The Impact of Substance Abuse on Welfare Recipients

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Introduction

In 1996 the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) marked the beginning of the welfare to work initiative (Legal Action Center [LAC], 2002b). The initiative was necessary in order to decrease reliance on the government for financial support; however, many individuals have suffered as a result of this policy. Many welfare recipients have the desire to work; however, they often face insurmountable barriers.

One of the biggest obstacles for welfare recipients today are substance abuse problems. Substance abuse often causes persons to lose motivation and responsibility, preventing them from holding a job or performing the duties that a job entails. Their priorities become skewed, and people do not realize that they have a problem nor have the ability to deal with the addiction independently. Substance abusers need intervention in order to control both the physical and psychological dependencies on the drug; however, substance abuse treatment is very expensive and requires time. In many cases an individual will be required to stay in a treatment center in order to handle the withdrawal symptoms and to avoid a relapse. Additionally, drug addicts often require psychotherapy after they have quit the drug to help them cope with their new lifestyle.

Therefore, in order to allow all individuals the opportunity to escape poverty, resources must be available to help individuals overcome the barriers of substance abuse. Current welfare policies make this task very difficult. First, any individual who has committed a drug felony is permanently ineligible for food stamps; however, individuals who have committed murders or rapes are qualified for food stamps (LAC, 2002a; LAC, 2002b; LAC, 2000; LAC, 1999; LAC, 1997; Welfare Information Network, 1997).

Furthermore, the reimbursement rates that Medicare provides for psychotherapy sessions are minimal, forcing welfare recipients to work with an unqualified psychiatrist or forego psychotherapy completely. Either way the person does not receive adequate treatment, which is an integral part of making the transition from welfare to work.

This paper explores many complex facets of the impact of substance abuse on welfare recipients. First, the prevalence of drug use among the total population and individuals on welfare are studied. Next, the barriers created by substance abuse are analyzed, including barriers that mothers with children encounter. The various types of treatment are then discussed, as well as the availability of these treatments for welfare recipients, especially women. Finally, welfare policies regarding substance abuse are analyzed and recommendations are made regarding these policies. Substance abuse causes serious problems for welfare recipients and is deserving of research and attention so that individuals have a chance to become reintegrated in society and capable of moving from welfare to work.

Definitions

When discussing drug use several important concepts must be differentiated in order to fully comprehend the nature of the discussion. Several different terms are defined here so that these conditions are understood in their entirety throughout this paper. The most basic concept regarding substance abuse is the acknowledgement of what constitutes a substance. A substance is any natural or synthesized product that has psychoactive effects and changes behavior, emotions, perceptions, and thoughts (Nolen-Hoeksema, 2004). Substance use encompasses any ingestion of a substance. Substance

abuse involves recurrent use of a substance that results in significant harmful consequences (Nolen-Hoeksema, 2004). According to the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) a person is diagnosed with substance abuse if one or more of the following standards leads to significant impairment or distress during a twelve-month period: failure to fulfill important obligations at home, work, or school; repeated use of the substance in situations in which it is physically hazardous; repeated legal problems; continued use of the substance despite social or legal problems as a result of the substance use (Nolen-Hoeksema, 2004).

The story of Samantha illustrates the concept of substance abuse and the harmful consequences that it can have. Samantha abused both cocaine and heroin and resorted to shoplifting and selling stolen jeans to finance her habit. She was caught shoplifting and charged with grand theft on two occasions, both resulting in jail time. Samantha was then arrested again for stealing, which resulted in more imprisonment and the loss of her daughter. Five days after she was released from jail, she was caught shoplifting yet again, as she attempted to gather money so she could afford a place to sleep. This time she was put in jail for eight and a half months (Anonymous One, n.d.b). Samantha's battle with drugs clearly illustrates several of the criteria necessary for being diagnosed with substance abuse.

Substance dependence is often used synonymously with drug addiction; however, these two concepts are different. Addiction is compulsive use of a drug for nonmedical reasons and is not necessarily accompanied by physiological changes (Cancer Pain Release, n.d.). Substance dependence, by contrast, involves evidence of physiological dependence plus repeated problems due to the use of the substance. According to the

DSM-IV persons can be diagnosed with substance dependence if they have a maladaptive pattern of substance use which leads to three or more of the following: tolerance, as defined by experiencing less effect from the same dose of a substance or requiring more of the substance to experience intoxication; withdrawal, as manifested by either the characteristic withdrawal syndrome for the substance or by the same or a closely related substance taken to relieve or avoid withdrawal symptoms; the substances are taken in larger amounts or over a longer period than was intended; having a persistent desire or an unsuccessful effort to cut down or control the substance use; spending considerable amounts of time in obtaining and using the substance or recovering from the effects of the substance; sacrificing important social, occupational, or recreational activities as a result of substance use; continuation of the substance use despite knowledge of recurrent physical or psychological problems which are caused or exacerbated by the substance (Nolen-Hoeksema, 2004).

