WHITE CLAIMS TO ILLNESS AND THE RACE-BASED MEDICALIZATION OF ADDICTION FOR DRUG-INVOLVED FORMER PRISONERS

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ABSTRACT

Critical Race Theory scholars have long argued that the War on Drugs is a war waged against low-income, black urban citizens. However, as the spotlight has shifted somewhat from policing street drug use and trafficking among poor, inner-city blacks, to concerns about the chronic pharmaceutical substance abuse of middle- and upper-class white suburban citizens, so, too has the rhetoric. Some aspects of contemporary penal discourse have evolved from the “Get Tough” orientation of yesteryear to a revived rehabilitative agenda, designed to treat and heal wayward souls. The depraved, incorrigible, and inherently pathological drug-using caricature of twenty years ago has taken on a lighter, more sympathetic hue. If white privilege confers upon its possessors the right to hold themselves in higher esteem, arguably even the deepest of drug-entrenched individuals may be granted space to construct the onset and longevity of their addiction as processes external to their will. Rather than embrace the ineluctably criminal persona assigned to black addicts, white users may instead claim their victimhood, illness, and eschew accountability. This essay examines interview narratives from a mixed-race sample of 304 drug-involved former prisoners, and focuses on how respondents conceive of their addiction and the extent to which race modifies ownership of a deviant status.

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INTRODUCTION

This essay examines the role that treatment programming has on desistance outcomes, and whether the successful adoption of treatment programming is moderated by race. Specifically, I explore the extent to which the adoption of cognitive-based treatment ideology and the language that animates that process—accountability, personal responsibility, and internal change—confers disadvantaging effects for drug-involved black former prisoners, in a way that white former prisoners seldom ever come to know. In other words, do substance-addicted white prisoners align themselves with an illness narrative that black users are excluded from or reject? This analysis draws on narratives from respondents' detailed life histories documented at length in a recent study seeking to establish the mechanisms through which a contemporary drug-involved cohort of former prisoners negotiates the desistance process. Former prisoners provide a unique view of the effectiveness of cognitive-based treatment intervention and the extent to which programming gains any significant measure of traction in their decision-making processes following treatment. Further, because these men and women are subject to community supervision and drug-monitoring protocol, their understanding of the ability to control their substance abuse becomes central to the prisoner reentry effort.

My objective is to provide an expanded illustration of correctional drug treatment ideology, identify the intended internalized narratives mobilized by that treatment agenda, and detail the extent to which white and black treatment participants come to adopt those meanings as their own. This analysis is motivated by Cheryl Harris's seminal Whiteness as Property thesis and serves to empirically test the ways in which whites may resist accountability narratives and instead are granted access to victimhood, sick roles, and less stigmatizing labels. Blacks are denied that freedom from liability, and the paucity of deservedness among black men and women may affect markedly deleterious outcomes for desistance and reentry.

Prisoner reentry is a significant national issue. Approximately 80 percent of federal inmates, 81 percent of state inmates, and 73 percent of local inmates are substance-involved and meet the medical diagnostic criteria for substance abuse addiction. Further, most inmates will be released from custody and supervised as parole or probation clients, which means that inmate addiction is also a community supervision issue.

1. Ronet Bachman et al., Roads Diverge: Long-Term Patterns of Relapse, Recidivism and Desistance for a Cohort of Drug Involved Offenders (Grant Number 2008-JJ-CX-1107) (2013).
3. National Center on Addiction and Substance Abuse at Columbia University, Behind Bars II: Substance Abuse and America's Prison Population at 10 (2010).
Treatment for drug-involved offenders is rather scarce and the reality is that the absence of comprehensive community services needed by many former prisoners only exacerbates the reentry process. Parole and probation personnel are charged with addressing public safety and rehabilitation concerns simultaneously, and that effort's design relies heavily upon releasees' classification and the subsequent mandates that guide their monitoring protocol. Drug-addicted clients are required to attend meetings, and if compliant, satisfy their officers' expectations.

