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UNDESERVING ADDICTS: SSI/SSD AND THE PENALTIES OF POVERTY

DEAN SPADE*

"We're in a war."

--Former Los Angeles Police Chief Daryl Gates.¹

INTRODUCTION

Since the late 1980's, American media and politicians have produced and participated in a moral panic around the issue of illegal drug use. This panic has generated vivid pictures in the American imagination of drug users as a morally depraved, irresponsible, and willfully criminal underclass. Such images have fueled the "war on drugs," a multi-faceted rhetoric and policy approach to drug use that focuses on incarceration, interdiction, and other criminal justice strategies.

The punitive approach of the war on drugs has bled into poverty and disability policy with alarming persistence. The trend has influenced numerous poverty alleviation and disability programs and protections, leaving drug users increasingly isolated and unaided. This comment explores the impact of such changes on the Americans with Disabilities Act² (ADA) and two social security policies, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI). It questions the wisdom of a punitive response to drug use by examining the alternative model of harm reduction and applying the principles of harm reduction analysis to the exclusion of drug users from poverty alleviation and disability programs.

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¹ Gates made this statement in defense of his testimony before the U.S. Senate that casual users of illegal drugs should be taken out and shot by police. Kenneth J. Vanko, *In Search of Common Ground: Leveling the Playing Field for Chemically Dependent Workers Under the Americans with Disabilities Act of 1990*, 1996 U. ILL. L. REV. 1257, 1294 n.279 (1996).

² 42 U.S.C. §§ 12101, 12213 (1991).

Part I describes recent changes in disability policy, which reflect a decrease in coverage for persons disabled by drug use. Part II describes the context in which these changes occurred, with the war on drugs in full force, and offers critiques of drug war strategy. Part III describes the harm reduction model as an alternative to the drug war approach. Part IV examines the impact of drug war policy on the poor, arguing that pushing drug users further into poverty by denying them public assistance will increase drug-related harms. Furthermore, this section suggests that strong social welfare systems can operate to reduce the intersecting harms of poverty and drug use.

I. OVERVIEW OF CHANGES TO DISABILITY POLICIES TO EXCLUDE DRUG USERS

In 1990, President Bush signed into law one of the most comprehensive civil rights statutes in American history, the Americans with Disabilities Act (ADA).³ The passage of the ADA signified a welcoming of disabled people into

³ 42 U.S.C. §§ 12101, 12213 (1991). The ADA has three main parts, Title I, Title II, and Title III. Title I prohibits employers from discriminating against qualified individuals with disabilities and is the most written about and analyzed part of the statute. Title II prohibits disability discrimination by "public entities," and Title III lays out particular requirements for accessibility of new buildings built to be accessible to persons with disabilities. Title II, though not as commonly written about as Title I, is particularly interesting for purposes of this paper because of the impact it could have on public benefits systems. Because Title II requires that public entities not discriminate against persons with disabilities, it imposes a duty on the government to make public benefits systems equally accessible for disabled and non-disabled individuals. One case that demonstrates the potential ramifications of such a requirement is *Henrietta D. v. Giuliani*, 1996 WL 633382 (E.D.N.Y.). In *Henrietta D.*, plaintiffs, persons with HIV and AIDS who qualified for public assistance, sued to prevent the elimination of New York's Division of AIDS Services (DAS) which provides HIV positive and AIDS public benefits recipients with special assistance to help them have access to public benefits. The plaintiffs used Title II to argue that DAS was not simply an "extra" provided by the city to facilitate beneficiaries with HIV/AIDS in getting benefits, but was in fact required by the ADA as a measure that makes public benefits accessible to these disabled beneficiaries. "Plaintiffs liken[ed] DAS to the ramp that is required for persons in wheelchairs to access public buildings. Without DAS case managers to coordinate and facilitate the processing of their benefits, plaintiffs argue[d] that their disability would prevent them from accessing those benefits to which they are entitled." *Id.* at 8. Such a use of Title II indicates that the ADA should be looked at, in some respects, as an important statute for poverty alleviation purposes. It may provide a legal strategy for improving access to public benefits systems for numerous beneficiaries with all types of disabilities. When seen in this light, and considering the above analysis about the ways in which poverty exacerbates the harms of drug use, the exclusion of drug users from this statute is even more serious.

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“mainstream” society and intolerance for discrimination based on disability.⁴ A primary goal of the ADA is the integration of individuals with disabilities into employment, public accommodations and social services from which they have been excluded, in order to facilitate economic self-sufficiency and full participation in society.⁵

The predecessor to the ADA was the 1973 Rehabilitation Act (RA).⁶ The RA prohibited discrimination against people with disabilities in programs that received federal funding.⁷ The ADA expands coverage to include public and private entities, which do not receive federal funding, making it a far more comprehensive statute than the RA. In addition to changing the scope of entities prohibited from engaging in disability discrimination, the passage of the ADA also altered the definition of a “disabled individual” for purposes of the statute by excluding persons disabled by drug addiction from the definition. Prior to the passage of the ADA, the RA covered individuals disabled by drug addiction even if they were currently using illegal drugs.

In 1977, after some confusion among courts and legislators regarding whether substance abusers were protected by the RA, Attorney General Bell issued an opinion stating that Congress had intended to include alcoholics and drug abusers in the category of persons protected from disability discrimination. He stated that the RA:

does not unrealistically require that recipients of Federal . . . grants ignore all the behavioral or other problems that may accompany a person's alcoholism or drug addiction if they interfere with the performance of his job At the same time, the statute requires that . . . grantees covered by the act not automatically deny employment . . . to persons solely because they might find their status as alcoholics or drug addicts personally offensive. . . .⁸

⁴ See 29 U.S.C. § 12101(a), (b) (West 1995).

⁵ *Id.*

⁶ 29 U.S.C. § 794(a) (1994).

⁷ *Id.*

⁸ 43 Op. Att'y Gen. 12 (1977), available at 1977 U.S. AG LEXIS 4, *24; cited in Vanko, *supra* note 1, at 1262-63.

A year later, Congress amended the RA to specifically include substance abusers.⁹ As Attorney General Bell's opinion states, employers are not required to hire anyone who is unqualified or who behaves in a manner that disrupts the workplace due to their substance use. As a result, the real effect of including substance users in disability discrimination coverage is that it prevents employers or service providers from arbitrarily discriminating against a qualified individual based on knowledge that the person is a substance user. Including substance abuse in the RA likens it to other disabilities in that it seeks to prevent the exclusion of disabled workers who are otherwise qualified for the position or program.

A. Exclusion of Current Users

One critique against the exclusion of current drug users from the definition of "disabled individual"¹⁰ is that it arbitrarily distinguishes alcoholics who currently use alcohol from current drug users. One problem with excluding current drug users is that it may deter people from seeking treatment because they have to worry that once they are identified as a user they can be fired, or that if they try treatment and relapse they can be fired.¹¹ Second, it can be argued that drug abuse and alcoholism are sufficiently the same to merit similar treatment under the statute. They produce similar harms, and similar forms of treatment exist for both.¹² Lastly, the ADA's exclusion of current users is equally as economically unwise as excluding disabled people generally. The cost to society of not employing substance abusers has been estimated at \$50 billion per year.¹³

⁹ Vanko, *supra* note 1, at 1263.

¹⁰ The ADA sets out a very specific definition of "disability." The term "disability" means, with respect to an individual: "(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." 42 U.S.C.A. § 12102 (2001).

¹¹ *Id.* at 1294 (citing Robert B. Fitzpatrick, *Alcoholism as a Handicap Under Federal and State Employment Discrimination Laws*, 7 LAB. LAW 395 (1991)).

¹² *Id.* at 1297.

¹³ *Id.* at 1258 (citing Nat'l Inst. on Alcohol Abuse and Alcoholism, U.S. Dept. of Health and Human Services, Sixth Special Report to the U.S. Congress on Alcohol and Health 22 (1987)).

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If the purpose of the ADA is to bring otherwise qualified individuals into the mainstream of society, there is no monetary benefit in excluding qualified people disabled by drug use.¹⁴

Bringing qualified individuals with substance abuse problems into the workforce will likely reduce external healthcare and crime-fighting costs to society.¹⁵ Following the logic of Attorney General Bell, employers would still be able to discharge employees for misconduct and refuse to hire unqualified applicants, so the real effect of inclusion would be to prohibit arbitrary discrimination on the basis of user status.¹⁶ Critics suggest that the arbitrary distinction between current drug users and alcoholics who currently use alcohol undermines the rehabilitative thrust of the ADA. The distinction only exists because of the political pressures that existed in the context of the former Bush administration's "zero tolerance" policy to approach drug problems punitively.¹⁷

Kenneth Vanko has called the differential in protection for illegal drug users and alcoholics an "unnecessary distinction."¹⁸ Vanko suggests that it derives from the war on drugs approach to drug users as morally blameworthy, rather than from a reasoned understanding of addiction and rehabilitation.¹⁹ Adrienne Hiegel has similarly critiqued the ADA's exclusions of particular disabilities. Hiegel argues that while the ADA attempts to "change extra-legal norms associated with disability" and curtail bias against the disabled that denies individuals with disabilities dignity and respect, it fails to eliminate the moral approach to disability and only redraws moral lines.²⁰ Hiegel suggests that the

¹⁴ *Id.* at 1257.

¹⁵ *Id.* at 1302.

¹⁶ *Id.*

¹⁷ *Id.* at 1294. Part II of this article examines the political climate of "zero tolerance" approach to drug use, which influenced the change in definition of "disabled individual" to specifically exclude drug users.

¹⁸ *See id.* at 1294-97 (comparing the drug policies of Bush I with those of the Clinton Administration).

¹⁹ *Id.* at 1259.

