Alcoholism as a Disability Under the Social Security Act - An Analysis of the History, and Proposals for Change

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INTRODUCTION

Alcoholism is recognized as a disability for the purposes of the Americans with Disabilities Act, yet the most recent amendments to the Social Security Act provide that alcoholism is not a disabling condition for the purposes of both Title II and Title XVI (SSI) disability. Thus, this question arises: Why the disparate treatment of one disease under two remedial statutes. Congress acted in a knee jerk reaction to media pressure in exposing alleged abuses by disability recipients who were said to be spending their benefits on drugs and alcohol. The anomaly presented by the current state of the law is that so long as an alcoholic can, with "reasonable accommodation," perform his or her job, s/he is considered disabled under the ADA. However, once his or her alcoholism reaches the point where s/he can no longer engage in substantial gainful activity, upon application for disability benefits either under Title II of the Social Security Act (upon his or her own earnings record) or Title XVI (Supplemental Security Income), the individual finds that s/he is not disabled because alcoholism is not a
disabling impairment.6

This paper will explore the social history of the use of alcohol, the question of whether alcohol is an "illness" as defined by the medical community, how alcoholism is treated under the ADA, the history of the treatment of alcoholism under the Social Security Act (including the media coverage which led up to the passage of Pub.L.No.104-121), policy concerns about payment of benefits to alcoholics, and lastly, proposals for changing the manner in which the Social Security Act treats alcoholism.

I. Social History

Scholars tell us that the use of alcohol dates to prehistoric times.7 Biblical scholars have noted that drinking in moderation was considered appropriate, whereas drinking in excess was treated as an evil.8 Wine is used in religious ceremonies by Jews, Christians, and Buddhists9 and thus children raised in these religions are exposed to alcohol early in life.

Moses Maimonides, a noted physician and Talmudic scholar (born in Spain on March 30, 1135)10 wrote extensively on the benefits

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8 Rabbi A. Cohen, in EVERYMAN'S TALMUD (1949) at 232 notes statements from the Talmud (which contains the bulk of Jewish scholarship between 200 C.E. and 500 C.E.) such as: "There is no gladness without wine" (Pes.109a); "At the head of all medicines am I wine; where wine is lacking drugs are necessary." (B.B. 58b) He also recounts the story of Noah, to whom Satan appeared when he sought to plant a vineyard. (Gen.ix.20) When Satan asked Noah what he was doing, Noah replied that he was planting a vineyard whose fruits were sweet and from which wine "which gladdens the heart" was made. Satan then brought a sheep, slew it, then slew a lion, pig and monkey, and allowed the blood of each to drip into the vineyard and drench the soil. According to Dr. Cohen, Satan's message was that when someone drinks wine "he is simple like a sheep." When he drinks in moderation, he is strong just as the lion is strong. When he drinks in excess, he is "like a pig wallowing in filth" and when intoxicated he "becomes like a monkey, dancing about, uttering obscenities before all, and ignorant of what he is doing." (Tanchuma Noach 13)


of wine for its medicinal value but cautioned against excessive use and drunkenness. Early societies legislated the sale of alcohol, tavern ownership, and public intoxication.

In American society, the use of alcohol went largely unnoticed until the publication by Dr. Benjamin Rush of *An Inquiry into the Effects of Spirituous Liquors on the Human Mind and Body*. Thereafter, the first temperance society was founded in Litchfield, Connecticut in 1789. In 1808, Dr. Billy Clark founded a temperance society in Saratoga County, New York.

Rooted in its puritan heritage, Boston was the site of the founding of the American Society for the Promotion of Temperance. The movement gained ground, and by 1857, businessmen as well as preachers were railing against "demon rum." The Prohibition movement evolved simultaneously with the Progressive era of American History, and one noted social historian commented that "Drinking was pre-eminently a vice of those classes - the plutocrats and corrupt politicians and ignorant immigrants - which the reformers most detested or feared." Culminating in the Eighteenth Amendment, Americans showed their public disdain for drinking, while in their private lives they ushered in the era known as the "roaring twenties" (a period characterized by private drinking clubs known as speakeasies) to flout the law. No one anticipated that enforcement would be a

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11 Id. at 256-262.
12 EwING & ROUSE, *supra* note 7 at 32-33.
13 First published in 1784, it was reprinted in its entirety in 4 QUART. J. OF STUD. ALC. 321-341, 1943.
14 EwING & ROUSE, *supra* note 7 at 44.
16 Id. at 932.
18 Richard Hofstadter, THE AGE OF REFORM 290, 291 (1955). Professor Hofstadter notes the proliferation of articles appearing in the early 1900's on the evils of drink (titles such as "The Experiences and observations of a New York Saloon-Keeper"; "The Story of an Alcohol Slave, as Told by Himself"; and "Beer and the City Liquor Problem").
19 Frederick Lewis Allen, ONLY YESTERDAY 14-18 (1931).
major problem, yet clearly it was.\textsuperscript{20} Not until 1933 and the ratification of the Twenty-third Amendment was the use of alcohol decriminalized.\textsuperscript{21} The debate was, however, far from over. The American society continues to be troubled by the issue of when the use of alcohol exceeds socially acceptable norms, and how to deal with those who abuse alcohol.

II. Is Alcoholism a Disease?

Any discussion of disability due to alcoholism must necessarily address the question of whether alcoholism is a disease. It was Dr. Benjamin Rush who first put forth the theory that alcoholism is indeed a disease.\textsuperscript{22} Over the years, many researchers have argued that the disease concept is a myth. Some researchers argued instead that heavy drinking is simply a way of life rather than a disease.\textsuperscript{23} Neither the myth theory, nor the way of life theory have been widely accepted.\textsuperscript{24}