Unless recognized as drug-addicted, the obligation of treatment programming attendance may not necessarily be enforced and those community supervision clients may both lose out on an opportunity to get the help that they need and deserve, as well as an opportunity to demonstrate compliance with community supervision expectations. If black men and women are denied this treatment, they may assume the ranks of the racialized other, the noncompliant offender, and/or the subject of failure who has willingly forfeited their right to our attention and compassion. The consequences of such relegation are dire and we must look further into how those costs manifest. Through a demonstration of how both the War on Drugs and the medicalization of substance use explicitly advances white supremacy, the following analysis will corroborate Professor Harris's thesis that white privilege is transferred intergenerationally, even to society's most outcast members.

In this article I will demonstrate how these patterns emerge, how these processes are conditioned by race, and why those mechanisms are longstanding and evidence a greater racial hierarchy and framework of race-based social control. Part I presents a polemic against notions of a colorblind War on Drugs and instead, outlines the historical legacy of race-based prosecution and persecution of drug users. For over a century, the state's preoccupation with the manufacture and distribution of illicit substances has closely mirrored a sustained concern over who manages that enterprise. The racial threat imposed by non-whites amassing economic and political control gleaned from mounting drug sales has been historically countered through criminalization mandates, therein sustaining white supremacy and limiting any threat of non-white strongholds on drug markets. Part II explores the parallel mechanisms by which whites' substance abuse is medicalized and perceived as treatable illness, while non-white substance abusers must confront criminal sanction for the very same behaviors. In the effort to measure the extent to

which medicalization practices reserved for whites permeates contemporary correctional settings, Part III examines the interview narratives of 304 drug-involved former prisoners who participated in a prison-wide drug treatment Therapeutic Community program. Specifically, the analysis that follows focuses on within-group conceptions of this mixed-race sample's prescription opioid abuse practices. Storylines highlight respondents' internalization of the "sick role" status and whether their own understanding of medicalized substance abuse and addiction rhetoric vary by race. Part IV offers implications for punishment scholars and policymakers.

I. THE WAR ON DRUGS EMBODIES WHITENESS AS PROPERTY

Critical Race Theory establishes the fundamental role that the law and legal institutions play in the maintenance of racial hierarchies, and black subordination in particular. Further, for all of its benevolently colorblind intentions, the criminal legal system has proven especially debilitating for black lives and the communities from which they originate. In fact, studies suggest that racial discrimination against alleged black and brown offenders unfolds at every stage of criminal justice processing including stop-and-frisk, arrest, conviction, sentencing and the discretionary decision to release an inmate to parole supervision. Furthermore, the


collateral consequences emergent from the stigmatized criminal record is a burden disproportionately borne by citizens of color, where limitations on housing and employment are particularly pronounced for this group.

Ultimately, the War on Drugs and the mass incarceration practices that stem from this political agenda, mobilize a legally codified reinforcement and reification of white supremacy. Studies demonstrate that drug enforcement related criminal justice policymaking maintains a legacy of critical investment in whiteness and white privilege. Race-based identity politics are largely responsible for animating distinctions between "us" and "them" as well as "deserving" and "insignificant." Most importantly, whiteness thrives on imagery and narratives that highlight black abjection and in doing so, criminal justice institutions can both deny and embrace racial inequality and race-based discrimination, by shifting blame to the individuals and communities rather than the institutions from which they sprang. The War on Drugs embodies this agenda as it calls for white Americans (policymakers and regular "Joes," alike) to celebrate individual accountability for everyone but themselves. The root cause of this phenomenon can be linked to the criminal justice narratives that reinforce white supremacy and denigrate black personhood. In essence, the War on Drugs is a scapegoat and a mechanism of white privilege that advances the white supremacy project at the expense of black and brown citizenship.