²⁰ Adrienne Hiegel, *Sexual Exclusions: The Americans with Disabilities Act As a Moral Code*, 94 COLUM. L. REV. 1451, 1453, 1467 (1994).

exclusion of some groups of people who would otherwise be considered disabled under the statute "reifies the moral grid that lies beneath the notion of a disability."²¹

B. Punitive Approaches

The establishment of a two-tiered definition of "disability" under the ADA, which separates politically unpopular disabled individuals from others, has made its way into the eligibility requirements for income assistance for disabled individuals as well. In 1994, Congress passed the Social Security Independence and Program Improvements Act (SSIPIA), which altered and restricted the receipt of SSI and SSDI benefits by persons who are disabled wholly or partially as a result of drug or alcohol addiction.²² The changes included an expansion of the "representative payee" system, requiring SSDI recipients who had previously not been required to receive their benefits through a payee to do so.²³

²¹ *Id.* at 1452-53. Heigel focuses primarily on the exclusion of sexual deviants from the ADA, but her analysis of the meaning of excluding unpopular contingents of disabled individuals from the Act is applicable to drug users as well. She describes how health and illness have historically had social, moral, and legal content. *Id.* at 1453. Heigel notes that diseases such as tuberculosis, cancer, epilepsy, and, most recently, AIDS, have all carried strong moral associations and judgments about the persons afflicted with them. *Id.* at 1454-56. The law has had an important role in drawing lines between what is understood as criminality and what is understood as illness or disability, as is clear in the history of mental illness as well as drug addiction. She suggests that the ADA is part of a positive move toward eliminating moral judgments associated with disability, but that the decision to exclude a narrow set of disabled individuals from coverage by the statute undermines the ADA's purpose by constructing a new moral line at which certain disabled individuals can be freely judged. "By leaving open a space of permissive . . . discrimination, the Act identifies the . . . new pariah, using the legal machines of the state to mark as outsiders those whose noncompliant body renders them unfit for full integration . . ." *Id.* at 1453.

²² Social Security Independence and Program Improvements Act of 1994, Pub. L. No. 103-296, 108 Stat. 26, 1464 (1994) (codified as amended in scattered sections of 42 U.S.C.A (West Supp. 1995) [hereinafter *1994 changes*], cited in Linda G. Mills & Anthony Arjo, *Disability Benefits, Substance Addiction, and the Undeserving Poor: A Critique of the Social Security Independence and Program Improvements Act of 1994*, 3 GEO. J. FIGHTING POVERTY 125 (1996).

²³ Mills and Arjo explain the significance of the changes:

Prior to the passage of the Amendments, SSI benefits for an individual "who is medically determined to be a drug addict or alcoholic" were required to be paid to a representative payee who must manage the money in the interest of

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Additionally, the Act added greater emphasis to the requirement that beneficiaries be engaged in prescribed treatment. The Act also instituted greater monitoring of treatment, conditioned receipt of benefits on participation in treatment, and devised punitive responses for failure to engage in prescribed treatment.

Most importantly, the Act imposed a thirty-six month limit on receipt of SSI and SSDI benefits by individuals whose disability results from addiction.²⁴ This limitation, characterized as a punitive approach, marks the first time in the history of these programs that benefits are time-restricted. All other disabled people covered by these programs receive benefits until their condition is resolved to an extent that they can return to work. Consequently, this approach may seriously curtail rehabilitative possibilities for the individuals affected. Individuals who are able to complete the arduous SSI application process, which can take 2-7 years and involves multiple stages of appeal and close investigation of applicants' conditions, are legitimately sick people. Those addicts who receive SSI/SSDI are a small fraction of all addicts, the most severely disabled, who have been judged incapable of performing any type of work, and who are generally the most difficult to treat.²⁵ Severely limiting the period of such individuals' rehabilitation is unrealistic and will endanger the well being of this class of disabled recipients.

the claimant. This medical determination arises when addiction "is a contributing factor material to the finding" of disability, and when the individual would not be disabled independent of the addiction. Before the Amendments, DI recipients were not subject to these conditions, unless the claimant was legally incompetent or mentally or physically incapable of managing benefit payments. The Amendments extend the SSI payee requirement to the DI program, both prospectively and retroactively.

Mills & Arjo, *supra* note 22, at 131.

²⁴ Mills & Arjo, *supra* note 22.

²⁵ *Id.* at 135. The SSA defines disability as "[the] inability to engage in substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423 (d)(1)(A); 20 C.F.R. §40.1505 (a). "Mental or physical impairment" is defined as "an impairment which results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical or laboratory diagnostic techniques." 42 U.S.C. §423 (d)(3); 20 C.F.R. §404.1508.

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In 1995, the Subcommittee of Human Resources of the House Ways and Means, Committee held hearings²⁶ on the SSIPIA in response to heightened media coverage of the growth in the SSI and SSDI program enrollments,²⁷ and anecdotes of SSI recipients using their benefits to support addictions,²⁸ and the general tide of welfare reform cutbacks. The subcommittee proposed the exclusion of drug addicts and alcoholics.

The following year, Congress passed the Contract with America Advancement Act²⁹ ("Contract with America"), which excluded from the category of disabled individuals under SSI and SSDI persons whose "alcoholism or drug addiction would . . . be a contributing factor material to" the determination that they are "disabled."³⁰ Fueled by heightened media coverage of

²⁶ *Contract with America: Welfare Reform Part 1: Hearings on Welfare Reform Before the Subcommittee on Human Resources of the House Ways and Means Comm.*, 104th Cong. (1995).

²⁷ Between 1989 and 1995, the number of SSI beneficiaries classified as drug addicts and/or alcoholics increased from 16,100 to 130,924. During the same period, the number of SSI beneficiaries enrolled for drug addiction alone grew from 5,210 to 61,569. S. L. BARBER, OFF. OF PROGRAM BENEFITS, SOCIAL SECURITY ADMIN., SUPPLEMENTAL SECURITY INCOME RECIPIENTS FOR WHOM THE ALCOHOLISM AND DRUG ADDICTION PROVISION APPLY (DAA RECIPIENTS) (1996), cited in Ricky N. Bluthenthal et al., *Collateral Damage in the War on Drugs: HIV Risk Behaviors Among Injection Drug Users*, INT'L J. OF DRUG POLICY, 1999, at 37.

²⁸ See M. Dorgan, *Addicts Feed Habits with U.S. Hand Outs*, SAN JOSE MERCURY NEWS, Dec. 19, 1994; M. Rust, *Social Security Scam: Uncle Sam as Enabler*, INSIGHT, April 11, 1994, at 7, cited in Bluthenthal, et al., *supra* note 25, at 37; S. L. Satel, *Hooked: Addicts on Welfare*, NEW REPUBLIC, May 30, 1995; Daniel Seligman, *The SSI Follies*, FORTUNE, June 13, 1994, at 151; C.L. Weaver, *Welfare Reform is Likely to Leave This Monster Intact*, WALL STREET JOURNAL, Apr. 6, 1994; C. M. Wright, *The Supplemental Security Income Program: The Welfare State's Black Hole*, USA TODAY, Nov. 1995, at 14; William S. Cohen, *Playing Social Security for a Sucker*, WASH. POST, Feb. 23, 1994 at A17; William J. Eaton, *House Votes to Limit Addicts Social Security Pay*, L.A. TIMES, May 18, 1994, at A22; Burt Hubbard, *Denver Addicts Tell of Monthly "Christmas,"* ROCKY MTN. NEWS, May 8, 1994, at 4A; *Junkies Junket: Save the Addicts*, ARIZ. REPUB., June 29, 1994, at B4; Sean P. Murphy & Charles M. Sennott, *Addicts on Disability Unchecked: SSI Recipients on Honor System*, BOSTON GLOBE, Feb. 25, 1994, at 1; Sally Satel, *Subsidizing Substance Abuse: A Federal Giveaway Finances Drug and Alcohol Binges*, SAN DIEGO UNION TRIB., May 17, 1994, at B5; Debra J. Saunders, *Fed Boondoggle for Junkies*, S.F. CHRON., Feb. 7, 1994, at A20.

²⁹ Pub. L. No. 104-121, §105, codified at 42 U.S.C. § 423 (1996).

³⁰ 42 U.S.C. § 423 (d)(2)(C).

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the growth in the SSI and SSDI program enrollments³¹ and anecdotes of SSI recipients using their benefits to support addictions,³² and the general tide of welfare reform cutbacks, the Subcommittee on Human Resources of the House Ways and Means Committee held hearings³³ on the programs' problems even before the 1994 changes had gone into effect. Without finding out if the 1994 changes had succeeded in solving the perceived problems of abuse of the SSI and SSDI programs, the Subcommittee proposed the exclusion of drug addicts and alcoholics which eventually passed into law as part of H.R. 3136, the Contract with America, in March of 1996.

The 1994 changes to the SSI and SSDI programs were the first efforts to regulate recipients based on given disabilities.³⁴ Similarly, the 1996 wholesale exclusion of persons disabled by drug and alcohol addiction from SSI eligibility is the first time in the history of the program that Congress has eliminated entire

³¹ Between 1989 and 1995, the number of SSI beneficiaries classified as drug addicts and/or alcoholics increased from 16,100 to 130,924. During the same period, the number of SSI beneficiaries enrolled for drug addiction alone grew from 5,210 to 61,569. BARBER, *supra* note 27, at 37.