Lucy, an 18 year-old crack and heroin user, illustrates the maladaptive patterns which define substance dependence. Lucy entered a detoxification program, but she immediately relapsed after she was released. Lucy made an effort to stop using crack and only use heroin; however, her attempt was unsuccessful. Instead she resorted to prostitution and working in a crack house to facilitate her need for crack. She was participating in activities that she had never contemplated before (Nolen-Hoeksema, 599). The distinctions between the various terms relating to drug use are all very important; however, it is clear that abuse, dependencies, and addictions can all have devastating effects on an individual's life.

Scope of the Problem

Substance abuse is a problem across the United States. Individuals both rich and poor constantly struggle to overcome drug problems. In 1998, the National Household Survey on Drug Abuse (NHSDA) estimated that almost 14 million Americans, or 6 percent of the population over the age of 12, had used a drug, excluding alcohol, in the previous month (Legal Action Center (LAC), 2002a). Despite the shocking nature of this number, it is also disturbing how many of these individuals constitute the low-income sector of the population. Data consistently shows that between 10 and 20 percent of adult welfare recipients have problems with drugs or alcohol, rates which tend to be higher than those of non-recipients (LAC, 2002b; LAC, 2001b; LAC, 1999a; LAC, 2001a; LAC, 1997; LAC 1998; Welfare Information Network, 1997). One of the original statistical studies investigating drug use among welfare recipients and non-recipients was performed in 1992. This National Longitudinal Alcohol Epidemiologic Survey found that 17.9 percent of welfare recipients were dependent on a substance, compared to only 8.9 percent of non-recipients (LAC, 2002a; LAC, 1997).

Over the 1990's it appears that this gap has become smaller. The 1998 NHSDA estimated that 18 percent of welfare recipients reported past year drug use compared to 10.1 percent of those not receiving welfare (LAC 2002a). The 2000 NHSDA also found a higher prevalence among individuals receiving government aid, with 9.6% of government assistance recipients between 12 and 64 years old reporting illicit drug use in the past month, as compared to only 6.8% of individuals who did not receive government assistance (Substance Abuse and Mental Health Services Administration (SAMHSA), 2002). Additionally, the 2002 National Survey on Drug Use and Health reported that

dependence or abuse of any illicit drug or alcohol was found for 11.4% of individuals receiving government assistance but for only 9% of individuals not receiving government assistance (SAMHSA, 2003a).

Another concern regarding drug use among welfare recipients is the prevalence among women, especially women with children. For all women, 4.5 percent reported using drugs in the past month while 8.5 percent reported a binge-drinking episode. Among women who had given birth, 5.5 percent had used drugs and 18.8 percent had drunk alcohol at some point during their pregnancy. In addition, 5.7 percent of women with children at home had used a drug in the past month, while 4 percent had engaged in binge drinking. The numbers for women who receive welfare are more disconcerting. These women were not surveyed for use, but rather for abuse or dependency. A 1992 study reported that 7.3 percent of women on welfare abused or were dependent on alcohol, while 3.3 percent abused or were dependent on drugs (LAC, 1999a). Although there is some research available regarding drug and alcohol use among pregnant women or women with children, additional studies are necessary to provide support and validation for the current data. The prevalence of drug use among welfare recipients is disturbing, and it is an issue that must be addressed in order to combat the plague of poverty.

Contributing Causes of Substance Abuse in Welfare Recipients

Several different variables have been cited as possible explanations for the discrepancies in substance abuse rates of welfare recipients and non-welfare recipients. Factors which frequently influence drug habits include age, education level, and

employment status (LAC, 1997). Drugs users tend to be younger, have lower levels of education, and tend to be unemployed, all of which are also characteristic of low-income individuals. A 1995 study supports these trends, finding that 14.3 percent of unemployed adults over 18 were current drugs users, compared to only 5.5 percent of full-time employed adults (LAC, 1997). Although these factors may not be the only reason for higher drug use among low-income individuals, they certainly can be considered contributing factors.

