“Just Say No” to Welfare

The president who didn’t inhale now denies benefits to those who do

November 1, 1998 By Jeanne Bergman

A little over two years ago, Republicans and Democrats joined forces to eliminate the public-assistance entitlement that had provided security to poor Americans for six decades. Yet in addition to radically tightening eligibility, the sweeping 1996 Personal Responsibility Act implemented a conservative, “family values” agenda by punishing teen parents, providing a massive $50 million for “abstinence only” education in schools and—most important for many people with HIV—introducing strict antidrug policies into welfare law. Every major federal benefit for low-income people is now linked to the so-called War on Drugs. Since 1988, public-housing tenants can be evicted if anyone in their household even smokes a joint on the premises. In early 1996, Congress narrowed the Social Security Act to deny benefits to people whose disability stems in part from drug or alcohol addiction. And now the legislation that created TANF (Temporary Assistance for Needy Families, the new time-limited federal welfare program) has incorporated this “zero tolerance” philosophy.

President Bill Clinton, who enthusiastically signed the welfare bill, has consistently pursued harsh drug policies, including large budget increases for enforcement of drug laws (but not for treatment), mandatory drug testing for teens applying for drivers’ licenses and longer prison sentences for drug-related crimes. Clinton’s political stake in the drug war is exemplified by his refusal to lift the ban on federal funding for needle-exchange programs, despite an affirmation by his own Department of Health and Human Services that such programs sharply reduce the spread of HIV without increasing drug use.

The welfare reform bill contains two specific antidrug provisions designed to promote “personal responsibility” by attempting to compel people to stop using and return to work—and punishing those who don’t get clean. One provision permits states to test public-assistance applicants for drugs and deny benefits to those who test positive. The second requires states to deny welfare and food stamps to people convicted of drug-related felonies after the bill was signed, unless a state enacts special legislation to opt out. (Other felons—murderers, for example—would be eligible for benefits upon release, but not those convicted of selling pot.) No funds at all were earmarked for drug treatment.

These punitive policies significantly impact people with HIV who have used illegal drugs (or, for that matter, medical marijuana). Injection drug use was implicated in 36 percent of all AIDS cases reported to the Centers for Disease Control and Prevention through 1997. Almost half of New York City's AIDS cases are among injection drug-users (IDUs), their sex partners and children—the fastest-growing category of new infections nationally. But many drug-treatment experts say denying survival benefits to IDUs won't help them stay healthy or get off drugs. "Restricting access to essential benefits feeds the conditions that generate drug use," says Chris Lanier, coordinator of the National Coalition to Save Lives Now, which advocates for needle exchange and harm reduction. "If we deny people what they need to live, we'll prevent them from addressing both their drug use and their HIV." But maintaining benefits may have the opposite effect. Karyn Peña, an HIV positive former heroin user and convicted drug felon, is now a case manager at Housing Works, a New York City agency aiding homeless PWAs. In the early 1990s, public assistance served her well. "I needed Medicaid [usually accessed through public assistance] to get into a private methadone program," she says, "and welfare to support me until I could get to where I am now: working hard for other people with AIDS."

The new option to test welfare applicants for drugs has proved popular. More than half the states already screen or test applicants, or plan to. Six are implementing mandatory, across-the-board urine-testing programs. Many others plan to screen applicants to identify people likely to be actively using, and may subsequently test them. The majority of these states will then require recipients to enter drug-treatment programs as a condition for receiving cash assistance. Only about half have "safety net" programs to provide food or other noncash benefits to rejected users.