³² See M. Dorgan, *Addicts Feed Habits with U.S. Hand Outs*, SAN JOSE MERCURY NEWS, Dec. 19, 1994; M. Rust, *Social Security Scam: Uncle Sam as Enabler*, INSIGHT, April 11, 1994, at 7, cited in Bluthenthal, et al., *supra* note 25, at 37; S. L. Satel, *Hooked: Addicts on Welfare*, NEW REPUBLIC, May 30, 1995; Daniel Seligman, *The SSI Follies*, FORTUNE, June 13, 1994, at 151; C.L. Weaver, *Welfare Reform is Likely to Leave This Monster Intact*, WALL STREET JOURNAL, Apr. 6, 1994; C. M. Wright, *The Supplemental Security Income Program: The Welfare State's Black Hole*, USA TODAY, Nov. 1995, at 14; William S. Cohen, *Playing Social Security for a Sucker*, WASH. POST, Feb. 23, 1994 at A17; William J. Eaton, *House Votes to Limit Addicts Social Security Pay*, L.A. TIMES, May 18, 1994, at A22; Burt Hubbard, *Denver Addicts Tell of Monthly "Christmas,"* ROCKY MTN. NEWS, May 8, 1994, at 4A; *Junkies Junket: Save the Addicts*, ARIZ. REPUB., June 29, 1994, at B4; Sean P. Murphy & Charles M. Sennott, *Addicts on Disability Unchecked: SSI Recipients on Honor System*, BOSTON GLOBE, Feb. 25, 1994, at 1; Sally Satel, *Subsidizing Substance Abuse: A Federal Giveaway Finances Drug and Alcohol Binges*, SAN DIEGO UNION TRIB., May 17, 1994, at B5; Debra J. Saunders, *Fed Boondoggle for Junkies*, S.F. CHRON., Feb. 7, 1994, at A20.

³³ *Contract with America: Welfare Reform Part 1: Hearings on Welfare Reform Before the Subcommittee on Human Resources of the House Ways and Means Comm.*, 104th Cong. (1995).

³⁴ Mills & Arjo, *supra* note 22, at 132 n.102.

categories of disease or diagnosis as a basis for eligibility.³⁵ Critics of the 1994 changes suggest that the changes, influenced by a drug scare political climate, undermine the rehabilitative thrust of the SSI and SSDI programs.³⁶

Prior to 1982, the position of the Social Security Administration (SSA) on the issue of whether substance abuse constituted a disabling condition for purposes of SSI/SSDI eligibility was unclear. However, prompted by numerous court decisions,³⁷ the SSA formally ruled that alcoholism and drug addiction could be disabling conditions in 1982.³⁸ Mills and Arjo suggest that the position adopted by the SSA in 1982 is the correct position, and that the moral view of addiction reflected in the 1994 changes does not comport with current medical understandings of addiction as a disabling disease.³⁹ Analysis of two of the major changes imposed on the programs in 1994, the 36 month limitation on benefits and the monitoring of treatment, suggest the connections between the political climate of the drug war, examined in detail in the next section, and the redefinition of disability status.

³⁵ Nicole Fiocco, *The Unpopular Disabled: Drug Addicts and Alcoholics Lose Benefits*, 49 ADMIN. L. REV. 1007, 1008 (1997).

³⁶ Mills & Arjo, *supra* note 22.

³⁷ See, e.g., *Ferguson v. Schweiker*, 641 F.2d 243, 248 (5th Cir. 1981) (holding that alcoholism alone or combined with other causes can constitute a disability); *Johnson v. Harris*, 625 F.2d 311, 313 (9th Cir. 1980) (holding that "severe alcoholism alone may be disabling within the meaning of the Social Security laws"); *Lewis v. Califano*, 574 F.2d 452 (8th Cir. 1978) (holding that administrative law judge failed to develop full and fair record during claimant's hearing for benefits due to alcoholism); *Griffis v. Weinberger*, 509 F.2d 837, 838 (9th Cir. 1975) (stating that "the proposition that chronic acute alcoholism is itself a disease ... is hardly debatable today"), *cited in* Mills & Arjo, *supra* note 22, at 138 n.168.

³⁸ S.S.R. 82-60, (Cum. Ed. 1982).

³⁹ Mills & Arjo, *supra* note 22, at 139. The author notes some hesitancy in the identification of substance use and abuse as a "disease." Harm reduction advocates have pointed out that the identification of substance addiction as "disease" is often part of an understanding of substance use as something, which must be "cured" with abstinence. As discussed in Part III of this article, abstinence-based approaches to drug use have proven ineffective, are often part of a punitive approach to drug use, and may increase harm. However, for purposes of discussing the entitlement of persons disabled by substance addiction to public benefits, it is useful to employ the "disease" terminology because that is the current medical approach to addiction, and SSI/SSDI eligibility is contingent on medical diagnoses.

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Second, the increased monitoring of recipient enrollment in mandatory treatment programs reflects punitive approaches to substance abuse that have questionable success and an increased likelihood of leading to greater harm to recipients. Conditioning receipt of benefits on success in treatment is problematic because: 1) it is widely recognized that there is insufficient treatment for all those who need and demand it,⁴⁰ 2) those individuals eligible for SSI and SSDI are unable to control their use, and 3) they are very difficult to treat. As a result, it is unthinkable to cut off benefits when substance abusers relapse or when treatment fails.⁴¹

This portion of the 1994 changes reflects a general trend in drug policy of prioritizing monitoring and punishment over treatment. Resources are being used towards the establishment of agencies to monitor the compliance of recipients with drug treatment plans, but no resources are devoted to establishing treatment programs.⁴² The punitive measures deviate from the supportive goals of the Social Security Program."⁴³

C. The Effects of Changes

Mills and Arjo suggest that the 1994 changes were influenced by "an anecdotal hysteria on the misuse of benefits coupled with a misinformed understanding of the nature of addiction."⁴⁴ The congressional report that was influential in the ultimate decision to make the 1994 changes relies heavily on anecdotal evidence of extreme abuses.⁴⁵ The panic which erupted about

⁴⁰ See *infra* notes 92-97 and accompanying text.

⁴¹ Mills & Arjo, *supra* note 22, at 137.

⁴² *Id.* at 133.

⁴³ *Id.*

⁴⁴ *Id.* at 126. See *supra* note 33. Mills and Arjo also point out that SSI benefits are politically attractive for cutbacks in an age of budget deficits because SSI is a need-based welfare program, and payments come from the general treasury rather than the separate Social Security Disability Insurance Trust Fund and are sometimes supplemented by state governments. Mills & Arjo, *supra* note 22, at 128.

⁴⁵ *Id.* at 139 (citing SENATE SPECIAL COMM. ON AGING, TAX DOLLARS AIDING AND ABETTING ADDICTION: SOCIAL SECURITY DISABILITY AND SSI CASH BENEFITS TO DRUG ADDICTS AND ALCOHOLICS; 140 CONG. REC. § 1333-37 (daily ed. Feb. 10, 1994).

beneficiaries using their benefits to buy drugs and alcohol was not sufficiently quelled by the 1994 changes to stop Congress from eliminating addicts who could not prove that they had another disabling condition from eligibility altogether in 1996. According to one report, this policy change resulted in at least 65% of alcohol and/or drug addicted SSI recipients losing their benefits (including cash benefits and Medicaid services) by January of 1998.⁴⁶

What is the effect of the changes in SSI/SSDI eligibility? Why should we be concerned about the loss of income support for disabled people based on substance abuse status? A recent study on the effects of the 1996 change in SSI eligibility suggests that the “punish to deter’ approach as it relates to . . . eligibility for public assistance has created harm for drug users without reducing their drug use.”⁴⁷ The study tracked over a thousand injection drug users in six San Francisco Bay Area communities from 1996 through 1997 to determine the effects of particular drug war policies on their behaviors. Authors of the study interviewed respondents who were SSI beneficiaries before and after the change in SSI eligibility to trace the results of their exclusion from eligibility. They found that those disqualified from SSI were more likely to be homeless compared to those who retained SSI benefits.⁴⁸ Additionally, bivariate analysis revealed that among former SSI recipients, 16.7% reported sharing syringes in the past 30 days as compared to 0% among current SSI enrollees.⁴⁹ Additionally, respondents who had lost SSI benefits were more likely to report participation in illegal activities in the past 30 days than those who had not been cut off (48.1 vs. 26.5%).⁵⁰ Finally, the study found a difference in the mean frequency of injection in the prior 30 days. Respondents who had been cut off of benefits injected 43.8 times per month as compared to those who retained benefits who injected 36.4 times per month.⁵¹

⁴⁶ Bluthenthal et al., *supra* note 27, at 29 (citing C. L. Wetzstein, *SSI Reforms Drive Drug Users, Drunks to Faith Based Welfare*, INSIGHT ON THE NEWS, Jan. 26, 1998, at 42-43).

⁴⁷ Bluthenthal et al., *supra* note 27, at 32.

⁴⁸ *Id.* at 31.

⁴⁹ *Id.* at 32.

⁵⁰ *Id.*

⁵¹ *Id.*

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Based on these statistics, the authors concluded that “disqualifying drug users from public income supports may very well increase drug use among [injection drug users]” and may put those affected at an increased risk for HIV infection.⁵² It was further noted that in a 1995 multivariate analysis, that SSI recipients were less likely to be homeless, to report illegal income, and were over two-and-a-half times more likely to be in drug treatment than those not receiving SSI.⁵³

These figures suggest the serious negative consequences of altering the definition of “disabled individual” to exclude drug users, thereby excluding them from need-based income support. The changes in the ADA, RA, SSI, and SSDI, do not appear to deter people from using drugs, instead there is an increase in “drug-related problems” such as the spread of infectious diseases and homelessness. If this is the case, why have these changes been made? The remainder of the paper will explore the approach to drug policy, which has characterized the war on drugs, and examine the critiques of this approach. In the third section, the harm reduction model is offered as an alternative way of looking at drug use, which both highlights the failures of punitive approaches and suggests a rehabilitation-focused alternative, which comports with the original purposes of both the ADA and the Social Security disability programs.

II. “ZERO TOLERANCE” AND MORAL PANIC: THE CONSTRUCTION OF THE CURRENT WAR ON DRUGS

In examining the articulation of “drug problems” in American political consciousness, Murray Edelman in *Constructing the Political Spectacle*, asserts that political developments and social problems are social constructs.⁵⁴ Political problems, he suggests, come into discourse and, therefore existence, not because they simply appear or are suddenly important to well being, but as reinforcements of ideologies. Political problems constitute people as subjects, behavior as good or bad, create authority, and construct areas of immunity from concern.⁵⁵ Moreover, political spectacles are “meaning machines” in which “facts” become

⁵² *Id.* at 33.