Drug abusers frequently reflect on their substance abuse problems and recognize factors that influenced the progression of their problems. Monty, a former heroin addict, describes the factors that he perceived as contributing to his drug use:

> I later learned that my problem was not in fact heroin, but that heroin was a mere symptom of my problems. My problem was my thinking, I lacked the tools and skills to live life on life's terms so I chose to escape with tools such as heroin, coke, alcohol, sex... the actual problems were not being dealt with and the problems of yesterday were stacking onto the problems of today. The only remedy was more drugs. (Anonymous One, n.d.a)

Monty's description of his substance abuse problem provides valuable insight into the mentality and motivation of a drug user. If an individual lacks education and marketable skills, then ensuing disadvantages in life are often avoided by using drugs. Monty explains that the consequential burdens of drug use can snowball and result in apathy and disregard for these problems. The only apparent solution for drug users is to resort to more drug use. Monty's situation illustrates several contributing factors in the perpetual

cycle of drug use, which revolves between life problems and drug use as a method of coping and disregarding these problems.

Substance Abuse as a Barrier to Escaping Welfare

Substance abuse can be cited as a barrier to escaping poverty, regardless of which factors are responsible for contributing to abuse among low-income individuals. Many welfare recipients themselves have cited addictions as a barrier to self-sufficiency (LAC, 1997). Additionally, a 1995 study found that between 10 and 30 percent of welfare recipients were limited in job training, job searching, and job retention due to alcohol or drug problems (LAC, 1997). An important factor regarding substance abuse and job opportunities is the increased frequency in drug testing as part of the hiring process. New testing policies could cause many problems for welfare recipients who are looking for employment while still using drugs (Booth et al., 2001).

Substance abuse acts as a barrier towards women with children as well. One of the greatest barriers that women experience is the stigma associated with drug and alcohol use and treatment. Several women feel guilt, shame, and low self-esteem as a result of their drug and alcohol use. These emotions can lead to depression, isolation, and a lack of motivation and courage to enter substance abuse treatment programs. In addition, when a women leaves a treatment program, she will often have a difficult time finding a job due to the stigma associated with women who have had drug and alcohol problems (LAC, 1999a; LAC, 1997).

Another barrier that women face is experience with violence. Many women who have drug and alcohol problems have been either raped or assaulted. Histories of this

nature often make these individuals especially susceptible to relapse identified by certain triggers. The suppressed memories associated with these violent episodes must be addressed in order to have a successful recovery (LAC, 1999a; LAC, 1997). Substance abuse can become a burden for many individuals, especially those who desire independence from welfare; however, they are unable to do so due to the resulting hindrances of their drug or alcohol problem.

Treatment Services

A variety of treatment services are available for substance users. The initial step in drug or alcohol treatment is an assessment and diagnosis regarding the client's condition. An assessment involves an evaluation of the client's disease course and stage and a proper referral is then made for further treatment (LAC, 1997). The diagnosis is critical so that the client receives appropriate treatment for his or her situation

Medication management or detoxification commonly follows up assessments. Medication management involves a licensed physician who administers medications to help wean individuals off of a substance, reduce the desire for a substance, or to control the level of substance use. Several different types of medications are available including antianxiety drugs, antidepressants, and antagonists. These medications reduce the desire for certain substances and therefore reduce the use of those substances. Another common method of management, which brings heroin addictions to a controlled level, is methadone maintenance programs. Methadone is a synthetic drug that is less potent and has longer lasting affects that heroin. Methadone maintenance involves substituting

methadone for heroin, so that there the severe withdrawal effects are reduced, and the drug dependency is brought down to a controlled level (Nolen-Hoeksema, 2004).

Detoxification aids patients through the medical and psychological conditions accompanying withdrawal. When a patient enters a detoxification program, he or she is first assisted in terminating use of the substance. The body then rids itself of the substance completely. This process often takes place in a hospital setting, so that the patient can be monitored and so medical assistance is available in case of an emergency. The withdrawal process from several drugs, including cocaine, amphetamines, and inhalants, can often cause permanent brain damage, so having a physician present to intervene is necessary (Nolen-Hoeksema, 2004; LAC, 1997). Detoxification services help provide safe withdrawal and a timely entry into continued treatment.