The War on Drugs, and all of the legislation upon which it is bolstered, is sustainable only because of the social construction of race and racism. The traction that racial discrimination maintains in public sentiment serves as justification for the use of force aimed towards a disliked population. The War on Drugs creates space for the creation of idealized and


18. Doris Marie Provine, Race and Inequality in the War on Drugs, 7 ANNU. REV. L. SOC. SCI. 41–60 (2011).
demonized subjects, many of whom are delineated along racial, ethnic, and cultural lines. Locality and identity emerge quite centrally in these processes, as the law identifies outsiders from whom the rest of us must be protected. The Progressive Era was marked by an ascendance of federal regulatory power over drug use and drug trade among racially marginalized groups. This legally codified historical legacy of identifying the drug-involved social menace began with the Harrison Narcotics Act of 1914, which placed the prescription and dispensing of narcotics under the purview of federal government. The call for federal limits on the distribution of cocaine and opium at the time was lobbied by politicians like Commissioner Hamilton Wright, who believed that the Chinese-run opium trade was responsible for the illicit sexual relations unfolding between supposed “pure” white women and “predatory” Chinese men. Similarly, interest in the distribution of marijuana only grew roots with the emergence of Mexican and Mexican-American control of its trade. Once appointed as the first Commissioner of the Federal Bureau of Narcotics, Harry Anslinger mobilized a campaign against Mexican distributors and users of “loco weed,” propagating the image of the brown social menace. The passing of the 1951 Boggs Act and 1956 Narcotics Control Act were largely steered by nativism and racist antipathy aimed at a growing Mexican presence in the drug trade.

After World War II, however, punitive measures aimed at deterring racially marginalized drug-involved men and women decreased as a greater prevalence of white, middle-class Americans began to more frequently partake in illicit drug use. If we focus exclusively on the relationship between marijuana use and criminal justice response, it is evident that the correlation between a user’s race and socioeconomic status and the likelihood that they will be punished for marijuana possession is quite strong. Poll data illustrate that by 1972, cannabis use had become a very regular, mainstream American pastime with as many as eight million people using it regularly and more than half a million Americans reporting using it daily. Concurrently, by 1973 the annual number of federal, state and local law enforcement arrests had skyrocketed to 421,000 from a

25. Note that marijuana production was always a domestic enterprise. The problem arose when Mexicans and Mexican-Americans began to see a larger share of the profits stemming from that practice.
mere 20,000 annual arrests reported in 1965.\textsuperscript{27} Public pushback against the criminal justice policy that now swept up white, middle-class marijuana users compelled state legislators to review and reform federal regulation of marijuana use. Subsequently, the Comprehensive Drug Abuse Prevention and Control Act\textsuperscript{28} was passed, it distinguished marijuana from other illicit drugs and lowered the maximum penalty for possession of an ounce of marijuana to one year in jail and a $5,000 fine, with the option of probation or a conditional discharge at the judge’s discretion.\textsuperscript{29} One stipulation, proposed by former Pennsylvania Governor, Raymond Shafer, was to legalize small amounts of private marijuana possession and only impose a formal criminal response in instances where marijuana was used or sold in public. The implications and fallout connected to the policing of “public” drug use is particularly salient in black and brown communities.

For example, the Anti-Drug Abuse Act of 1988\textsuperscript{30} sparked a resurgence of federal drug legislation’s disproportionate impact on people of color. The laws associated with this act required Public Housing Agencies (PHAs) to draft leases that included a clause prohibiting tenants, and members of a household or family, guest, or other individual under the tenant’s control and supervision, from engaging in criminal activity, including drug-related criminal activity, on or near public housing premises. Should this activity transpire, the registered tenant charged with responsibility for that criminal context could face eviction. Since then, the Housing Opportunity Program Extension Act of 1996\textsuperscript{31} and the Quality Housing and Work Responsibility Act of 1998\textsuperscript{32} were enacted and focused on providing safer environments for subsidized housing residents. This revised legislation allows PHAs fairly broad discretion in crafting their public safety policies, many of which operate to create harsh outcomes for many families of color, with a disproportionate likelihood of having a household member marked by a criminal record.\textsuperscript{33} More recently, the Supreme Court ruling in \textit{Department of Housing and Urban Development v. Rucker}\textsuperscript{34} clarified that under the Anti-Drug Abuse Act of 1988, public housing authorities maintain the discretion to terminate the lease of a tenant for whom either a member of the household or a guest engaged in drug-related activity, regardless of whether the tenant knew, or should have known of the drug-related activity. Under these laws, the onus is on

\begin{thebibliography}{99}
\bibitem{27} \textit{Id.}
\bibitem{31} Pub. L. No. 104-120.
\bibitem{32} Pub. L. No. 105-276.
\bibitem{33} Peter J. Saghir, \textit{Home is where the no-fault eviction is: the impact of the drug war on families in public housing}, 12 J. L. Pol’y 369–419 (2003).
\bibitem{34} \textit{Department of Housing and Urban Development v. Rucker}, 122 S. Ct. 1230, 1238 (2002).
\end{thebibliography}
tenants to keep drugs off and out of public housing premises. In communities of color marked by concentrated disadvantage and breakdowns in informal social control, this is a nearly impossible charge.\(^{35}\)