⁵³ *Id.* at 34.

⁵⁴ MURRAY EDELMAN, *CONSTRUCTING THE POLITICAL SPECTACLE* (1988).

⁵⁵ *Id.* at 12.

irrelevant because every person and object becomes "an interpretation that reflects and perpetuates an ideology."⁵⁶

Using Edelman's framework, William Elwood has suggested that the articulation of social problems through rhetoric performs a crucial function of creating shared meanings by which mass publics can understand a problem and become convinced of the correctness and necessity of a particular proposed solution.⁵⁷ The characterization of the drug problem as a problem of a morally deficient, poor, non-white, criminal class has fueled the punitive, "zero tolerance" approach to drug policy embodied in the War on Drugs.⁵⁸ Understanding the "war on drugs" as a rhetorical strategy that constructs drug use and drug problems in narrow terms is vital to analyzing the effectiveness of drug war policies and interrogating the rationales of such policies.

In *Crack in America*, Craig Reinerman and Harry Levine trace the histories of previous "drug scares" in the United States, and examine how those

⁵⁶ *Id.* at 10.

⁵⁷ WILLIAM N. ELWOOD, RHETORIC IN THE WAR ON DRUGS: THE TRIUMPHS AND TRAGEDIES OF PUBLIC RELATIONS 7 (1994).

⁵⁸ Elwood understands the war on drugs as being not primarily driven by a desire to eliminate drug use, but rather as being a tool in a larger struggle about increased authority and social control over urban and minority populations. *Id.* at 15. He describes how Presidents Bush and Reagan articulated the drug problem as an urban minority problem, creating a rhetoric that blamed social ills on minorities without communicating a sense of apparent racism, and enabled policies which target more social control in the form of crime control toward these communities. *Id.* at 11, 34. Elwood quotes a Bush speech that particularly exemplifies this strategy:

And while illegal drug use is found in every community, nowhere is it worse than in our public housing projects. You know, the poor have never had it easy in this world. But in the past, they weren't mugged on the way home from work by crack gangs. And their children didn't have to dodge bullets on the way to school. And that's why I'm targeting \$50 million to fight crime in the public housing projects, to help restore order and to kick out the dealers for good.

Id. at 34-35. Elwood suggests that identifying the drug problem with the poor capitalizes on the antipathy of white audiences who already resent using tax money for public assistance and who identify poverty with crime. He further asserts that such strategies have been "successful" in terms of producing a drug policy which disproportionately impacts people of color. He notes that drug-related arrests increased 106% between 1980 and 1991, but when race is accounted for, drug-related arrests of African-Americans increased 270% during that period. Despite the fact that white people constitute 50% of drug users in most American cities, African-Americans account for 85% of drug related arrests. *Id.* at 134.

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events were often connected to racial and economic tensions of their times.⁵⁹ They define “drug scares” as times when “all kinds of social problems have been blamed on one chemical substance or another” and describe how drug scares typically link a scapegoated substance to a subordinate group.⁶⁰ One example was the opium scare in California in the 1870's, which contributed in large part to anti-Chinese agitation. Similarly, the first U.S. cocaine scare that occurred in the 1910's was fed by press accounts linking drug use with blacks, prostitutes, criminals, and transient workers. Despite the fact that there was no evidence that African-Americans used cocaine as much as whites, white politicians used race to muster public support for prohibition. Rather than being sparked by a real drug problem, this scare was “animated by ‘white alarm’ about ‘black rebellion’ against segregation and oppression.”⁶¹ The notion of “drug scares” suggests that widespread moral and social panics about drugs are often less the result of real changes in patterns and attendant harms of drug use but more the result of complex political contexts.

Critics of the current war on drugs have suggested that this war is best understood within the political context of 1980's and 90's. The war on drugs is one piece of a larger trend of asserting that moral depravity and lack of “personal responsibility” are the root of social problems, rather than systemic causes of poverty, homelessness, and racism.⁶² The suggestion is not that drugs produce

⁵⁹ Craig Reinerman & Harry G. Levine, *Crack in Context: America's Latest Demon Drug* [hereinafter Reinerman & Levine, *Crack in Context*], in *CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE 1* (Craig Reinerman & Harry G. Levine eds., 1997) [hereinafter REINERMAN & LEVINE, *CRACK IN AMERICA*].

⁶⁰ *Id.*

⁶¹ *Id.* at 7.

⁶² For the Reagan administration and the Right, America's drug problems functioned as opportunities for the imposition of an old moral agenda in the guise of a new social concern. Moreover, the remedies that followed from this view were in perfect harmony with “traditional family values”—individual moral discipline and abstinence, combined with police and prisons for those who indulged. Such remedies avoided all questions about the economic and political sources of and solutions to America's social problems. The Reagan administration preached this ideology from the highest platforms in the land and transformed public policy in its image. It made a most hospitable context for a new drug scare.

Craig Reinerman and Harry G. Levine, *The Crack Attack: Politics and Media in the Crack Scare*, in REINERMAN & LEVINE, *CRACK IN AMERICA*, *supra* note 59, at 18, 39; see Diana R.

no harmful consequences, nor that drug problems are nonexistent. Rather, it is that the representation of drugs and drug users by politicians and the media, and the clearly ineffective policies chosen to alleviate drug problems, are more a product of inflammatory rhetoric and scapegoating than they are reflective of the actual dynamics of drug use.

Critics have suggested that the drug war panic relies on, and has created, narrow understandings of drugs and drug users, which justify ineffective policies and erect barriers to serious examination of the causes and consequences of drug use and abuse. Some have suggested that "pharmacological determinism,"⁶³ the overzealous belief that devastating social consequences flow directly from the molecular structure of certain illicit drugs, has clouded the ability of policymakers to approach drug use in logical and effective ways. Reinerman and Levine suggest that, "[s]uch rhetoric squeezes out of public discourse any serious consideration of the social, cultural, economic and psychological variables that are essential for understanding drug use and its behavioral consequences."⁶⁴

A. *The Current War on Drugs*

This current drug war is characterized by its focus on criminal justice, its failure to distinguish casual users of illegal drugs from "hard-core" users and addicts, and numerous negative unforeseen consequences. One recurring critique of the war on drugs is that the choice of taking a criminal justice approach, rather than a public health approach to drug use in the U.S., is at the root of the problems with drug war policy.⁶⁵ The passage of the Anti-Drug Abuse Act of 1988 and the establishment of the Office of National Drug Control Policy ("ONDCP") marked the beginning of the current drug war. From the outset, under Dr. William Bennett's leadership, the ONDCP "emphasized law

Gordon, *Drugs, Race and the 'Dangerous Classes': Policy Politics in American Drug Prohibition*, in *DE-AMERICANIZING DRUG POLICY: THE SEARCH FOR ALTERNATIVES TO A FAILED REPRESSION* (Lorenz Böllinger ed., 1994); ELWOOD, *supra* note 57.

⁶³ Reinerman & Levine, *Crack in Context*, *supra* note 59, at 8.

⁶⁴ *Id.* at 13.

⁶⁵ Melody M. Heaps & James A. Swartz, *Toward a Rational Drug Policy: Setting New Priorities*, 1994 U. CHI. LEGAL F. 175, 176-77 (1994).

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enforcement and interdiction over treatment and education.”⁶⁶ The ONDCP’s approach immediately focused on “buy-and-bust” operations, and aimed at reducing all drug use, without regard to important differences between the harms society experiences from casual use and those which result from drug abuse.⁶⁷

Numerous critics have analyzed the results of the punishment-focused war on drugs.⁶⁸ William F. Buckley, Jr., Nobel Prize winning economist Milton Friedman, George Schultz, Walter Cronkite, and Hugh Downs, George Soros and countless others from across the political spectrum, have pointed out that this war has ultimately been a failure.⁶⁹ Even criminal justice professionals have vocally opposed drug war policies in large numbers. In 1993, more than fifty senior federal judges started a boycott of drug cases because they felt the drug control system was ineffective and that the mandatory minimum sentences were often

⁶⁶ *Id.* at 179.

⁶⁷ *Id.* at 182. Michael Massing further discusses the poor judgment of a drug war, which fails to differentiate between “hard-core” users and casual users. Massing suggests that “there are an estimated 4 million “hard-core” drug users in the United States. Though making up only twenty percent of all drug users nationwide (the rest being occasional users), this group accounts for two-thirds to three-quarters of all drugs consumed here.” Michael Massing, *It’s Time for Realism*, THE NATION, Sept. 20, 1999, at 12. He notes that of the \$18 billion the government spends each year on the drug war, less than 10 percent goes toward treating “hard-core” users, “who constitute the real heart of the problem,” while most goes toward failed attempts to reduce the supply of drugs. *Id.* at 14.

⁶⁸ Corinne Carey asserts that despite rumors and rhetoric suggesting that the Clinton administration would tone down the harshly punitive nature of the war on drugs, the drug war in fact escalated under the Clinton administration. Carey explains that Clinton proposed testing driver’s license applicants for drugs, expanding the death penalty for drug dealers, and drug testing federal parolees. Clinton voiced support for longer mandatory minimum sentences, broader interdiction efforts, more funding for law enforcement efforts, and mandatory drug testing of high school athletes. The administration rejected proposals to reduce or eliminate the disparity between sentences for crack sellers and sentences for powder cocaine sellers from the United States Sentencing Commission. Clinton increased the funding of the Drug Enforcement Administration by eighteen percent, and proposed the largest anti-drug budget ever for fiscal year 1997. Corinne A. Carey, *Crafting a Challenge to the Practice of Drug Testing Welfare Recipients: Federal and State Response as the Most Recent Chapter in the War on Drugs*, 46 BUFF. L. REV. 281 (1998).