Medication management and detoxification are usually most effective when paired with counseling services. Counseling services cover a wide spectrum of areas. Counseling services are often available regarding the use and abuse of alcohol, familial relationships, eating disorders, self-esteem problems, gender-specific issues, parenting counseling, and relapse prevention (LAC, 1997; LAC, 1999a). In some rural areas innovative techniques are being used to provide counseling services to drug users. One new method involves the use of interactive televisions so that mental health professionals and primary care providers can communicate and discuss patients' treatment plans. The use of telecommunication technologies would allow rural areas to have access to a wider range of professionals, including qualified specialists, without having to travel great distances (Booth et al., 2001).

Outpatient and ambulatory services overlap with counseling services in a lot of respects. Outpatient services usually help clients reintegrate into the community. Counselors assist individuals with lifestyle, attitudinal, and behavioral changes that accompany life without substance abuse. Clients are taught to identify situations in which they would be most likely to use drugs and are then taught methods to help cope with these situations. They also learn to evaluate these situations and recognize the potential consequences of using drugs or making other poor decisions. Counselors also teach clients to cope with stress and adverse situations without resorting to drug use (Nolen-Hoeksema, 2004; LAC, 1999a).

Finally, residential inpatient services provide 24-hour professionally directed evaluation, care, and treatment (LAC, 1997). Residential inpatient services include individual therapy, group therapy, medical care, and education. Clients in residential programs are commonly taught life skills as well, such as stress management, coping skills, parenting skills, educational training, and English language competency (LAC, 1999a). All of these skills are vital to being successful in becoming reintegrated into society and working towards self-sufficiency. Life skills also reduce the likelihood of relapse because they give clients various techniques to fall back on instead of relying on drugs.

The most widespread treatment approach for both inpatient and outpatient clients are 12-step programs, such as Alcoholics Anonymous (AA), to gain and maintain sobriety (Betty Ford Center, n.d.). These 12-step programs believe that the only way to control substance abuse is to abstain from use completely. Clients in these programs are required to admit that they have a problem with a substance and that they are powerless

to control the effects of the substance. Through belief in a higher power, moral and social support from other group members, and self-discipline, individuals work towards complete abstinence (Nolen-Hoeksema, 2004).

Treatment Availability

It is important to note that the availability of substance abuse programs is only important if individuals have the desire to enter these programs. Research often distinguishes between an individual needing to receive treatment as opposed to wanting to receive treatment. When statistics are presented, it is important to take into consideration the fact that although individuals may need substance abuse treatment, it does not mean that these people are actively seeking or willing to participate in treatment programs.

Research consistently shows that there is a huge gap between the demand for treatment and number of treatment facilities. The current national trend is that there is a largely unmet demand for substance abuse treatment for both welfare-recipients and non-recipients. In 1997 it was reported that only 50% of substance users who required treatment received it (LAC, 1998).

A more recent study in 2002 found that of 7.7 million persons aged 12 or older who were classified as needing treatment for an illicit drug problem, only 1.4 million (about 18 percent) received specialty treatment in the past year. Of the 6.3 million people who did not receive treatment, 37 percent cited the costs of treatment as the reason for not seeking help. Additionally, almost 18.6 million persons aged 12 or older were classified as needing treatment for an alcohol problem, while only 1.5 million (about 8

percent) received specialty treatment in the past year. Of these individuals who did not receive treatment, 40 percent cited the cost of treatment as a contributing factor to their not receiving treatment (SAMHSA, 2003b). Therefore, poorer drug users have a smaller window of opportunity for receiving treatment, which perpetuates the cycle of drug use and poverty. Clearly, an inadequate number of individuals are being served by the current drug and alcohol treatment centers. Changes must be made to meet the needs of these individuals.

Women have a very difficult time accessing alcohol and drug treatment as well. A study of the general population between 1991 and 1993 found that only 41 percent of women and 47 percent of men who needed treatment received it. For welfare recipients 48 percent of women received treatment, while 61 percent of men received treatment (LAC, 2001a; LAC, 1999a). A 1994-5 study supported this finding, reporting that 36.6 percent of women and 47.8 percent of men with drug problems were in treatment in the past year (LAC, 1999a). There is a clear disparity between men and women regarding treatment availability.

The lack of availability of drug and alcohol treatment facilities for women could be detrimental to the well being of several mothers and children. According to estimates of prevalence rates among women, there are between 400,000 and 800,000 women on welfare who are seeking treatment. When women only make up 30 percent of treatment admissions into public programs, and 17 states report that there are gaps in treatment services for women, then there are going to be numerous individuals who are going to have unmet needs (LAC, 1999a).