In 1946, E.M. Jellineck first published his research on the "Phases of Alcohol Addiction."\textsuperscript{25} Expanding on his work in 1952, he explained that the "disease concept" of alcoholism separates drinkers into two groups. One, those drinkers who regularly drink heavily without "loss of control" were considered "nonaddictive alcoholics" or "habitual symptomatic excessive drinkers." The other group he termed "alcohol addicts." He opined that both groups displayed the symptom of "excessive drinking", but that in the group known as "nonaddictive alcoholics," "loss of control" never occurs. In the group known as "alcohol addicts" "loss of control" develops after years of excessive drinking.\textsuperscript{26} He further opined that "the 'loss of control' is a disease condition per se which results from a process that superimposes itself

\begin{itemize}
  \item \textsuperscript{20} Id. 173-190.
  \item \textsuperscript{21} U.S. CONST. amend. XVIII repealed by U.S. CONST. amend. XXIII.
  \item \textsuperscript{22} See supra, note 13.
  \item \textsuperscript{23} Herbert Fingarette, HEAVY DRINKING: THE MYTH OF ALCOHOLISM AS A DISEASE, 134.
  \item \textsuperscript{24} See discussion of the work of Jellineck and Kissin, infra.
  \item \textsuperscript{25} E.M. Jellinek, PHASES IN THE DRINKING HISTORY OF ALCOHOLICS. Analysis of a survey conducted by the official organ of Alcoholics Anonymous (Memoir of the Section Studies on Alcohol, (Yale University, No. 5) 7 Quart. J. Stud. Alc. 88 (1946).
  \item \textsuperscript{26} Id. at 674.
\end{itemize}
upon those abnormal psychological conditions of which excessive drinking is a symptom."27 Four phases of the disease are described. First, one sees the "prealcoholic symptomatic phase" where the future alcoholic finds relief from stress with the use of alcohol, increasing the use of alcohol (with a concomitant increase in tolerance) without becoming intoxicated, until drinking occurs on a daily basis.28 Next comes the "prodromal phase," characterized by periods of amnesia without loss of consciousness, followed by "drinking behaviors which indicate that ... spirits have practically ceased to be beverages and have become sources of a drug which he 'needs'." The individual becomes preoccupied with drinking, and experiences feelings of guilt.29

The point at which the individual loses control is known as the acute or crucial phase. It is at this juncture that a physical demand for alcohol becomes apparent. This phase generally lasts until the addict becomes so drunk that his body will not accept more alcohol. After recovering from this episode, a new cycle of drinking starts as a result of the same factors which influenced the initiation into drinking. The cycle then begins in full again.30

Dr. Jellinek answers the question of why the individual begins drinking again by noting that the alcoholic believes s/he has the free will to control his problem. In fact, s/he "has undergone a process which makes it impossible for him to control his alcohol intake."31 At this point, the alcoholic undergoes personality changes including rationalization, guilt and remorse, as well as periods of abstinence. The ability to socialize and to function in the work setting is compromised, and ultimately s/he begins to neglect personal hygiene and nutrition.32 The chronic phase is characterized by "benders," drinking with those far below one's social status, tremors, psychomotor difficulties, and an obsession with drinking.33 This obsession has been likened to a

27 Id. at 674.
28 Id. at 676.
29 Id. at 679.
30 Id. at 680.
31 Id. at 681.
32 Id. at 682.
33 Id. at 682-683. See also E.M. Jellinek, THE DISEASE CONCEPT OF ALCOHOLISM (1960).
compulsive neurosis.34

An English researcher sought to disprove the Jellinek theory and conducted an experiment over a period of three weeks. A pharmacist prepared two mixtures, one included vodka and one did not (the subjects were told they would be receiving vitamin therapy in an attempt to help them refrain from drinking). Four ounces were administered at breakfast, and late in the morning. The subjects were asked to rate their cravings on a scale of 0 (no craving) to 4 (very strong). There was an alternation in the pattern of administration, so that at various points in the experiment, all patients received both mixtures. Neither the patients nor the nurses administering the dose were aware of what it contained. The author of the study suggested that the results did not support a conclusion that "one drink of alcohol necessarily precipitates a hitherto abstinent 'loss-of-control' drinker into a drinking bout" nor did it "support the assertion that a small amount of alcohol triggers off a biochemical abnormality assumed ... to be the basic cause of alcoholic addiction."35 Only nine patients participated in this study, and later research (discussed below) does not bear out its conclusions.

Another researcher, Dr. Benjamin Kissin, who has written extensively in the field opined that "some form of craving which leads to renewal of alcohol-seeking behavior does occur when the full-blown picture of physical dependency had been achieved...."36 In answer to the question of whether alcoholism is a "symptom" or "disease," he and his co-author conclude that in the early stages alcoholism represents a symptom of the "underlying pathologies," whereas once loss of control and craving are present and physical dependence exists, alcoholism is then a "disease."37 Pointing to the child born with fetal alcohol syndrome,38 the authors postulate that this lends further support for the

34 Lewis R. Wolberg, MD, Medical Hypnosis 157 (1948).
37 Id. at 8.
38 Jones and Smith reported that abnormalities in newborn of alcoholic mothers included prenatal growth deficiency, postnatal growth deficiency, developmental delay, cardiac abnormalities, anomalous external genitalia, distortion of fine motor function, microencephaly, micrognathia, cleft palate, and joint abnormalities. (Kenneth L. Jones and
disease concept.\textsuperscript{39}

Genetic research also supports the disease concept theory. A 1971 study by Denes de Torok concluded that "genetic material is involved with alcoholism."\textsuperscript{40} The findings included a "relationship between alcoholism and quantitative chromosomal changes ...,\textsuperscript{41}" and further noted that the research made a "strong case for the conclusion that alcoholics possess a markedly disturbed genetical constitution."\textsuperscript{42} Another study noted that "[t]he association of alcoholism with a genetic marker strongly supports the hypothesis of a genetic predisposition to the disease."\textsuperscript{43}

In 1990, a two year study was undertaken by a 23 member committee of the National Council on Alcoholism and Drug Dependence and the American Society of Addiction Medicine. Its mission was to redefine the term "alcoholism." The committee stated that alcoholism is:

\begin{quote}
[A] primary, chronic disease with genetic, psychosocial, and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences, and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic.\textsuperscript{44}
\end{quote}

The authors noted that the term disease was intended to mean an "involuntary disability," when referring to alcoholism as a "primary"

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\textsuperscript{39} Id. 10.

\textsuperscript{40} \textit{Id}. at 142.

\textsuperscript{41} \textit{Id}. at 143.

\textsuperscript{42} \textit{Id}. at 143.

\textsuperscript{43} \textit{Id}. at 1013.

\textsuperscript{44} \textit{Id}. at 1013.
disease. It is a "disease entity in addition to and separate from other pathophysiologic states that may be associated with it." Thus it is clear that the medical community views alcoholism as a disease separate and apart from any other disease process which affects the individual. It is in the context of this definition that the American Psychiatric Association defines alcohol related disorders. Two categories of impairments are recognized. The first involves "Alcohol Use Disorders," while the second relates to "Alcohol Induced Disorders." As the second group deals with disorders such as alcohol withdrawal, alcohol dementia, alcohol-induced psychotic disorders, it is only the first group that merits discussion herein.