Despite the dominant rhetoric identifying a non-white, hopelessly drug-addicted, social menace, studies suggest that while controlling for a host of drug-use related risk factors, white men and women are at an increased risk of non-medical prescription drug abuse compared with non-whites.\(^{36}\) Additionally, when controlling for the influence of race and ethnicity, nonmedical use of prescription drugs is quite prevalent among all men and women who are less educated,\(^{37}\) unmarried,\(^{38}\) unemployed,\(^{39}\) exhibit extensive criminal histories,\(^{40}\) suffer from prolonged mental illness,\(^{41}\) and who consort with drug-using peers.\(^{42}\) In other words, consistent with the United States' historically documented legacy of citizens'
drug abuse, prescription drug abuse is an unfortunately common, mainstream issue that crosses color lines.

II. WHITENESS AS PROPERTY AND THE MEDICALIZATION OF SUBSTANCE ABUSE

Despite repeated findings suggesting that substance use and abuse are prevalent practices among all racial groups, whites are routinely afforded protection from the criminalization of that practice. For many white Americans, substance use, and addiction to those substances are approached with a softer clinical forgiveness, rather than a criminal sanction. Their experiences are medicalized. Peter Conrad defines medicalization as, “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.” In earlier writings, Zola expressed concerns over how in-

43. Nationally based self-report data from high school students surveyed between 1975-2011 indicate that white students were slightly more likely to have used an illicit substance in the past 30 days than their black counterparts. See Lloyd D. Johnston et al., Monitoring the Future: National Survey Results on Drug Use, 1975-2011: Volume I, Secondary school students (2012). The same trend is consistent within adult samples, too. See Lloyd D. Johnston et al., Monitoring the Future: National Survey Results on Drug Use, 1975-2011: Volume II, College students and adults ages 19, 32-33 (2012). Study findings also demonstrate that of those illicit substance abusers that do seek medical attention for non-medical prescription drug use, the majority of them are white, members of fraternities and sororities, earned lower grade point averages and were enrolled in colleges with relatively higher admissions standards. These users faced relatively minimal criminal legal sanctioning, if any at all. See Sean Esteban McCabe et al., Non-Medical Use Of Prescription Stimulants Among US College Students: Prevalence And Correlates From A National Survey, 100 Addiction 96–106 (2005).

44. Numerous studies illustrate not only that black men and women have less access to regular healthcare than their white counterparts, see, e.g., Peter Franks et al., The Burden Of Disease Associated With Being African-American in The United States And The Contribution Of Socio-Economic Status, 62 Soc. Sci. & Med. 2469–78 (2006); Thomas A. LaVeist, Darrell Gaskin & Patrick Richard, Estimating the Economic Burden of Racial Health Inequalities in the United States, 41 Int'l. J. Health Serv. 231–238 (2011), but also that for black people, a nontrivial measure of hesitation, dissatisfaction, and mistrust of healthcare providers preclude the likelihood that they will seek professional health, see Derek M. Griffith, Julie Ober Allen & Katie Gunter, Social and Cultural Factors Influence African American Men's Medical Help Seeking, 21 Res. Soc. Work Pract. 337, 340–45 (2010); Vickie L. Shavers, William M. P. Klein & Pebbles Fagan, Research on Race/Ethnicity and Health Care Discrimination: Where We Are and Where We Need to Go, 102 Am. J. Public Health 930–32 (2012)). Furthermore, the proportion of black men and women who are under supervision and assessed as having a greater risk of offending following a medical screening, surpasses the high-risk assessment applied to comparable white men and women. See Ann F. Garland et al., Racial and Ethnic Differences in Utilization of Mental Health Services Among High-Risk Youths, 162 Am. J. Psychiatry 1336–43 (2005); Seth J. Prins et al., Exploring Racial Disparities in the Brief Jail Mental Health Screen, 39 Crim. Justice Behav. 635, 638–40 (2012); Nancy Rodriguez, Concentrated Disadvantage and the Incarceration of Youth: Examining How Context Affects Juvenile Justice, 50 J. Res. Crime Delinq. 189–215 (2013). It may be the case that black men have self-selected themselves from medicalization privileges, but the choice does not appear to be arbitrary as there are several barriers to care that explain that behavior.