⁶⁹ Craig Reinerman & Harry G. Levine, *Real Opposition, Real Alternatives: Reducing the Harms of Drug Use and Drug Policy* [hereinafter Reinerman & Levine, *Real Opposition*], reprinted in REINERMAN & LEVINE, CRACK IN AMERICA, *supra* note 59, at 345-46.

unjust.⁷⁰ A 1995 survey of 365 police chiefs, police officers, judges and district attorneys found that about 90% in all groups felt that “the U.S. was losing the war on drugs” and many supported alternative approaches to drug policy.⁷¹ The American Society of Criminology, similarly found that “[e]nforcement strategies have consumed resources, aggravated health risks associated with drugs, . . . increased the levels of violence surrounding drug markets . . . increased profits for drug dealers.”⁷²

One of the most salient critiques of U.S. drug policy is that the war on drugs simply has not decreased drug use and trafficking in any meaningful way. According to the Substance Abuse and Mental Health Services Administration, over 11 million Americans regularly consumed illegal drugs during 1992, with drug war policies in full force.⁷³ Use of many serious drugs by junior high school and high school students continues to increase.⁷⁴ A 1999 study reported that rates of heroin use among teens doubled between 1991 and 1995 and have remained stable into the present, and that 1996 and 1997 represented peak levels over all illicit drug use by American teens.⁷⁵ Illegal drug use among adults 35 and older did not decrease at all between 1979 and 1993.⁷⁶ The drug war itself

⁷⁰ *Id.* at 347.

⁷¹ Joseph D. McNamara, Changing Police Attitudes Support Reform of National Drug Control Policies, Address at the 37th Annual International Congress on Alcohol and Drug Dependence (August 20-25, 1995), *cited in* Reinerman and Levine, *Real Opposition*, *supra* note 69, at 348.

⁷² American Society of Criminology, *Task Force Reports from the ASC to Attorney General Janet Reno*, reprinted in *THE CRIMINOLOGIST* 20 (1995), *cited in* Reinerman & Levine, *Real Opposition*, *supra* note 69, at 348-49.

⁷³ ELWOOD, *supra* note 57, at 2.

⁷⁴ *Id.* (*citing Health Report: The Bad News*, *TIME*, July 26, 1993, at 20); *Low-Grade Highs: Drug War Blues*, *U.S. NEWS AND WORLD REPORT*, Apr. 26, 1993, at 4; *Wasted Youth: More Students Are Starting to Use Drugs and Sniff Glue at an Early Age*, *TIME*, Apr. 26, 1993, at 16; J. Smolowe, *Choose Your Poison: While the Government Boasts That Drug Use Has Fallen, the Range of Intoxicants Has Ensnared a New Generation*, *TIME*, July 26, 1993, at 56-57.

⁷⁵ Press Release, University of Michigan Institute for Social Research, Drug Trends in 1999 among American Teens Are Mixed 2-3 (1999). This press release is also available at <http://monitoringthefuture.org/pressreleases/99drugpr.html>.

⁷⁶ *Id.*

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creates many casualties because of the violent tactics employed by the government in fighting it. "The evidence of failure can be found in every city. For example, cocaine and heroin emergencies in New York City hospitals rose in each of three successive quarters in 1991 and 1992"⁷⁷ despite the fact that the drug war was already four years fought.⁷⁸ Furthermore, critics argue that the drug war itself has produced a new level of violence, which claims many victims. In fact, some have estimated that the "crime-fighting" violence of the war on drugs kills more people each year than does overdosing.⁷⁹

The drug war's emphasis on punishment is coupled with a severe neglect of the need for treatment. This has resulted in an overburdened criminal justice system⁸⁰ as well as a large population of users who cannot get treatment even if they seek it.⁸¹ The government annually spends \$18 billion on the drug war.⁸² The majority of this money (65%) goes toward incarceration and prosecution.⁸³ The remainder (35%) goes toward prevention, education, research and treatment.⁸⁴ The U.S. has the highest incarceration rate of any nation, with more

⁷⁷ Gordon, *supra* note 62.

⁷⁸ *Id.*

⁷⁹ William F. Buckley, Jr. *The War on Drugs is Lost: A Panel Discussion*, NAT'L REV., Feb. 12, 1996, at 34.

⁸⁰ A 1994 Department of Justice Survey of twenty-five hundred police chiefs, sheriffs, jail administrators, prosecutors, public defenders, judges, and probation and parole directors found nearly nine in ten agreeing that the drug war has created workload problems for their agencies . . . too many good cops are called upon to put their lives on the line for minor busts when they know that the bulk of the violence associated with drugs is a function of our drug laws. . . . The War on Drugs was sold to the public as a crime control measure, but in many ways, it has become a fetter on crime control.

Reinarman & Levine, *Real Opposition*, *supra* note 69, at 348.

⁸¹ *See infra* notes 92-97 and accompanying text.

⁸² Massing, *supra* note 66, at 14.

⁸³ HARM REDUCTION COALITION., WHAT IS HARM REDUCTION? OUTREACH WITH LONG TERM HUMANITARIAN GOALS, (n.d.) (on file with the author).

⁸⁴ *Id.*

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than one million people incarcerated, costing \$20 billion each year.⁸⁵ It is estimated that 30% of incarcerated men and 33% of incarcerated women are there because of drug violations. African Americans and Latinos are 75% of people incarcerated for drug use.⁸⁶

A 1994 RAND study sought to compare the effectiveness of four different types of drug control: 1) source-control programs (attacking the drug trade abroad), 2) interdiction (stopping drugs at the border), 3) domestic law enforcement (arresting and imprisoning buyers and sellers), and 4) drug treatment.⁸⁷ RAND attempted to figure out how much additional money the government would have to spend on each approach to reduce the national cocaine consumption by 1 percent.⁸⁸ The study found that treatment was seven times more cost-effective than law enforcement, ten times more effective than interdiction, and twenty-three times more effective than attacking drugs at their source.⁸⁹ This conclusion, which sparked much debate in drug policy circles, has been affirmed again and again by further studies.⁹⁰ Despite this overwhelming evidence, U.S. drug policy remains focused on criminal law approaches, with treatment options still widely under funded, and millions of users unable to access treatment on demand.⁹¹

⁸⁵ Robert W. Street, *The War on Drugs is Lost: A Panel Discussion*, NAT'L REV., Feb. 12, 1996, at 44.

⁸⁶ HARM REDUCTION COALITION, *supra* note 83.

⁸⁷ C. Peter Rydell & Susan S. Everingham, *Controlling Cocaine: Supply vs. Demand Programs*, RAND, MR-331-ONDCP/A/DPRC, (1994). A summary is available in *Projecting Future Cocaine Use and Evaluating Control Strategies*, RAND Drug Policy Research Center Research Brief, RB-6002, (Jan. 1995).

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ Massing, *supra* note 67, at 14. *See Drug Policy Director Leaves with Critical Shot at GOP: Brown Chides Legislators for Rewriting Guidelines*, BALT. SUN, Dec. 15, 1995, at 10A ("Former drug czar Lee Brown emphasized that treatment, as contrasted with interdiction, reduces drug-related crimes and saves society seven dollars in criminal justice and health care cost for every dollar spent on treatment. ") *See also* Vanko, *supra* note 1, at 1262-63.

⁹¹ *See infra* notes 92-97 and accompanying text.

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Only 600,000 treatment slots are available in the U.S. for an estimated 2.8 million users who could use treatment.⁹² Most of the treatment that does exist is punitive in nature, severely disrupts the lives of the clients, is abstinence-oriented, and is geared towards men.⁹³ Generally, there are less treatment slots available to women, and those that do exist often have requirements that prohibit women with children from utilizing them.⁹⁴ Inpatient slots usually do not provide any housing options for a client's children, and outpatient treatment services often require strict attendance and time commitments that women with children cannot meet.⁹⁵ Additionally, the punitive measures and the extreme stigma attached to women drug users has resulted in less women visiting, medical professionals because they correctly suspect that it could result in the loss of their children.⁹⁶ Pregnant women are particularly underserved by current treatment options. There are an estimated 675,000 pregnant users right now, and only 11% have access to treatment programs.⁹⁷

Drug users face increasingly extreme punishments for drug use or possession, but most cannot, even if they wish to, access effective treatment programs. This understanding of the war on drugs and its failure to offer rehabilitative options for drug exposes the underlying punitive logic, which influenced and was mirrored by the changes in disability policy in the 1990's. Despite the strong critiques of the drug war, many Americans are not aware that realistic and inexpensive alternatives to ineffective drug war policies exist.

⁹² HARM REDUCTION COALITION, *supra* note 83.

⁹³ Marsha Rosenbaum, *Women and Treatment*, The Drug Policy Letter, Winter 1998, at 11-14.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ *Id.*

III. HARM REDUCTION: AN ALTERNATIVE TO PROHIBITION

*"The basic idea [of harm reduction] is that you have a fallback strategy for dealing with people who are engaged in behavior that can be risky or dangerous. So if you're smoking cigarettes, smoke less or don't smoke around kids or don't throw your ashes into dry timber. If you're drinking alcohol, don't drink and drive. You ride a bicycle--use a helmet. That's harm reduction."*⁹⁸

--Ethan Nadelman, Lindesmith Center

Harm reduction is a public health strategy for approaching the harms associated with drug use. Advocates of the harm reduction approach to drug use provide critical perspectives on drug policy.⁹⁹ Harm reduction is most commonly associated with needle exchange programs. Needle exchange typifies the harm reduction approach, because it does not emphasize total abstinence from drug use, but rather works to reduce the harms to users that are associated with injecting drugs with unsterilized or pre-used syringes.

