Without a Net:

A Study of Early Impacts of Supplemental Security Income Benefits Elimination for Persons with Disabilities due to Drug and Alcohol Abuse in Cook County, Illinois

Impacts, Policy Alternatives and Action Steps

A
Mid-America Institute on Poverty
Research and Policy Report

in collaboration with
The SSI Coalition for A Responsible Safety Net

March, 1998

The Mid-America Institute on Poverty

The Mid-America Institute on Poverty (MAIP) is the research and policy division of Heartland Alliance (formerly Travelers & Immigrants Aid). MAIP conducts research, policy analysis, and advocacy which facilitates the identification and illumination of emerging poverty issues and the development of solutions. MAIP facilitates and participates in community planning and organizational efforts directed toward collaborative approaches to problem solving. Contact us at 208 S. LaSalle St., Suite 1818, Chicago, IL 60604; (tel) (312) 629-4500, ext. 4525; (fax) (312) 629-4550; (e-mail) maip@heartlandalliance.org.

The SSI Coalition for a Responsible Safety Net

The SSI Coalition for a Responsible Safety Net ("SSI Coalition") was started in 1992 as part of an initiative to reform and improve the federal Supplemental Security Income program, a federal benefits program that assists needy persons who are age 65 or older, blind, or disabled. The Chicagoland SSI Coalition, as it was then called, worked with other advocacy groups and individuals to improve the SSI program. The SSI Coalition has continued its work on behalf of low-income elderly and persons with disabilities, working to ensure and preserve dignity, and to advocate on behalf of programs and policies that assist them to become self-sufficient.

The SSI Coalition's ongoing work includes:

- Children's SSI issues—including the policy analysis, and the effects, of the new Children's SSI regulations, updates on the Social Security Administration's implementation of new procedures;
- Non-citizens and SSI—SSIC continues to provide updated information, advocacy and policy analysis of the changes that affect elderly and disabled non-citizens; and
- SSI and Welfare to Work— The SSI Coalition has three distinct projects focusing on the work incentives programs of the Social Security Administration: 1) Welfare to Work for People with Disabilities—Creating Opportunities for Self-Support; 2) HIV, SSI and Welfare to Work; and 3) Work Incentives Support Center (WISC)-a demonstration project.

The SSI Coalition can be reached at 205 W. Monroe St., 3rd Fl. East, Chicago, IL 60606-5013; (tel.) 312.223.9600; (fax) 312.223.9518; (e-mail) mgrey@ssic.org; (website) http://www.ssic.org.

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ACKNOWLEDGMENTS

Primary Author
Maryann Mason, Director, MAIP

Research Associates
Jeffrey Lewelling, Policy Specialist, MAIP
Amy Rynell, Intern, MAIP

Editorial Assistance
Linda E. Traeger, Vice President, Heartland Alliance
Sid Mohn, CEO and President, Heartland Alliance
Barbara Otto, Executive Director, SSI Coalition for A Responsible Safety Net

Advisory Committee
Sunny Fischer, City County Task Force on Welfare Reform
Marcia Knudson, Lakefront SRO
Cynthia Randall TIA/Chicago Connections —Supportive Housing
Susan Flynn, Haymarket House
David Carvalho, Cook County Health
Heidi Romans, Chicago Health Outreach
Les Brown, Chicago Coalition for the Homeless
Nancy Radner, Corporation for Supportive Housing
Representative Bobby Rush
Representative Danny Davis
State Senator Earlean Collins
Rev. Richard Bundy, New Faith Baptist Church
Dr. Carl Bell
State Senator Art Turner
Nick Gantes Illinois Dept. of Human Services —Office of Alcohol and Substance Abuse
State Representative Larry McKeon
Wayne Salter, Paternal Involvement Project
Linda Traeger, Heartland Alliance

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Mary Ellen Swangren, Joan Schwingen, Sid Groseclose, Debbie Kroopkin, Ginger Seery, Becky Liddicoat, Jessica Engel, Chris Fair, Tom Yates, Sue Augustus and Maureen Grey

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EXECUTIVE SUMMARY

Background

On March 28, 1996, Congress passed the Contract with America Advancement Act of 1996 (H.R. 3136), the first of the major welfare "reforms" implemented, affecting more than 200,000 people across the country.[1] This bill, among other things, eliminated drug addiction and alcoholism (DA & A) as a basis for disability in both the Title II (Social Security Disability Insurance) and Title XVI (Supplemental Security Income) programs. By January of 1997 more than 15,000 individuals lost SSI benefits and/or SSDI benefits in greater Chicago.

This is the first published study of its kind attempting to track the impact of the cuts in SSI/DI on the drug and alcohol addicted. Many of the findings in this study confirm the predictions of advocates. Ironically, much of what we learned flies in the face of stated goals of welfare reform – moving people into work and promoting self-sufficiency. In addition to the loss of cash benefits, beneficiaries also lost eligibility for both Medicaid and Medicare because their primary disability was substance abuse.

The SSI Research Advocacy Project

The Mid-America Institute on Poverty and the SSI Coalition for A Responsible Safety Net partnered in July of 1996 creating ***The SSI Research and Advocacy Project*** to track and examine the impact of SSI DA&A benefits elimination with the intent of providing factual data to further inform the debate and facilitate subsequent policy development.

The SSI Research and Advocacy Project has these goals:

- to analyze the impact of benefits elimination for those disabled by drug and/or alcohol abuse; and
- to use these findings as parameters to develop policy recommendations at the federal, state, county and municipal levels for mitigating negative impacts of benefits elimination.

National figures released by the Social Security Administration indicate that Chicago has a disproportionately large number of persons affected by these cuts — the largest number of any city or metropolitan area in the United States. Chicago tops the list of impacted cities with 18,700 SSI DA&A beneficiaries to whom termination notices were sent[2]. Detroit, with the next highest number, had only 5,000 beneficiaries at the time cuts were made. As a result, it is anticipated that the impact of this federal policy change will be felt more sharply in Chicago than in other places in the United States.

[1] Benefits ceased in December of 1996 for SSI beneficiaries; January of 1997 for SSDI beneficiaries.

[2] A factor which may contribute to the high number of SSI DA&A beneficiaries in Chicago compared to other metropolitan areas could be the concerted effort made by social service providers to enroll clients in entitlement programs, especially after the state General Assistance program ended in 1991.

The Mid-America Institute on Poverty and the SSI Coalition for a Responsible Safety Net analyzed the impact of the loss of SSI DA&A benefits in Cook County, Illinois. Throughout the research process, we worked with an advisory committee comprised of service providers, policy makers, and program administrators. The final report is the responsibility of its authors and the advisory committee does not unanimously endorse each of the policy recommendations offered.

SELECTED FINDINGS AND KEY POLICY RECOMMENDATIONS

Who are we talking about?
The typical former DA&A beneficiary who participated in this study is a 41 year old, male African-American with less than a high school education, and without a steady source of cash income. More than two-thirds of those interviewed were parents of children 17 years of age or under. Participants in this study have poor health, reporting medical problems ranging from cluster headaches to chronic heart conditions. A large portion (44%) suffer from chronic or life threatening health problems such as HIV/AIDS, hypertension, asthma. Nearly half (40%) of those with chronic illnesses are HIV positive.

Nearly all, (95%) interviewed for this study held jobs in the past. However, for many, their pattern of employment has been irregular odd jobs when available, occasional construction work, and factory day labor. The median length of time on their last job was a little over nine months. We found a significant portion of previous work experience of the former beneficiaries we interviewed has been in jobs that require physical strength and agility – 30% worked as laborers, in the construction trades or custodial services.

The high level of physical health problems experienced by those interviewed for this study make it unlikely that they will be able to return to these types of jobs.

Over one half (60%) of former SSI DA&A beneficiaries in our study received state-funded General Assistance (GA) at some time in the past. The majority (69%) left GA for SSI in 1992 when Illinois eliminated the program.

Although almost a quarter of our sample were veterans, none received VA cash assistance benefits. A significant sub-group of the veteran population in our sample did, however, receive medical and/or substance abuse treatment services through the VA (see the Health Care and Substance Abuse Treatment sections of the report for more on this).

Finally, most of those who participated in the study did not re-qualify for SSI/DI benefits under another disability category (84% of the 100 former beneficiaries we interviewed did not re-qualify). The majority of former beneficiaries interviewed receive food stamp benefit.

The study is divided into five main sections: Housing, Employment and Training, Health Care, Substance Abuse Treatment and Food & Nutrition. While each of the substantive sections is presented as a discrete topic, it is important to recognize the level of interdependence among these issues: for example, we know that substance abuse treatment is most effective when the person receiving it has stable housing. The inter-relationships are important and have significant consequences for structuring programs and model policies. While we have attempted to deal holistically with issues affecting this population, there are some issues which were not incorporated into our study. Among the most important of these are the role of criminal justice (though we do briefly address linkages to treatment), mental health and child support systems.

HOUSING

Obtaining and retaining adequate housing seems to be an on-going issue for the majority of former DA&A beneficiaries in our study.

Key Findings:

- 49% have moved since their benefits were cut;
- 61% of those who moved, entered shelters;
- 50% retained housing, in part, due to Section 8 subsidies which index rent to income.

Key Policy Recommendations:

Policy changes are needed at the federal, state, and local levels to support implementation, or in some cases, expansion of existing programs and models. At the local level, the City of Chicago is currently in the planning stages of restructuring its shelter and homeless services provided through the Chicago Department of Human Services. This restructuring process presents an opportunity to make positive changes in ways in which Chicago provides human services to homeless persons.

Our findings suggest certain elements must be included in that restructuring if the City is to adequately address the needs of former DA&A beneficiaries. These necessary elements include:

- **Establish shelters patterned after the Safe Haven model expressly for homeless persons with substance abuse issues.** The Safe Haven model is currently designated only for those with the dual diagnosis of major mental illness and substance abuse. As such, those whose only disability is drug or alcohol abuse related are prevented from utilizing this type of shelter, nor do the existing Safe Havens have the capacity for addressing the level of need for this service among substance abusers. Changes in HUD rules authorizing implementation of the Safe Haven Model for substance abusers will be needed to open federal funding possibilities for expanding this model to former SSI DA&A beneficiaries who are homeless and actively using substances.

- **Plan for–and fund–on-site service providers and service delivery at shelters and other providers within the shelter system (e.g. food pantries, etc.).** Supportive services should include medical, mental health, treatment, and employment and training services. Because housing is foundational to many other basic needs, the shelter environment provides an ideal starting point for linking homeless former SSI DA&A beneficiaries to needed services. The City of Chicago has an opportunity in restructuring its shelter services to build in co-location as a basic feature of shelter environments.

Special note: Not all those in need of services are in shelters. Our data indicate that a portion of the former SSI DA&A population stay on the street, not in shelters. Therefore, to effectively reach these homeless persons in need of basic services, street outreach must be a systems component of the City's plan.

The proposed federal budget includes expanded funding for HUD programs serving the homeless and low-income renters. This indicates a climate in which program expansions may be feasible. In particular, we support expanded funding for:

- **Shelter Plus Care (supportive housing) subsidies.** Shelter Plus Care housing subsidies are designed to support persons for whom independent living is a reasonable goal. For many former DA&A beneficiaries in our study, particularly those with a recent work history, this may be the most appropriate housing option.

- **Project-Based Section 8 SRO funding.** Participants in our study in Project-Based Section 8 units, maintained housing after benefits ceased. Former beneficiaries and social service providers alike agreed that these subsidized units were a lifeline for those who lost benefits.

EMPLOYMENT AND TRAINING

While many former DA&A beneficiaries are connected to families, they are non-custodial parents which make them ineligible for much of the targeted welfare to work dollars coming out of Washington. In fact, the loss of the SSI/DI benefit has effectively disconnected them from any public benefits or other supports within the "system." There are few—if any—vehicles outside the system designed to assist them in moving toward self-sufficiency, or, at a minimum, stabilize their condition.

Participants in the study had low skill levels which translates into low wages. For example:

- 53.6% have less than a high school diploma. The mean hourly wage of those without H.S. diplomas or GEDs who held jobs at the time of our interviews was $5.09.
- 31% have a H.S. diploma or GED. The mean hourly wage for those who held a high school diploma but had no additional education was $6.60.

Few (29%) in our study have received job training of any kind (including on the job or post secondary education). Only 11% of former beneficiaries in our sample had been involved in the Earnfare employment program. Earnfare, the only employment program geared toward single adults in Illinois, offers 5,000 slots state-wide. Participation is limited to six months in a one-year period and the program provides limited pre-employment training and does not provide substance abuse services.

Key Findings:

- 49% have no income
- 8.5% had steady employment at the time of interview, another 15% had income from activities such as pan handling, day labor and scavenging
- those employed earned on average $350/month
- 68 percent had criminal records

Welfare reform's stated goals of moving people from public assistance to work has created a flurry of employment and training policies, programs, and resources. However, most of the attention in this regard has been directed toward adults heading households that receive Temporary Assistance to Needy Families (TANF), formerly Aid for Families with Dependent Children.

The employment and training needs of single adults who do not have custody of dependents, like the former DA&A beneficiaries we studied, are largely excluded from the work-related policies and programs developed in response to welfare reform. Yet, a large segment of this population are connected to TANF households. For example, we found that nearly a third (31%) of the former beneficiaries we interviewed have children who receive TANF subsidies.

In 1998 Illinois will receive $48.6 million dollars in 1997 federal Welfare-to-Work grant money, of which the City of Chicago will receive $27.4 million under the direction of the Chicago Workforce Board. Grant guidelines allow for designating up to 30% of these funds for employment and training activities for non-custodial fathers whose children receive TANF. A portion of these funds should be targeted to programs serving former DA&A beneficiaries whose children receive TANF assistance.

In addition, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 sets up a new employment and training fund for food stamp beneficiaries. The Act mandates that 80 percent of the funds be spent on 18-55 year old food stamp beneficiaries not caring for minor children. A significant portion of these funds should be ear-marked for former DA&A beneficiaries.

Programs funded by expanded funds must incorporate components demonstrated to be effective for this population including: treatment services, extended pre-employment skills development, linkage to stable housing opportunities, job coaching and other supportive services, and long-term job stabilization assistance. Adequate funding is

important as well. Employment and training experts estimate that on average the cost for preparing hard-to-employ persons for gainful employment is about $5,000 (*Network News, December 12, 1997*). Other estimates, specific to homeless persons, put the training and placement costs higher.

Key Policy Recommendations:

Improving existing large-scale programs.

Earnfare. In order to effectively reach and serve former DA&A beneficiaries the program should:

- expand to include treatment services (*eg.* meeting support, drug and alcohol screening and counseling);
- add pre-employment/basic skills training services so that Earnfare participants are able to complete the program and increase their chances of obtaining unsubsidized employment using their Earnfare completion as a reference.
- expand slots available to better meet the demand for services (this is especially important given welfare reform legislation which restricts food stamps to single persons aged 18 to 55 unless they are involved in a work activity see also the Food and Nutrition section of the report).

Illinois Department of Human Services/Office of Rehabilitation Services (ORS). Though those disabled by substance abuse are considered disabled under the definition of disability used by the Rehabilitation Act of 1973 and therefore are qualified for ORS services, the general perception and experience of social service providers in our focus groups has been that the services offered by ORS do not adequately address the employment barriers presented by this population including substance abuse. To more effectively serve this population, ORS must:

- extend staff capacity to service this population by training staff on substance abuse issues;
- create specialized staff positions for dealing with substance abuse clients;
- create a demonstration program adapting the Life Coach program, now geared to the mentally ill, to the needs of clients whose primary disability is substance abuse.

