

THE PROBABLE IMPACTS OF THE REMOVAL OF THE ADDICTION DISABILITY BENEFIT IN ONTARIO

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ABSTRACT

In Ontario, those dependent on substances are no longer eligible for welfare payments based on an addiction disability. While the impact of this program has not been assessed, evidence from a similar policy shift in the USA suggests deleterious effects on the health and social functioning of about half of those who lose this form of social support. A review of the research on the chronic-illness view of addiction, the fostering of stigma by exclusionary social policies, and the negative effects on mental health and homeless status associated with the loss of welfare benefits leads to the conclusion that this is an ill-advised policy for Ontario. Its continuation there, and its extension to other provinces, is not recommended.

INTRODUCTION

Canada has a long-standing social welfare tradition of supporting those who are unable to support themselves. In Ontario, the two principal social assistance programs are Ontario Works (OW) and the Ontario Disability Support Program (ODSP). ODSP is intended for recipients who are unable to obtain and maintain paid employment due to a wide range of physical and mental disabilities that included, until recently, substance dependence.¹ Since 1998, the new criteria exclude anyone whose disability is “attributable to the use or cessation of use of alcohol, drugs or other substances” (*Ontario Disability Support Program Act*, Section 5(2), 1997). If another disabling concurrent condition such as mental illness is diagnosed, ODSP may be provided only if the legitimate disability is shown to be independent of substance abuse. Those with drug dependencies are directed to OW, where they are required to maintain an active job search, cooperate in a treatment program, and undertake a workfare placement in order to continue to draw benefits. The maximum monthly payments for OW are \$536 and for ODSP, \$959. It is important to note that the Canadian poverty line for a single person with no dependents in 2003 reached a gross-income level of between \$13,680 (for rural areas) and \$19,795 (for metropolitan centres)—a range equivalent to approximately \$1140-\$1650 per month (National Council on Welfare, 2004).

Even though formal governmental justification for the exclusion criteria of ODSP is lacking,² the grounds for this policy can be reconstructed from a current court case involving the ODSP and two disqualified individuals (*Tranchemontagne and Werbeski v. Director of the Ontario Disability Support Program*, 2002, 2003). The rationale for the exclusion criteria for the ODSP appears to rely upon the following points, as presented in affidavits for the government case: (1) the individual-level psychological

construct motivation-to-change, most clearly proposed in the Transtheoretical Model of Change (Prochaska, DiClemente, & Norcross, 1992), serves as the primary causal factor in long-term addiction recovery; (2) the levels of support provided by the former ODSP (without the exclusion criteria) undermined an individual's motivation-to-change; (3) the resultant state of weakened motivation-to-change perpetuated and exacerbated the liabilities associated with substance dependence; (4) the transfer of substance-dependent persons into the Ontario Works program would increase their motivation-to-change; and (5) this heightened motivation-to-change would actually result in clear therapeutic improvements in addiction severity and long-term recovery. This case is before the Ontario Superior Court of Justice (Divisional Court) and is due to be heard in early 2006 (Legal Aid Ontario, 2005, personal communication).

The scope of the problem is difficult to gauge. However, figures from the Drug and Alcohol Treatment Information System (DATIS; Ogborne, Braun, & Rush, 1998), a large-scale client information system currently in use in Ontario, estimate that up to 20% of OW clients ($N \approx 67,000$) have addiction problems and 755 are receiving treatment (Corea, 2004). These data are incomplete and do not include clients of the Centre for Addiction and Mental Health (CAMH) in Toronto or the Homewood Health Centre in Guelph. Information on the proportion of those receiving OW who were previously on ODSP is not available. Nor are figures published on how many individuals left ODSP and either subsequently requalified on other grounds or who may have dropped through the cracks, currently receiving no public assistance.

While no studies have been conducted to date on the actual effects of the removal of the disability benefit for substance dependence in Ontario, some probable impacts can be presented based on the available literature. These will be discussed in relation to three topics: the scientific evidence that addiction does constitute a disability comparable to other mental and physical conditions; the fostering of stigma by exclusionary social policies; and the social research indicating the negative effects on mental health and homeless status, particularly that evaluating the effects of the elimination of the addiction disability benefit in the USA in 1997. This leads to the conclusion that the policy likely has imposed considerable hardship, should be reversed in Ontario, and is inadvisable for the rest of Canada.