creasingly larger elements of everyday life were more frequently coming under "medical dominion, influence, and supervision." Medicalization is a controlling force in contemporary society.

Conrad discusses three general forms of medical social control. Technology consists of the tools through which treatment is administered, most commonly presented in the form of prescription drug and psychosurgery. Collaboration manifests when health providers work in concert with other authoritative institutions. For example, physicians working in total institutions like prisons cannot practice independent of the mandates handed down from the governing institutions (few of which place the advancement of inmates' health and wellbeing at the forefront of the initiative). Third, Conrad identifies the ways in which ideology, or the use of language employed by medical authorities, simultaneously legitimizes patient suffering and removes blame or the burden of personal failure from the medical subject. In this way, medicine, its tools, and the auxiliary language associated with its practice, minimizes, eliminates, and normalizes deviant behavior.

Medicalization assigns meaning and understanding to traits that were otherwise seen as aberrant or inexplicable beyond the possessor's own personal failings. All three general forms of medical social control effectively minimize accountability for patients who have access to medical institutions, their personnel, and the language that animates those spaces. Once behavior or attributes have been medicalized and recognized by medical institutions, however, individuals who exhibit the same patterns of behavior but lack access to the protection that come with a "medicalized" notary are left at a severe disadvantage. It is important to highlight, also that the costs and benefits of medicalization vary with patient privilege. For those who are better politically and economically well heeled, the medicalization of their "conditions" could absolve them of responsibility and sanction in the long run. For those who occupy the more powerless rungs of the social ladder, the imposition of the medical diagnosis could mandate institutional intervention, irrespective of one's wishes or consent to the prescribed treatment.

47. Peter Conrad, Types of Medical Social Control, 1 SOCIO. HEALTH ILLN. 1, 3 (1979).
49. The medicalization of an array of human behaviors is well documented in social science literature. Less has been said about the partnership that exists between medicalization tendencies that steer racist legal policy and consequently exacerbate disadvantage among marginalized subpopulations of color. For thoughtful discussions about these trends, I direct readers to studies about medicalization, law and mandated attempts to manage or treat the following disorders: homosexuality (see Charles L. Briggs, Communicability, Racial Discourse, and Disease, 34 ANNU. REV. ANTHR. 269, 279 (2005); Susan Sterett, Legal identities and the in-between rules, 1 POLIT. GROUPS, IDENTITIES 244–247 (2013)); Special Education Assignment in schools (see Wanda J. Blanchett, Disproportionate Representation of African American Students in Special Education: Acknowledging the Role of White Privilege and Racism, 35 EDUC. RES.
increasingly marked by medicalization, the implications for substance abuse among those who are criminal justice supervised and politically disenfranchised are immense.

III. ONE CONTEMPORARY COHORT’S INSIGHTS ON SUBSTANCE ABUSE AND PRISONER REENTRY

This research makes use of the Roads Diverge: Long-term Patterns of Relapse, Recidivism, and Desistance for a Re-Entry Cohort dataset. This study was built upon earlier work that examined the relative effectiveness of three models of drug abuse treatment: 1) a 12-month in-prison therapeutic community (KEY) for males only, followed by conventional work release; 2) an intensive outpatient approach for males and females which combined treatment and case management functions (ACT); and, 3) conventional community supervision for male and female releasees (COMPARE). The therapeutic community (TC) study examined the effectiveness of a 6-month residential work release TC treatment program—CREST Outreach Center—for male and female prison releasees with histories of drug abuse. Delaware’s CREST was the first work release TC in the nation, and it has been a model for a number of new
transitional criminal justice treatment facilities in the last two decades since its inception.54