Yet actually implementing screening and treatment programs has proved far more difficult—and costly—than inventing them. State bureaucracies, already overwhelmed by the enormous task of tracking the new welfare time limits and work requirements, will now have to add criminal-justice records and drug-treatment information to the mix, further burdening systems never known for efficiency. Drug screening requires trained counselors, and urine testing is expensive—around $20 per drug and another $70 for a confirmatory test. Drug-treatment programs will have to be significantly expanded, at great expense, to handle the demand that all this screening and mandatory treatment will create. Estimates of the number of welfare recipients nationwide who use illegal drugs range from 10 percent to 27 percent—from 400,000 to over a million people potentially in need of treatment. But even before welfare reform linked treatment to benefits, 50,000 people languished on waiting lists for treatment.

Just after the welfare act was signed into law, Republican Sen. Phil Gramm of Texas said, "I am very proud of the provision…, which for the first time takes the public policy position that if you are convicted of a drug felony, we are not going, through our welfare programs, to give you a base pay in welfare and food stamps while you are out selling drugs at the local junior high school." He was talking about an amendment he crafted—one of the act's most punishing—that forever denies cash benefits and food stamps to anyone convicted of a felony involving the possession, use or distribution of a controlled substance after August 22, 1996. Those likely to lose assistance will be less dealers than users who particularly need HIV prevention, drug treatment and care—services they'll be unlikely to get if losing benefits forces them onto the streets. Jeff Crowley, deputy

director of programs at the National Association for People With AIDS, recalled activists' fights against the Gramm amendment. "We had finally won a federally accepted standard of care and a decline in AIDS deaths," he says, "and now we're eliminating the baseline programs that will keep people healthy."

States can reject or modify the Gramm amendment, but doing so is politically risky; 30 states have accepted the ban as written. The remainder have modified it or opted out altogether. Some states now require individuals convicted of drug-related felonies to participate in a drug treatment program to get benefits; others narrowed the list of excludable felonies to only a few of the most serious crimes.

Katie O'Neill, vice president for AIDS programs at the national Legal Action Center, remains hopeful that the welfare reform bill will generate opportunities for more people to get appropriate drug treatment. But, she adds, "we need to ask what kinds of treatment will be authorized, and how they will be paid for." Only 20 states plan to use TANF funds for drug-treatment programs, and even fewer—about a quarter—will use the funds for prevention. Drug-treatment providers say that in the long term, residential family programs achieve the greatest success. However, expanding such intensive treatment will be difficult: A Catch 22, the welfare reform law prohibits the use of TANF for medical purposes, and Medicaid cannot be used for most inpatient mental-health facilities. So most states will be forced to limit addiction services to detox and short-term care, effectively guaranteeing that large numbers of recipients will relapse—and lose their benefits.

In the current political climate—in which, for instance, New York City Mayor Rudy Giuliani has vowed to limit clients at city methadone clinics to three months' treatment—harm reduction and methadone maintenance are less likely to be accepted by states than abstinence. Equally troubling is that treatment providers now have the power to decide whether someone has successfully completed a program. Eligibility for federal benefits will thus increasingly be determined by the staff of privately run programs, many of them based on strong religious or philosophical principles. Refusal to submit to a "higher power," for example, as required by 12-step programs, might cut someone off from welfare.

Advocates recommend that people with HIV who depend on government benefits and use drugs—even medical marijuana—take certain steps. Users, they say, should get informed about their state's new rules. And those who are ready to quit should seek drug treatment now, so they can find a program sensitive to their needs, rather than being sent somewhere else later by the welfare department.

As the enormous financial costs and public-health consequences of the welfare bill's antidrug provisions become clear, advocates are strategizing over how to protect people living with and at risk of HIV. New York attorney and AIDS law specialist Corrine Carey says the new drug screening programs could be successfully challenged in court. "Drug testing of poor people without any suspicion," she says, "violates the basic constitutional rights to due process, equal protection and privacy." As with the welfare reform bill's other contested provisions, efforts to soften the antidrug

policies are focused on the states. Advocates in New York, California and elsewhere have begun to lobby legislators for revisions to the law’s harsh drug rules. Their message: Resist the simplistic, ineffective ideology of the War on Drugs and develop policies that assist drug-users instead of punishing them.

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