A person is considered alcohol dependent when there are signs of physiological dependence characterized by withdrawal symptoms occurring twelve or more hours after consumption of large amounts of alcohol over a prolonged period. The alcohol dependent individual follows a pattern of compulsive behavior directed at acquisition and use of alcohol. Concomitant with this, deficiencies in social function and job performance usually develop. Typically, the alcohol dependent person continues to drink notwithstanding adverse physical or psychological consequences. One diagnosed with "Alcohol Abuse" generally has social and employment problems (e.g. excessive absences from work, neglect of children or other home responsibilities), and often has legal problems related to drinking. These clinical signs are coupled with tolerance to the alcohol, withdrawal and compulsive behavior. It should also be noted that in order to meet the diagnostic criteria for alcohol abuse disorders, the individual must also meet the DSM criteria for substance dependence and/or abuse. Thus, what emerges from the current medical definition of alcohol abuse is a

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45 Id., at 1013-1014.
46 Id.
47 Diagnostic and Statistical Manual of Mental Disorders 195-204 (4th ed. 1994).
48 Id.
49 Id., at 195-196.
50 Id.
51 Id. at 196.
52 Id. at 181-183.
picture of an individual obsessed with consuming alcohol, an individual who devotes substantial time to acquiring and consuming alcohol, who neglects his/her home and work life, ignores all medical and legal consequences, and who often denies the existence of a problem. It is within the framework of this definition that we undertake an examination of the treatment of this disease under the Americans with Disabilities Act and the Social Security Act.

III. Alcoholism as a Disability under the ADA

The ADA\textsuperscript{53} was a major step forward for individuals with chronic illness who prefer working to its alternative. Enacted in 1990,\textsuperscript{54} the Act requires employers to make "reasonable accommodations" to "qualified individuals" when the employer is aware of the employee's medical condition and the limitations it imposes.\textsuperscript{55} An employer who does not make reasonable accommodations faces liability for failure to do so.\textsuperscript{56} The Act refers specifically to alcoholism providing that it is a covered disability (unlike its sister illness, substance abuse by current illegal drug users).\textsuperscript{57} Courts have made it clear that an alcoholic is entitled to protection under the Act,\textsuperscript{58} while protecting employers' actions where dismissal is predicated upon misconduct rather than the disease.\textsuperscript{59} However, it is not always easy to distinguish between the two. Clearly, an employee who is an alcoholic who decides to enter a rehabilitation program and notifies his employer can not be fired. If he is fired after entering the program, this employee is covered by the Act.
and entitled to damages for wrongful termination.\textsuperscript{60}

The ADA protects a "qualified individual with a disability" unless the employer "can demonstrate that the accommodation would impose an undue hardship on the operation of the business."\textsuperscript{61}

Outlining what constitutes a "reasonable accommodation" which is not an "undue burden" upon a federal administrative agency, one court suggested that the agency must offer counseling to an alcoholic employee,\textsuperscript{62} provide the employee with a "firm choice" between treatment and discipline,\textsuperscript{63} and must be sensitive to the fact that the employee may relapse.\textsuperscript{64} The agency should consider remedies short of dismissal, and where it appears that dismissal may be warranted, the agency needs to consider if retention of the employee poses an "undue burden." The court also noted that the agency should offer an unpaid leave of absence for further treatment before dismissal if the employee agrees, and it appears that treatment "seems promising."\textsuperscript{65}

Applying the test of whether an accommodation would cause an employer undue hardship, courts have held that the Act does not protect the employee who shows up for work under the influence of alcohol.\textsuperscript{66} Courts have also held that it does not protect the employee who requires multiple inpatient detoxification programs unless the employer consents.\textsuperscript{67} The act does not cover the alcoholic who cannot perform his or her job properly with reasonable accommodations, or one who does not adhere to appropriate standards of conduct when relevant to job performance.\textsuperscript{68}

\textsuperscript{61} 42 U.S.C. 12112 (b) (5) (A) (1998).
\textsuperscript{63} Id.
\textsuperscript{64} Id. at 598 F. Supp. 134.
\textsuperscript{65} Id. at 134.
\textsuperscript{66} Flynn, 868 F. Supp. at 386. See also 29 C.F.R. 1630.16(b)(2) (1998).
\textsuperscript{67} Flynn v. Raytheon Company, No. 96-1019, 1996 U.S.App. LEXIS 20837 (1st. Cir. 1996). However, one court, ruling on the issue under Section 504 of the Rehabilitation Act has ruled that an alcoholic was entitled to leave without pay to enter a treatment program after two failed attempts. McElrath v. Kemp, 714 F. Supp. 23 (D.D.C. 1989).
What becomes of this type of individual when s/he can no longer work, and where does s/he turn? Often s/he will apply for Social Security disability benefits, and it is at this juncture that s/he is "not disabled" under the Social Security Act.69

IV. TREATMENT OF ALCOHOLISM UNDER THE DISABILITY PROVISIONS OF THE SOCIAL SECURITY ACT

A) Disability Defined

The definition of disability is identical under both Title II and Title XVI of the Act. The statute reads (in pertinent part) as follows:

(A) [A]n individual shall be considered to be disabled for purposes of this title [42 USC § 1381 et seq.] if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months.

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work.70

69 Supra, note 3.
The definition, in simple terms, requires the existence of a medically determinable condition, based upon objective criteria, which precludes the individual from not only performing his/her past work, but any work existing in substantial numbers in the national economy. The regulations set forth a five step process which adjudicators must follow in order to reach a conclusion as to whether an individual is currently engaged in "substantial gainful activity." If a person is actually working s/he will not be entitled to benefits. Thus, the second step is not reached and the application must be denied at this step. If the individual is not working, the adjudicator must then decide if the individual has a "severe impairment" (one which affects basic work functions such as sitting, standing, walking, lifting, seeing, hearing, understanding instructions, responding appropriately in a work setting, etc.). If, and only if, a severe impairment exists, does the adjudicator move to step three. This step requires a comparison of the individual's condition(s) to those listed in Appendix 1 of the Regulations. If the condition(s) is(are) the same as a listed impairment, or equal in severity to a listed impairment, then disability is granted on medical grounds alone. An individual whose impairment is not at this severity level does not lose at this point. The evaluation continues to a determination of what limitations, if any, the condition(s) impose(s), and whether those limitations precluded the individual from performing his or her past relevant work. Someone who can perform past relevant work will be denied disability benefits. On the other hand, someone who can no longer perform past relevant work is entitled to a consideration of whether he or she can perform any other work existing in the national economy. This step requires an evaluation in combination, of the individual's age, education, past work experience, and the limitations the condition imposes upon the individual (known as residual functional capacity). Only if the individual is unable to perform any work activity after consideration of these factors, is he/she entitled to

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72 Id. subsection (c).
73 Id. subsection (d). This portion of what is known as the sequential evaluation process will become important in later discussion of the issue at hand.
74 Id. subsection (e).
75 Id. subsection (f).
disability benefits. It is in the context of these statutory provisions that the analysis continues.