ADDICTION AS A DISABILITY

The World Health Organization has recently released a major report, *Neuroscience of Psychoactive Substance Use and Dependence*, with contributions from 30 international experts. It concludes that "substance dependence is not a failure of will or of strength of character but a medical disorder that could affect any human being. Dependence is a chronic and relapsing disorder, often co-occurring with other physical and mental conditions" (WHO, 2004, p. 248).

Modern addiction science has come to view substance dependence as the complex product of many factors—an interaction of genetics, family background, culture, and environment—which shape the choices made by individuals. While most people can use drugs occasionally without becoming dependent, there is no way at present to identify the small minority who will lose control, nor distinguish those who will regain control from those whose lives will continue to be dominated by a need for drugs. Risk factors have been identified, and will be discussed more fully below, but these can only predict aggregate outcomes, rather than individual recurrence.

THE IMPACTS OF THE REMOVAL OF THE ADDICTION DISABILITY BENEFIT

The modern understanding of addiction still vies with the historical dichotomy of the *moral* and the *medical* views. The moral view is that drug use, even in the most persistent forms, is a voluntary behaviour in which people freely engage, and for which they therefore must be held accountable. Drug users who favour illicit substances, with only a black market supply of questionable quality as their source, are subject to arrest, prosecution, and imprisonment. Overdose or other complications that arise from the drug's illegality are considered risks willingly undertaken and consequences deserved. Punishment is the primary response.

The medical view has presented addiction in the past as an oversimplified "disease" over which the user has no control. The only cure is total abstinence. In other words, addiction is an acute, treatable illness as long as the victim abstains from drugs. Of course, since "cures" are rare and relapse is the norm, this led to the disappointing conclusion that drug dependence was not a legitimate medical specialty with tried and true interventions. To be effective, treatment had to be combined with strict controls and coercion in the community, or as part of a mandatory treatment program. Since the user's own capacity for control was constrained by having caught an "addictive disease," intervention focused on the individual in a restrictive context intended to reinforce abstinence. Instead of punishment, users live with a life-long fear of their vulnerability to relapse; because their own sense of control is eroded, this view encourages them to abrogate their own responsibility to that of the power of the substance. Neither the medical nor the moral models are congruent with the contemporary scientific understanding of drug dependence.

Over the last several decades, an accumulating body of evidence has demonstrated that addictions usually follow a chronic, relapsing course, often lasting many years with multiple episodes of treatment and relapse to substance use (Anglin, Hser, Grella, Longshore, & Pendergast, 2001; McLellan, Lewis, O'Brien, & Kleber, 2000). For example, after an initial period of substance abuse treatment, approximately 25-35% of clients return to treatment within a 12-month period (Peterson, Swindle, Ciaran, Recine, & Moos, 1994; Simpson, Joe, & Broome, 2002). Both prospective and retrospective studies have demonstrated that a majority of clients undertake three to four episodes of treatment before reaching a stable state of abstinence (Grella & Joshi, 1999; Hser, Grella, Chou, & Anglin, 1998). Other researchers have found that among those seeking publicly funded substance abuse treatment in Chicago, for example, the median time from substance use initiation to at least one year of abstinence reached 27 years, and the median time from first treatment entry to the first period of 1-year abstinence covered 8 years (Dennis, Scott, Funk, & Foss, 2005).

The inadequacy of the moral and medical models has galvanized a growing number of researchers to argue for the importance of a chronic-illness view of addiction (O'Brien, 2003; McLellan et al., 2000; Scott, Dennis, & Foss, 2005; Weisner et al., 2004; White, Boyle, & Loveland, 2002). These authors draw parallels to such chronic conditions as diabetes, hypertension, and asthma, all of which are not presently curable, but can be managed effectively with appropriate interventions and supportive programs. For example, people with diabetes are not told simply to stop consuming sugar, or those with hypertension to eliminate salt, in order to recover; these steps may help but are only part of the overall approach. As with substance abuse programs, treatments can be effective for varying periods, but non-compliance, poor lifestyle choices, or personal biology can lead to a worsening of these chronic conditions. An area of profound similarity among diabetes, hypertension, asthma, and substance dependence is that "adherence and ultimately outcome are poorest among

patients with low socio-economic status, lack of family and social supports, or significant psychiatric co-morbidity” (McLellan et al., 2000, p. 1693).