Harm reduction emerged out of grassroots activism around the AIDS epidemic in the early 1980's.¹⁰⁰ Activists and drug users advised the public that sharing needles could lead to HIV infection, and devised strategies such as disseminating information and sterilization kits to injectors, educating users on safer sex practices, and making referrals to drug treatment, health and social service agencies. They organized needle-exchange programs in defiance of drug paraphernalia laws, and slowly convinced public officials in some cities to allow needle exchange programs to operate without harassment and citation, and even to help fund such programs.¹⁰¹ "Their work helped open the space in public

⁹⁸ Press Release, Lindesmith Center, THE NATION Exclusive Profiles Soros/Nadelmann Role in Drug Policy: Magazine Article Extols Soros Funded Lindesmith Center and Its Director Ethan Nadelmann as Center of Drug Policy Reform Movement (Sept. 7, 1999).

⁹⁹ See <http://www.drugpolicy.org>.

¹⁰⁰ Reinerman & Levine, *Real Opposition*, *supra* note 69, at 353.

¹⁰¹ *Id.*

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discourse for the critics and laid the foundation for the alternatives to punitive prohibition that are taking shape.”¹⁰²

Harm reduction relies on a continuum model of use and abuse of prescription, legal, and illegal drugs. It recognizes the role of drug use in coping with the consequences of racism, poverty, and homelessness. Harm reduction does not support an “all or nothing” approach to intervention, but rather seeks to help clients “where they’re at.” Rather than imposing a fixed regime on clients, the pace harm reduction assistance depends on the individual. Harm from drug use is viewed as multi-dimensional, including harm to self and the community. To reduce such harm, service providers seek to address immediate needs such as sterile equipment, safer sex equipment, food, shelter, medical care, HIV testing and counseling, and non-judgmental, culturally specific drug treatment. Most importantly, the harm reduction approach does not punish client for their use, and recognizes the competency of users to make choices.¹⁰³

Harm reduction advocates have criticized the war on drugs suggesting that punitive drug policy, which takes a criminal justice approach rather than a public health approach to drug use, is responsible for a large portion of drug-related harm. Examples of such harm include incarceration, arrest, lack of access or fear of accessing medical and social services, and lack of employability due to arrest records. Harm reduction advocates also note that treatment programs rarely achieve total abstinence for addicts. Thus, harm reduction rejects an abstinence-only approach as unrealistic and as an obstacle to meaningful assistance to drug users.

Prohibitionist and harm reduction approaches to drug use differ in understandings of who drug users are, what drug problems are, and what should be done. Where drug war policies understand all use of drugs as inherently dangerous, and all illicit drug users as inevitably addicts and abusers, harm reduction policies suggest that most people can use drugs in controlled, moderate ways. “Harm reduction policies . . . build upon informal social controls and approach users as people who are full citizens of society and who have a self-interest in getting and using information about the risks of the drugs they use.”¹⁰⁴

¹⁰² *Id.*

¹⁰³ HARM REDUCTION COALITION, *supra* note 83.

¹⁰⁴ Reinerman & Levine, *Real Opposition*, *supra* note 69, at 359; see NORMAN E. ZINBERG, DRUG, SET, AND SETTING: THE BASIS FOR CONTROLLED INTOXICANT USE (1984); Norman E. Zinberg et al., *A Study of Social Regulatory Mechanisms in Controlled Illicit Drug Users*, 7 J. OF DRUG ISS. 117 (1977).

Harm reduction relies on the assumption that most users of illicit drugs, like most people who consume alcohol, adhere voluntarily to informal social controls, which keep the harms of their use to a minimum. Only a small sector of the drug using population seeks an extreme experience, and who abuses drugs.¹⁰⁵

Common sense tells us that most people can self-medicate with drugs or use drugs socially and function in the world normally, undermining the idea that all illicit drug use "spirals" into life-endangering addiction. These basic assumptions disrupt the logic of the drug war, and suggest that massive incarceration, social isolation, and exclusion of illicit drug users from social institutions may produce more harm than it eliminates. Since most people affected by these harms are not the small population of "hard-core" users whose harmful behaviors the public has an interest in addressing, but whose problems are unlikely to be aided by punitive approaches.

A. Illustrations of Harm Reductions Programs

One example of harm reduction principles at work comes from a pamphlet produced by harm reduction activists in Bridgeport, CT. The pamphlet instructs readers on how to avoid unnecessary injuries when smoking crack cocaine. The pamphlet includes warnings about the dangers of cutting your lips or burning your hands or mouth, smoking without adequate ventilation, and preventing sexually transmitted diseases. The focus is not on discontinuing crack use, but preventing harms associated with crack use.

A second, more controversial, illustration of harm reduction practice can be seen in a recent Swiss government program.¹⁰⁶ One thousand hard-core heroin addicts were admitted to a program where heroin was prescribed to them by doctors, and support services were offered.¹⁰⁷ In this experimental group, crime dropped by 60 percent, homelessness was eliminated, half of the

¹⁰⁵ *Id.*

¹⁰⁶ *Status Report on the Medical Prescription of Narcotics*, Swiss Federal Office of Public Health, (Jan. 1995), at <http://www.soros.org/lindesmith/library/tlcswiss.html>. Other detailed information about and analysis of this program and calls for similar programs in the U.S. can be found on the website of The Lindesmith Center-Drug Policy Institute, <http://www.drugpolicy.org>.

¹⁰⁷ *Id.*

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unemployed found jobs, and a third of the welfare cases became self-supporting.¹⁰⁸ Additionally, by the end of the experiment, 83 addicts had chosen to pursue abstinence on their own.¹⁰⁹ This experiment suggests the possibilities of non-punitive, non-abstinence based approaches to drug addiction, and to addressing the needs of drug users in order to enable them to make choices, which benefit themselves and society.

The harm reduction model offers a pragmatic approach to drug use, which rejects inaccurate and hyperbolic images of drug users and drug problems that have fueled the war on drugs.¹¹⁰ This model attempts to utilize the life experiences of drug users and people in their communities to find the best approach for dealing with the harms associated with drug use. Abstinence and punishment are bypassed in favor of direct services which allow users to make choices about their drug use to reduce the risks associated with their behaviors. This approach emphasizes that the punitive policies have had a devastating effect on poor communities and communities of color.¹¹¹ Drug use and abuse are often coping mechanisms for people who live at the margins of society due to racism, poverty, homelessness and unemployment.¹¹² Providing treatment on demand, as well as remedying educational inequities, providing adequate healthcare and

¹⁰⁸ *Id.*

¹⁰⁹ Mike Gray, *Perils of Prohibition*, THE NATION, Sept. 20, 1999, at 18.

¹¹⁰ One source of such hyperbolic images in recent years has been the Partnership for a Drug Free America, a group partially funded by major companies in the alcohol and tobacco industries. Harm reduction advocates have suggested that one notable flaw in drug war policy—the focus solely on illegal drugs despite the serious harmful effects of alcohol, tobacco, and prescription medications—is the result of political and economic alliances between advocates of the drug war and the producers of legal addictive substances. Justeen Hyde, Remarks at UCLA's Speaking Truth to Power: A Conference on Progressive Law and Community Action Strategies (Sept. 25, 1999) (transcript on file with author).

¹¹¹ See Troy Duster, *Pattern, Purpose, and Race in the Drug War: The Crisis of Credibility in Criminal Justice*, in REINARMAN & LEVINE, CRACK IN AMERICA, *supra* note 59, at 260; CLARENCE LUSANE, PIPE DREAM BLUES: RACISM AND THE WAR ON DRUGS (1991).

¹¹² Reinarmann & Levine, *Crack in Context*, *supra* note 59, at 13 (suggesting that drugs are often a self-medication process for poor, unemployed or otherwise marginalized people who lack other kinds of support systems such as professional mental health services, and to whom treatment is less available than to middle class people who experiment with drugs); HARM REDUCTION COALITION, *supra* note 83.

housing, and addressing other aspects of social injustice will, in the end, provide the most help to drug users and their communities and reduce the harms of drug use.¹¹³ Harm reduction analysis provides a method of examining the connections between the harms of poverty and drug use.

IV. LOOKING AT DRUG USE IN THE CONTEXT OF POVERTY: AN ANALYSIS OF HARMS

As the punitive rationales and "deterrence" strategies of the drug war continue to dominate American drug policy, one of the most disturbing developments has been the adoption of the drug war logic into poverty policy.¹¹⁴

¹¹³ Such an approach was recently characterized by Michael Massing as a "root causes" approach to drug problems. "This holds that the problem of drug abuse in America reflects deeper ills in our society, such as poverty, unemployment, racial discrimination and urban neglect." Massing, *supra* note 63, at 11. Criminologist Elliott Currie, in arguing the benefits of such an approach, asserted that treatment is most successful in the long-term when the client has a realistic opportunity for a stable life, including employment and housing. Elliot Currie, *Yes, Treatment, But...*, THE NATION, Sept. 20, 1999, at 19.