Improved integration of employment and training and treatment services.

The reality is that treatment including employment and training services is more effective. Maintaining the separation of these funding streams at its current level to some degree hampers successful service delivery and outcomes for beneficiaries. One problem faced by treatment providers is that employment and training services are not reimbursable under Illinois Office of Alcohol and Substance Abuse (OASA) regulations. Additionally, OASA funds *do not* support employer education and assistance with dealing with substance abuse issues. Other studies indicate such education and assistance can facilitate the employability of those with substance abuse histories.

OASA targets its funds to treatment services and the Department of Commerce and Community Affairs (DCCA), funds employment and training activities. Given this, new partnerships allowing for creative pairing of these funding streams must be forged — including providing OASA assistance to employers willing to hire a person with an

extensive substance abuse history. This will require changes in regulations (and possibly legislation) at the state level.

HEALTH CARE

Substance abuse and poor health are logically inter-related. Often times substance abuse problems develop as a result of self-medicating physical or emotional pain. In these cases, substance abuse is symptomatic of pre-existing health conditions.

Substance abuse takes a toll on health. One study of a large, inner-city teaching hospital showed that of 1010 consecutive hospital admissions, 16% were found to be substance abusers. This figure is probably much higher since only 28% of those admissions were considered to be properly screened. (Hopkins, T.B. et. al, 1997). Many chronic conditions such as hypertension, diabetes, and liver disorders can be caused or exacerbated by overuse of drugs and alcohol. In addition, serious illnesses such as HIV/AIDS and hepatitis are related to intravenous drug usage.

Key Findings:

- 74% lost health care (Medicaid/Medicare) coverage as a result of changes in the federal SSI/DI program;
- 73% reported medical problems;
- 44% of those with medical problems suffered from chronic or life threatening medical conditions;
- after January of 1997 the percentage of care episodes provided by private hospitals decreased; care episodes provided by public health providers (primarily the Cook County Bureau of Health Services) increased.

Appropriate and consistent health care can restore health— even if a chronic condition exists. The key to health restoration in many cases is consistent care and monitoring of medical conditions. For this population though, there are numerous barriers to appropriate health care including lack of private health insurance or Medicaid/Medicare coverage, poverty, homelessness, and mental illness.

While the system of providers serving the medically indigent offers a range of services and health care environments available to former SSI DA&A beneficiaries, the costs and utilization of services are concentrated in particular sectors. Our data indicate that the greatest share of the burden for uncompensated care falls on the Cook County Bureau of Health Services system. Clearly this is not a sustainable situation as County funds are not expansive enough to meet these needs, particularly when coupled with other fallout of welfare reform such as the loss of Medicaid coverage for new immigrants and changes made to Medicaid reimbursement programs in the 1997 Balanced Budget Act.

Many former SSI DA&A beneficiaries we interviewed receive only emergency or crisis care despite their on-going medical problems. The lack of preventive or maintenance

care has several negative consequences: one, it can exacerbate or worsen manageable conditions, and two it drives up the cost of medical care (when care is delayed, a condition may worsen and subsequently require more intensive and expensive care as a result).

In order to deal with these increased uncompensated care costs and provide appropriate health care for this population we have identified the following policy and program recommendations.

Key Policy Recommendations

Improve utilization of Medicaid or VA benefits by former DA&A beneficiaries. The majority of former SSI/DI beneficiaries did not re-apply for benefits under another disability category or appeal SSA's determinations—despite the fact that many have other medical and mental health conditions which could qualify them for benefits under another category. There are multiple reasons for this, but the most common reason was the difficulty of collecting and submitting medical records to provide evidence of another disabling impairment to meet the new federal disability standard. Without the intervention of a direct service provider or advocate, many former beneficiaries just gave up.

In addition, a significant portion (nearly 25%) of former DA&A beneficiaries we interviewed are qualified veterans. If they meet the following conditions they may be eligible for VA provided medical care: served two years of active duty or have a service-connected disability, no other medical insurance, and are low income (below $21,000 annually).

Targeted screening of former DA&A beneficiaries with chronic health conditions for assistance in applying for SSI/DI or for Veteran's Administration medical coverage when appropriate will ultimately save money by reducing the cost of uncompensated care. In addition, targeted screening will help establish a health care provider relationship to manage chronic conditions so that they do not become medical crises (with higher associated medical care costs).

Targeted screening may be best accomplished at the sites with the highest incidences of uncompensated medical care for this population— primarily the Cook County Hospital emergency room. Other hospital emergency rooms and social service sites (particularly in suburban locations) will also provide opportunities to identify individuals likely to qualify for health care and cash assistance due to chronic health conditions. Funding should be provided for social workers specializing in entitlement benefits to work on-site at emergency room facilities because ultimately these services could pay for themselves as uncompensated costs are reduced with enrollment in compensated coverage.

Increase funding for Community Health Centers (including Health Care for the Homeless Program) and Dep't of Public Health Neighborhood Health Centers. Community health care centers are equipped to handle the health conditions presented by

this population as represented in our sample, and have the capacity and the mandate to provide services at low or no cost. In order to better reach this population, however, extensive outreach and community education may be necessary to draw former DA&A beneficiaries into a relationship with these health care providers. The outreach efforts employed by a number of model programs and practices we highlight in this report may be useful in creating better service matches.

Some of the elements of successful outreach we have identified include:

- provision of low demand services in order to facilitate a trusting relationship with those reluctant to seek medical care when not in crisis;
- going out into the community to find those in need of services (e.g. sending a medical team to soup kitchen, etc.); and
- use of peer educators to inform others in the community about services offered at the center.

The **Health Care for the Homeless** program provides outreach and primary and preventative care services including substance abuse referrals and supportive services (e.g. case management, transportation) in shelter settings. It also funds medical teams including a nurse practitioner, a physician, and one or two community health nurses traveling to shelters delivering primary health care services to homeless persons. The service delivery is done with an emphasis on building trust and outreach.

Extend Medicaid coverage to Earnfare participants (supporting efforts in the state legislature, H.B. 3388).

State Representative Coy Pugh is sponsoring a bill extending Medicaid coverage to single adults participating in the Earnfare program. Access to health care and other supportive services (like substance abuse treatment) covered by Medicaid increases the likelihood of success for participants in the Earnfare program.

SUBSTANCE ABUSE TREATMENT

The majority of former DA&A beneficiaries we interviewed (73%) reported receiving treatment for substance abuse problems at least once in the past five years. These rates are consistent with the utilization of treatment by the drug and alcohol addicted population as a whole, according to the Illinois Office of Alcohol & Substance Abuse (OASA). Approximately eight percent of those receiving treatment services after benefits elimination were living in recovery homes at the time of our interview contact.

Key Findings:

- 74% lost Medicaid eligibility—the program that paid for most substance abuse treatment for this population
- the percentage of those seeking treatment decreased significantly after benefits elimination and demand for mental health services increased

- private hospitals are providing less service to former SSI DA&A beneficiaries for substance abuse treatment, partly due to the loss of Medicaid benefits for this population and declining demand for services

Overall, our findings regarding utilization of treatment services are cautiously encouraging. A significant number of former DA&A beneficiaries received treatment services and a significant sub-group continue to receive treatment even after their benefits were eliminated. However, the loss of medical benefits means this population will need to seek services from a different set of providers than they have relied on in the past. We believe there may be a need for outreach to inform people of treatment services for which they are still eligible and which are accessible to them.

Our data also indicates the quantity of services clients are eligible for is decreasing (e.g. shorter number of treatment hours covered, etc.) For many in this population who have had substance abuse problems so severe that they have been unable to function —-this will likely reduce the likelihood of successful treatment outcomes.

Fiscal constraints pose significant barriers to providing services to this population. The loss of Medicaid or Medicare eligibility for this population means that more of the treatment dollars must come from special federal grants or from the state and local levels. In response to the cuts in the SSI/DI program Congress created a new stream of funding dedicated for the treatment needs of former DA&A beneficiaries as a special SAMHSA (Substance Abuse and Mental Health Services Administration) grant to the states. (Illinois' allocation is $2 million dollars annually until FY 99—$1.5 million of these funds —will be dedicated to paying for treatment services, $500,000 has been earmarked for outreach.) OASA funded providers are eligible to receive payment for persons served under this program. Persons seeking services under this funding stream must provide treatment providers with a social security number so that prior eligibility for SSI/DI benefits for DA&A can be documented.

In addition, the welfare-to-work funds for non-custodial parents allow for spending a portion of employment and training funds for substance abuse treatment and support services.

Key Policy Recommendations
Given the emergence of these new funds and the need for a broader continuum of treatment outreach and services, consideration should be given to the following:

Improved coordination of treatment and employment and training services (see Employment and Training section of the report).
Link treatment with employment and training services to foster better outcomes for those who are doing well in recovery.

Retain capacity of recovery homes.
Recovery Homes provide alcohol and drug free housing with activities and structure directed toward maintaining recovery. Both former DA&A beneficiaries and service

providers alike felt that recovery homes were a vital link between treatment and integration back into community settings. See discussion of recovery homes in the Housing section of this report for more information and recommendations.

Outreach to former DA&A beneficiaries to educate about treatment options in post-medicaid status.

FOOD AND NUTRITION

Adequate nutrition is essential for survival and as such forms the most basic element of safety net services. The degree that former beneficiaries of SSI for DA&A utilize assistance to meet this basic need is characteristic of their dependence upon emergency services. The majority of former beneficiaries in our sample (65.4%) received food stamps and an even larger percentage (74%) obtained food and meals from food pantries and soup kitchens in the two weeks prior to their interview.

Of the former SSI DA&A beneficiaries interviewed for this study, one out of five residing in shelters were not receiving food stamps, even though this condition almost always entitles one to expedited or emergency food stamps.

Key Findings:

- 74% used food pantries at least once in the two weeks prior to our interviews
- food and nutrition service providers document a growing demand for food and nutrition services, yet do not have increased resources with which to meet these needs

Key Policy Recommendations

Repeal the work requirement for eligibility for food stamps for individuals between the ages of 18 and 50 years of age.

The findings of this report conclude that former beneficiaries rely on both food stamps and Emergency Food providers. Neither food stamps nor emergency food services provide an immediate an answer to the problem of eliminating hunger for this population. However, eliminating the work requirement for food stamp eligibility for individuals between the ages of 18 and 50 would remove the threat of absolute destitution for this population. We have documented elsewhere in this report that employment and training services do not come close to meeting the demand for services by this population.

CONCLUSION

The SSI Research Advocacy Project has attempted to document for advocates and policy makers the impact of the first wave of welfare reform. Little, if any, attention has been paid to the elimination of substance abuse from the federal disability standard. While there is a wealth of anecdotal information, as far as we know the SSI Research Advocacy

Project is the first study of its kind.

We feel the need to underscore the inter-relationships between each of the policy recommendations that we put forth in this study. Stable housing, for example, increases the likelihood of success in substance abuse treatment and improves health status. All three of these policy and service areas are related to the former DA&A beneficiaries' success in employment and training programs. These concepts of integrated services are not new – many mainstream welfare advocates have called for these approaches for decades.

The issues presented by the former DA&A beneficiaries we interviewed also call for a more holistic approach to policy making, one which effectively integrates this population into the larger welfare reform debate. Effective policy initiatives must address the inter-dependence of each of these populations and opportunities for programmatic collaboration. For far too long single adults disabled by their substance abuse have been compartmentalized and essentially left out of welfare-to-work proposals. We hope this study and the accompanying policy recommendations will provoke more discussion, and ultimately, inclusion of the former DA&A beneficiaries in the on-going welfare-to-work debate.

RESEARCH REPORT

SSI BENEFITS ELIMINATION FOR PERSONS WITH DISABILITIES DUE TO

ALCOHOL AND/OR DRUG ABUSE

INTRODUCTION

In 1994, Congress passed the Social Security Administrative Reform Act (PL 103-296) affecting Supplemental Security Income (SSI) benefits for persons whose qualifying disability was drug abuse and/or alcoholism (DA&A) . Reforms included a 36 month time limit, mandated treatment, non-compliance sanctions, and a representative payee structure for payment disbursement. Less than two years later, before these reforms were fully implemented, Congress enacted the Contract with America Advancement Act (PL 104-121), which eliminated drug abuse and alcoholism as a category under which SSI disability benefits are granted[1]. Under that law, in December of 1996, SSI benefits were ended for persons whose qualifying disability was alcoholism or drug abuse.

Local Impact

National figures released by the Social Security Administration indicate that Chicago has a disproportionately large number of persons affected by these cuts: the largest number of any city or metropolitan area in the United States. Chicago tops the list of impacted cities with 18,700 SSI DA&A beneficiaries to whom termination notices were sent[2]. Detroit, with the next highest number, had only 5,000 beneficiaries at the time cuts were made. As a result, it is anticipated that the impact of this federal policy change will be felt more sharply in Chicago than in other places in the United States.

At the time benefits were eliminated, more than 26,733 persons in Illinois were receiving SSI cash assistance for disabilities due to drug abuse or alcoholism (DA&A), with nearly 20,000 of those in Cook County (approximately 18,000 in Chicago and 2,000 in suburban Cook County). Approximately 15,000 Cook County beneficiaries did not re-qualify for benefits under another disability category and subsequently lost cash assistance benefits.

Nearly one half (47%) of those receiving SSI benefits for drug and alcohol disabilities

[1]The drug and alcohol abuse category was established in 1972 with the inception of the SSI program.

[2] A factor which may contribute to the high number of SSI DA&A beneficiaries in Chicago compared to other metropolitan areas could be the concerted effort made by social service providers to enroll clients in entitlement programs, especially after the state General Assistance program ended in 1992.

also received Medicaid/Medicare benefits[3]. Because Illinois links Medicaid/Medicare eligibility for disabled persons to SSI eligibility categories most, if not all, of those SSI DA&A beneficiaries with Medicaid/Medicare coverage also lost their medical benefits as a result of the elimination of the drug and alcohol abuse disability category. In Illinois, loss of Medicaid/Medicare benefits for this population began in March of 1997. At the time of publication no statistics were available regarding loss of Medicaid/Medicare benefits for former SSI DA&A beneficiaries.

What are the consequences of loss of cash assistance for this population, to Cook County, the City of Chicago, and those charged with providing services to this population? At the time these cuts were made, the effects could only be anticipated. Some policy makers thought that the loss of benefits would force former beneficiaries into work; others, mainly service providers, anticipated an increase in service needs and crisis situations. The SSI Research and Advocacy project —a partnership between Heartland Alliance's Mid-America Institute on Poverty and the SSI Coalition for a Responsible Safety Net— began in July 1996 to track and examine the impact of SSI DA&A benefits elimination with the intent of providing factual data to further inform the debate and facilitate subsequent policy development.

This project has three main goals:

- to analyze the impact of benefits elimination for those disabled by drug and/or alcohol abuse;
- to use these findings as parameters for development of a set of practices and program models which are illustrative of means for ameliorating negative consequences of benefits elimination, as well as, improving existing practices;
- to develop policy recommendations at the federal, state, county and municipal levels for mitigating negative impacts of benefits elimination.

The report is divided into five main sections: Housing, Health Care, Employment and Training, Food and Nutrition, and Substance Abuse Treatment. Each section presents findings, best practices and model policies, and specific program and policy recommendations. A short statement of overall systems change recommendations concludes the report.