In many current substance abuse treatment practices, even after “successfully” completing a short treatment program, the “recovered” addict is usually discharged into the community without aftercare, and followed up some months later to see if he or she is still abstinent. Alternatively, in a chronic-care model, relapse becomes the focus of efforts to improve and intensify the treatment (Scott, Dennis, & Foss, 2005; Dennis, Scott, & Funk, 2003; White et al., 2002). Treatment is an extended process of maintenance and monitoring, without expectation of a complete or lasting cure. This, these authorities propose, is a more rational approach to a substance dependent person, rather than the more common expulsion from abstinence-oriented programs after relapse (McLellan et al., 2000).

Drawing upon models of ongoing monitoring and early re-intervention used in the long-term management of other chronic medical conditions, a group of researchers has developed a therapeutic program of post-discharge recovery management checkups (RMC) as a way to improve the long-term outcomes of individuals with chronic substance use disorders (Dennis, Scott, & Funk, 2003; Scott, Foss, & Dennis, 2005). The RMC approach includes quarterly recovery management checkups (i.e., assessments, motivational interviewing and linkage to treatment re-entry) as the post-treatment intervention strategy to shorten the cycles of relapse, treatment re-entry, and stable recovery (Scott, Dennis, & Foss, 2005). In an experimental evaluation of recovery management checkups (RMC) for people with chronic substance use disorders, Scott et al. (2005) found that participants assigned to receive recovery management checkups were significantly more likely than those in the control group to return to treatment, to return to treatment sooner, and spend more subsequent days in treatment; also, they were significantly less likely to be in need of additional treatment at 24 months.

In light of the empirical evidence, a compelling case can be made that substance dependence, understood as a chronic, relapsing condition, is a disability that substantially impairs and restricts a person’s ability to function in the community, hold a regular job and fulfill personal and family obligations. The essence of the addiction is that obtaining and using drugs, usually on a daily basis, have priority over other aspects of life, including not only health and well-being, but also, literally, survival. How a person gets to this point is complex and, although some do recover, the trajectory is not easily reversed, meaning that for the most disadvantaged, recovery is an unrealistic expectation. The chronic-illness model of addiction not only offers a more compelling account of the nature of addiction, it also undercuts the broader and more deleterious effects of stigma associated with substance dependence in society at large.

STIGMA

A major barrier to the reintegration of substance-dependent users into society is the social stigma and ostracism they face. As was documented in a WHO study of attitudes toward 18 disabilities in 14 countries, “Drug addiction ranked at or near the top in terms of stigma” (Room et al., 2001, p. 247) and the WHO report further concludes that in order to remove these barriers, it is essential that “[people with substance dependence] have the same rights to health, education, work opportunities and reintegration to society as does any other individual” (WHO, 2004, p. 248). Measures that treat substance-dependent people differently from citizens with other

disabilities, and deny them the help and support necessary to remain in or rejoin their communities, continue and promote this tradition of discrimination.

The research literature provides many examples of the stigma faced by even less serious, non-dependent drug users. A Toronto study found that employers were less willing to pursue the job application of someone who had a history of a marijuana arrest, regardless of sentence, than of those without such a record (Erickson & Goodstadt, 1979). Those with a history of opiate or cocaine dependence, most of whom also have criminal records, are likely to experience even more severe rejection as job candidates (Fischer, Medved, Gliksmann, & Rehm, 1999). A study of treated addicts in Hong Kong found that perceived discrimination from the public was associated with post-treatment return to drug use (Cheung & Cheung, 2003). While some social disapproval attaches even to dependent users of legal drugs such as tobacco and alcohol, it is a much milder form of social control than that attached to dependence on illicit drugs.

The issue of stigma should be understood both as the loss of personal capital by individual drug users and as diminished social capital in the communities in which they tend to congregate. Thus, for example, more serious problems of drug dependence tend to be evident in the more socially disadvantaged parts of cities. This was illustrated in a Toronto study which found that crack cocaine users from better neighbourhoods with more social capital tended to have few problems controlling their use and had very low rates of dependence; in contrast, 30 crack-using women in a poor, inner-city neighbourhood reported heavy problem use of cocaine and other drugs (Erickson & Cheung, 1999; Butters, Hallgren, & McGill, 1997). A similar pattern was observed cross-nationally in a WHO (1995) study of cocaine dependence in 19 countries. Compared to the fairly universal middle-class route of snorting cocaine, the practices of smoking and injecting the drug were concentrated among the poor and socially marginalized groups in all the participating countries. Thus, building the economic resources and social capital of communities is an important strategy in an overall approach to reducing the personal and social harms of drug dependence and mitigating the effects of stigma. An individual focus is not sufficient.