In addition, there are several factors that influence the ability of a woman with children to find an appropriate treatment program. First, the treatment facility must have childcare available. In order to be able to enter a treatment program or receive services, a mother must first find care for her child. Unfortunately this is very difficult in publicly funded treatment facilities, with only 12.9 percent of these facilities having childcare (LAC, 1999a; LAC, 1997). A mother also risks losing custody of her child if she seeks out treatment. Many states take action against drug abusing women and report the situation to child protective services, which puts the mother at risk of having her child taken away. These barriers must be addressed and removed so that more women are inclined and able to enter drug and alcohol programs. Treatment programs are imperative in helping mothers regain control over their lives so that they can care for themselves as well as their children. The populations of women and mothers with children deserve more attention and require more services in order to prevent negative consequences.

Medicaid coverage for drug and alcohol treatment is also scarce. Very few states provide comprehensive services through Medicaid. The four services provided are methadone maintenance, outpatient services, non-hospital residential services, and hospital-based services. Only fifteen states reported methadone maintenance coverage, twenty-five states reported outpatient services, twenty-one states reported non-hospital residential services, and twenty-six states reported hospital-based services. Ten states reported having all four services available (LAC, 1997). In addition to the deficiencies in availability of treatment, it is important to consider the quality of the available treatment. Although there is no research documenting the quality of services available in public versus private programs, it is reasonable to assume that private programs are much more

comprehensive and extensive. Therefore we can assume that welfare recipients have less substance abuse treatment programs available and those that are available are significantly poorer than private programs.

Treatment Effectiveness

Numerous success stories demonstrate that afflicted persons have been able to overcome their addictions and become reintegrated into society. One inspiring story is about a woman named Renee. Renee describes her experience with a drug treatment program at an organization called the Epiphany House. She entered the program so that she could deal with her drug addictions, her depression, and the stress of having a new child. At the Epiphany House she learned valuable life skills that helped her deal with everything from budgeting to self-confidence. She comments, "I had to relearn everything I lost when drugs took over my life. I felt like I was in a hole and couldn't crawl out . . . I was never accountable for my debts. Now I know what I have to do so I'II never be homeless again . . . Today I realize that some days I am confident and some I'm intimidated but one day at a time I work through these feelings."(Epiphany House, 1997) Since leaving the program at the Epiphany House, Renee has gone on to earn a degree from the local community college and found a job administering CPR as part of a hospital team.

Studies consistently find data support the possibility of reintegration into society. Treatment can also increase employment and earnings, decrease the use of welfare programs and drug and alcohol use and health care costs for welfare recipients (LAC,

1997). These factors are critical for escaping poverty and constitute a strong argument for increasing substance abuse treatment for welfare recipients.

The reduction of drug and alcohol abuse is the primary focus of substance abuse treatment programs and is the most basic measure for evaluating treatment effectiveness. The 1994 California Drug and Alcohol Treatment Assessment study (CALDATA) and the 1998 National Treatment Improvement Evaluation Study (NTIES) are two studies which have found impressive rates of reduction of drug and alcohol abuse. First, data from the CALDATA study showed that participants reduced crack, cocaine, and amphetamine use by one-half, heroin use by one-fifth, and alcohol use by one-third (LAC, 2002a; LAC, 1997). The NTIES reported a decrease in crack use by 50.7 percent, heroin use by 46.5 percent, and overall drug use by 50 percent (LAC, 2002a; LAC, 1997). Other state-reported data have found lower overall drug use than the NTIES study, reporting only a one-third reduction in drug use (Welfare Information Network, 1997).

Treatment programs also promote employment, especially among welfare recipients. The NTIES reported an 18.7 percent increase in employment after one year of treatment, and the CALDATA reported a 30 percent increase in employment for individuals who completed more than four months of residential treatment (LAC, 1997). State reported data showed larger increases than these two studies, reporting a 60 percent increase in employment after treatment (Welfare Information Network, 1997). Data was consistent for women as well, with the Pregnant and Postpartum Women with Infants (PPWI) program reporting more than an eightfold increase in employment (LAC, 1999a).

In addition to higher employment rates, individuals are likely to receive higher wages and be employed full-time after treatment. The NTIES found a 6 percent increase in income, while an Oregon study found that individuals who completed treatment had wages 65 percent higher than others who did not complete treatment (LAC, 2001a; LAC, 2001b). Finally, a Minnesota study reported an 18.1 percent increase in full-time employment after six months of treatment (LAC, 1997; LAC, 2001a; LAC, 2001b).