¹¹⁴ Current drug users are excluded not only from ADA coverage and SSD benefits, but also from the Fair Housing Act (42 U. S. C. §3602 (h) (1988)), and, as of July 1, 2000, federal financial aid. On October 7, 1998, President Clinton signed the Higher Education Act (H.R. 6), a statute first created in 1965 to establish student financial assistance, which gets reauthorized every six years. In 1998, for the first time, this bill included an amendment which links drug conviction to federal aid eligibility. H.R. 6 prohibits the receipt of aid for any student convicted of any state or federal drug offense, including possession of marijuana or any other controlled substance. Suspension of aid ranges from one year to an indefinite duration, depending upon the number and type of conviction. Critics of this most recent example of the drug war's effects on poverty alleviation measures have pointed out that H.R. 6 restricts educational opportunity only for middle- and low-income drug offenders while wealthy offenders will not have educational opportunities foreclosed. The Drug Reform Coordination Network (DRCNet) has also pointed out that the legislation will have a racially discriminatory effect because drug law enforcement is heavily focused on minority communities. In addition to these insights, a harm reduction perspective also raises the issue of whether keeping people with drug histories and whose economic circumstances preclude attending college without financial aid from accessing higher education will benefit anyone. Proponents of the legislation seem most interested in the protecting taxpayer dollars from reaching undeserving drug users. Mark Souter, a Republican representative from Indiana, identifies the benefits of the legislation: "Taxpayers have a right to know that students who have a drug abuse problem aren't using tax dollars to go through school." Hillary Chute, *High Crimes*, THE VILLAGE VOICE: VOICE EDUCATION SUPPLEMENT, Fall 1999, at 76. Additionally, some states have begun to devise policies of making welfare receipt contingent on negative drug tests. In 1999, Michigan instituted the country's first statewide drug testing requirement for welfare recipients. Florida, Louisiana, and Oregon have

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In their essay, "Two Women Who Used Cocaine Too Much: Class, Race, Gender, Crack, and Coke," Sheigla B. Murphy and Marsha Rosenbaum trace the drug using careers of two young women.¹¹⁵ "Monique" is an African-American woman who grew up in a public housing project, and "Becky" is a white middle-class woman who grew up in her mother's home. Murphy and Rosenbaum describe the narratives of drug use of these two women who were close in age, lived in the same city, and both used cocaine, in order to illustrate that "class, race, and gender are more important in shaping these different experiences with and consequences of cocaine use than cocaine itself."¹¹⁶ They use the stories of the two women to illustrate trends which they saw frequently throughout interviews with one hundred women crack and powder cocaine users. These two stories provide a window into the serious differences that occur between the harms of drug use when they do and do not coincide with the harms of poverty. This section will apply a harm reduction analysis to examine how conditions of poverty exacerbate the harms of drug use in order to demonstrate the misguidedness of an approach to drug problems, which restricts drug users from income support programs such as SSI and SSDI.

Her mother, who lived on public assistance, raised Monique in public housing projects in San Francisco. Monique became a prostitute at age 15 in order to buy things for herself that her mother could not provide. When she was arrested for prostitution, she was placed in a group home for troubled teenagers.

Her mother, who worked as a lawyer in private practice, raised Becky in a middle-class neighborhood in San Francisco. Becky's youth was protected by "middle-class privileges like private schools, access to job opportunities, and safe housing."¹¹⁷

also considered instituting such programs. Selma Goode, a welfare activist in Michigan, has criticized the state for implementing a program that punishes poor parents for drug use when drug treatment for people with children is severely lacking in the state. Kary Moss, Executive Director of the ACLU of Michigan, has criticized the program for making parents choose between their privacy rights and providing for their children. Press Release, Michigan American Civil Liberties Union, Michigan ACLU Seeks Halt to Nation's First Mandatory Welfare Drug Testing Program (Sept. 30, 1999).

¹¹⁵ Sheigla B. Murphy & Marsha Rosenbaum, *Two Women Who Used Cocaine Too Much: Class, Race, Gender, Crack, and Coke*, in REINARMAN & LEVINE, *CRACK IN AMERICA*, *supra* note 59, at 98.

¹¹⁶ *Id.* at 100.

¹¹⁷ *Id.* at 103.

Because of their different economic and social vulnerabilities, the contexts of these two women's drug use differed greatly. Becky used and bought drugs primarily through her co-workers at a nightclub. After leaving a group home and losing her job, Monique relied heavily on sex-for-drugs exchanges in order to get cocaine.¹¹⁸ Becky had her own room both at her home and at her work, and was able to use drugs in secret. Monique suffered stigma, rejection of her mother, and state punishment because of the discovery of her drug use, which usually occurred on the streets since she had no private space. Becky's middle-class "non-deviant identity" helped her camouflage her drug use, "while similar behavior brought Monique both formal and familial stigma and the attendant loss of self-esteem."¹¹⁹

At the time of the last interviews, Monique lived in a homeless shelter with no possessions but the clothes she was wearing. She had no prospects for employment; her mother had left the state without leaving a change of address. Becky, on the other hand, moved to Hawaii to live with her father, and had used the opportunity to make a fresh start and step away from the nightclub lifestyle and her escalating drug use. Both women had come to see the serious harms of drug use in their lives, but only Becky had found an avenue to eliminate and control these harms.¹²⁰

The stories of Becky and Monique are not representative of all women in their respective situations. There is no doubt that sex-for-drugs exchange and stigma associated with drug use occur in the lives of people of all races and economic backgrounds. However, these stories are helpful in understanding the ways in which the harms of poverty exacerbate the harms of drug use.¹²¹

¹¹⁸ *Id.* at 103-05.

¹¹⁹ *Id.* at 107.

¹²⁰ *Id.* at 108.

¹²¹ Reinerman and Levine explain that controlled drug use, in compliance with social norms of self-regulation, is more likely to occur in people who "have balanced lives, who can look forward to a decent life in the future, and who therefore have some stake in conventional life and society." Reinerman & Levine, *Real Opposition*, *supra* note 69, at 359. They describe how economic vulnerability is connected to harmful drug use. "Just as marginalizing drug use into deviant subcultures increases the likelihood of abuse, so does socioeconomic marginalization increase the likelihood of sets and settings that increase the likelihood of drug problems." *Id.* They see this as the primary connection between social justice issues and the public health-based understanding of drug use and abuse.

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There are further examples that illustrate the point. Poor people, because they lack economic resources, are far more likely than middle and upper-class people with similar drug habits to turn to crime in an effort to pay for drugs.¹²² This makes them vulnerable to numerous other harms, such as arrest, losing their children to state control, and violence, which can accompany crime. Attendant to interaction with the criminal justice system, users can face difficulties finding employment because of having an arrest record, they may be subject to further scrutiny in the parole or probation systems, which considering their slim chances for receiving treatment, may lead to getting caught with drugs again. Mental and physical health services for poor people are also complicated by drug use, because lack of medical insurance may put them at the mercy of public care where they are less insulated from scrutiny and state sanction for their drug use. For this reason, many poor users do not seek medical care, fearing that using a public health system and being identified as a user could lead losing their children or facing criminal charges. Generally, the stories of Monique and Becky show how drug use can be far more risky for people who lack economic safety nets in the form of actual assets or access to class privileges such as job opportunities, safe housing, private medical services, and drug treatment.¹²³

¹²² *Id.*

¹²³ Heaps and Swartz discuss the increase in harms of drug use when it occurs in the context of poverty. They argue that addicts who turn to crime to support their habits are often “poorly educated . . . and lack the skills necessary to secure even a low-paying job.” Heaps & Swartz, *supra* note 65, at 200. They also assert that users in areas “of high social and economic isolation and poverty . . . ‘are most likely to become addicted . . . [and] are most likely to suffer from and themselves cause the harmful effects of drug use.’” *Id.* at 194 n.84. Reinerman and Levine support this understanding, and further assert that drug war strategies have made experiences of poor drug users more difficult and harmful.

[T]he inner-city poor and working class are far less often employed and more often live at the margins of the conventional order. When their lives become too difficult, they rarely have psychiatrists, but they sometimes self-medicate, escape, or seek moments of intense euphoria with what might be called *antidespondents*, such as crack. When some of them become addicted, they have far fewer resources to use to pull themselves out of trouble and far fewer opportunities to make a successful life. And when some of the inner-city poor began having trouble with crack, politicians declared a drug war that did *not* help them stabilize their lives.

Reinerman & Levine, *Crack in Context*, *supra* note 59, at 13.

The stories of women around the U.S. who have been charged with various crimes as a result of testing positive for illegal drugs while pregnant or after childbirth offer poignant examples of the specific dangers of drug use in the context of poverty, and of how drug war strategies often maximize the harms of drug use to poor people. During the "crack baby" scare of the late 1980's, more than two hundred women in almost twenty states were criminally prosecuted for passing drugs to their babies through their bodies during pregnancy or directly after childbirth.¹²⁴ Prosecutors used a variety of theories from assault with a deadly weapon (cocaine)¹²⁵ to felony child neglect¹²⁶ and endangering the welfare of a child.¹²⁷ In 1989, eighteen women in South Carolina were charged with criminal neglect of their fetuses under a protocol developed by the public hospitals, police, prosecutors, and department of social services.¹²⁸ In addition to criminal proceedings, civil proceedings against women whose babies test positive for drugs have had major consequences on poor mothers. Hundreds of women have lost custody of newborns because of positive tests at birth.¹²⁹ In one case, a woman lost custody of her baby for months because she admitted to using marijuana during labor to ease the pain based on the advise of a friend who was a nurse.¹³⁰

¹²⁴ Loren Siegel, *The Pregnancy Policy Fight the War on Drugs*, in REINARMAN & LEVINE, *CRACK IN AMERICA*, *supra* note 59, at 249; *see also* Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991).

¹²⁵ *North Carolina v. Inzar*, (Sup. Ct. Robeson County 1991), *cited in* Siegel, *supra* note 123, at 249 n.1. Sandra Inzar was charged with assault with a deadly weapon with intent to kill her fetus, for which the maximum penalty is twenty years in prison.

¹²⁶ *Virginia v. Smith*, (Cir. Ct. Franklin County 1991), *cited in* Siegel, *supra* note 123, at 249 n.2. Britta Smith was charged with felony child neglect when her newborn tested positive for a cocaine metabolite.

¹²⁷ *New York v. Morabito* (City Ct. Ontario County 1992), *cited in* Siegel, *supra* note 123, at 249 n.3.

¹²⁸ Siegel, *supra* note 124, at 250.

¹²⁹ *Id.* at 251.

¹³⁰ *Nassau County Dept. of Soc. Services v. Leavy* (Family Ct. Nassau County 1989), *cited in* Siegel, *supra* note 123, at 251 n.8.