A comparative study of matched samples of addicts in the USA (Brooklyn, New York) and Australia (Cabramatta, Sydney) highlights the destructive consequences of institutionalizing stigma in formal social policies (Johnson, Maher & Friedman, 2000). While heroin users in both communities experience high degrees of informal stigma from multiple statuses (i.e. homeless, poor, chronically unemployed drug addicts), the Australian sample had access to publicly funded health care, a national income-transfer payment system for the unemployed (AU\$170/week) and in some instances, a housing rental allowance. The US sample members were denied income support benefits (formerly US\$50/week) after the workfare program was initiated and most were dropped from the rolls for failure to comply with its requirements. Over the study period, 1995–1998, nearly two-thirds of the New York addicts had died, mainly from AIDS, while only one Sydney addict was dead, of a heroin-related overdose. Moreover, homelessness in the American sample increased over the course of the research, from 75% to 89%, while it actually declined from 25% to 14% in Australia. The authors concluded that in Australia, “[t]he transfer payments provided their [addicts’] one regular income source permitting them to be housed and fed, albeit at a very low standard of living” (Johnson et al., 2000, p. 39). The formal exclusion from minimal benefits experienced by the American addicts was not part of the policy approach in Australia where such benefits are universally available to all classes of citizens. The American approach of denying welfare to drug dependent

individuals not capable of working is characterized as an example of "[U.S.] government-sponsored programs that target stigmatized persons for exclusion from a variety of services available to normal citizens" (Johnson et al., 2000, p. 16). It is evident that while a government cannot legislate away the informal stigma which reside in the attitudes of its citizenry, it can formalize and perpetuate a serious negative impact through social policies which institutionalize stigma. Along with the broader social consequences of stigma, addiction-related exclusion criteria for social assistance have dramatic effects on the social functioning of disqualified individuals, especially in relation to psychiatric illness and homelessness.

SOCIAL FACTORS

There are a number of factors intertwined with drug dependence, such as poverty, poor health, chronic stress and anxiety, and lack of secure housing, which affect overall social functioning and the potential for reintegration into society. In the USA, the elimination of the Supplemental Security Income (SSI) for drug addiction and alcoholism disability in 1997 affected about 210,000 recipients nationally. While it was initially estimated that about 70% would re-qualify for benefits on other grounds of impairment, only half that number had done so by 2000 (Swartz, Lurigio & Goldstein, 2000). The largest number of those affected in any city, nearly 20,000 individuals, were located in Chicago, prompting extensive research on the impact of the policy on substance dependent persons in that city (Goldstein, Anderson, Schyb, & Schwartz, 2000; Anderson, Shannon, Schyb, & Goldstein, 2002). Summaries of a number of findings from these studies follow.

In a random sample of 204 prior recipients one year after loss of welfare, Swartz et al. (2000) found that 14% had found employment paying at least \$500 per month, 34% had requalified for SSI, usually on the grounds of medical or psychiatric impairment, and the remaining 52% received no public aid and had no apparent means of support. This latter group had a five times greater likelihood of drug dependence than the other two, and was seven times more likely to have multiple psychiatric disorders. The three groups were not significantly different in positive tests for current illegal drug use. The small number who had made the transition to work was the least psychiatrically impaired of the former recipients. Those who managed to regain benefits were intermediate in impairment. The more than half who lacked either alternative were considered most in need of disability benefits but least able to complete the process. These authors also conclude that those receiving addiction disability benefits are a diverse, heterogeneous group, and that any one approach is not likely to be successful across the board. They caution that the most disadvantaged group, by virtue of serious substance dependence, mental illness, or both, is also the one lacking the will, experience and resources to take care of themselves, much less surmount the hurdles to regain benefits or achieve work. The loss of resources increases the stress related to meeting basic needs of food, medicine, clothing, and shelter. Malnourished individuals are especially vulnerable to the adverse effects of drug consumption. The likelihood is that most will continue to experience serious health compromising conditions as a result of their addiction disability and associated poverty unless further social supports are put in place.