B) Treatment of Alcoholism Prior to 1994

Any discussion of how alcoholism is treated under the disability provisions of the Social Security Act must start with a recognition of the fact that the Social Security Administration has consistently opposed treating alcoholism as a medical condition which, standing alone (without another physical or mental impairment) could be considered a disabling condition. Without a finding of another mental or physical impairment which meets the disability criteria, an alcoholic could not be found to be disabled. The sequential evaluation process in these cases generally ended at step three (involving the question of whether the impairment met or equaled a listed impairment). Thus, in the absence of end-organ damage or another mental condition, the Social Security Administration refused to find that an alcoholic was disabled.76

The regulatory provisions in existence prior to 1975 did not treat alcoholism as a disabling condition. Rather, alcoholism was defined "as a 'personality disorder' characterized by patterns of socially unacceptable behavior which does not result in an inability to engage in substantial gainful activity in the absence of an associated severe psychoneurosis or psychosis." (emphasis added)77 That regulation, 20 C.F.R. § 404.1519(c)(2)(iii), was repealed in 1975. The new standard stated that:

[T]he presence of a condition diagnosed or defined as addiction to alcohol or drugs will not, by itself, be the basis for a finding that an individual is or is not under a disability. As with any other condition, the determination as to disability in such instances shall be based on symptoms, signs and laboratory findings.78

In interpreting these regulations, courts have held that

76 See, e.g., Brashe v. Celebretze, 340 F. 2d 413 (8th Cir. 1965).
77 Adams v. Weinberger, 548 F. 2d 239, 242 (8th Cir. 1977).
alcoholism alone (without another physical or mental disorder) can be a disabling condition under the Social Security Act. In 1975, the Ninth Circuit noted that: "the proposition that chronic acute alcoholism is itself a disease, 'a medically determinable physical or mental impairment,' is hardly debatable today." Reaching the conclusion that alcoholism standing alone may be a disabling impairment the court stated:

The presence or absence of "underlying" physical or mental impairment as accompaniments or products of the disease may be relevant evidence relating to the decision of that question, but absence of them is not controlling.

Decisions in cases such as Adams and Griffis led the Secretary of the Department of Health and Human Services in 1982, to issue a ruling outlining the agency policy on alcoholism. In this ruling, the Secretary made an unequivocal statement that "drug addicts or alcoholics cannot be considered 'disabled' on the basis of that diagnosis alone." Alluding to the line of cases indicating that "loss of control" can be the basis of a grant of benefits, the ruling states:

[I]t must be recognized also that the issue of whether the individual has lost the ability to control the use of drugs or alcohol affects the matter of diagnosis. The loss of ability to control these substances identifies the individual as a drug addict or alcoholic diagnostically, but does not provide a conclusive basis

80 Id.
81 See also Ferguson v. Schweiker, 641 F. 2d 243 (5th Cir. 1981); Cannon v. Harris, 651 F. 2d 513 (7th Cir. 1981); Brennan v. Schweiker, 542 F. Supp. 680 (E.D. Pa. 1982).
82 SSR 82-60 (C.E. 1982). 1982 SSR LEXIS 24, 3. The initials SSR stand for Social Security Rulings. Under general principles of administrative law, an agency publishes regulations pursuant to public notice provisions in the Federal Register when the policy statement is required by legislation. However, when the policy statement is an interpretation of a statute or rule of law, a ruling (which is not subject to public notice provisions) is generally issued. See, 1 Kenneth Culp Davis, ADMINISTRATIVE LAW TREATISE 5.01 (1958); Baltimore Gas & Electric Co. v. NRDC, 42 U.S. 87 (1983).
for evaluating the severity of the impairment.\textsuperscript{83}

Reiterating its position, the Social Security Administration directed adjudicators to evaluate drug addiction under the listing 12.04 (functional nonpsychotic disorders).\textsuperscript{84}

In 1983, when the same issue was presented to the Third Circuit, it held that:

The ALJ in the case at hand apparently believed that if he found no objective physical impairment resulting from alcoholism, the inquiry was ended. That theory, however, has been rejected by the courts. In \textit{Hicks v. Califano}, 600 F.2d 1048, 1051 (4th Cir. 1979), the court said, "Nothing in the Social Security Act permits rejection of a disability claim simply because the claimant has not experienced significant end organ damage. [citation omitted] Where there is evidence of alcohol abuse, the Secretary must inquire whether the claimant is addicted to alcohol and, as a consequence, has lost the ability to control its use."

The record here demonstrates conclusively that the issue of alcoholism was neither evaluated nor investigated properly. The case therefore must be remanded to the Secretary for additional fact finding and reassessment, to determine whether the \textit{alcoholism standing alone}, or in conjunction with the plaintiff's other impairments, entitled him to benefits under either the disability or SSI provisions.\textsuperscript{85} [emphasis added].

In the years following this ruling, the Social Security Administration began an extremely restrictive policy concerning the determination of disability for individuals with mental impairments. The Secretary took the position that unless a claimant's other medical

\textsuperscript{83}SSR 82-60 (C.E. 1982). 1982 SSR LEXIS 24, 3.
\textsuperscript{84}Id.
\textsuperscript{85}McShea v. Schweiker, 700 F. 2d 117, 119 (3rd Cir. 1983).
or psychiatric impairment met or equaled a listed impairment, that individual would be found to be not disabled. In these cases the Secretary concluded that if the claimant's impairments (other than alcoholism) did not meet or equal a listed impairment and/or cause end organ damage (damage to a vital organ such as the heart, liver, kidneys etc.), the claimant retained the ability to perform low stress unskilled work. Mental health advocates fought the policy on two fronts; through litigation (a class action suit was commenced in 1982 by the Minnesota Mental Health Association) and in Congress (Sen. John Heinz held hearings on the issue in April 1983). The battle culminated in the Disability Reform Act of 1984. Section 5 of the Act mandated a moratorium on decisions in cases involving mental impairments until such time as the Secretary promulgated new regulations, including new medical listings for mental impairments. Regulations were finally published on August 28, 1985. Although these regulations added a listing titled "Substance Addiction Disorders," the introduction explained that:

"[T]he listing itself only serves as a reference listing by

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86 In Hicks v. Califano, 600 F. 2d 1048 (4th Cir. 1979), the Administrative Law Judge made no findings about the claimant's alcoholism. The only finding was that there was no end organ damage and that cirrhosis of the liver was controlled. A remand was ordered for a full analysis of the claimant's alcoholism.