While each of the substantive sections is presented as a discrete topic, it is important to recognize the level of interdependence among these issues: for example we know that substance abuse treatment is most effective when the person receiving it has housing. The inter-relationships among these areas is important and has significant consequences for structuring programs and model policies. The recommendations reflect these inter-relationships and in many cases cross substantive areas. In addition, while we have attempted to deal holistically with issues affecting this population, some issues were not incorporated into our study. Among the most important of these are the role of criminal

[3]In Illinois receipt of SSI benefits does not automatically qualify or enroll a beneficiary in the Medicaid program. A separate application must be filed. Subsequently, not all of those receiving SSI DA&A benefits were receiving Medicaid/Medicare coverage at the time cash assistance benefits were eliminated.

justice (though we do briefly address linkages to treatment), mental health, and child support systems.

Data Sources
The findings for this study are based on a non-probability sample of 100 former SSI DA&A beneficiaries and 98 representatives of social service agencies providing services to this population both before and after benefits were eliminated.

Data on former beneficiaries were obtained through one-on-one in-depth interviews conducted on-site at social service agency offices or housing sites. See Appendix II for a geographic breakdown of interview sites. Interviews were conducted on-site at the following types of agencies:

- shelters
- food pantries and soup kitchens
- permanent housing sites
- substance abuse treatment centers
- township public assistance offices
- recovery homes

The type of social service providers that were interviewed or participated in focus groups are identified in the table below.

Table 1: Service Providers Represented

Type of Service Provided	Number of Organizations
Housing	20
Shelter	31
Health Care	9
Treatment (including after care)	32
Food pantries/soup kitchens/nutrition services	22
Employment and training	6
Township public assistance offices	5

Some agencies provide multiple services and are counted under several of the categories with respect to the information they provided for the study. Each of the focus groups lasted between one and half and two hours and followed a standard format. Interviews with providers lasted between a half hour and an hour and a half.

While the sample sizes of our two primary data sources are significant enough to provide reliable data for this population, we have identified two potential biases in the methodology: 1) the oversampling of those who use social services because we located former beneficiaries through their contacts with social service providers; and 2), an undersampling of those who have become employed, as they would have been less likely to be available to participate. Despite these biases, it is important to remember that the

effects that we have documented are real and experienced concretely by providers and former beneficiaries alike and therefore, should not be discounted. For a detailed discussion of methodology and methodological issues see Appendix I.

Demographic Profile of Former Beneficiaries in Study Sample
The typical former SSI DA&A beneficiary interviewed for this study who did not re-qualify for SSI benefits under another disability category (84% of the 100 former beneficiaries we interviewed did not re-qualify), is a 41 year old, male African-American with less than a high school education, and without a source of cash income. The majority (65.4%) of former beneficiaries interviewed receive food stamp benefits with a median amount of $120 per month).

The demographic statistics of those who did re-qualify for SSI benefits under another disability category were somewhat different. Those who re-qualified for benefits under another disability were, on average, somewhat younger than those who did not re-qualify. A significantly higher proportion of those who re-qualified were women.

See table 2 below for a summary of these differences.

Table 2: Demographic Comparison by current SSI benefits receipt status[4]

Current SSI status	Average Age	Gender		Race	
		male	female	Caucasian	African American
Do not receive SSI benefits currently (n=84)	41years	84.5%	15.5%	8.5%	91.5%
Do receive SSI Benefits currently (n=16)	35 years	69.2%	30.8%	0%	100%

The remainder of this report focuses on those former SSI DA&A beneficiaries who have not re-qualified for SSI benefits under another disability category.

Connections to other types of cash assistance
Over one half (60%) of former SSI DA&A beneficiaries in our study received General Assistance (GA) at some time in the past. The majority (69%) left GA because they switched to SSI for DA&A. This number is likely even higher than 69 percent as some respondents indicated that they left GA when the program ended. Because they subsequently received SSI for DA&A we may infer that they moved from GA to SSI

[4] due to rounding, percentages in columns may not add to 100%.

DA&A as a result of the termination of state GA.

Many townships established their own GA benefits program when the state eliminated its GA program in 1991[5]. As a result, a number of those living in suburban Cook County currently receive GA benefits. Township officials interviewed for the study indicated a small but growing increase in applications for GA since SSI DA&A benefits were eliminated. A minority of township social service offices were doing outreach to find and enroll former SSI DA&A beneficiaries for GA benefits. The average monthly GA benefit amount was $150.

Almost a quarter of our sample were veterans, however, none received Veterans Administration (VA) cash assistance benefits. A significant sub-group of the veteran population in our sample did, however, receive medical and/or substance abuse treatment services through the VA (see the Health Care and Substance Abuse Treatment sections of the report for more on this).

Connections to Children

About one third (32%) of the former SSI DA&A beneficiaries who did not re-qualify for benefits under another disability category have no children. Of those that do have children, the average former beneficiary had between one and two children.

The children of former beneficiaries in our sample ranged in age from under one to 37 years old. Over half (52%) of the children of former SSI DA&A beneficiaries were 17 years of age or younger. Just under a third (31%) of the children of former SSI DA&A beneficiaries we interviewed had children receiving TANF assistance at the time of our interviews.

The majority of children under the age of 18 of the former SSI DA&A beneficiaries, reside with their mothers (most former beneficiaries in our sample were male).

Nearly half (44%) of the former SSI beneficiaries we interviewed who had not re-qualified for benefits under another disability had contact with their children within one month prior to our interviews. Just under a third (31%) had no contact with their children within six months or more of the interview date.

HOUSING

Substance abuse, unemployment, and physical and mental health problems can make it difficult for many individuals and families to obtain or sustain housing. Conversely, housing can play a fundamental role in support of recovery from substance abuse, health, and employment problems. For example, a study examining the contribution of supportive housing in recovery from substance abuse indicates that secure and stable

[5]The City of Chicago did not establish its own GA program when the state's GA program ended.

housing plays a significant role in continued and successful participation in treatment programs (Sosin, et. al, Jan. 1994). Linkages between housing and other basic needs are clear as well. For example, preventative health care and health enhancing behaviors are more easily achieved by housed individuals than those who lack stable shelter. Nutritional demands are also met more easily when stable housing is available.

Obtaining and retaining adequate housing seems to be an on-going issue for the majority of former SSI DA&A beneficiaries in our study[6]. Nearly one half of former SSI DA&A beneficiaries in our sample (49%) have moved since their SSI DA&A benefits were cut.

Table 2 below indicates the changes in housing type for those who moved after their benefits were eliminated. Over one third (42%) of former beneficiaries who moved after losing benefits had no monthly income.

The largest percentage who moved after losing benefits left permanent housing and entered shelters. Another significant change was the reduction in the percent of persons who were staying with friends and family after their benefits were eliminated. This shift was highlighted by provider focus group participants, particularly in suburban locations, wherein providers reported an increase in former beneficiaries who were asked to leave family housing situations either because they could no longer contribute to rent or because family members feared former beneficiaries would steal from them in order to buy drugs or alcohol.

Table 3: Changes in housing status for persons who moved after losing SSI DA&A benefits[7]

Type of housing	pre-benefits elimination	post benefits elimination
house	4%	5%
apartment	11%	7%
SRO	22%	14%
shelter	22%	61%
staying with relatives or friends	33%	7%
Homeless (not in shelter)	7%	5%
other	0%	2%

Nearly half of the sample retained the housing they held prior to benefits elimination. For these former beneficiaries housing status is broken down as presented in the table 4 below.

[6] In this section as in all substantive sections of this report, we focus on outcomes for those persons who did not re-qualify for benefits under another SSI disability category.

[7] Due to rounding percentages in columns may not add to 100%.

Table 4: Housing Status for persons who did not move after losing SSI DA&A benefits[8]

Type of housing	Percent of "non-movers" residing in type of housing
house	5.3%
apartment	37%
SRO	32%
shelter	10.5%
staying with relatives or friends	5.3%
homeless	5.3%
other	5.3%

Half (50%) of the former beneficiaries who did not move after losing benefits had no monthly income. Reasons those with no income gave for being able to keep their housing without a source of income included:

- Section 8 subsidies which are indexed to income: when income fell, rent did too;
- the willingness of a landlord, roommate or family member to take food stamps in lieu of cash for rent[9] and;
- the generosity of friends or family member who allowed former beneficiaries to continue staying with them even though they were not contributing rent.

Housing providers interviewed for this study have felt the impact of SSI DA&A benefits cuts in several different ways. For operators of Single Room Occupancy (SRO) buildings not subsidized by Section 8 or other income indexed assistance programs, tenants' loss of SSI DA&A benefits has decreased their rental income. For example, one SRO operator indicated that he knew of four tenants who had lost their incomes as a result of SSI DA&A cuts and that they have either failed to pay rent or moved out. Operators depend on rental income, primarily for operating expenses (in some cases including on-site social services). Operators had two choices in most cases, evict tenants for non-payment of rent, or suffer losses in rental income. Because of the thin profit margin many housing providers serving this population operate on, the second option is not likely to be feasible for the majority of providers.

Another housing provider with several project-based Section 8 SRO buildings noted that when former beneficiaries lost their income, they no longer had to pay rent. Because providers may use a portion of tenant rents to support on-site social services in the building, this meant that there was less rent revenue to support social service delivery in these buildings, though the losses were not of a magnitude which threatened the continued viability of the building.

[8]Due to rounding percentages in columns may not add to 100%.

[9]The practice of trading food stamps for cash or rent is not legal, however it is part of a well established barter exchange practice within some low income communities.

Shelter providers reported two emerging trends in patterns of shelter use by former SSI DA&A beneficiaries. First, they report a noticeable difference in how former beneficiaries use shelter services. Prior to benefits elimination, many former beneficiaries used shelters as a piece of their housing situation: staying at shelters at particular times during the month (most often near the end of the month) and at other times renting rooms in hotels, or staying with family or friend (most often early in the month after receiving benefits checks). After benefits elimination, shelter providers reported a noticeable increase in persons who use shelters almost exclusively as their source of housing: former beneficiaries no longer had the funds to rent rooms or contribute to family or friends for their shelter.

Second, shelter providers, particularly those who operate transitional services, reported more prolonged stays in shelters as former beneficiaries were unable to secure more permanent housing due to lack of income. Several transitional shelters reported the return of former SSI DA&A beneficiaries who had successfully transitioned from shelters to permanent housing, as former beneficiaries were no longer able to pay rent in their permanent housing situation.

Prior to benefits elimination, the average beneficiary in our sample was using approximately 40 percent of his/her cash assistance to pay rent, with an average monthly rent of $182. After benefits elimination, former beneficiaries' average monthly rent was $65[10].

The great majority of former beneficiaries in the study have lost the ability to pay any reasonable housing costs: 49 percent have no income. Even among those with income most are unable to pay reasonable unsubsidized housing costs. Those with income typically had a monthly income of $200. Those who earned their income through work (about half of those with income) typically had a monthly income of $350.

Over a third (34%) of our sample population had stayed in a homeless shelter in the last two weeks before our interview contact indicating that even those who consider themselves housed use shelters occasionally. A far lower percentage (18%) reported staying on the street or in abandoned buildings during the two weeks prior to our interview contact. Six percent both used shelters and stayed on the street at least once during the two week period prior to our interview contact.

A small proportion (8.5%) of those who stayed in a shelter at some time in the two weeks preceeding our interview contact had some form of employment.

Best Practices & Model Programs

Our findings suggest that a continuum of options is necessary to ensure more adequate housing for the former SSI DA&A population. For some of the former beneficiaries who

[10]These averages do not include those who were living in shelters, staying with friends or homeless or otherwise had no rent obligations: for example a person in treatment.

participated in the study independent living is not appropriate due to health conditions, substance abuse, or mental health issues. These former beneficiaries need a level of housing that offers support and assistance. However, for others, independent living is the most appropriate option.

For almost all of the former beneficiaries in the study, rental subsidies are necessary if they are to be housed. Because income levels are so low, these subsidies must be significant, in most cases covering the entire cost of housing. The model options outlined below offer some of the best existing practices and policies incorporating these factors of continuum of support and affordability, that appear relevant for this population.

"Safe Haven" style shelter housing. This type of shelter places minimal requirements of those it serves (e.g. someone using drugs or alcohol can remain in shelter, complying with limited rules). Supportive services are offered on-site. This model is typically used for homeless persons with dual diagnoses (major mental illness and substance abuse) with the goal of helping those who use Safe Haven facilities to enter into social services and stabilization.

A key part of the success of the Safe Haven model is the small size of shelters, making them more manageable and allowing staff time to work more intensively with residents. The Safe Haven as a model for substance abusers could also be seen as a part of pre-treatment outreach to engage users who have not yet identified substance abuse as a condition for which they wish to seek treatment.

Supportive Housing or Shelter Plus Care. This term includes a range of housing types, from transitional housing to independent living, with a focus on providing social and supportive services on-site.

- Transitional Supportive Housing. Residents are allowed to stay for up to two years. Extensive social services are provided on-site. This well developed model is in use for a number of special needs populations, including victims of domestic violence, recovering substance abusers, and those living with mental illness. The ultimate goal of this type of housing is to transition participants from shelters to successful independent living.

- Permanent housing within an independent living environment (e.g. no shared meals, etc.) but with social services available on-site. This model has become more popular in recent years in response to federal homelessness elimination efforts. The focus of this housing is to support residents in maintaining housing stability.

Subsidized SRO units. Independent living for single adults with no or very low income. These units, in many cases, have a social worker on-site. The main goal of this type of housing is to help maintain independent housing for persons with very low income.

Recovery Homes. A form of temporary congregate housing, recovery homes are often part of the treatment continuum after-care phase. The goal is to provide a structured

alcohol and drug free environment resulting in transition to permanent and sober independent living situations such as an SRO or supportive housing.

Group Homes. Similar to Recovery Homes but with less emphasis on transition to independent living. Support services are integrated into program operations. The objective is to provide stabilized, supervised living situations for persons who have disabilities interfering with normal functioning.

Policy Discussion & Recommendations

Policy changes are needed at the federal, state, and local levels to support implementation or, in some cases, expansion of existing programs and models. The discussion below indicates potential opportunities for change.

Incorporating recommendations into city shelter restructuring.

At the local level, the City of Chicago is currently planning to restructure shelter and homeless services provided through the Chicago Department of Human Services. This restructuring process presents an opportunity to make positive changes in ways in which Chicago provides human services to homeless persons.

Our findings suggest that certain elements must be included in the restructuring plan if the City is to adequately address the needs former SSI DA&A beneficiaries. These necessary elements include:

- **Safe Havens for Shelters-**
  Establishing shelters patterned after the Safe Haven model expressly for homeless persons with substance abuse problems. The Safe Haven model is currently designated only for those with the dual diagnosis of major mental illness and substance abuse. As such, those whose only disability is drug or alcohol abuse related are prevented from utilizing this type of shelter, and the existing Safe Havens do not have the capacity for addressing the level of need for this service among substance abusers. Changes in HUD rules authorizing implementation of the Safe Haven Model for substance abusers will be needed to open federal funding possibilities for expanding this model to former SSI DA&A beneficiaries who are homeless and actively using alcohol or drugs.

- **Co-Location for On-Site Service Provision-**
  Planning for and funding of the on-site service providers and service delivery at shelters and other providers within the shelter system (e.g. food pantries, etc.). Supportive services should include medical, mental health, treatment, and employment and training services. Because housing serves as a foundation to many other basic needs, the shelter environment provides an ideal starting point for linking homeless former SSI DA&A beneficiaries to needed services. The City of Chicago has an opportunity in restructuring its shelter services to build in co-location as a basic feature of shelter environments.