The baseline sample of CREST study treatment recipients included 1,250 offenders.55 At the first baseline, the original sample’s mean age was 29.6, 44 percent of the cohort had prior incarcerations, they had an average of 11.2 years of education prior to baseline incarceration, and 73 percent were in some form of substance abuse treatment. This analysis will highlight the experiences of white and black subjects, which resulted in 1,044 subjects of whom 79 percent were male and 73 percent were black.56 Tracking respondents for reassessment in the original study yielded a response rate of 80 percent at the 6-month and 18-month follow-ups, and in the 75 percent range for subsequent follow-ups. Respondents were interviewed immediately prior to their release from prison and again 6 months, 18 months, 42 months, and 60 months subsequent to release.57 Tracking information was retained on the sample, and subject consent forms left open the possibility that respondents would be re-contacted in the future.

The Roads Diverge dataset features follow-up interviews conducted with approximately 300 randomly selected men and women from the larger sample of 1,044 former prisoners. In depth interviews, which took place between 2008 and 2010, were semi-structured and digitally recorded. The goal of these interviews was to uncover what Agnew refers to as “storylines” in understanding criminal offending.58 For each criminal and drug relapse event self-reported or obtained from official records, respondents were asked to recreate the event both perceptually and structurally, including information about what his or her life conditions were at the time (e.g. employment, intimate relationships, education, children), how the event transpired, and his or her perceptions of the circumstances (e.g. what they were thinking about themselves, the risks and benefits associated with engaging in crime). These storylines illuminated the events and processes related to respondents’ reentry efforts, particularly shedding light on their experiences with community corrections officers’ regulation of their drug habits. I was one of the six trained field researchers who collected these qualitative data and probed respondents on a number of different life course domains, including their experiences with healthcare and legal institutions.

The stories that emerged evidence not only that white drug-involved men and women are afforded protection that their black counterparts were less likely to see, but also that the language that animates the justifi-

55. Id.
56. Because of the focus of this essay and their relatively small number, this analysis will not feature a discussion of Hispanic exoffender narratives, nor will it include excerpts from respondents whose race/ethnicity was not reported.
57. Id.
58. A storyline is a “temporally limited, interrelated set of events and conditions that increase the likelihood that individuals will engage in a crime . . .” Robert Agnew, Storylines as a Neglected Cause of Crime. 43 J. RES. CRIME & DELINQ. 119, 121 (2006).
cations for that leniency is steeped in privilege and meritocratic rhetoric. More than half of the sample interviewed reported that they were still using drugs, and black and whites were equally represented in that activity.\(^{59}\) However, many of the white respondents in this study believed that they were owed chances and accommodations that black interviewees were far less likely to suggest.

A. Race-Based (De)Regulation of Pharmaceutical Abuse

The analysis that follows will focus exclusively on prescription opioid abuse. The decision to narrow my focus to this class of drug abuse rather than marijuana, cocaine, alcohol, barbiturates, or amphetamine stimulants, stems from substance abuse literature illustrating pathways to substance abuse practice. Men and women who abuse prescription opioids were likely to have been legally prescribed those drugs for a legitimate ailment or illness at some point.\(^{60}\) This drug use onset implicates the discretion and supervision (or lack thereof) of licensed medical professionals. That said, of all of the prejudicial characteristics assigned to drug-addicted people, men and women who "got hooked" on drugs that they were initially legitimately prescribed are arguably the most sympathetic and are more forgivable even among the most critical audiences (including the users who are hardest on themselves).\(^{61}\) This is where an empirical analysis of Professor Cheryl Harris's thesis becomes especially compelling. Is there a difference in the measure of recognition and empathy extended to white and non-white pharmaceutical abusers? Is there a difference in the amount of self-blame that white and non-white users place on themselves? And if so, where does that come from?