87 Mental Health Association of Minnesota v. Schweiker, 554 F. Supp 157 (D. Minn. 1982) aff'd 720 F. 2d 965 (8th Cir. 1983). See also City of New York v. Heckler, 548 F. Supp. 1109 (E.D.N.Y 1984) where the Agency's policy of denying benefits for mental impairments was termed "covert," "sub-rosa" and "clandestine." (Id. at 115-1161).

88 A citation to the Congressional Record is unavailable. However, for a discussion of the Minnesota case and Sen. Heinz's hearing see SOCIAL SECURITY FORUM Vol.5, No.3, May 1983.


90 Id. The Act was specific in stating that "the revised criteria and listing, alone and in combination with assessments of the residual functional capacity of the individuals involved, shall be designed to realistically evaluate the ability of a mentally impaired individual to engage in substantial gainful activity in a competitive workplace environment."

indicating which of the other listed impairments must be used to evaluate the behavior or physical changes resulting from the regular use of substances. (For example, should an individual with a substance addiction disorder experience seizures as a result of that disorder, either listing 11.02 {Epilepsy-major motor seizures} or 11.03 {Epilepsy-minor motor seizures} should be used for the evaluation of the substance addiction disorder.)

At the same time, however, the Secretary sent adjudicators and the public a mixed message by stating that: "Severe substance addiction disorders alone can be disabling and do not require other impairment involvement." However, an examination of the listing itself reveals that the Secretary continued to regard substance addiction disorders (alcoholism and drug abuse) as disabilities only when there were resulting physical or psychological impairments which met the requirements of another listed impairment.

The Social Security Administration continued to deny claims where uncontrolled alcoholism without another physical or mental impairment was the only condition alleged, and the courts continued to hold that alcoholism per se, when uncontrolled, constituted a basis for

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92 Id. at 35040.
93 Id.
94 The listing reads as follows:

Substance Addiction Disorders: Behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system.

The required level of severity for these disorders is met when the requirements in any of the following (A through I) are satisfied.
A. Organic mental disorders. Evaluate under 12.02
B. Depressive syndrome. Evaluate under 12.04.
C. Anxiety disorders. Evaluate under 12.06.
D. Personality disorders. Evaluate under 12.08.
F. Liver damage. Evaluate under 5.05.
G. Gastritis. Evaluate under 5.04.
H. Pancreatitis. Evaluate under 5.08.
I. Seizures. Evaluate under 11.02 or 11.03. (see 20 C.F.R. 404, Appendix 1, Section 12.09).
Addressing this issue in 1985, the Third Circuit noted that "the Social Security Administration ignored its own amended regulations and adhered to its former position that alcoholism was not itself a disabling condition." The Social Security Administration continued to non-acquiesce in these court decisions which resulted in a Third Circuit class action suit.

C) Media Coverage

Beginning in 1993, stories began to appear in newspapers across the country bearing headlines geared to stir public sentiment against disability benefits for alcoholics and drug addicts. A striking example is the article which appeared in a California paper. The headline read "Addicted to tax money; Alcohol and narcotics users get up to $620 a month. And as Long as they keep abusing, the money keeps coming sometimes for Life." Focusing primarily on drug addicts who were said to be using federal funds to finance their illegal purchases, alcoholics were lumped into the same category although their conduct was not illegal. Critics argued that a finding of disability "virtually guarantees ... addicts will sign up for Lifetime spots on the government

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95 See, infra, note 96 and Cooper v. Bowen, 815 F.2d 557 (9th Cir. 1987); Kellar v. Bowen, 848 F.2d 121 (9th Cir. 1988).
96 Purter v. Heckler, 771 F. 2d 682, 697 (3rd Cir. 1985)
97 Non-acquiescence is a policy of federal administrative agencies in which the agency, rather than appealing a court decision which is unfavorable to the agency, chooses to ignore it. In the context of Social Security disability claims, this has been a bone of contention for many years. Courts have routinely ordered the Secretary to adhere to its decisions (see Shisler v. Heckler, 787 F. 2d 682 (2nd Cir. 1986). Congress now has the issue under consideration, a bill known as the Federal Agency Compliance Act which would require all federal agencies to follow the precedents of the U.S. Courts of Appeals for the Circuit, specifically noting that administrative law judges would be required to adhere to these decisions. Action was taken in the House of Representatives on March 2, 1998 which passed the bill (H.R. 1544) by a vote of 241 to 176 ( SSA Legislative Bulletin 105-8).
rolls with no push to get off." In December 1993, the results of a Knight-Ridder investigation into the issue was reported. Again the headline was designed to evoke the public ire: "Out of Kilter; Addicts feeding habits with Social Security Benefits." Alleging that the SSI program had grown by 1,700 percent over a nine year period, the article went on to allege that "Nationwide, some 70,000 drug addicts and alcoholics now receive Lifetime 'disability' payments" and that "Typically, those doing so are itinerants whose connections with society are marginal at best." The article provided no basis for these conclusions, and the entirety of its tenor was inflammatory.

In February 1994, a joint report by the Senate Special Committee on Aging (minority staff) and the General Accounting Office was issued. It concluded that in 1993 over 250,000 addicts received a total of $1.4 billion in disability benefits. The report also concluded there were significant problems with the manner in which payment was made to addict beneficiaries. Often cash was paid directly to the addict rather than to a representative. Only a few days after the release of the report, a House subcommittee held hearings on the issue. The Baltimore Sun reported that Shirley Chater, the

100 Id. (inappropriate capitalization appears in the headline). This statement alluded to the underlying problem that the Social Security Administration was not pursuing the statutorily required process for re-evaluating continuing disability. This became the focus of Congressional hearings but a discussion of this issue is well beyond the scope of this paper.


102 Id.

103 Id.

104 I know of no systematic studies on the subject. However over a period of almost 17 years of hearing these disability appeals, few if any of the addicts who have appeared before me (whether alcoholics or drug addicts) have been of the cast alluded to by the article's author. In fact, most had homes and families. Although I have not done a statistical analysis, it is my belief that this statement is far off the mark.

105 The law requires that when the Commissioner of Social Security (previously the Secretary of Health and Human Services) determines that an individual is not competent to handle benefits, payment may be made to a representative payee. The Commissioner is responsible for the investigation of the person who is to serve as the representative payee and is also responsible for monitoring the actions of the representative payee (42 U.S.C. 405(a), 42 U.S.C. 1383(a)(ii)(I) (1998.))