- **Aggressive Outreach Efforts-**
  Emphasis on street outreach for those who are homeless but not utilizing shelter

services. Our data indicate that a portion of the former SSI DA&A population stay on the street, not in shelters. Therefore, to effectively reach these homeless persons in need of basic services, street outreach must be a systems component of the City's plan.

Expanded Funding for Housing Subsidies.
The proposed federal budget includes expanded funding for HUD programs serving the homeless and low income renters. This indicates a climate in which program expansions may be feasible. In particular, we support expanded funding for:

- **Shelter Plus Care (supportive housing) subsidies**. Shelter Plus Care housing subsidies are designed to support persons for whom independent living is a reasonable goal. For many former SSI DA&A beneficiaries in our study, particularly those with a recent work history, this may be the most appropriate housing option.

- **Project-Based Section 8 SRO funding.** Those former beneficiaries included in our study who were housed in Project-Based Section 8 units, maintained housing after benefits elimination. Former beneficiaries and social service providers alike found that these subsidized units were a lifeline for those who lost benefits.

Retaining Recovery Home Capacity.
Recently the Illinois Department of Human Services (IDHS), through the Office on Alcoholism and Substance Abuse (OASA), issued regulations which require licensing of recovery homes. These regulations provide a streamlined definition of recovery home and mandate certain programmatic features. These requirements may prove helpful in improving services to those in recovery home settings. However, these regulations also have the potential to close down a number of recovery homes for whom it may not be fiscally feasible to comply with new building codes and zoning requirements established in the new regulations. As such, we recommend that OASA establish an administrative practice grandfathering recovery home programs which meet the regulations' programmatic requirements but for whom the extensive capital improvements necessary for compliance with new regulations would prohibit continued operation.

Action Opportunities

Incorporate into the City of Chicago shelter restructuring plan: Safe Havens for persons with substance abuse, supportive services on-site location and service delivery, and aggressive outreach services which include mobile service delivery.

Amend HUD Safe Haven regulations to include service to persons disabled primarily from substance abuse.

Expand HUD funding for Shelter Plus Care and Section 8 SRO programs.

Amend OASA regulations to include a "grand fathering" clause for existing recovery homes regulatory compliance with new physical site standards.

HEALTH & HEALTHCARE

Substance abuse and health issues are inter-related in a number of ways. For many, substance abuse problems develop as a result of self medicating physical or emotional pain. In these cases, substance abuse is symptomatic of pre-existing health conditions.

Substance abuse takes a toll on health. One study of a large, inner-city teaching hospital showed that of the 1010 consecutive hospital admissions, 16% were found to be substance abusers. This figure is probably much higher since only 28% of those admissions were considered to be properly screened (Hopkins, T.B., et. al, 1997). Many chronic conditions such as hypertension, diabetes, and liver disorders can be caused or exacerbated by overuse of drugs and alcohol. In addition, serious illnesses such as HIV/AIDS and hepatitis are related to injected drug use.

The prevalence and severity of medical conditions found among substance abusers does not necessarily mean that those who suffer from health problems are permanently disabled. Appropriate and consistent health care can restore a person's functioning even if they suffer from a chronic condition. The key to health restoration in many cases is consistent care and monitoring of medical conditions. For the population with which we are concerned, there are numerous barriers to appropriate health care, including lack of insurance or Medicaid/Medicare coverage, poverty, homelessness, mental illness, and addiction.

The following findings, best practices and recommendations discussions concentrate on the group of former beneficiaries who did not re-qualify for SSI under another disability. Those former SSI DA&A beneficiaries who retained Medicaid/Medicare benefits because they re-qualified under a different disability (16% of our study sample), presumably experienced little or no change in their ability to obtain health care services as a result of SSI DA&A benefits elimination.

The majority of former beneficiaries (73%) who did not re-qualify for benefits in our sample (73%) report having a medical problem. Medical problems reported range from cluster headaches to chronic heart conditions. A large portion (44%) of those with medical problems suffer from chronic or life threatening health problems such as HIV/AIDS, hypertension, and asthma. Nearly half (40%) of those with chronic illnesses are HIV positive.

Of those with medical conditions, the majority (83%) take or have been prescribed medication on a regular basis[13]. Over half (56%) of these former SSI DA&A beneficiaries' medications are provided free of charge (e.g. not covered by

[13]Some do not take the prescriptions they are prescribed (something true of all populations, but producing more significant stigma among the addicted; particularly addicts with HIV).

Medicaid/Medicare or paid for out of pocket).

Overall, those we interviewed reported significant and serious health problems. Many were chronic conditions which, if monitored and cared for, could allow for normal functioning. Untreated, or treated only in crisis, though, these conditions can result in serious and life threatening disabilities. For example, diabetes, if controlled and treated, is not necessarily a disabling condition; however, without proper care, significant health problems (e.g. circulation problems, gangrene and loss of vision) can develop. The frequency and extent of health problems reported by our sample of former SSI DA&A beneficiaries indicate that health care is a pressing need for many in this population.

In Illinois, Medicaid/Medicare eligibility for disabled persons is tied to SSI disability categories established in federal statute. But a person qualified for SSI benefits does not automatically receive Medicaid/Medicare: a separate application is required. Illinois uses more restrictive financial guidelines for Medicaid/Medicare eligibility than used by the Social Security Administration for SSI benefits determination. Therefore, in some cases, a person who is qualified for SSI cash assistance may not qualify for Medicaid/Medicare. Based on information provided by the Illinois Department of Public Aid, we estimate that nearly one half of all former SSI DA&A beneficiaries in Illinois were enrolled in Medicaid/Medicare at the time SSI DA&A benefits were eliminated. Of the former SSI DA&A beneficiaries interviewed for this study, 80.5% were enrolled in Medicaid or Medicare prior to benefits elimination. Thus the Medicaid or Medicare enrollment rate among the group of former beneficiaries we interviewed was considerably higher than that for all former SSI DA&A beneficiaries in Illinois. Termination of Medicaid/Medicare benefits for former SSI DA&A beneficiaries began in March 1997. The majority (74%) of former beneficiaries in our sample who were enrolled in Medicaid or Medicare prior to benefits cuts and did not re-qualify under another disability, lost Medicaid/Medicare coverage as a result of SSI DA&A benefits elimination.

Some former SSI DA&A beneficiaries who are required to take prescription medications to control seizures, severe high blood pressure, or diabetes may qualify for Transitional Assistance (TA) Medical Assistance. The TA medical card covers health care in a non-hospital setting. However, it appears that few if any of the former beneficiaries in our sample received these benefits.

Nearly a quarter (24%) of the former SSI DA&A beneficiaries we interviewed who did not re-qualify for benefits under another disability category were veterans. Of those veterans, less than half (45%) received medical care through the Veteran's Administration (VA). For those veterans who did utilize VA medical services, VA hospitals provide a significant portion (about 40%) of care episodes[2]. The use of VA medical services as a proportion of health care episodes increased after benefits elimination.

[2] Care episodes are visits to hospitals or medical care providers during which medical services were received. Each reported visit is counted as a care episode.

More than half (55%) of veterans in our sample were not receiving medical treatment through the VA. These data suggest that those non-VA providers serving veterans may wish to investigate enrollment in VA health services for this population as a means of avoiding unnecessary uncompensated care costs for this population[14].

Without Medicaid/Medicare benefits and with very limited incomes (49% of former beneficiaries in our sample had no income at all) the majority of former beneficiaries in our sample are medically indigent. As such they must rely on health care providers who serve the medically indigent.

A number of types of providers currently serve the medically indigent, including free clinics, City of Chicago Department of Public Health Neighborhood Health Centers, the Cook County Bureau of Health Services system, and non-profit community health centers[15]. Others may have some capacity to serve the uninsured as a result of "cost shifting" from compensated reimbursements. Table 5 below outlines major provider types serving the medically indigent and the primary sources of funding available for uncompensated care.

[14] In order to qualify for VA medical benefits a veteran must have served at least 2 years active duty or have a service connected disability; have no other available form of medical insurance; and have a low income.
[15] Community Health Care Centers are federally funded the Public Health Service Act. Their mission is to provide primary health services in medically under-served areas.

Table 5: providers of health care to the medically indigent and their sources of funding

Type of provider	Major source(s) of uncompensated care funds
Cook County Bureau of Health Services	Cook County tax revenue, Medicaid Disproportionate Share Hospital (DSH) Payments and, other Medicaid/Medicare reimbursements
Chicago Department of Public Health Neighborhood Health Centers	Chicago tax revenue, cost-based Medicaid reimbursements under Federally Qualified Health Center (FQHC) program, federal and state grants, reimbursement from Medicaid and Medicare covered services, and Center for Disease Control and Prevention funds
Private hospitals	cost-shifting and charity care dollars
Free clinics	private donations and volunteer services
Non-profit community health centers (including Federally Qualified Health Centers and Health Care for the Homeless services)	federal grants (including the Community Health Center grant program of HHS, and Health Care for the Homeless funds), state and local grants, cost-based Medicaid reimbursements under the FQHC program for those centers with FQHC status, private grants.

The funding sources outlined above now provide the predominant resources available for medical care available to former SSI DA&A beneficiaries with low income who do not qualify for VA medical benefits, have failed to acquire private insurance or re-qualify for Medicaid/Medicare benefits under another disability category.

Prior to benefits elimination, the majority of former beneficiaries in our sample received medical treatment through private hospitals, paid for through Medicaid/Medicare. After benefits elimination, most former beneficiaries received medical treatment through Cook County Hospital. In most cases, the cost of these episodes after benefits were eliminated was uncompensated. See table 6 below for documentation of these trends

Table 6: changes in source of medical care pre and post benefits elimination[17]

Source of Medial Care	% of care episodes reported prior to benefits elimination	% of care episodes reported after benefits elimination
Cook County Bureau of Health Services sites	32%	44%
VA	5%	16%
Private Hospitals	60%	28%
Other	3%	12%

The former SSI DA&A beneficiaries in our sample tend to use emergency room services as their point of contact for medical care. For most, especially after loss of Medicaid/Medicare benefits, health care was obtained through emergency room visits to Cook County Hospital. Because these visits are uncompensated, this represents uncovered costs for the Cook County Bureau of Health Services at an average cost of $219 per emergency room visit[16].

The loss of Medicaid/Medicare coverage coupled with the high rate of medical problems found in this population point to a great need for medical resources in this area. Complicating these conditions is the highly transient nature of this population, the shortage of affordable housing, substance abuse problems, and lack of food and nutrition. Difficult as it may seem to provide appropriate health care in this context, we have identified several programs and policies which promote these objectives. They are outlined below.

Chicago Department of Public Health Neighborhood Health Centers
The City of Chicago operates a network of community and mental health centers funded primarily by federal and state grants, Medicaid reimbursements, and some City corporate funds (local tax revenue). Most services are offered on a sliding-fee scale (linked to household size and income), though selected services are offered free of charge. Services are provided on an out-patient basis and include preventive care, primary care, laboratory and pharmacy services, and health education and counseling.

Community Health Centers (including those designated as Federally Qualified Community Health Centers —FQHCs).
These community-based clinics offer low or no cost services. Services provided include comprehensive primary care including preventive health and dental services; acute and chronic care services; hospitalization and specialty referrals, and, ancillary services (laboratory tests, X-ray, and pharmacy services). Many of these clinics also provide

[17] Due to rounding percentages in columns may not add to 100%.
[16] The average cost of emergency room visits for all persons served at Cook County Hospital. Because of the chronicity of medical problems in this population, the average cost for their emergency room visits may be higher.

support services such as transportation, health education, nutrition, and counseling. Part of the Community Health Center mandate is to serve the medically indigent.

In addition, a Community Health Center in Chicago— Chicago Health Outreach —has received federal funds under the **Health Care for the Homeless** program to provide outreach and primary and preventive care services, including substance abuse treatment and supportive services (e.g. case management, transportation, etc.), in shelter settings. The Health Care for the Homeless program funds medical teams, including nurse practitioners, physicians, and community health nurses traveling to shelters delivering primary health care services on-site to homeless persons. The service delivery is provided with an emphasis on outreach trust building.

The Cook County Bureau of Health Services system includes Cook County, Provident, and Oak Forest hospitals and a number of outpatient clinics. The Cook County system provides a full range of medical services including preventive care, primary care, acute care, specialty services, hospitalization, laboratory, and pharmacy services.

Veterans Administration medical centers in the Chicago area include Hines, North Chicago, Lakeside, and Westside. VA medical centers provide comprehensive inpatient and outpatient services to qualified veterans.

Use of Providers

While the system of providers serving the medically indigent offers a range of services and health care environments available to former SSI DA&A beneficiaries, the costs and utilization of services are concentrated in particular sectors. Our data indicate that the greatest share of the burden for uncompensated care for our study population falls on the Cook County Bureau of Health Services system. Clearly this is not a sustainable situation. County funds are not expansive enough to meet these needs, particularly when coupled with welfare reforms such as the loss of Medicaid coverage for new immigrants and changes made to Medicaid reimbursement programs in the 1997 Balanced Budget Act.

Many former SSI DA&A beneficiaries we interviewed receive only emergency or crisis care despite their on-going medical problems. The lack of preventive or maintenance care has several negative consequences: 1) it can exacerbate or worsen manageable conditions; and 2) it drives up the cost of medical care (when care is delayed, a condition may worsen and subsequently require more intensive and expensive care as a result). In order to deal with these increased uncompensated care costs and provide appropriate health care for this population we have identified the following policy and program recommendations. The recommendations are based on our findings of outcomes for former beneficiaries, interviews with service providers, and a review of health care service models and funding streams.

Policy Discussion & Recommendations

Improving utilization of VA benefits and Transitional Assistance Medical

Assistance by former SSI DA&A beneficiaries. While the majority of former beneficiaries we interviewed no longer qualify for Medicaid/Medicare as a result of the elimination of the SSI DA&A disability category, a small but significant portion may be able to obtain Transitional Assistance (TA) Medical Assistance. Persons required to regularly take prescription medications to control seizures, severe high blood pressure or diabetes qualify for TA cash grants which also makes them eligible for TA medical assistance. The TA medical card covers health care provision in non-hospital-based settings.

Additionally, former SSI DA&A beneficiaries who are qualified veterans may be eligible for VA provided medical care if they meet the following conditions: having served two years of active duty or having a service-connected disability; have no other medical insurance and are low income (below $21,000 annually).

There is potential to recapture or re-direct uncompensated health care costs through the enrollment of former SSI D&A beneficiaries for these benefits, although it is not an easy process for this difficult to reach population. It is likely that benefits could be better utilized if an initial investment of state, county and municipal resources were set aside to target and screen former SSI DA&A beneficiaries with chronic health conditions for enrollment in TA Medical Assistance or Veteran's Administration medical coverage when appropriate. Ultimately this will save money by reducing uncompensated care costs accrued and by establishing a health care provider relationship to manage chronic conditions so that they do not become medical crises (with higher associated medical care costs).

Targeting and screening may be best accomplished at the sites where former beneficiaries receive uncompensated medical care: in this case, primarily the Cook County Hospital emergency room, though certainly other hospital emergency rooms (particularly in suburban locations) will also provide opportunities to identify individuals likely to qualify for TA Medical Assistance due to chronic health conditions. Funding should be provided for social workers specializing in entitlement benefits for location on-site at emergency room facilities because ultimately these services could pay for themselves as uncompensated costs are reduced with enrollment in compensated coverage.