One perceived disadvantage of substance abuse treatment are high costs of treatment facilities and recovery programs; however, cost-benefit analyses consistently show that the costs of treatment programs are more than compensated for by the consequential decreases in the use of welfare, and lower healthcare costs. By creating the ability for individuals to become employed, there is less of a dependence on welfare payments. The CALDATA found that women reduced their welfare participation by 22 percent after receiving treatment, while the NTIES reported a 10.7 percent reduction (LAC, 1997). Additionally, an Oregon study found that three years after treatment, clients had reduced their food stamp costs by $877 (LAC, 2001a). The reports of reduction in healthcare costs showed staggering figures as well. CALDATA participants had a 23.5 percent reduction in total health care costs between the year before treatment and the year after treatment (LAC, 2002a). In addition, the public substance abuse treatment initiative in Minnesota saved the state $7.9 million in medical hospital days, $10.8 million in psychiatric hospitals days, and $3.3 million in detoxification admissions (LAC, 1997). Although the financial incentives for substance abuse treatment are not initially apparent, there are clearly huge benefits to investing in these programs. A

California study supports this idea, reporting that for every dollar invested in alcohol and drug treatment, taxpayers save seven dollars (LAC, 1997).

Studies on the effectiveness of alcohol and drug treatment among women have had positive results as well. The aforementioned PPWI had successful results in addition to the increase in employment among pregnant and postpartum women. Of the women in the PPWI program, 67.4 percent were not using drugs or alcohol, 90.3 percent were not involved with the criminal justice system, and 86.5 percent of children were living with their mothers (LAC, 1998). The success rate among this program is especially important due to the target group, and the benefits coming from the program will trickle down and benefit the children's development as well. The NTIES also had impressive statistics about women in federally funded alcohol and drug treatment programs. There was a 40 percent reduction in drug use, as well as decreases in arrests, drug selling, and shoplifting (LAC, 1999a). Both of these studies show that treatment programs for women have significant positive results, and access to these beneficial services need to be maximized.

Although available data has shown consistent, positive results, where the savings of treatment programs exceed the costs, more studies regarding treatment effectiveness are necessary. Many of the existing studies do not specifically study welfare recipients or focus on the effectiveness of treatment programs for women. There are also huge discrepancies in the findings of many of the studies. Finally, very little information is available regarding long-term effectiveness of substance abuse treatment.

Funding

There are several different sources of funding for public alcohol and drug treatment services. In 1994, $4 billion was available for public sources of drug and alcohol treatment, as opposed to $1.6 billion in the private sector. In the public sector, federal sources supplied $1.4 billion, while states provided $1.5 billion, local sources contributed $247.4 million, and other sources provided $723 million. The federal funds come from several different programs. The largest contribution comes from the Substance Abuse Block Grant, which is provided by the Center for Substance Abuse Treatment (CSAT), a division of the United States Department of Health and Human Services. In 1997, this block grant provided $1.36 billion for treatment programs, and required that a certain percentage of the grant must be spent on women's services. In addition, the Prevention Demonstration Programs of the CSAT and the Drug Free Schools and Communities Act provided $156 million and $556 million respectively for prevention programs. Finally, Medicaid provided $230 million in 1997for treatment of drug dependencies (LAC, 1997).

States also are able to invest TANF funds in alcohol and drug treatment programs; however, many states do not use significant amounts of TANF funds for these services. In 2002 only 61 percent of the states reported investing TANF funds for substance abuse treatment programs, with spending ranging from $178,000 to $20.2 million. The average amount of money allocated was $5 million. Although states are providing acceptable amounts of money, it is disappointing that most states are spending less than one percent of their total TANF funds on alcohol and drug treatment (LAC, 2002b). By spending a slightly higher percentage of the total TANF funds, states would be able to provide significantly more treatment services, benefiting welfare recipients.

No further information was available regarding the sources or allocations of state, local, and private funds.

Welfare Policies and Substance Use

The 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) changed the welfare system drastically. The PRWORA established several provisions, which have created many barriers for welfare recipients who are substance users.