Commissioner of Social Security, acknowledged the Agency's poor performance in overseeing both the representative payee program and treatment programs for addicts. The media continued its full court press with more headlines such as "Getting High On The Dole." Senator William S. Cohen (one of those responsible for commissioning the GAO study) wrote an editorial piece for the Washington Post (reprinted in other papers across the country) blasting the implementation of the SSI program as it was applied to addicts. Quoting a homeless shelter director, the Senator called the program "'suicide on the installment plan' because the program provides ready cash to addicts and alcoholics with no strings attached for follow-up or treatment." Senator Cohen called for reform which would pay benefits to an institutional representative payee, prevent addicts from receiving lump sum retroactive benefit checks, and requiring treatment as a condition for payment of benefits.

D) The 1994 Amendments

The result of the media blitz was the passage of Pub. Law No. 103-296 which was to take effect February 13, 1995. The statute provided for payment of benefits to addicts for a limited period of time (36 months), continuation of medical benefits and dependents benefits, payment of retroactive benefits to the representative payee, prorated rather than in a lump sum, requirements for the beneficiary to enter and remain in a treatment program, and selection of organizations (i.e. community non-profit social services agencies) as representative payees.

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107 John B. O'Donnell, Addicts, alcoholics to get U.S. Funds., THE BALTIMORE SUN, Feb. 11, 1994, (News) at 14A.
110 Id.
rather than family members.\textsuperscript{112} The heart of this legislation was the requirement that adjudicators make a finding as to whether alcoholism or drug addiction was a material factor contributing to the disability.\textsuperscript{113} Final regulations were published February 10, 1995.\textsuperscript{114} Adopting in its entirety the language of SSR 82-60, the new regulations provided that:

(a) General. If we find that you are disabled and have medical evidence of your drug addiction or alcoholism, we must determine whether your drug addiction or alcoholism is a contributing factor material to the determination of disability.

(b) Process we will follow when we have medical evidence of your drug addiction or alcoholism. (1) The key factor we will examine in determining whether drug addiction or alcoholism is a contributing factor material to the disability is whether we would still find you disabled if you stopped using drugs or alcohol.

(2) In making this determination, we will evaluate which of your current physical and mental limitations, upon which we based our current disability determination, would remain if you stopped using drugs or alcohol and then determine whether any or all of your remaining limitations would be disabling.

(i) If we determine that your remaining limitations are disabling, you are disabled independent of your drug addiction or alcoholism and we will find that your drug addiction or alcoholism is not a contributing factor material to the determination of


\textsuperscript{113} Interestingly, this concept was not new to disability determination law. The language first appeared in the 1960 ruling dealing with evaluation of addictive disorders. See, text accompanying note 77. SSR 82-60, although providing that alcoholics and drug addicts could not be found disabled on the basis of the diagnosis alone, provided that where disability was established due to other impairments, a determination as to whether "the drug addiction or alcoholism was a factor material to the finding of disability" needed to be made in order to decide whether a representative payee was required for those applying under Title XVI (Supplemental Security Income).

\textsuperscript{114} 60 Fed. Reg. 8147 (Feb. 10, 1995).
Adjudicators began applying these concepts, but again, legislators were besieged with media coverage and public resistance to paying disability benefits to addicts. No distinction was made between drug addicts who pursued illegal activity to satisfy their cravings, and alcoholics, who committed no illegal acts in purchasing, possessing and consuming alcohol.

E) The Media Coverage, the second time around.

In January 1995, the Arizona Republic carried an editorial opinion written by a man who required oxygen 24 hours a day and who worked diligently, sometimes at more than one job, who by his own description was "not officially poor enough, old enough, young enough (no children at home) or foreign enough to qualify for help with $700-$800 a month medical bills." His anger at the system was reflected in his allegation that "I am not a drug addict or an alcoholic. ... If I were ... I would 'qualify' for any number of health-care-programs and receive all the benefits I need to stay alive." Later the same month, the Baltimore Sun ran a series entitled "The Disabling of America." The authors, Jim Haner and John B. O'Donnell noted that among the homeless veterans on the disability rolls, approximately 250,000 were "believed to be hard-core substance abusers who routinely squander the cash on drugs and alcohol." Reporting that Congress would begin hearings on the issue, they noted that "[s]ome are already vowing to give addicts the ax." Recounting case after case of men who were addicts but not otherwise impaired, the article decried the fact that "said addiction alone could qualify as a disabling disorder, making it possible for virtually anyone hooked on dope or booze to get

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117 The Disabling of America, THE BALTIMORE SUN, Jan. 23, 1995, at 1A.

118 Id.
a monthly check even though they have no other disability."\textsuperscript{119} Discussing the changes made by the 1994 amendments, the writers opined that the 36 month limit in payment of benefits was of little value because treatment was not being provided, and monitored, and further, because a majority of the beneficiaries affected suffered from other disabling impairments and thus would not be terminated.\textsuperscript{120} In the last article of the series, Messrs Haner and O'Donnell correctly placed the blame for the failure of the disability program (as to all, not just as to addicts) on the repetitive swing in the political climate:

The Reagan attempt to tame the program and the counter-attack it drew illustrate a cycle that has been apparent for more than a decade: Members of Congress pass bipartisan laws opening up the program to make it easier for their constituents to get in, only to clamp down again to mollify middle-class voters who are paying the bills.... The Reagan purge and the constant whipsawing by Congress have brought on a profound and lasting crisis at the Social Security Administration.\textsuperscript{121}

Media attention continued,\textsuperscript{122} and Congress held hearings on how to deal with addicts seeking disability benefits.

**E) Congressional Action 1995-1996**

On March 2, 1995, Senator William S. Cohen, the author of the 1994 legislation, and Chair of the Senate Special Committee on Aging, held a hearing on "The Disabling of America." Professor Sally L. Satel, of the Yale University School of Medicine, Department of Psychiatry, identified the crux of the problem, stating that: "[A] program that gives

\textsuperscript{119} Id.

\textsuperscript{120} Id.

\textsuperscript{121} The Disabling of America, THE BALTIMORE SUN, Jan 25, 1995, at 1A.

\textsuperscript{122} See, Puzzling Payments, THE TIMES-PICAYUNE, Feb. 20, 1995, at B6 ("Drug addicts and alcoholics can receive benefits to buy more drugs and alcohol, but children with disabilities are denied medical assistance because of a parent's income."); Many Say Program for Addicts Is A Bust, Should Be Cut, ST. LOUIS POST DISPATCH, June 11, 1995, at 14A.
cash to addicts invites misuse ..." and that "[T]he perverse incentive of a cash benefit effectively rewards addiction while it punishes functional adaptation and recovery." 123 Dr. Satel suggested that the answer was rehabilitation. She put forth a model (based on a program in operation) in which a clinic provided a payee account for each patient. Through this account, electronic transfers to landlords satisfied rent obligations, the program supervised food shopping and other shopping, and through the course of treatment, as patients improved, they received greater financial independence.