Improving utilization of Community Health Centers and Chicago Department of Public Health Neighborhood Health Centers.

One of the more surprising findings of our study is the relative under utilization of non-profit and community health care centers by former SSI DA&A beneficiaries. We believe that a reason for this underutilization may be the tendency of former beneficiaries to delay health care until a crisis occurs and then seek emergency room services.

Community health centers are equipped to handle the health conditions presented by this population as represented in our sample, and have the capacity and the mandate to provide services at low or no cost. To better reach this population, however, extensive outreach and community education may be necessary to draw former SSI DA&A beneficiaries into a relationship with these health care providers. The outreach efforts

employed by a number of model programs and practices we highlight in this report may be useful in creating better service matches.

Some of the elements of successful outreach we have identified include:

- provision of low demand services in order to facilitate a trusting relationship with those reluctant to seek medical care when not in crisis;
- going out into the community to find those in need of services (e.g. sending a medical team to a soup kitchen, etc.);
- use of peer educators to inform others in the community about services offered at the center; and
- training Community Health Center providers on addiction issues so that they may be more able to recognize and address these types of problems.

Providing funds to respond to patterns resulting from benefits cuts.

The changing characteristics of the uninsured and fallout from welfare reforms such as the SSI DA&A benefits elimination suggest that Community Health Centers and Department of Public Health Neighborhood Health Centers will be called on to play an expanded role in the health care system serving low income populations. Funding for these services must be expanded accordingly. The need for outreach to divert an explosion in uncompensated care costs for the Cook County Bureau Health system means that Community Health Centers and Department of Public Health Neighborhood Health Centers will need additional funds for community outreach and education.

While our data indicate that former SSI DA&A beneficiaries do not report use of Health Care for the Homeless services, we expect that growth of homelessness among this population will increase the need for shelter- and street-based contacts with this population. Therefore, there is the potential for increased delivery of Health Care for the Homeless services to this population. However, federal funding for the program has not met the need for continued, much less expanded, services for this program. In order to reach this population, federal funding would need to be increased.

One way to stretch existing funds available for Community Health Centers and Department of Public Health Neighborhood Health Centers in Illinois may be to support amendment of the Nurse Practice Act to allow advance-practice nurses (a category which includes nurse practitioners) to practice more independently. Current law requires physicians to oversee the work of nurse practitioners and does not allow nurse practitioners to prescribe drugs without the approval of a supervising physician. Illinois is one of a few states that does not recognize the independent functioning of advance practice nurses.

Federal funding issues

The Balanced Budget Act of 1997 included two provisions with potentially devastating impact on the ability of safety net service providers to continue serving the uninsured including former SSI DA&A beneficiaries.

FQHCs and FQHC "look-a-likes"[18] are guaranteed Medicaid reimbursement for the reasonable costs of providing specific services to Medicaid enrollees. This pays for the enhanced services that vulnerable populations require to gain access to health care. It also strengthens these organizations to serve community members who do not have Medicaid/Medicare or other health insurance (National Health Care for the Homeless Council, 1997). The Balanced Budget Act calls for phase out of cost-based Medicaid FQHC reimbursement by the year 2004. This phase out is very likely to compromise the ability of Community Health Centers to serve indigent uninsured.

The Balanced Budget Act of 1997 also includes as a cost saving measure a $10 billion reduction in the Disproportionate Share (DSH) payments available to hospitals with service sectors that include a large percentage of Medicaid beneficiaries. These supplemental payments provide a more realistic cost-based reimbursement for Medicaid covered services than the standard Medicaid reimbursement rate.

While DSH payments do not directly support uncompensated care costs at Cook County Hospital, these payments allow the Cook County Bureau of Health Services system to reserve more of its County tax funds for uncompensated care: a category of care for which no other dollars are available. DSH payments are a vital part of County's ability to serve former SSI DA&A beneficiaries as well as other medically indigent populations.

Ultimately, reduction of DSH payments to Cook County Hospital will result in further cost shifting from the state and federal level[19] to the County. County tax revenue then becomes the predominant source of funding for hospital based health care services formerly covered by the Medicaid program. This cost shift will result in a heavy burden on the County tax system and could ultimately result in fiscal distress as Medicaid/Medicare coverage is scaled back as a result of the SSI DA&A benefits elimination and other welfare reforms.

Action Opportunities

- Re-establish federal funds for FQHC reimbursement rates.

- Maintain federal funds for DSH payments for hospitals with a high percentage of Medicaid compensated care and which also serve high levels of uninsured patients.

- Invest state, county, and municipal funds for entitlement screening at health care and social service delivery sites.

- Expand and improve community outreach efforts for CDPH Neighborhood Health Centers and Community Health Centers including efforts for co-location of heath care services at social service delivery sites (food programs, soup kitchens, shelters, etc.)

[18] FQHC "look-a-likes" are non-profit health centers and public health centers that qualify for FQHC cost-based reimbursements but do not receive federal Community Health Center grants.
[19] Medicaid funds in Illinois are 50% federal funds with a 50% state match.

- Increase funding for Community Health Centers (including the Health Care for the Homeless Program) and CDPH Neighborhood Health Centers.

- Amend the Illinois Nurse Practice Act to include expanded responsibilities for advance practice nurses.

See also, recommendations under the Substance Abuse Treatment section of the report.

EMPLOYMENT AND TRAINING

The major focus of welfare reforms enacted in the past several years is to increase work force participation. The goal of bringing those disabled by drug and alcohol abuse into the work force is a commendable one. There are many benefits to working: for example, improved economic status, a greater likelihood of maintaining recovery, strengthened self-esteem, and greater independence. However, our data show that the transition from receipt of SSI DA&A benefits to employment has not occurred for the majority of the 100 former beneficiaries we interviewed[20].

Current employment status of sample population
Only 24% of former SSI DA&A beneficiaries who did not re-qualify under another disability category have earned income. The majority of former beneficiaries did not try to, or were not successful in, obtaining employment after benefits were eliminated.

Most of those who do have earned income earn it from formal employment[21]. Only 8.5 percent of the former beneficiaries we interviewed who did not re-qualify for SSI benefits under another disability category were employed in the formal economy. The median wage for these workers was $6.12 per hour. Former beneficiaries with these types of jobs had held them for an average of 5.8 months at the time of our interviews. The majority of those with formal employment obtained their jobs after their benefits were eliminated.

A small percentage (16%) of those with earned income earn it through activities in the informal economy. Some of the informal economic work, former SSI DA&A beneficiaries in our study reported are odd jobs, collecting scrap metal, and street vending. Workers are paid in cash, and pay varies greatly day to day. The median hourly wage was $6.70 per hour, however the number of hours worked each month were quite small.

A third sector, day labor or temporary service employment, has been utilized by some of the former SSI DA&A beneficiaries in our study. Nearly a quarter (22%) of those with income from work had worked day labor or a temporary employment assignment since

[20] As in other sections of this report, we focus our discussion on those former SSI DA&A beneficiaries who have not re-qualified for SSI benefits under another disability category.
[21] Formal employment for the purposes of this report refers to work for which tax records are kept.

losing SSI benefits. The wages in this sector were very low: the average hourly wage earned at day labor was $4.55 (this may reflect transportation costs which some day labor agencies deduct directly from workers paychecks).

Barriers to employment

The relative lack of success in former SSI DA&A beneficiaries moving from cash assistance to viable employment raises serious questions about the feasibility, at least in the short term, of such goals. We analyzed data from former beneficiaries on employment background, educational attainment and criminal records to provide insight into the factors which may be influencing employment outcomes. We have identified the following as factors inhibiting former SSI DA&A beneficiaries re-entry into the workforce after their benefits were eliminated.

- **Low skill levels**.

The majority of former SSI DA&A beneficiaries we interviewed had low skill levels. These former beneficiaries, in today's technology focused economy, are unlikely to find secure employment at wages which will allow them to provide adequately for themselves and their families.

- **53.6 percent have less than a high school diploma.**

The mean hourly wage of those without H.S. diplomas or GED who held jobs at the time of our interviews was $5.09.

- **31 percent have a H.S. diploma or GED.**

The mean hourly wage for those who held a high school diploma but had no additional education was $6.60.

Compounding the low level of educational attainment, very few (29%) of the former SSI DA&A beneficiaries in our study have received job training of any kind (including on the job or post secondary education). Only 11 percent of former SSI DA&A beneficiaries in our sample had been involved in the Earnfare employment program (see Employment and Training issues discussion below). Only one person obtained a job through Earnfare.

- **Criminal records**

A large segment (68%) of former beneficiaries interviewed for this study report a past criminal conviction. Most of these convictions for which we have information are related to substance use. Employers' resistance to hiring persons with criminal records makes it difficult for many to get hired. Others, discouraged by what they perceive as likely rejection due to their past criminal records do not even attempt to seek employment.

- **Erratic work history**

Nearly all, (95%) of the former SSI DA&A interviewed for this study have held jobs in the past. However, for many, their pattern of employment has been irregular: odd jobs when available, occasional construction work, and factory day labor —17 percent of the most recent jobs held by former beneficiaries we interviewed were temporary day labor positions. The median length of time on their last job was a little over nine months.

- **Focus on manual labor experience**

We found that a significant portion of previous work experience of the former beneficiaries we interviewed has been in jobs that require physical strength and agility.

- 11.5 percent previously held positions as laborers
- 8 percent have worked in the construction trades
- 10.3 percent worked in custodial services

The high level of physical health problems experienced by the former SSI DA&A beneficiaries interviewed for this study make it unlikely that they will be able to return to these employment sectors. Another reason why manual labor is a less than optimal career choice for members of this population in recovery is the high incidence of substance abuse among workers in this industry (U.S. Department of Health and Human Services), which could trigger relapse.

- **Patterns of substance abuse and mental health issues**

While we made no attempt to diagnose the presence of mental illness in those former beneficiaries interviewed, nor are we qualified to do so, we did witness atypical patterns of behavior, which if not addressed, would surely prohibit obtaining employment[21]. For example, during several of the interviews, although facilitators were skilled at working with this population and the milieu was non-threatening, participants became agitated and abusive. Other times, interviewees were unable to function in the interview because they were abusing drugs and/or alcohol: for example we detected the smell of alcohol and slurred speaking. Still others lacked the ability to communicate coherently and stay focused for the duration of the 20 to 30 minute interview. While these incidents did not occur in the majority of interviews, they do indicate that a segment of this population will not, in the short term, be able to move into sustaining employment. We estimate that about three percent of the former SSI DA&A beneficiaries interviewed for this study are currently unemployable for these reasons.

- **Former beneficiaries' beliefs that work is not feasible for them**

In numerous interviews, former beneficiaries indicated that they had not sought employment or training since their benefits were ended because they did not believe they would be able to find or keep work. The most frequent reasons for not pursuing employment were: physical and mental health problems, criminal records and substance abuse history which deter employers from hiring, and lack of skills.

Employment and training issues.

Our findings point to very limited success so far in moving persons from SSI DA&A benefits to employment. While the short term lack of success is cause for concern, the barriers which we have identified and discussed above are not, for many of the former beneficiaries we interviewed, insurmountable. However, it is likely that former beneficiaries will continue to fail in making the transition to employment unless

[22] Treatment Alternatives for Safer Communities (TASC) estimates that 35% of the former SSI DA&A population face mental health problems (TASC Reports, Spring 1997).

appropriate employment and training activities are available and members of this population are recruited via outreach for participation in employment and training activities. Again, as with most of the other issue areas discussed in this report, outreach will be an important part of helping members of this population access appropriate services. This is especially true with employment and training as the former beneficiaries in our study demonstrated beliefs that employment is not feasible for them and lacked familiarity with employment and training options.

From interviews with former beneficiaries and social service providers, and a review of literature, we identified the following employment and training service issues which are likely to influence this population's success in making the transition from SSI to employment.

- **An overall lack of employment and training services targeted to this population.** Providers working with this population concur that there are very few employment and training resources available to and appropriate for this population. The two large-scale programs identified — Earnfare and the State Vocation Rehabilitation Agency (in Illinois known as Illinois Department of Human Services Office of Rehabilitation Services or ORS, formerly the Department of Occupational Rehabilitation Services or DORS) — were not seen as adequate to address the needs of this group.

Begun in 1992, Earnfare is the state of Illinois' employment program for single adults who receive food stamps. Participants can work up to 80 hours a month in the program. First they work off, at minimum wage, the value of their food stamps. After they work off the value of their food stamps, participants are paid minimum wage for each hour they work for a maximum of 80 (including food stamp work off hours). Participation is limited to six months in a one year period. There is no limit to the number of times a person can enroll in Earnfare. Participants also receive clothing and transportation allowances needed for their work assignment.

Earnfare offers 5,000 slots state wide: far short of the capacity which would be needed to serve those who lost SSI DA&A benefits and others who are unemployed in Cook County, Illinois. Officials at the IDHS/ Office of Employment and Training have stated that persons volunteering for the Earnfare program receive pre-employment training from regional IDHS offices as a condition of receiving food stamps. Interestingly, none of the persons interviewed for this study who were receiving food stamps reported that they had received or were receiving pre-employment training. Besides regional IDHS offices and Township governments which run Earnfare programs, IDHS also contracts out Earnfare services through a "request for proposal" (RFP) process to employment and training organizations that must be "comprehensive service providers." As comprehensive service providers these organizations are required to provide "job readiness" services, or pre-employment training, but there is no funding for substance abuse services through Earnfare. This lack of substance abuse services in the Earnfare program makes it difficult for persons like the former SSI DA&A beneficiaries we interviewed to succeed in the program.

A 1994 evaluation of the Earnfare program by the University of Northern Illinois, found that substance abuse was a problem for the program: "Addiction to alcohol and drugs is a major block to Earnfare participation and to the success of those who do participate. Not all abusers are, however, unable to work" (p24).

That same NIU study found that both employers and participants in the Earnfare program thought that providing job search skills, job training, counseling, GED classes, and remedial education would strengthen the Earnfare program and improve outcomes (p.15).

The other major employment and training resource identified by service providers was the Illinois Department of Human Services, Office of Rehabilitation Services (IDHS/ORS).[23] However, past experiences in obtaining ORS services for former SSI DA&A beneficiaries were in general not favorable. Comments from service providers regarding ORS services for this population included:

- Of 10 referrals to ORS, only two were successful.
- ORS' focus is on physical disability and
- ORS counselors with whom providers had contact appeared unskilled in dealing with substance abuse.

Though those disabled by substance abuse are considered disabled under the definition of disability used by the Rehabilitation Act of 1973 and therefore are qualified for ORS services, the general perception and experience of social service providers in our focus groups has been that the services offered by ORS do not adequately address the employment barriers presented by this population, including substance abuse.

Service providers believe that unless ORS extends its competencies in dealing with substance abuse and mental illness it will not be an appropriate resource for assisting former SSI DA&A beneficiaries in obtaining and retaining work skills and employment placements.

The relative lack of appropriate employment and training programs available for this population may to some degree contribute to the low utilization of training services by the former SSI DA&A beneficiaries we interviewed.