The first provision is found in Section 115 of PRWORA and states that any individuals who are convicted of a drug felony after August 22, 1996 are permanently ineligible to receive food stamps and TANF (LAC, 2002a; LAC, 2002b; LAC, 2000; LAC, 1999; LAC, 1997; Welfare Information Network, 1997). States have the option to opt out or modify the ban; however, only 52 percent of the states have made use of this option (LAC, 2002a). The implications of this law extend beyond the obvious prohibition of food stamps and TANF. Several public treatment facilities rely on food stamps and TANF to help cover the costs of room and board. Without the allotment of these welfare payments many treatment programs have to reduce their caseload (LAC, 2002b; LAC, 2002a; LAC, 1997). Furthermore, even if the individual participates in a drug treatment program, avoids recidivism, abstains from drug use, or has a successful job history, the ban will not be lifted. The number of individuals who could potentially be impacted by this provision is noteworthy. Studies show that in 1994 alone, there were 300,000 Americans who were convicted of drug felonies. Another survey of women's treatment programs found that 24 percent of the clients had felony drug convictions

(LAC, 1997). This new provision significantly impairs the ability of many welfare recipients to become reintegrated as active members of society.

Another key provision of the PRWORA states that individuals who violate a condition of their parole are ineligible for TANF, food stamps, Supplemental Security Income (SSI), and public housing benefits (LAC, 1999; LAC, 1997). The ambiguity of this provision is problematic, because it does not specify what constitutes a violation of parole, and provides very little definition about the duration of the ineligibility. Again, the provision could also have a very large impact, given that more than 3.6 million Americans were on parole in 1994 (LAC, 1997).

Another important provision involves treatment reimbursement in the Medicaid program and the Institution for Mental Diseases (IMD) exclusion. The IMD exclusion prohibits Medicaid spending in residential treatment facilities with more than 16 beds for individuals between the ages of 22 and 64 with "mental diseases", with substance abuse being included as a mental disease (LAC, 2002a; LAC, 1997; Welfare Information Network, 1997). Consequently, inpatient substance abuse coverage is limited to short-term detoxification centers or hospital emergency room services (Welfare Information Network, 1997). Many individuals who need treatment will be unable to access the necessary services due to an inability to pay. For instance, Medicaid would not cover prenatal care for a woman in a residential drug or alcohol treatment program that has more than sixteen beds.

Many welfare recipients are also negatively impacted by the lack of a federal mandate to include drug and alcohol treatment as a service provided through Medicaid (LAC, 1997; LAC, 2002a). Because treatment is not a federally required service, states

are able to restrict the amount of reimbursement that clients receive; therefore, many individuals are unable to access drug and alcohol treatment services due to poor reimbursement rates. The imposed restrictions vary from state to state, but frequently include low payment rates for providers, low limits on the number of days for inpatient and outpatient treatment, and restrictions on the types of providers that can be reimbursed (LAC, 2002a).

Another provision included in Section 408(a)(6) of PRWORA states that TANF funds many not be used for medical services (LAC, 1997; LAC, 2002b; Welfare Information Network, 1997). The failure to define what constitutes medical services discourages states from funding alcohol and drug treatment programs. Many states fear penalization for misuse of funds because they are unclear about the regulations of the provision. As a result, many welfare recipients who need substance abuse treatment are unable to receive the needed services.

The institution of time limits for receiving TANF is another provision that could have adverse effects for many welfare recipients. With the enactment of PRWORA, a family is only allowed to receive TANF assistance for five cumulative years. States have the right to exempt up to 20 percent of the caseloads from the time limit; however, there are still numerous people who are affected by the new law (LAC, 1997). The time limit was set in order to promote employment among recipients and to decrease the reliance on government assistance. Although this is an important initiative many people may require more time to achieve self-sufficiency and may not be included in the 20 percent exemption. Drug users who participate in treatment programs are one group who may require government assistance for more than five years. If these individuals are in

treatment and receiving benefits, then the time counts towards their five-year time limit. Once drug users have completed substance abuse programs, they have already exhausted a significant amount of their five-year allotment of assistance while in treatment. By having less time available to receive assistance, there are increased levels of stress and pressure to gain self-sufficiency, which could potentially cause a relapse and throw individuals back into drug use.