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Proceedings against women based on positive drug tests on their children are typically triggered by a hospital report of a positive drug screen to the local or state agency, which deals with child abuse and neglect.¹³¹ Poor women and women of color have been disproportionately targeted for prosecution. In a 1989 study conducted in Pinellas County, Florida, 380 pregnant women in public clinics and 335 in private care were tested for drugs. 15.4 percent of white women and 14.1 percent of black women were found to be positive. However, black women were nearly ten times more likely to be reported for substance abuse than their white counterparts.¹³² Economic status is relevant to this disproportionate reporting because public clinics and hospitals, which primarily serve low-income women, comply with reporting more than do private hospitals and doctors. Additionally, doctors often rely on profiles of drug users, which incorporate class bias. In South Carolina, one element of the profile used in public hospitals is no prenatal care or prenatal care beginning after twenty-four weeks. This disproportionately impacts poor women because Medicaid does not cover prenatal care before the nineteenth week of pregnancy.¹³³

The criminalization of drug using mothers reflects both the heightened risks poor drug users face, and the harm maximization of punitive drug war policies on drug users and their families and communities. While treatment for pregnant women remains under funded and unavailable to most women, policy makers have chosen prosecution over treatment for pregnant users.¹³⁴ Like

¹³¹ Siegel, *supra* note 124, at 251.

¹³² *Id.* (citing Ira J. Chasnoff, *The Prevalence of Illicit Drug or Alcohol Use During Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida*, 322 *NEW ENG. J. MED.* 1201 (1990)).

¹³³ *Id.* at 251-52.

¹³⁴ Siegel tells the story of Jennifer Johnson, a Florida woman who sought treatment for addiction during her pregnancy but was rejected by every program. When she gave birth to a healthy infant, she told the obstetrician of her cocaine use in order to get the best medical care for the infant. She was convicted of delivering cocaine to her infant and sentenced to one year of house arrest and fourteen years of closely supervised probation. The judge who convicted her stated:

Pregnant addicts have been on notice for years that taking cocaine may be harmful to their children. This verdict puts pregnant addicts on notice that they have a responsibility to seek treatment for their addiction prior to giving birth. Otherwise, the state may very well use criminal prosecution to force future compliance with the law or, in appropriate cases, to punish those who violate it.

Monique, poor pregnant users face the increased likelihood of harms related to state intervention stemming from the fact that they lack the resources which facilitate hiding drug use from state forces.

The stories of poor pregnant women prosecuted for drug use, and the tracing of Monique and Becky's life histories, provide examples of how the harms of poverty are connected and intertwined with the harms of drug use, as well as how drug war policies disproportionately effect poor people. These observations create a background on which to assess the wisdom of drug war-inspired changes to social welfare. If drug use is most dangerous and disruptive to the lives of users, their families, and society when the users have inadequate income, does it make sense to further reduce access to income support for drug users?

Stephen Mugford examines the role of social welfare in drug problems in his article, "Crack in Australia: Why Is There No Problem?"¹³⁵ In this essay, Mugford attempts to account for the fact that despite many similarities between the United States and Australia, Australia did not experience the serious harmful effects of crack cocaine such as those experienced in the United States.

Mugford asserts that the key differences which explain this disparity are "social-structural differences that lead to the U.S. having a greater demand for crack, a greater supply of individuals willing to sell crack; and a greater public concern about the immorality of drug use, which leads to harsher penalties that exacerbate the problem."¹³⁶ One central difference Mugford cites is that Australian cities do not have the same types of racial ghettos that exist in the United States, where youth are deprived of economic opportunities and can find no better or often no alternative way to make money than selling drugs.¹³⁷ This racialized aspect of the distribution of capital, which results from the segregation common in the United States, influences the patterns of drug distribution.

Mugford argues that a stronger support network for poor people exists in Australia. Unemployment and welfare benefits are more generous and of longer

Siegel, *supra* note 124, at 249-50 (citing *State v. Johnson* (Cir. Ct. Seminole Co. 1989)).

¹³⁵ Stephen K. Mugford, *Crack in Australia: Why Is There No Problem?*, in REINARMAN & LEVINE, *CRACK IN AMERICA*, *supra* note 59, at 194, 195.

¹³⁶ *Id.*

¹³⁷ *Id.* at 201.

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duration than their United States equivalents.¹³⁸ Consequently, "Australia does not have an underclass in the same way that the U.S. does."¹³⁹ Mugford focuses on the approaches of the two countries' attempts at drug regulation. Australia's drug control system, in comparison to that of the U.S., is "less zealous and punitive," and addresses drug use more as a public health problem than a criminal law problem.¹⁴⁰ Mugford points to the two countries' approaches to needle exchange programs to exemplify the difference. He demonstrates that the difference in drug policies between the two countries seriously influences the harms of drug use by noting that in Sydney, where needle exchange has been far less controversial than in the United States, the level of HIV infection in the injecting drug community remained low at around 2 percent in 1995. In cities in the United States, on the other hand, such as New York and Newark, 1995 infection rates were as high as fifty to sixty percent.¹⁴¹

Like other drug war critics, Mugford connects poverty to the harms of drug use, and uses the Australian example to show how poverty alleviation can be a part of a program for reducing harms of drug use. Mugford asserts the following:

Social policies that truly improve the life circumstances and life chances of the growing ranks of poor people will, . . . almost certainly strengthen their bonds to conventional life and reduce their drug abuse. Clearly, such social policies would actually contribute to reducing drug-related harms, unlike high-tech panaceas like 'bug wars' against coca crops or aircraft carriers in the Caribbean or increasing the already appalling level of imprisonment of young black men.¹⁴²

Mugford echoes other drug war critics as he suggests that Reagan-Bush policies worked to redistribute wealth upward and reduce programs that aided poor,

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ *Id.* at 202.

¹⁴¹ *Id.* at 203.

¹⁴² *Id.* at 205.

disadvantaged, and unemployed people.¹⁴³ These effects, combined with increasing political rhetoric about “parasitic” poor people living off welfare, led American voters to be less willing to spend money on poverty alleviation, and more willing to support expensive and ineffective policies that maximize harm from drug use to poor people.¹⁴⁴

Mugford’s work suggests that the connections between the harms of poverty and the harms of drug use demand an interrogation of poverty policy as an important component of the United States’ methods of addressing drug problems. Since harm from drug use is exacerbated by poverty, excluding persons disabled by drug use from income support and from protection from employment discrimination is not only likely to increase harm to those individuals and curtail their hopes of treatment, but also to increase the cost to society of their drug use. This cost will come through the exclusion of qualified workers from the workforce, crime-fighting and incarceration expense, and increased use of expensive emergency medical services for those who have been cut out off Medicaid. While America’s increasing fear and reprehension for drug users has produced widespread sentiment that public benefits should be denied drug users for fear of their use to purchase drugs, a more complex, long term understanding of the intersections of harm and poverty and the cost to society of a punitive approach suggest that excluding drug users costs society far more than it saves.

As the RAND study discussed above demonstrates, people made ineligible for SSI benefits due to their drug use end up in situations, which are more dangerous to themselves and society. They not only lose access to many medical services including already hard-to-access drug treatment, but they also must find new ways to access income. Homelessness, lack of job skills and education, and instability resulting from drug addiction will leave most of these disabled people without the ability to earn income in a traditional job, and many may be forced to turn to crime in order to survive. While eliminating drug users from disability programs and protections may seem attractive in the short term, it does nothing to address the underlying drug problem, and exacerbates the harms of drug use to the individual and society. A reasoned approach, not fueled by drug scare hysteria, would suggest that improving the ability of people disabled by drug addiction to get treatment and basic income support, rather than eliminating access, will yield the best results. Rehabilitation, rather than

¹⁴³ *Id.*

¹⁴⁴ *Id.* at 205-06.

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punishment and exclusion, should be the goals of disability policy. Making treatment and benefits more available to those disabled by drug addiction will enable them to access healthcare, address their disabling condition, and not have to engage in criminal conduct for survival. Additionally, as Mugford suggests, a broader program of reducing poverty generally and increasing job training and education opportunities would go far in reducing the harms of drug use. Unfortunately, the U.S. government has opted for prison expansion and exclusion of drug users from poverty alleviation programs rather than treatment expansion and income support for the disabled.

Since the 1980's, political rhetoric and media sensationalism have produced a "drug problem" in the American imagination with grossly inaccurate, uncompassionate portrayals of ruthless, dangerous, and morally depraved illicit drug users and an ever-present threat of the spread of such an element into the sanctity of upper-class suburbia. These images have produced drug policies that are ineffective at combating the real harms drug use can entail. The "war on drugs" has succeeded in incarcerating an unprecedented number of people (particularly poor people of color), tearing apart numerous families, and taking away basic income support from needy people, but has failed to reduce drug use.

V. CONCLUSION

In the past ten years, the moral approach to drug use has increasingly influenced disability and poverty alleviation programs, producing policies that punish disabled addicts for their addictions and deprive people in need treatment, basic income support, and medical coverage. The harm reduction approach to drug use provides a model through which to analyze the wisdom of punitive poverty and disability policies. Because the harms of poverty exacerbate the harms of drug use, it makes little sense to exclude poor drug users from poverty alleviation programs. Punishment and exclusion have not been shown to reduce drug use, but instead prove only to increase harms associated with drug use, such as crime, homelessness, inadequate medical coverage, and unemployment.

Critics of drug war policy have shown that drug policy fueled by moral panic is ineffective at eliminating problems associated with drug use, and may in fact create additional harms. Drug war rhetoric has made the exclusion of drug users from public assistance programs "politically irresistible."¹⁴⁵ The consequences of these exclusions, however, are increased harms to users and to society. It is essential to begin to consider alternatives to punitive policies, and

¹⁴⁵ Bluthenthal et al., *supra* note 27, at 29.

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to begin focusing on making treatment available on demand, increasing employment and educational opportunities, alleviating poverty, and integrating all disabled individuals into the mainstream of society.