- **Insufficient integration of employment and training (vocational services) and treatment.**

One of the themes that has surfaced repeatedly, both in our data and in the relevant employment and training evaluation literature we reviewed, is the need for integrating employment and training activities with treatment services for those with substance abuse problems. Several of the studies we reviewed find that treatment is more effective if employment training occurs concurrently (Wright, et. al., 1990, Schechter, L., 1973, Brewington, et. al., 1987). Similarly, several treatment providers we talked to believe

[23] Attempts under the Freedom of Information Act (FOIA) to obtain ORS data regarding services provided to former SSI DA&A beneficiaries were denied by ORS administrators.

that incorporating employment and training services into treatment can often give those in treatment a focus and goal for which to strive, though they cautioned that it is important to make sure that employment and training services are incorporated at a point in treatment when they are appropriate for the client.

A recent survey of substance abuse providers completed by the Community Development/Substance Abuse Work Group, a joint project of the Mayor's Office on Substance Abuse Policy (MOSAP) and the University of Illinois Great Cities Program found a lack of coordination with job placement programs in the Chicago area. Similarly, members of the Workforce Development Working Group of the Chicago Jobs Council, a group of employment and training providers, have identified substance abuse issues as an area in which they, as training providers, need more assistance with in dealing with their clients.

Currently, many employment and training programs require completion of a drug treatment program or documentation of sobriety for a set amount of time (sometimes as long as a year) before accepting applicants into their programs. This often creates gaps of several months or more between completion of treatment and eligibility for employment and training programs. That gap can often make it more difficult for recovering substance abusers to maintain sobriety.

- **Need for extended long-term employment training including pre-employment skills**

The consensus of social service providers serving this population is that the majority are not job ready. Lacking job skills, recent work histories, and battling substance abuse, the majority of this population are unsuccessful in obtaining regular employment which pays a sustainable wage. One provider recounted statistics from her program to back up these observations: only ten percent are working full time, and only four percent are making more than $10,000 annually, even with employment placement assistance. Given this, providers have identified ***long-term*** employment services, starting with pre-employment training as a necessary factor to successful re-entry into the work force. Based on her organization's experience running an employment and training program, one provider estimated employment services programs lasting at least a year are necessary for this population and even then, some will simply not be able to work.

- **Support services connected to employment and training are necessary.**

One way to help those who obtain employment retain their positions is through programs which offer placement and extended job support services in which the worker is entitled to support from job coaches or counselors over the course of their working life. Job coaches, while not necessarily needed on a daily basis by this population, can play a significant support role in helping former beneficiaries when crises arise or when clients feel uncertain about how to handle situations at work. These counselors are often able to help their clients maintain employment by mediating disputes/conflicts with employers, teaching communication skills, and assisting in identifying new work opportunities or helping clients to advance in their existing workplace.

In addition to career-span job coach supports, other services such as transportation, clothing assistance, and recovery supports available at work sites (e.g. AA meetings, etc.) or through employee assistance plans (EAPs) offer promise in helping this population obtain and keep jobs, especially in the early stages of entering the work force. One provider in our focus groups estimates that it takes, on average for this population, five to seven paychecks to adjust to working life and that providing support services during this period of transition can made a critical difference in helping this population maintain employment.

In particular, support services that help to educate employers about substance abuse issues in the work place and hiring those with substance abuse histories can help break down employer resistance to hiring recovering substance abusers and can promote the development of work places that are skilled in early identification of relapse, and appropriate interventions (Gardiner, 1978).

- **Emerging trend: social service providers planning and implementing employment and training programs for this population.**

A number of service providers (primarily those providing housing and shelter services) indicated that they are exploring the idea of starting employment training programs geared to former SSI DA&A beneficiaries, or have plans to do so in the future. Most have decided to do so because they have been unable to locate appropriate employment and training programs for the former SSI DA&A clients they serve. One of the biggest barriers they face in these efforts is obtaining adequate funding.

- **Acceptance that some portion of this population may never be able to work in independent settings**.

Finally, though it appears that a significant portion of this population may be able, with the right supports and services, to become employed, our data also indicate that independent employment may not be feasible for a segment of this population. We estimate that about 3 percent of the former beneficiaries interviewed for this study are unlikely to obtain and maintain employment in independent settings.

Best Practices & Model Programs

Following are program profiles of several types of employment and training programs which incorporate some or all the factors identified above as contributing to successful employment outcomes.

The Sober Transitional Housing and Employment Project (STHEP) is a long-term program addressing the recovery, vocational, and housing needs of homeless alcoholics in Los Angeles County, California. The program has two phases. Phase one includes concurrent recovery and pre-employment programs and lasts 90 days. At the end of phase one, participants, with staff assistance, develop an exit plan which contains among other elements, plan for obtaining stable employment. Phase two is a 120 day transitional recovery, employment, and housing program. Staff work intensively with participants to help them develop appropriate social skills, obtain vocational training through the state vocational assistance program, and begin job search activities.

Supportive services such as heath care, are available as well. Preliminary evaluation data indicate that all graduates of Phase II were employed at completion of phase two of the program (Wright et. al., 1990).

The Job Seekers Workshop is a behaviorally based skill training program for drug treatment clients. The goal of the workshop is to increase job interviewing and finding skills. Workshop activities are based on observations of problem behaviors clients showed in interview situations as well as particular barriers to employment (e.g. poor work histories, criminal records, ignorance of effective interviewing behaviors, and ignorance about informal job seeking resources). A program evaluation indicates that this approach has significant positive influence on employment outcomes for participants (Hall, et. al. 1984).

The Cooperative Demonstration Program offers work-based learning in building trades for incarcerated substance abusers. The program integrates eight weeks of pre-apprenticeship carpentry vocational training classes with supportive services including life skills training, substance abuse counseling, continuing education, and pre-placement support programs. Upon program completion, graduates are placed in jobs at companies which are members of the cooperative partnership (U.S. Department of Education, 1993). The trade focus may not be as appropriate for the population we describe due to health and recovery issues identified.

The Individual Placement and Support Model (IPS), though developed for persons with serious mental illness, this program offers a mix of program elements which may be successfully adapted for those working with a population of substance abusers. IPS emphasizes client choice, rapid job finding, competitive jobs, and follow-along support services. This program is unique given its de-emphasis on pre-vocational training.

The Life Coach Project of the Illinois Department of Human Services, Office of Rehabilitative Services (IDHS/ORS) serves individuals with a serious mental illness, but could be adapted for those suffering from substance abuse-related disabilities. The Life Coach Project attempts to promote collaborative efforts between ORS and other human service systems to improve service delivery to the project's target population. One of the major responsibilities of the Life Coach is to coordinate services to assure that client needs and employer expectations are being met. Particularly, for substance abusers who have intermittent work histories, this program could provide facilitation services, helping those re-entering the work force deal with communication problems and expected behaviors in the work place which in the past may have been problematic.

The Job Club Model is an integration of vocational counseling and behavioral psychology. This model provides support, and information to enhance job search outcomes. In particular, this model is helpful in addressing problems of learning, motivation, and maintenance of desired behavior. A study has found the Job Club approach to be effective in reducing the unemployment rate of job seekers (Access program literature).

Anixter Center of Chicago primarily serves those with physical and/or mental disabilities but occasionally works with persons who have co-existing substance abuse disabilities as well. For this population, Anixter's employment and training efforts are designed to link to substance abuse treatment services in a "blended" model. Clients in treatment begin employment and training activities slowly, starting with training in basic life, daily living, and interpersonal skills. As clients progress, case managers look for an appropriate time to move more heavily into employment and training activities with the ultimate goal of competitive job placement. Case managers are careful to facilitate these transitions when they and their clients feel they are at a point at which they could succeed. Previous experience has indicated that placing treatment clients into employment settings too soon can lead to relapse.

Next Step: Jobs is an employment program for supportive housing residents. The program is a partnership between the Corporation for Supportive Housing and non-profit supportive housing providers in New York, Chicago, and San Francisco. Twenty providers are involved in the program. Through Next Step: Jobs, supportive housing providers offer employment and training services in the context of the supportive housing environment. Housing providers utilize common space and supportive services provided through the housing environment to facilitate increased employment among tenants of supportive housing. Most offer an array of vocational services including skill training, access to clothing, resource rooms that centralize posting of openings, computers, phones for making job contacts, listings of internship and transitional job opportunities, referral and scholarship information, access to job-related transportation, support groups, and opportunities for employment in non-profit businesses (often on staff at the housing development). In Chicago, a city-wide job bank run by tenants which enables supportive housing providers to place tenants in jobs at other organizations is now starting. Preliminary evaluations indicate positive employment outcomes for Next Step: Jobs participants.

Policy Discussion & Recommendations

Expanding funding opportunities.

The emphasis of welfare reform on moving people from public assistance to work has created a flurry of employment and training policies, programs, and resources. However, most of the attention in this regard has been directed toward adults heading households with children that receive Temporary Assistance to Needy Families (TANF).[324]

The employment and training needs of single adults who do not have custody of dependents, like the former SSI DA&A beneficiaries we studied, are largely excluded from the work-related policies and programs developed in response to welfare reform. Yet, a large segment of this population is connected to TANF households. For example, we found that nearly a third (31%) of the former beneficiaries we interviewed have children who receive TANF subsidies.

In 1998 Illinois will receive $48.6 million dollars in 1997 federal Welfare-to-Work grant

[24] Formerly Aid to Families with Dependent Children or AFDC.

money of which the City of Chicago will receive $24.7 million under the direction of the Chicago Workforce Board. Grant guidelines allow for designating up to 30% of these funds for employment and training activities for non-custodial fathers whose children receive TANF. Because of the limited funds available for employment and training for this population and the overlap between former SSI DA&A beneficiary and non-custodial parent populations whose children receive TANF, a portion of these funds should be targeted to programs serving former SSI DA&A beneficiaries who have children receiving TANF assistance.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 sets up a new employment and training fund for food stamp beneficiaries. The Act mandates that 80 percent of the funds be spend on 18-50 year old food stamp beneficiaries not caring for minor children. A significant portion of these funds should be ear marked for former SSI DA&A beneficiaries.

Other potential funding streams for employment and training for this population include Tax Increment Financing (TIF) District dollars. By law, TIF dollars can be used to pay for job training and placement services. Chicago currently has numerous operational TIF districts generating funds which could be deployed to fund employment and training program services for this population.

Programs funded by expanded funds must incorporate components demonstrated to be effective for this population including: treatment services, extended pre-employment skills development, linkage to stable housing opportunities, job coaching and other supportive services, and long-term job stabilization assistance. Adequate funding is important as well. Employment and training experts estimate that on average the cost for preparing hard to employ persons for gainful employment is about $5,000 (Network News, December 12, 1997). Other estimates, specific to homeless persons put the training and placement costs higher.

Improving existing large-scale programs.
Earnfare. In order to effectively reach and serve former SSI DA&A beneficiaries the program should:

- expand to include treatment services and treatment support (meeting support, drug and alcohol screening and counseling);
- strengthen pre-employment/basic skills training services (i.e. ensure food stamp beneficiaries are participating and that these services, whether provided by comprehensive service providers or IDHS) so that Earnfare participants are able to complete the program and increase their chances of obtaining unsubsidized employment using their Earnfare completion as a reference.
- expand slots available to better meet the demand for services (this is especially important given welfare reform legislation which restricts food stamps to single persons aged 18 to 55 unless they are involved in a work activity: see also the Food and Nutrition section of the report).
- add Medicaid coverage for Earnfare participants.

IDHS/ORS. To more effectively serve this population, we recommend that ORS:

- extend staff capacity to service this population by training staff on substance abuse issues;
- create specialized staff positions for dealing with substance abuse clients;
- create a demonstration program adapting the Life Coach program, now geared to the mentally ill, to the needs of clients whose disability is related to substance abuse.

Improved integration of employment and training and treatment services.
One problem faced by treatment providers is that employment and training services are not reimbursable under OASA regulations. Additionally, OASA funds do not support employer education and assistance with dealing with substance abuse issues which as studies indicate can facilitate the employability of those with substance abuse histories.

While it is understandable that OASA desires to target its funds to treatment services and prefers that those charged with funding employment and training services (in Illinois, the Department of Commerce and Community Affairs or DCCA), fund employment and training activities, the reality is that treatment which includes employment and training services is more effective. Maintaining the separation of these funding streams at its current level to some degree hampers successful service delivery and outcomes for beneficiaries. Given this, new partnerships which allow for creative pairing of these funding streams must be forged including providing OASA assistance to employers willing to hire a person with an extensive substance abuse history. This will require changes in regulations (and possibly legislation) at the state level.

We found that the level of interconnect between the criminal justice system and former SSI DA&A beneficiaries in our sample is extremely high. Given this, one way to effectively reach former SSI DA&A beneficiaries who are in need of employment and training services may be to offer such services through the Cook County Department of Corrections. Such a program could target those whose incarceration is related to substance use and abuse and provide employment and training services including a combination of in-facility employment and training programming, and transitional employment training. A similar program focused on treatment services was ended in FY 94-95 when appropriations were cut.

Emphasis on job creation: leveraging government resources.
Former SSI DA&A job seekers face profound difficulties in obtaining employment due to criminal records and substance abuse histories. Employers are understandably reluctant to hire persons with these issues. However, persons with these issues can and do make good employees when given the chance. One way to help former SSI DA&A beneficiaries segue into private employment is to leverage government resources in support of these job seekers through connecting former SSI DA&A beneficiary job seekers with job opportunities created with government funds.

The proposed Chicago Living Wage ordinance includes a “community hiring hall” provision which is designed to maximize access for low- and moderate-income

Chicagoans to jobs that are created, maintained, or subsidized through City assistance. The proposed hiring halls would provide a registry and referral service operated by a non-profit organization or labor union through which employers would list city contract related job openings. Hiring hall operators would then refer job seekers registered at the hiring hall to employers seeking workers. Such linkages have the potential to provide increased access to employment opportunities for job seekers including the former SSI DA&A beneficiary population.

Action Opportunities

Advocate for employer acceptance of individuals with past criminal records.

Set-a-side a portion of the Welfare to Work non-custodial parent employment and training funds for programs serving former SSI D&A beneficiaries whose children receive TANF assistance. Programs funded should incorporate model components discussed above.

Increase the appropriation of Earnfare funds to expand available slots and to pay contracting agencies for pre- and post-employment and substance abuse service delivery.

IDHS/ORS adopt substance abuse as an area of specialization including provision of training on substance abuse issues for staff, creating substance abuse specialist positions, and adapting the Life Coach program to serve those who's disabilities are due to substance use and abuse.

Enact the Chicago Living Wage ordinance inclusive of the "Community Hiring Hall" provision.

Change OASA and DCCA regulations to allow for more creative partnerships between treatment and employment and training services.

Educate employment and training and substance abuse providers on the importance of, and opportunity for, integration in order to facilitate partnerships which produce better outcomes for both providers.

Require that the Mayor's Office on Employment and Training (MET)—the city entity which makes employment and training grants—include the demonstration of *effective* partnership linkages to substance abuse service providers as a condition of contract award.

Establish a transitional demonstration program housed within the Cook County Department of Corrections linking treatment and employment and training services to assist former SSI DA&A beneficiaries find and maintain employment.

SUBSTANCE ABUSE TREATMENT[25]

In many ways, successful treatment outcomes are tied to each of the substantive areas discussed in this report. Successful treatment outcomes can go a long way to supporting improved health, stable housing situations, and secure employment for many in the former SSI DA&A population. In addition, successful treatment outcomes are ultimately money savers. The 1996 Department of Alcoholism and Substance Abuse (now the Office of Alcoholism and Substance Abuse) Comprehensive State Plan for Alcohol and Drug Services estimates that for every dollar spent on treatment, seven dollars are saved in reduced corrections costs, hospital admissions, and job losses.