She concluded that "Not only is income maintenance irrelevant to that goal, [referring to rehabilitation] it can actually harm recipients." 124 She strongly urged that Congress provide residential treatment and rehabilitation. 125

In his own statement to the Senate Finance subcommittee on Social Security and Family Policy, Senator Cohen suggested that:

[T]here is more work to be done to tighten the restrictions enacted last year on drug addicts and alcoholics on SSI and SSDI but flatly abandoning all assistance to SSI and SSDI recipients whose primary impairment is substance abuse may be harsh and counterproductive. Stripping these recipients of Medicaid eligibility would ensure that they do not receive treatment for their substance abuse, thus guaranteeing that they will not be rehabilitated and return to work. 126

Unfortunately, that is precisely what the Congress did when it enacted Pub. L. No. 104-121. 127 The new statute provided that

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124 Id.

125 Id.


127 The law became effective March 29, 1996.
addiction to alcohol and/or drugs would no longer be a basis for disability under the Social Security Act, and mandated that the Social Security Administration notify all then current recipients that their benefits would terminate January 1, 1997. Provision was also made for appeals so that addicts could seek a new determination as to whether their addiction was a material factor contributing to disability, or whether the addict could be found disabled on the basis of other medical conditions.  

V. PROPOSALS FOR STATUTORY AND REGULATORY CHANGE

It is difficult to understand why Congress acted so swiftly to eliminate the 1994 provisions for time-limited benefits and mandatory treatment for addicted beneficiaries. Had Congress allowed a substantial period to elapse before scrapping the program, data could have been gathered to evaluate its efficacy. Given the level of public opposition to the payment of benefits to addicts, one can only surmise that Congress's swift action was intended as a response to this opposition. While it is understandable that some taxpayers are unwilling to pay cash benefits to addicts, the unfortunate result is that addicts have not received treatment and their families have been denied the financial support they would have received as ancillary beneficiaries under the Social Security Act.

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128 Americans with Disabilities Act (1996). Further clarification with regard to the legislation was passed later in 1996, however, it does not relate to the substantive issues. Subsequent to the passage of the Act a class action law suit was filed by then Prof. Terrence Farrell (now an ALJ) of the Seton Hall University School of Law-Disability Law Clinic, challenging the retroactivity of the law. The status of this class action is not known. More recently a class action has been filed attacking the constitutionality of the statute. In Mitchell v. Apfel, Civ. Act. No. 3:97CV330-p (W.D.N.C), a motion for summary judgment is pending. As to the constitutionality question, a recent law journal article treats this issue (See, Nicole Fiocco, Note & Comments, The Unpopular Disabled: Drug Addicts and Alcoholics Lose Benefits, 49 ADMIN. L. REV. 1007 (1997)). (The issue was resolved by the U.S. District Court for the Northern District of Illinois in favor of constitutionality of the statute. (Stengel v. Callahan, 983 F. Supp. 1154 (N.D. Ill. 1997)).

129 See, note 3.

130 As suggested by Mr. Haner and Mr. O'Donnell in their series The Disabling of America, see, supra, notes 117 and 121.

Americans need to recognize that alcoholism is a problem which is not going to go away just because we would like it to disappear. In a society which allows alcohol to be a central part of our social life, we can not ignore those who become alcoholics. It is understandable that the American public does not want tax dollars used to feed an addict's habit. But without putting those tax dollars to work on rehabilitation, addiction will not only remain with us, but grow. America will likely see an increase in the crime rate, and the addict without medical insurance is sure to be a financial drain on the health care system.

Perhaps it is time that we distinguish between the alcoholic whose addiction does not require the commission of illegal acts to supply the habit, and the drug addict, whose conduct in securing drugs is patently illegal. The proposal that follows is suggested in the context of dealing with the alcoholic only, for s/he is a product of our society, and generally commits no illegal acts by using and abusing alcohol.

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132 Evenings out routinely start with cocktails as do most business functions. Beer and wine ads grace magazines and billboards, and even the Super Bowl pushes the use of alcohol with its "Bud Bowl." Thus, people are sent mixed messages about using alcohol, and undoubtedly many will, at some point, succumb to its lure. Further, we can not ignore the fact that some are genetically predisposed to alcoholism. (see TREATMENT AND REHABILITATION OF THE CHRONIC ALCOHOLIC, supra, note 36.

133 Doctors Kolb and Brodie note that "alcohol is implicated as the agent precipitating violence, which leads to assault and murder in a high number of instances, as well as being a major cause of self-directed violence through suicide or self-mutilative acts." They also note that "at least 50 percent of the fatalities in pedestrian accidents involved individuals who had been drinking." They also report that 35 per cent of fatal accidents in private aviation are linked to pilots who have consumed alcohol. (Lawrence C. Kolb, M.D. and H. Keith H. Brodie, M.D. MODERN CLINICAL PSYCHIATRY 625 (10th ed. 1982).

134 Alcoholism causes a multitude of medical problems including cirrhosis of the liver. See KOLB & BRODIE, supra., note 133 at 629), seizures, (Id.) vitamin deficiencies and encephalopathies (Id. at 636). Serious heart damage is frequently observed in the alcoholic known as alcoholic cardiomyopathy. See Cecil-Loeb Textbook of Internal Medicine 1095 (Paul B. Beeson, M.D., and Walsh McDermott, M.D. eds. 18th ed. 1971). Osteoporosis is also common in alcoholics, (Id. at 1864) as is acute and chronic pancreatitis. (Id. at 1314). Richard Epstein speaks of the financial drain on emergency centers caused by social ills, noting that "The bulk of the admissions relates to drugs, alcohol, firearms and the like." (Richard Epstein, MORTAL PERIL, 102 (1997).

135 I do not mean to suggest that the alcoholic never commits such acts, for we know that those who drive while drunk are committing a crime and have the potential to kill. However, dealing with these individuals is a separate problem requiring treatment under the criminal statutes.
We must move away from the far left and the far right (neither paying drug addicts cash benefits without restrictions, nor denying all benefits) to a middle ground that will, perhaps, provide for the possibility of rehabilitation and re-entry of alcoholics into the work force. We must recognize that this will cost money, but we must be prepared to allocate funding or face the reality that the problem of alcohol will remain and perhaps worsen. We must also recognize that the dependent child of the alcoholic bears no responsibility for his or her parent's conduct, and should not be denied support merely because s/he is the child of an alcoholic.