Two final provisions that greatly impact welfare recipients are found in Section 902 and Section 114 of PRWORA. Section 902 gives states the option to test welfare recipients for illegal drug use and sanction individuals, other than pregnant women, who test positive (LAC, 2002b; LAC 2002a; LAC, 2000; LAC, 1999; LAC, 1997). As of 1997, twenty-seven states had reported that they would screen welfare recipients for illegal drug use (LAC, 1997). Next, Section 114 allows states to sanction Medicaid benefits for individuals, other than pregnant women, who do not comply with TANF work requirements (LAC, 2002a; LAC, 2002b; LAC, 1997). By 2002, only thirteen states had adopted this provision (LAC, 2002a). Despite the fact that many states have not adopted these provisions, there still will be detrimental effects on many welfare recipients. By losing welfare benefits, individuals have fewer resources available to address their drug problems; therefore, with regards to drug and alcohol users, this legislation is not fulfilling its intended purpose of encouraging work among welfare recipients. As long as these people have drug addictions they will not be able to maintain a steady job, and losing benefits will cause them to fall deeper into poverty.

Policy Recommendations

Many recommendations have been made regarding the aforementioned policy barriers for welfare recipients with drug and alcohol problems. The current welfare policy inhibits substance users from overcoming their problems and moving towards self-sufficiency. Consequently, changes need to be made in order to prevent a regression into deeper poverty.

First, alcohol and drug treatment need to be added to the list of work activities that comply with TANF work requirements (LAC, 2001a; LAC, 2001b). If this change is made then individuals will not be sanctioned for non-compliance with the work requirements; therefore, they will retain their benefits and have resources available to work towards independence.

A related desired change involves exemption from federal time limits for welfare recipients in drug or alcohol treatment (LAC, 2001a; LAC, 2001b). An exemption from federal time limits would allow substance abusers time to overcome their drug problems and then have the full sixty months to gain self-sufficiency. The extra time available for receiving TANF benefits could help avoid potential relapses in an already fragile recovering addict. Another recommended exemption would be to spare individuals from TANF and Medicaid sanctions if they are participating in substance abuse treatment or willing to enter treatment (LAC, 2001a; LAC, 2001b). By retaining welfare benefits, people will be able to continue to afford substance abuse services and there will be a higher probability of moving from welfare to work.

Another major barrier for substance abusers is the "Institution for Mental Diseases (IMD)" exclusion. By not classifying substance abuse as a mental disease, people would be able to receive Medicaid reimbursements for inpatient substance abuse

services (LAC, 2001a; LAC, 2001b; LAC, 1998). Increased access to residential treatment would benefit some of the most at-risk substance abusers, who could fall much deeper into poverty otherwise.

Another recommendation is to exclude substance abuse from the group of medical services that TANF funds are not allowed to be used for (LAC, 2001a; LAC, 2001b). If states know that substance abuse is not included as a medical service, their reluctance to fund alcohol and drug treatment programs should decrease. Increased funding would lead to an increase in facilities and availability of services. An alternative solution would be to make alcohol and drug treatment part of the required services of Medicaid. If these services were required, then there would be an established source of funds and they would not be subject to discretionary allocations (LAC, 1998).

Finally, Congress should remove the ban on eligibility for food stamps and TANF for convicted drug felons (LAC, 2002b; LAC, 2001a; LAC, 2001b). These individuals need access to welfare benefits so that they have the capability to become active members of society. If these changes are enacted, substance abusers will be able to remain in treatment programs and will eventually be able to work towards self-sufficiency.

Conclusion

Drug use plagues individuals throughout the United States. Individuals both rich and poor become victims of drug addictions and experience negative consequences occupationally, socially, and emotionally. Families are destroyed and individuals fall into poverty as a result of drug dependencies. The adverse affects that drugs can have on individuals must be combated, especially among impoverished people, so that they can

escape the cycle of poverty; however, there are numerous barriers that afflicted persons are unable to overcome. Barriers extend from a lack of personal motivation or desire to deal with the drug problem to federal policies which inhibit self-sufficiency. These barriers must be dealt with in order to reduce the high prevalence rates of drug use in impoverished communities.

Several different recommendations have been made regarding the barriers that welfare recipients must rise above in order to deal with substance abuse problems. The most important recommendations are the aforementioned modifications to PRWORA. By changing welfare policies so that individuals are not punished as a result of their drug use, then individuals have more resources available to escape poverty. Policy revisions will give individuals such as Monty, Samantha, and Lucy renewed hope that they can overcome their problems.

More substance abuse treatment programs also need to be made available so that low-income individuals have access to treatment options. Research consistently shows that substance abuse treatment programs are effective and help promote self-sufficiency. By making these changes, welfare recipients will have more opportunities to overcome their drug problems and strive for independence from government assistance. Substance abuse is a problem that afflicts many people, especially impoverished individuals, and must be addressed in order to combat the war on poverty.

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