This section of the report examines pre- and post-benefits elimination treatment utilization and outcome patterns for the former SSI DA&A beneficiaries we interviewed who did not requalify for SSI benefits. In addition we explore, from the perspective of service providers, wider patterns of treatment usage and outcomes found in the general population of SSI DA&A beneficiaries with whom they have contact.

Substance Abuse Treatment and Treatment Support Services:
The terms substance abuse treatment and treatment support incorporates a wide variety of modalities and activities including:

- detoxification*
- in-patient rehabilitation services (both long and short term)
- out-patient rehabilitation (also referred to as day treatment)
- intensive out-patient rehabilitation
- aftercare (including recovery homes)
- case management*
- partial hospitalization programs
- methadone maintenance

In addition self-help groups* (primarily Alcoholics Anonymous ,Cocaine Anonymous, and Narcotics Anonymous) are a commonly used support service integrated into virtually all treatment modalities.

* These treatments and treatment supports are delivered in a variety contexts, including both inpatient and outpatient settings.

Trends in Treatment Services
As with medical care, the overall trend in substance abuse treatment services has been to shorten the length of service time. For example, OASA reimbursements for in-patient treatment programs have been reduced from 28 to 21 days. OASA has also capped the number of out-patient treatment hours for which providers may be reimbursed[26 4].

[25]Treatment for the purposes of this section is not restricted to a narrow clinical definition but rather refers to the range of different activities persons use to positively address substance abuse.

[26] Though OASA notes that non-reimbursed services can be provided if the client's service plan indicates a need and the provider uses contract dollars to pay for service delivery. The difficulty with this is that there are very rarely enough contract dollars to provide for the potential demand for non-reimbursed services.

Similarly the VA reports shortening in-patient stay days and shifting resources from in-patient to out-patient services; for example, in-patient treatment days have been reduced from 28 to 6 days.

Historical Patterns of treatment utilization for the former SSI DA&A beneficiaries in our study.
The majority of former SSI DA&A beneficiaries we interviewed (73%) reported receiving treatment for substance abuse at least once in the past five years. These rates are consistent with the utilization of treatment by the SSI DA&A population as a whole reported by OASA. In 1994, DASA reported that 15,000 of the state's then 19,000 SSI DA&A beneficiaries were admitted to treatment services. The length of time former beneficiaries received SSI DA&A benefits does not appear to be associated with whether or not they received treatment services.

If the 1994 reforms mandating treatment as a condition of benefits had been fully implemented before the DA&A disability category was eliminated, it is likely that the rate of utilization of treatment services for this population would have been even higher. The majority of treatment providers and case managers we interviewed observed increased utilization of treatment services after these regulations were put into effect.

A significant sub-group (34%) of those former beneficiaries who have received treatment have made repeated attempts at treatment in the last five years. In this sense, the former SSI DA&A beneficiaries we interviewed are very much like the general population treated for substance abuse problems. Because recovery as conceptualized by addictions specialists is a gradual process with the likelihood of periodic relapse, relapses and the need for additional treatment service for the former SSI DA&A population we studied is not surprising.

Treatment Providers
In Illinois, provision of treatment services for those without private medical insurance or the ability to pay for services is primarily handled by private providers who contract with OASA or the City of Chicago Department of Public Health. OASA contracts with approximately 200 treatment service providers statewide. The City of Chicago Department of Public Health has contracted out its addictions treatment services to two primary providers: Gateway, Inc. and Interventions, Inc.

For those former SSI DA&A beneficiaries who are qualified veterans, the Department of Veterans' Affairs provides low or no cost treatment services. These services include both in- and out-patient programs and referrals to treatment services through outreach to homeless veterans.

The types of service providers former SSI DA&A beneficiaries relied on for treatment services changed with the elimination of benefits. Most notably the use of private hospital and non-profit providers has decreased, while use of city or county Health Clinics has incresed. See Table 7 below for documentation of these trends.

Table 7: Changes in types of providers delivering treatment and treatment support services pre and post benefits elimination[27]

provider type	percent of all episodes of treatment received prior to benefits elimination	percent of all episodes of treatment received in 2 weeks prior to interview contact
Private hospitals	28%	17%
City of Chicago funded addictions services providers (e.g. Gateway, Inc. and Interventions)[26]	17%	21%
Self-help programs (e.g. CA, NA, AA)	5%	4%
VA	9%	8%
Private non-profits (the majority of whom contract with OASA for service provision)*	27%	17%
Recovery Homes	6%	8%
City or County public health clinics	0	8%
Other	9	17.5%

Of the 84 former beneficiaries who did not re-qualify for benefits under another category, nearly half (49%) report having received treatment or treatment support services in the two weeks prior to our interview. Over a quarter (27%) of all treatment and treatment support episodes reported (both pre and post cuts) occurred after benefits elimination. The predominate types of treatment episodes reported after the SSI DA&A cuts are self-help meetings (85%) and outpatient services (10%). Only three percent of the out-patient treatment episodes were received by former beneficiaries who retained Medicaid/Medicare benefits. And in general, those who retained Medicaid/Medicare benefits were no more likely to be in treatment after cuts than those who lost medical benefits.

The treatment providers we interviewed also documented a decrease in demand and usage of treatment services resulting from the elimination of SSI DA&A benefits. Many had observed a noticeable shift in the demand for services from alcohol and drug treatment to mental health, as former beneficiaries began to try to re-qualify for benefits under a mental illness diagnosis.

[27] Due to rounding percentages in columns may not add to 100%.
[28] There may be overlap between these two categories. We were not able to determine this because OASA was unable to provide a list of agencies with service contracts for verification purposes.

With loss of access to Medicaid/Medicare benefits for the majority of former SSI DA&A beneficiaries, we expected that the numbers of persons on waiting lists for non-Medicaid/Medicare funded treatment slots would expand greatly. However, data provided by OASA indicate that the total number of persons (both those with Medicaid/Medicare and those without) on waiting lists for treatment services funded by OASA have declined in the period following benefits elimination. See the table 8 below for specifics.

Table 8: Changes in number of persons on OASA treatment services waiting list 1996-1997

Region	August 1996	January 1997	May 1997
Region 4 (Cook County)	980	797	515
State totals[27]	2,002	1,416	1,147

OASA figures confirm accounts provided by treatment service providers who reported a decline in substance abuse treatment services sought by this population.

Treatment resource streams

The funding of treatment services in Illinois is quite complicated as funds from a variety of different sources are intermingled to cover service provision costs. For low income persons without medical insurance or Medicaid/Medicare benefits, payment for treatment services may come from a number of sources including: OASA funds (a mixture of state general revenue funds, federal Health and Human Services or HHS block grants); the Substance Abuse and Mental Health Treatment Administration (SAMHSA); and the SAMSHA operated Center for Substance Abuse Treatment (CSAT). For Chicago residents, funding is provided by a combination of local tax revenue, and state and federal grants. Additional, but not substantial, resources come from the Chicago Housing Authority, private grants, and the Cook County Department of Corrections.

Best Practices & Model Programs

Successful treatment outcomes are extremely hard to achieve. For instance, one of the most notable treatment supports, Alcoholics Anonymous has a success rate of only 5 percent (Rational Recovery, Trimpey, J., 1996). Added to this is the under utilization of treatment services — treatment specialists believe that only a fraction of persons who could benefit from treatment services seek them (Trimpey, J., 1996). These facts suggest that two program components are needed for obtaining successful treatment outcomes: outreach and a continuum of services.

Expanding services on the pre- and post-treatment ends of the continuum.

Our review of treatment modalities and programs indicate that pre-treatment services and aggressive outreach efforts may be useful with former SSI DA&A beneficiaries not currently receiving treatment services.

- Outreach and pre-treatment services modeled on the Health Care for the

[29] Because persons residing in Region 4 many not receive treatment within that region, state totals are also useful for interpreting changes in demand.

Homeless program's emphasis on street level service, trust building activities, and mobile service delivery (e.g. in shelter and on the streets) appear to work well with some homeless substance abusers.

- Incentives offered to get people in the door help increase participation in treatment (e.g. medical coverage extended for those who seek and obtain treatment). One approach to this is called contingency management. In this model persons with substance abuse problems would have their basic needs met (e.g. food, housing, etc.) through direct deposit of funds to housing providers and stores. Any remaining funds would be considered discretionary and participants would "earn back" this money through compliance with treatment, negative drug tests, and participation in employment and training programs. Several evaluations of this model show it is successful in helping persons in recovery maintain a drug free life style (Federation of American Scientists, September, 1997).

- The Assertive Community Treatment (ACT) model has proven successful in engaging the dually diagnosed population (e.g. those persons suffering from both a substance abuse problem and a major mental illness) in services.

The ACT model is based on the concept of delivering the range of services needed to stabilize mentally ill persons (counseling, medications, occupational therapy, etc.) outside of the walls of a hospital setting. Sometimes called a "hospital without walls", these ACT services are delivered by mobile treatment teams in the community settings where consumers are located. This service delivery model has had significant success in helping consumers live well within their community settings.

Adapted for a substance abuse treatment model, ACT services might include counseling, medications, assistance with housing and vocational education and placement.

- Recovery Homes provide alcohol and drug free housing with activities and structure directed toward maintaining recovery. Both former SSI DA&A beneficiaries and service providers felt that recovery homes were a vital link between treatment and integration back into community settings. See the discussion of recovery homes in the Housing section of this report for more information and recommendations.

- Link treatment with employment and training services to foster better outcomes for those who are doing well in recovery (see recommendations under employment and training section of the report).

Policy Discussion & Recommendations

Overall, our findings regarding utilization of treatment services are cautiously encouraging. A significant number of former SSI DA&A beneficiaries have received services and a significant sub-group continue to use treatment supports even after their

benefits were eliminated. However, the loss of medical benefits means that former SSI DA&A beneficiaries will need to seek services from a different set of providers than they have relied on in the past. This indicates that there may be a need for outreach for this population so that they understand the treatment services for which they still remain eligible and which remain accessible to them.

Our data also indicate that the quantity of services clients are eligible for is decreasing (e.g. shorter number of treatment hours covered, etc.). For many in this population who have had substance abuse problems so severe that they have been unable to function — this will likely reduce the likelihood of successful treatment outcomes.

Fiscal constraints are a reality in terms of providing services to this population. There are limited treatment dollars available, and the elimination of Medicaid or Medicare coverage for this population, means that more of the treatment dollars must come from special federal grants or from the state and local levels. There is, however, a new source of funds dedicated for the treatment needs of former SSI DA&A beneficiaries: a special SAMHSA (Substance Abuse and Mental Health Services Administration) grant to Illinois of $2 million annually for two years. This money was appropriated in response to the elimination of the SSI DA&A disability category. The majority —($1.5 million of these funds)—will be dedicated to paying for treatment services for former SSI DA&A population. OASA funded providers are eligible to receive payment for former SSI DA&A beneficiaries served under this program. Persons seeking services under this funding stream must provide treatment providers with a Social Security number so that prior receipt of SSI for DA&A can be documented.

In addition, to the SAMSHA treatment dollars, the welfare-to-work funds—for former SSI DA&A beneficiaries who are non-custodial parents with children receiving TANF—allow for spending a portion of employment and training funds for substance abuse treatment and support services.

Action Opportunities

Given the emergence of these new funds and the need for a broader continuum of treatment outreach and services consideration should be given to the following:

OASA set-a-sides for outreach services.

Improve coordination of treatment and employment and training services (see Employment and Training section of the report).

Under OASA, establish a demonstration program adaptation of the Assertive Community Treatment targeted toward those with substance abuse problems.

Retain capacity of recovery homes. See recommendations under Housing section of this report.

Create and implement a contingency management program funded by HHS.

Renew federal treatment funding stream in the Substance Abuse Block Grant in FY 1999, as well as subsequent Labor-HHS appropriations bills, for this population.

Change administrative rules governing expenditure of OASA funds to include expenditures for pre-treatment and outreach services.

Mandate the expenditure of a portion of the SSI DA&A SAMHSA funds for outreach and pre-treatment services–especially mobile outreach such as that provided by Health Care for the Homeless program.

OASA establish a demonstration program which adapts the ACT model for persons who are disabled by substance abuse.

OASA mandate linkage to employment and training providers as a contract condition for community-based service providers serving this population.

Expand the funding and mandate of the Health Care for the Homeless model to include increased capacity for pre-treatment and outreach services for substance abusers.

HHS establish a "contingency management" demonstration program targeted at former SSI DA&A beneficiaries who have not re-qualified for benefits under another disability category.

Amend OASA recovery home regulations to grandfather existing recovery homes.

FOOD & NUTRITION

Adequate nutrition is essential for survival and as such forms the most basic element of safety net services. The degree that former beneficiaries of SSI for DA&A utilize assistance to meet this basic need is characteristic their of dependence upon emergency services. The majority of former beneficiaries in our sample (65.4%) received food stamps and an even larger percentage (74%) obtained food and meals from food pantries and soup kitchens in the two weeks prior to their interview.

Other empirical evidence from our sample indicates the degree to which former beneficiaries rely upon assistance to meet their food and nutritional needs. While our sample showed some beneficiaries to be receiving as much as $168.00 per month in food stamps, the mean figure was $85.50. In the prior two weeks to being interviewed, on average, former beneficiaries obtained 11.5 meals at food kitchens, while asking a friend or family member for something to eat more than two and one half times (2.67).

Of the former SSI DA&A beneficiaries, interviewed for this study, one out of five residing in shelters were not receiving food stamps, even though this condition almost

always entitles one to expedited or emergency food stamps.

Emergency Food Service Providers

There are many different types of service providers who provide free meals or groceries. These service providers and agencies can generally be divided into four categories[28].

Food banks– These agencies serve as food warehouses for surplus, donated, and discount foods made available to local agencies at low or no cost. Most food banks belong to Second Harvest, the national food bank network of nearly two hundred food banks around the country. There are nine food banks that serve Illinois, with the Greater Chicago Food Depository (GCFD) serving Chicago and Cook County. While most of the nine food banks in Illinois distribute between two and three million pounds of food annually, the GCFD, on average, distributes twenty million pounds of food each year.

Food Pantries–These are local agencies that distribute food packages directly to clients. Largely volunteer driven, they typically have a very small staff, usually just one paid director or coordinator. Each of these agencies serve anywhere from fifty to five hundred households each month depending on their service area and the resources available to them.

Soup Kitchens–These are agencies that prepare foods and typically serve hot meals. Generally thought of as providing a service to a largely male homeless population, more and more of them are reporting an increase in the number of women and families with children, who are not necessarily homeless seeking their services. An administrator of a soup kitchen interviewed for this study reported that ten percent of the people receiving meals at his operation were families with children. Another five percent were seniors. And the majority, he estimated, as single males between the ages of 25 and 55.

Other agencies–there are a large number of other agencies that do not fall precisely into the categories above. In Chicago, groups like Catholic Charities and the Chicago Anti-Hunger Federation (CAHF) provide services to a large number of people. Recovery homes, places offering 12 step meetings, and drop in counseling centers also often provide free meals.