Other studies in the USA on the termination of addiction disability benefits have consistently demonstrated that homelessness increased for former recipients, as did their dependency on family and friends or recourse to illegal activities (Anderson et al., 2002). For example, housing hardship (such as doubling-up or moving to a

hostel) increased for those who lost their benefits, but not for those who requalified (Spiegelman, 2001; SSIC, 2002). Since substance-abuse treatment is known to be most effective for those in stable housing, the interrelationship of these needs is emphasized. Those who lost benefits were also disproportionately less educated, middle-aged, of minority status, and with a prior job history of physical labour (e.g. construction services) now precluded by their current health problems. It was also suggested that the effects of the policy have been particularly harsh on small subgroups of women with chronic substance dependence, who have children, and who are at high risk for violence and abuse (Dunlap, Golub, & Johnson, 2003). Finally, since trends in drug use overall were no different for those who lost benefits and those who retained them, the assumption that drug use is driven by the receipt of welfare cheques is brought into question (see also Macdonald et al., 2001). These various studies converge in their agreement that welfare restructuring which withdrew all addiction disability payments has imposed considerable negative consequences on a substantial proportion of former recipients, who are among the most vulnerable and socially disadvantaged members of society. This has led to calls in the USA for a new policy approach to addiction disability (Baumohl, Speiglmán, Swartz, & Stahl, 2003).

CONCLUSION AND IMPLICATIONS

Scientific models of addiction, rather than being isolated to academic research circles, have important implications for social attitudes and, ultimately, social policy. This paper has argued for the adoption of a new model of addiction—a framework drawn from those of chronic illnesses such as hypertension, diabetes, and asthma. The chronic-illness model of addiction not only provides a more persuasive account of those treatment/recovery/relapse cycles so often seen among addicts, it also serves to undermine the damaging effects of addiction stigma in society at large. This paper described in detail how addiction stigma have been instantiated in recent social-assistance policies in Ontario and the probable effects of such policies on addicts disqualified from social-assistance programs.

Background risk factors for problem drug use include family disruption, child maltreatment, social deprivation, parental history of dependence, poor school performance, young age of onset of drug use, and depression and suicidal behaviour in adolescence (WHO, 2004). By the time people with such histories are adults, substance dependent, and on welfare, the course of their lives is not easily reversed. Maintenance and support on disability is the most realistic social response for many (Benoit, Young, Magura, & Staines, 2004). The requirements of job seeking and regular hours and attendance at training or appointments are an undue hardship for those with long-term substance dependence. Most have a history of inability to meet society's expectations. Lives centred on drugs, while unpalatable to those in the mainstream, are the norm over many years for people with an addiction disability. Even for those who are able to participate in OW, the difference between Ontario Works and the Ontario Disability Support Payment (an amount of \$423/month) will have a tremendous impact on their ability to maintain housing, look after themselves, and pay their bills. Others who are unable to meet OW requirements or even to initiate the process in the first place, will have no legal income. Social support gives recipients an opportunity to live healthier, more secure lives with some dignity. Why should there be an exception for substance dependence?

NOTES

1. This policy change was implemented by the Conservative government of Premier Michael Harris in 1998, but has been continued, and defended through a continuation of the court challenge, by the Liberal Government of Premier Dalton McGuinty, elected in 2003.
2. Others may argue that the court cases present an *ex post facto* justification, and that what drove the policy change originally was simply the desire to remove as many of the poor as possible from the welfare rolls of Ontario (Editorial, *CMAJ*, 2001). As part of its "Common Sense Revolution," the Harris government also proposed mandatory drug testing and treatment for welfare recipients despite evidence that such an approach was unlikely to increase employment, would likely increase crime and health problems, and could be challenged in the courts as an infringement of human rights (Macdonald et al., 2001).

RÉSUMÉ

En Ontario, les personnes ayant une dépendance à l'alcool et d'autres drogues ne reçoivent plus d'assistance sociale basée sur l'invalidité associée avec leur dépendance. L'effet de cette annulation d'assistance sociale n'a pas été évalué dans le contexte de l'Ontario. Cependant, aux États-Unis, en mesurant l'effet d'une décision politique semblable, on a trouvé qu'à peu près la moitié des personnes affectées ont souffert du point de vue de la santé et de la compétence sociale. Les auteurs croient que la décision d'annuler l'assistance sociale pour la population en question est imprudente. Cette opinion s'accorde avec les recherches sur la toxicomanie conçue comme maladie chronique, l'effet de la politique exclusive sur la stigmatisation et le danger pour ces personnes de devenir de plus en plus sans abri et mentalement déséquilibrées. Les auteurs voudraient que l'assistance sociale soit offerte aux personnes ayant une dépendance à l'alcool et d'autres drogues en Ontario et partout au Canada.

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