I suggest that the statutory scheme created by Pub. L. No. 103-296\textsuperscript{136} be re-enacted with some modifications. Time-limited benefits conditioned upon voluntary rehabilitation is a logical solution.\textsuperscript{137} Benefits should not, however, be paid to institutional representative payees who have no interest in the well-being of the individual recipient. Instead, I propose that no cash benefits be paid to alcoholics. Rather, the disability program should provide medical care (including rehabilitation), rent subsidies, and food stamps. In this day of electronic transfer, there is no reason why direct payments can not be made to landlords. Food stamps should be issued, not to the alcoholic, but to a representative payee who is either living with the alcoholic, or who is able to perform the task of grocery shopping for the beneficiary. Benefits for alcoholics, whether they are dually diagnosed\textsuperscript{138} or simply "loss-of-control" alcoholics, must be conditioned on participation in a rehabilitation program. The regulations published to effectuate Pub. L. No. 103-296 provide an excellent framework for establishing what constitutes appropriate treatment. Payments to medical providers should be made under the auspices of the Medicare/Medicaid programs, and such payments must include the cost of rehabilitation services.

The application for benefits should include a question as to whether the individual is addicted to the use of alcohol. An affirmative response as to alcohol abuse would trigger the assessment of whether

\textsuperscript{136} See, supra, note 112.
\textsuperscript{137} Time-limited benefits strike a balance between those who object to supporting addicts for life, and those who believe that addicts should be provided with a chance for rehabilitation.
\textsuperscript{138} I.e. depression, chronic pancreatitis, etc. (See, DSM IV, supra, note 47).
the addiction is disabling alone or in combination with another impairment. The disability determination process would remain the same as it currently exists, including the question of whether alcoholism is a material factor contributing to the disability. If the only impairment is alcoholism, then the time-limited benefits provision would apply. Any individual whose other impairments would satisfy the standards for disability would be entitled to benefits without time limitations. In both instances, if the individual were actively drinking, no cash benefits would be payable. Past due benefits would be held by the Social Security Administration until the claimant has completed rehabilitation and remained sober for a minimum of one year. They would then be payable in equal installments over the course of two years (during which time the claimant would be required to continue with treatment and remain sober). The beneficiary would be required to enter treatment, and his/her progress would be monitored by having the treatment facility report to Social Security every six months. The individual's case would be reviewed annually. However, only at the end of the 36 month period could the individual be terminated due to a failure of rehabilitation. Each annual review should be directed towards encouraging the alcoholic to continue treatment.

I suggest that within the Social Security Administration, a branch be created which would be responsible for effectuation of any benefits program, monitoring rehabilitation, and reviewing cases at the end of the time limited period. Each applicant who alleges disability based on any alcohol related problem (whether it is merely the uncontrolled drinking, or the physical and/or mental sequelae of addiction) would be assigned a case manager at the level of the Social Security Administration.

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139 A negative response would not be conclusive. Rather, SSA would be required to investigate the issue of alcoholism if other evidence suggested its presence (i.e., medical records showing chronic liver disease, statements by family members, hospital records noting "ETOH").

140 Dependent children and spouses who may be entitled to benefits would receive cash benefits as if the wage earner were disabled due to a physical or mental impairment other than alcoholism. As to the children, benefits would be paid to a representative payee (as is the current situation). In the event that the spouse is also an alcoholic, those benefits would be subject to the same conditions as the wage earner.

141 An exception should be enacted for emergency situations such as eviction or mortgage foreclosure. In such cases arrangements could be made for electronic transfer of a portion of past due benefits directly to the creditor.
Security district office. The case manager would then be responsible for overseeing the effectuation of benefits and the rehabilitation efforts. Any beneficiary who is either unsuccessful or refuses to cooperate in the rehabilitation process would be terminated, however, dependents benefits would continue.

An additional and essential component of the program would be vocational rehabilitation and job placement. Congress has stated that:

It is declared to be the policy of the Congress that disabled individuals applying for a determination of disability, ... shall be promptly referred to the State agency or agencies administering or supervising the administration of the State Plan approved under Title I of the Rehabilitation Act of 1973 [20 U.S.C.A. 720 et seq.] for necessary vocational rehabilitation services, to the end that the maximum number of such individuals may be rehabilitated into productive activity.  

The statute provides for deductions from benefits when a claimant refuses (without good cause) to accept vocational rehabilitation services, and provides for the costs of the services. It also provides for the referral of alcoholics and drug addicts to the appropriate State Agency responsible for that state's substance abuse

142 The Social Security Administration is currently implementing a program in which every applicant's claim would be handled by a "disability claim manager" (See, Social Security Administration, U.S. Department of Health and Human Services, Disability Process Redesign-The Proposal and Background Report from the SS Disability Process Reengineering Team, SSA Pub. No. 01-002 (March 1994). The claims manager will be responsible for managing the claim from "intake through payment" (Id. at 32). "The goal will be to give claimants access to the decision maker and allow for ongoing, meaningful dialogue between the claimant and the disability claim manager." (Id.). Thus, it would be relatively easy to utilize the claim manager as a case manager for the alcoholic beneficiary. In such cases, the claim manager would receive the annual reports, review them, communicate with the beneficiary concerning his or her progress, and at the end of the time limited period, determine whether the claimant remains disabled or has been rehabilitated. The claimant would have the right to appeal this determination in accordance with the procedures for appeal of any other initial determination.)


144 Id.
program. Thus, there would be no need to enact legislation for the purpose of creating rehabilitation programs, as the legislation already exists. Each alcoholic, upon completion of the medical phase of rehabilitation should be evaluated for vocational rehabilitation. Those who are appropriate candidates should be trained for a return to the work force. Those who are not, either because of age or continued disability on other grounds would be entitled to a continuation of disability benefits. A trial period of six years should be set with the Social Security Administration reporting back to Congress after three years, and again after six years, at which time Congress will then be in a position to evaluate the efficacy of the program.\footnote{The success of the program should be measured by how many of the beneficiaries who have no other impairment are rehabilitated.}

VI. CONCLUSION

The first step towards reconciling the inconsistent treatment of alcoholics under the ADA and the Social Security Act is to recognize that alcoholism is a chronic illness and like all illnesses may or may not be subject to cure. The alcoholic should not be abandoned at a time when s/he most needs help. A program of time-limited benefits, mandatory rehabilitation, close monitoring, and vocational rehabilitation needs to be given sufficient funding and a chance to work. It strikes the right balance between the interests of taxpayers who do not want to pay benefits to alcoholics without restriction, and the alcoholic's need for rehabilitative, vocational, and medical services. I firmly believe that it is in the best interests of society to rehabilitate alcoholics and that the disability program is the logical place to begin.