We interviewed two of the larger umbrella organizations that organize food and nutrition services for low income and indigent persons, the Greater Chicago Food Depository (GCFD) and the Chicago Anti Hunger Federation (CAHF). The GCFD serves agencies, shelters, food pantries and other social service programs, such as day care and substance abuse treatment centers, that provide free meals. The GCFD distributes donated food, manages emergency food resources, provides assistance to agencies who are adjusting their services to meet changing needs in their service population, and assists agencies in meeting needs for refrigerator and freezer equipment. They operate a "food rescue" program which collects unused food from area restaurants and delivers the food to soup kitchens before it spoils.

[28] This categorization and description was provided by the Illinois Hunger Coalition

The CAHF includes 200 member agencies, mainly soup kitchens and food pantries, and provides training for food handling and sanitation. Other functions of the CAHF include distribution of groceries and commodities and issue advocacy such as monitoring of hunger and welfare issues. Presently the CAHF is working with the Illinois Hunger Coalition to track how federal benefits cuts will affect the services coordinated by Chicago Department of Human Services.

The GCFD reports that in 1997 they had a five to twelve percent increase in distribution of food and expects that for the first time more than 25 million pounds of food will be distributed in one year in Cook County. The CAHF also saw a spike in demand for food in the beginning of 1997. Figures for food distribution by the CAHF for March of 1997 are double that for March of the previous year.

Food and nutrition service providers have identified the following challenges to delivering their services:

- a lack of transportation to distribute food supplies to shelters, soup kitchens, and food pantries;

- not enough food to meet demands of food program operators;

- lack of food services in communities with high demand for these services, particularly in suburban locations;

- sites which require significant capital improvements;

- a lack of resources for helping those seeking food assistance in obtaining entitlement benefits such as food stamps, though they acknowledged that receipt of food stamps would not eliminate dependence on emergency services and;

- a need for training and technical assistance by agencies operating volunteer driven food programs.

Food Stamps

The Food Stamp Program is a federal program that helps people with low incomes purchase food. In Illinois, this program is administered by the Illinois Department of Public Aid. If an applicant qualifies based on income, that applicant will receive food stamps for each month he or she is certified eligible. The amount of food stamps granted is based on a complicated formula which takes into account income, housing and medical costs.

Food Stamps are coupons that can be used like money to buy any food except items such as hot prepared foods, alcoholic beverages, tobacco, pet foods, soap, paper goods, or any other non-food items. Food Stamps may be spent like cash for food at most food stores, certain group dining facilities, and for Meals-on-Wheels.

Besides the coupon form, food stamp assistance in some areas of Illinois is provided through the Link program. The Illinois Link program allows persons who qualify for food stamps and certain other public assistance benefits, to access these benefits through a plastic Illinois Link card, which is similar to a bank card. A beneficiary uses the card and their individual Personal Identification Number (PIN) to use benefits (such as food stamps) that Public Aid holds for the individual in an account. Like the coupons, food stamp benefits deposited in Link accounts can only be used to purchase food products.

Policy Discussion & Recommendations

Food stamp eligibility requirements were revised in the 1996 the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the 1997 Balanced Budget Act (BBA).

First, in 1996, PRWORA limited 18 to 50 year old food stamp beneficiaries not caring for minors to three months of food stamp assistance during each 36 month period unless the individual works at least half-time or is engaged in employment and training activities. States were permitted to seek waivers for individuals living in areas where unemployment rates exceed ten percent or areas where there are "insufficient jobs."

The Balanced Budget Act of 1997 lessened some of these restrictions. A new $1.5 billion fund for employment and training slots for food stamp beneficiaries was set up with the provision that 80% of the funds be spent on the 18 to 50 year old (not caring for minors) population. In order to receive these funds, each state is required to meet a maintenance of effort requirement. This has the potential to make it easier for this population to continue to qualify for food stamps presumably because new employment and training activities will become available.

The BBA also made allowances for states to exempt another 15 percent of the 18 to 50 year old population, above and beyond those living in exempted high unemployment areas, from the three month limit. These expansions are only applicable if the state makes the effort to apply for them and demonstrates a maintenance of effort. However, the necessity of seeking annual exemptions creates a climate of uncertainty regarding whether former SSI DA&A beneficiaries will continue to receive food stamp benefits in the future.

In particular, former SSI DA&A beneficiaries are dependent upon the state's willingness to apply for exemptions and the granting of waivers by the federal government. This year in Illinois, there was some hesitation in applying for waivers as the Governor believed that these waivers compromised the state's position on welfare reform.

Another major service provider for this population, the emergency shelter providers, are in a period of flux in terms of how they will continue to provide services. The Chicago Department of Human Services is proposing a reorganization of shelter programming which has stated as its goals "to encourage permanent solutions to homelessness that progress from effective outreach to permanent independent housing." This plan recognizes as one of its target populations "the some 16,400 who lost SSI benefits

because they only qualified as Drug & Alcohol dependent." As the shelter system with its own provision of nutritional aid and links to other providers of emergency food assistance prepares to address this population it appears an effort will be made in this area to provide entitlement screening.

Beyond providing entitlement screening the Shelter Plan calls for greater coordination between the city shelters and all available emergency food programs in their geographic area. The Plan also calls for health education activities on-site for the purpose, among others, of educating shelter residents about nutritional concerns.

The findings of this report however indicate that mere access to food stamps is not a definitive indicator that former SSI DA&A beneficiaries will no longer need to rely on emergency food providers. It should be noted however that most emergency food providers were established in the early eighties as a response to what was perceived at the time to be a short term crisis, and did not plan at that time to be in existence on a permanent basis. Emergency food providers should not be mistaken as an institutional solution for the SSI DA/A population or for hunger in general. Improved outcomes for this population in terms of food and nutrition is likely dependent on improved outcomes in terms of the other sections of this report (for example see the Employment and Training, Substance Abuse Treatment sections of the report).

Action Opportunities

- Facilitate maximum use of food stamp benefits through funding of entitlement screening staff at soup kitchens and food pantries as called for in the Chicago Department of Human Services Shelter Plan.

- Encourage local government, specifically the Chicago Department of Transportation and/or the Chicago Department of Human Services, to enhance the ability of food banks and like organizations to effectively deliver food to all emergency food services sites (i.e. provide vans or other assistance in terms of transportation). This assistance should include facilitating the "food rescue" efforts of local food banks.

- Fund the Shelter Plan proposal to coordinate efforts between shelters and all emergency food operations in each shelter's geographic area. This effort should include the identification of under served areas and the direction of technical and logistical assistance for beginner agencies for the purpose of producing better outcomes for persons in need of emergency food assistance.

- Repeal of federal limitations on food stamp eligibility for persons between the age of 18 and 50 not caring for minor children.

Systems Change Recommendations

One of the consistent themes in our report findings is a need for innovation in the way in which social services are delivered to this population. In particular, two basic themes

emerged along these lines: the need for outreach and mobile service delivery and the need for targeted funding so that funds may be better directed toward those most effectively serving the population for whom they are intended.

- Mobile service delivery: meeting needs in the situations in which people experience their needs, for example bringing health services to shelters or providing entitlement screening and advocacy services at feeding program sites is important to increase this population's exposure to and use of appropriate services.

- Targeted funding has the potential to more efficiently direct funding to intended populations so that the "ripple" effects of policy changes such as SSI DA&A benefits elimination may be more readily anticipated and responded to as well as to encourage service providers to develop and implement more responsive service modalities.

APPENDICES

APPENDIX I

METHODOLOGY

Study of the former SSI DA&A beneficiary population offers some methodological challenges and constraints. Foremost in terms of constraints is the federal privacy law which protects the privacy of those who receive SSI assistance. These protections, while necessary, also make it impossible to attain a truly random sample of the population by those conducting research independent of the Social Security Administration.

Secondly, this population is characteristically transient, moving residences frequently and often housed in non-traditional settings, making it difficult to contact potential study participants referred by those with connections to this population. And as with the general low income population, telephone access is often difficult: many of these households do not have telephone service, making it difficult to locate those who do not have regular contact with employers or social service providers.

Finally, our experience with this population indicates that substance abuse and mental health issues may present problems with the accuracy of information provided by beneficiaries. Given this, we designed an interview format which includes similar questions asked at different points during the interview to identify inconsistencies and probes for clarification of answers. In our analysis, we consistently screened out inconsistent or inappropriate data.

Study design Our study was designed in response to the constraints discussed above. Because we were interested in tracking the effects of benefits elimination on both beneficiaries and social service provider systems, we pursued two types of primary data. Data obtained from interviews and focus groups with social service providers serving this population provided one source of information. Data obtained from one-on-one in-depth interviews with former beneficiaries (including those who were able to retain benefits under another disability designation) provided data at the individual beneficiary level.

We collected data in interviews and focus group sessions from emergency service providers (shelters, food pantries, and soup kitchens), health care providers (hospitals, clinics, and health care centers), housing providers (SRO operators, managers of transitional housing programs, housing developers, and operators of supportive housing services), treatment providers (substance abuse social workers, program managers, hospital detox centers, and recovery home operators) and, employment and training providers (job placement staff, trainers, day labor employers, basic life skills trainers, and those working in vocational rehabilitation services). In all, we interviewed 98 service providers serving former SSI DA&A beneficiaries in both the city and suburban Cook County.

Selecting the sample of service providers. We used multiple methods for identifying service providers working with this population. For areas in which the project partners had contacts with social service providers, we began by calling providers and asking them to identify other providers who service this

population. Using this method we were able to produce a large sample of service providers in contact with this population. For areas of the County in which we had no contacts, we began with service provider listings in the telephone book and resource guides, concentrating on emergency services such as shelters and food programs. Researchers called listed providers and inquired as to their experience in serving former SSI DA&A beneficiaries and other providers in their area. Through this method we identified providers across a range of services for interviews and focus group participation.

We tried to maintain a diversity of geographic distribution, in selecting service providers for data collection, making sure that we had adequate representation in the areas in which significant former SSI DA&A beneficiaries were registered for benefits.

Sampling the former beneficiary population. As discussed above, achieving a random sample of this population was not feasible due to privacy protections, and the mobility of the population. Given this, we proceeded using purposive sampling techniques, drawing on referrals from social service providers in order to make contact with former SSI DA&A beneficiaries.

Researchers contacted providers explaining the study and then asked either to be allowed to come on-site and conduct interviews with persons served by providers or for service sites to provide clients with information about the study and a telephone number with which to call to arrange an interview. Nearly all of the interviews were done at service sites as clients visited service providers to obtain needed services or commodities.

In all, we interviewed 100 former SSI DA&A beneficiaries from Cook County, Illinois. In order to assure that our sample was representative of the distribution of former beneficiaries in the County, we made sure that the proportion of our sample from suburban Cook County was in keeping with the proportion of former beneficiaries living in Cook County, Illinois.

A note about the sample size and its generalizability to the population of former SSI DA&A beneficiaries. The study relied on a non-probability sampling method. In employing what is known alternatively as the judgment, purposive sampling, or expert choice method, we have relied on social service providers and social workers with knowledge of this population to identify the settings in which former beneficiaries may be located. This method, while subject to bias of unknown magnitude because of its non-probability basis, offers the best possible solution given the constraints discussed above.

The sample size of 100 former SSI DA&A beneficiaries must be evaluated with an understanding of the non-probability sampling method used. While, the sample provides a significant amount of information identifying common experiences and situations faced by former beneficiaries and those who provide social services to them, these data cannot be accurately interpreted as reflecting the whole of the former SSI DA&A population.

Known biases: In selecting the sample, we strove to maintain a diversity of representation among the sources of referral and geographic areas. However, it should be

noted that the sample is inherently biased toward those former SSI DA&A beneficiaries who elect to receive social services. Given this, the study results are likely to overestimate the impact on service providers and under estimate the support of family and friends as well as work activities for this population as a whole.

The potential bias inherent in the data does not diminish the impacts that we have documented through study findings. They are real and experienced concretely by providers and former beneficiaries alike and should not be discounted.

APPENDIX II

Geographical distribution of sample of former beneficiaries of SSI DA/A

CHICAGO		SUBURBAN COOK COUNTY	
West Side	33%	West Suburbs	5%
South Side	24%	South Suburbs	2%
North Side	32%	North Suburbs	5%

ACTION OPPORTUNITIES
HOUSING
, incorporate the following into the City of Chicago's shelter restructuring plan: Safe Haven shelters for person's with substance abuse problems, on-site supportive service delivery and, aggressive outreach including mobile service delivery
, amend HUD Safe Haven regulations to include service to persons suffering primarily form substance abuse
, expand HUD Shelter Plus Care subsidies
, expand HUD Project-Based Section 8 SRO funding
, amend OASA regulations to include a "grandfathering" clause for existing recovery homes regulatory compliance with new physical site standards
HEALTH CARE
, maintain Medicaid Disproportionate Share payments to hospitals with a high percentage of uncompensated care costs
, re-establish federal funds for FQHC reimbursement rates
, expand and improve community outreach efforts for Public Health Centers and Community Health Centers including efforts for co-location of health care services at social service delivery sites (food programs, soup kitchens, shelters)
, invest state, county, and municipal funds for entitlement screening at health care delivery sites
, increased funding for Public Health Centers and Community Health Centers (including Health Care for the Homeless Program)
, amend the Illinois Nurse Practice Act to include expanded responsibilities for advance practice nurses
EMPLOYMENT AND TRAINING
, set-a-side a portion of the non-custodial parent employment and training funds for programs serving former SSI DA&A beneficiaries with children receiving TANF aid
, increase the appropriation for Earnfare funds to expand available slots and pay contracting agencies for pre- and post-employment and substance abuse service delivery
, IDHS/ORS adopt substance abuse as an area of specialization including provision of training on substance abuse issues for staff, creating substance abuse specialist positions, and adapting the Life Coach program to serve those who's disabilities are due to substance use and abuse
, enact the Chicago Living Wage ordinance inclusive of the "Community Hiring Hall" provision
, change IDHS/OASA and DCCA regulations to allow for more creative partnerships between treatment and employment and training services
, educate employment and training and substance abuse service providers regarding integration in order to facilitate partnerships which produce better outcomes for both provider groups
, require that the Mayor's Office on Employment and Training (MET) contractually mandate that employment and training providers demonstrate effective partnership linkages to substance abuse service providers as a condition of contract award
, establish a transitional demonstration program housed within the Cook County Department of Corrections linking treatment and employment and training services in helping former SSI DA&A
,

ACTION OPPORTUNITIES *continued*
TREATMENT
♦ Change administrative rules governing IDHS/OASA funds to include expenditures for

pre-treatment and outreach services.
♦ Mandate the expenditure of a portion of the SSI DA&A SAMHSA funds for outreach and pre-treatment services, especially mobile outreach such as that provided by the Health Care for the Homeless Program
♦ OASA establish a demonstration program which adapts the ACT model for persons who are disabled by substance abuse
♦ OASA mandate linkage to employment and training providers as a contract condition for community-based service providers
♦ Expand the funding and mandate of the Health Care for the Homeless Program to include a focus on pre-treatment and outreach services for substance abusers
♦ HHS establish a "contingency management" demonstration program targeted at former SSI DA&A beneficiaries
FOOD AND NUTRITION
♦ Invest resources in entitlement screening for food stamps located at soup kitchens and food pantries
♦ Encourage local government to enhance the ability of food banks and like organizations to effectively deliver food to all emergency food service sites.
♦ Fund the CDHS proposal to coordinate efforts between shelters and all emergency food programs in each shelter's geographic area
♦ Repeal limitation on food stamp eligibility for persons between the ages of 18 and 50 not caring for minor children
OVERALL SERVICE DELIVERY STRATEGIES
♦ Increase mobile service delivery
♦ Target funding to better direct funds to service providers

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