaries for whom such services are not necessary. Our findings suggest that it might be more efficient to target intensive representative payee services to selected clients, rather than providing hit-or-miss services to all of those whose substance abuse appears to contribute to their disability.

The substance abuse epidemic is having a devastating effect on our society, and all possible remedies should be systematically investigated. This study suggests that policies that are developed on the basis of anecdotal evidence, even though they are responsive to the hardening tide of public opinion, may lead to inefficient and ineffective use of public resources, or to punitive withdrawal of funds that are desperately needed and that have been shown to contribute to achieving their desired goals.

NOTES
2. GAO, Disability Benefits for Drug Addicts and Alcoholics Are Out of Control
6. Where appropriate, clinical diagnoses were made by program clinicians with assistance from consulting psychiatrists using Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R) criteria. Psychological distress and psychiatric and medical problems were measured by the Brief Symptom Inventory (BSI) and the Psychiatric and Medical Composite Indices of the Addiction Severity Index (ASI). See L. Derogatis and J. Spencer, The Brief Symptom Index: Administration, Scoring, and Procedure Manual (Baltimore: The Johns Hopkins University Press, 1982); and A.T. McLellan et al., "An Improved Diagnostic Evaluation Instrument for Substance Abuse Patients: The Addiction Severity Index," Journal of Nervous and Mental Disease 168, no. 1(1980): 26-33. Health services use was assessed through interview questions concerning both VA and non-VA services, and through computerized administrative databases on VA service use. Complete results of the analysis are available from the authors at VA...
The coefficients were adjusted for the effects of ten covariates, which were found in preliminary analysis to have statistically significant relationships with measures of substance abuse: age, sex, race, lifetime alcohol use, psychiatric problems, medical problems, incarceration, duration of homelessness, Alcoholics Anonymous (AA) attendance in the past three months, and past hospitalization for substance abuse.

Since we do not know the detailed illness history of study participants, it also could be argued that although those who receive public support payments had been given a substance abuse diagnosis, many of them may have been in remission from active use. To evaluate this possibility, we repeated all analyses on the subset of veterans who reported at least one day of either alcohol or drug use during the thirty days prior to assessment. Active users constituted 64 percent (N = 129) of those receiving public support payments and 71 percent (N = 314) of those not receiving such payments. The results from this subsample were not substantially different from those of the full sample.

Cohen and Sokolovsky, Old Men of the Bowery; Snow and Anderson, Down on Their Luck; Rosenthal, Homeless in Paradise; and Shaner et al., “Disability Income, Cocaine Use, and Repeated Hospitalization.”

Rosenheck et al., “Effectiveness and Cost of Specific Treatment Elements.”