When we talk about aid and deservedness for help, one of the first questions posed by everyone, including the potential recipient of that help, centers on one's personal responsibility for their plight. Some of this forced reflection can be attributed to the law's presentation of idealized and demonized legal subjects. Some claimants deserve recognition and are granted access to redemption, while others are condemned to negotiate the shackles of individual responsibility. Still, self-loathing and the impetus to deny oneself the support that they need could also stem from misinformed understanding of how powerless drug-addicted people actually are. Until one has been labeled an addict and accepts that

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59. Of whites interviewed, 58% reported that they were still drug-involved compared to 56% of black men and women interviewed.

60. See Khary K. Rigg & John W. Murphy, Understanding the Etiology of Prescription Opioid Abuse: Implications for Prevention and Treatment, 23 QUAL. HEALTH RES. 963, 970 (2013).

61. For a discussion of the unique non-judgmental care and consideration that physicians must incorporate into their treatment plans for patients with histories of chemical dependency, see Edna Marie Jones, Doug Knutson & Danell Haines, Common problems in patients recovering from chemical dependency, 68 AM. FAM. PHYSICIAN 1971-78 (2003). For an exploration of the prevalence of typically unsympathetic drug-seeking patients who abuse physicians' trust, lack of suspicion, and/or lack of oversight, see John M Stogner, Amber Sanders & Bryan Lee Miller, Deception for Drugs: Self-Reported "Doctor Shopping" Among Young Adults, 27 J. AM. BOARD FAM. MED. 583-93 (2014).
objective status as a clinical illness instead of a personal failure, they may be more likely to blame themselves rather than seek treatment. They may instead see their drug abuse as due to personal choice and a lifelong series of poor decisions. As studies suggest that prescription opioid abuse is more prevalent among white drug users, the question of how they are treated or sanctioned, particularly among populations that are relatively hyper-supervised, begs investigation. Insofar as medical and criminal justice institutions are linked, the extent to which prescription drug abuse may disadvantage black men and women living under criminal justice supervision in ways that their white counterparts are not obliged to reconcile, is worth exploring.

B. Therapeutic Communities and the Damage of Rebuilding

Personal narratives matter significantly, especially in the lives of drug-addicted men and women working to rebuild themselves. Increased individual-level perception of self-blame, personal accountability, or the ability to “beat bad habits” on your own, diminishes the likelihood of seeking out positive institutional intervention, like drug abuse treatment. Simultaneously, a lack of trust in medical institutions whose reporting practices increasingly include legal institutional audiences may also preclude one’s willingness to seek medical treatment. However, as post-release sanctioning and surveillance of former prisoners grows increasingly ubiquitous and severe, probationers have found that in-treatment status has meant all the difference between a failed urinalysis that is expected and new drug offense probation violation. I am investigating whether for this sample, white prescription abusers express personal narratives

62. Recall the previous discussion outlining the mechanisms of medical social control. See Conrad, supra note 45.


64. For an excellent discussion of the considerations that community correctional personnel must make for methadone treatment clients, see Robert Heimer et al., Structural Interventions to Improve Opiate Maintenance, 13 Int’l. J. Drug Pol’y 103–11 (2002). For a discussion of findings that suggest that black probationers reported significant positive outcomes when enrolled in drug treatment programming, see Shannon Gwin Mitchell et al., Treatment Outcomes of African American Buprenorphine Patients by Parole and Probation Status., 44 J. Drug Issues 69–82 (2014). It is also worth noting that despite the dominant rhetoric that portrays black men as incorrigibly addicted to illicit substances and a criminal lifestyle, findings suggest that while black males “were disproportionately represented in felony probation caseloads, they were significantly more likely to have their probation revoked for a technical offense than for a new drug offense, a felony personal offense, or a felony property crime.” See W. W. Johnson & M. Jones, Probation, Race, and the War on Drugs: An Empirical Analysis of Drug and Non-drug Felony Probation Outcomes, 28 J. Drug Issues 985–1004 (1998); Nancy Rodriguez & Vincent J. Webb, Probation Violations, Revocations, and Imprisonment: The Decisions of Probation Officers, Prosecutors, and Judges Pre- and Post-Mandatory Drug Treatment, 18 Crim. Justice Pol’y Rev. 3–30 (2007).
that enable treatment seeking-behaviors and faith in medical institutions that their black counterparts systematically reject.65

Recall that all Roads Diverge study participants were also CREST graduates and participated for at least six months in Delaware's pilot Therapeutic Community (TC) drug treatment program. This residential treatment program was implemented during work-release and provided intensive supervision during the transition from prison to society. Inciardi and his colleagues suggested that TC programming was based on the perspective that, "drug abuse is a disorder of the whole person, that the problem is the person and not the drug, that addiction is a symptom and not the essence of the disorder, and that the primary goal is to change the negative patterns of behavior, thinking, and feeling that predispose drug use."66 In order to facilitate rehabilitation, TC serves as a total treatment environment where participants are housed separately from the rest of the prison population and the disruption that is characteristic of prison life. Participation in the prison therapeutic community, however, should not invoke images of vacation or summer camp. Rather, the TC model implements a boot camp ideology.

Therapeutic Community implementation unfolds in multiple stages, all oriented around accountability and responsibility for self. First, inmates are separated from the general population and undergo intensive drug treatment programming for a minimum of 12 months. Within this space, inmates are denied the minimal freedoms and comforts that their non-TC participant counterparts have access to, and focus fairly exclusively on confronting their addicted, "diseased" selves.67 Second, as TC participant inmates approach the end of their sentences they become eligible for the transitional work-release reintegration program. These men and women work for pay within the free community and during their nonworking hours, return either to the correctional institution or to a community based work-release facility.68 The final stage of TC participation takes place aftercare. These clients have completed work-release and will be living in the community under the supervision of community corrections personnel. Drug treatment programming continues, however, whereby clients should regularly occupy themselves with outpatient counseling and group therapy. Clients are encouraged to return to the work rooms for refresher and reinforcement sessions, to attend weekly

65. See previous discussions highlighting blacks' lack of access and hesitation to rely on formal medical institutions, particularly Armstrong et al., supra note 49; Braunstein et al., supra note 49; Reverby, supra note 49; Washington, supra note 49.
66. Inciardi, Martin & Butzin, supra note 54 (emphasis in original). For a full discussion of the evolution of TC programming, see George De Leon, Community as method: Therapeutic communities for special populations and special settings (1997); George De Leon, The therapeutic community: Theory, model, and method (2000).
67. Relative to the inmates in general population, TC participants are subjected to increased surveillance and public confrontation by TC personnel. For a discussion of the nature of "encounter groups," the compulsory bi- and tri-weekly TC group-based meetings marked by participant denigration and harsh confrontation among other inmates, see Eric Broekaert et al., Evolution of Encounter Group Methods in Therapeutic Communities for Substance Abusers, 29 Addict. Behav. 231-44 (2004).
68. Inciardi, Martin & Butzin, supra note 54.
groups, to regularly touch base with their treatment counselors, and to spend one day each month at the facility.69

The invitation to participate in the correctional therapeutic community not only extends to periods of time long after release, but is also strongly encouraged and looks favorable for clients under caseworker supervision. In other words, terminating one's TC participation could prove unwise and all the while, the programming rhetoric remains the same. TC participants are said to be broken, disordered people who must mend themselves before they can live a fully integrated drug-free life.70 The blame placed on the "diseased" individual rather than the disease that has overcome the individual, may vary by race.71 For this cohort, the extent to which TC participants fully adopt the notion that they are sick instead of simply irresponsible, appears to be moderated by race.

C. The Privilege of White Skin, Granting Oneself the Benefit of the Doubt, and the Protections That Come With It

Even among those who were still abusing prescription opioids at the time of their interview, many Roads Diverge study respondents shared that they had experienced several periods of intermittent drug use. As many as 42 and 44 percent of white and black respondents, respectively, indicated that they had desisted from substance use altogether. Of both the desisting and intermittent drug using respondents, I asked the same question: What pushed you to get clean?72 Black men and women were more likely to report some calculation or risk that outweighed the perceived benefits conferred from substance abuse. White respondents were more likely to attribute their desistance success (or periods of abstinence) to treatment tools and teachings that they had adopted while participating in the CREST therapeutic community.

For this sample, black narratives of pharmaceutical abuse habits very much underscored the personal responsibility rhetoric embedded in TC programming but were less likely to include language centered on addic-

72. It is important to note that when asked to describe sources or reasons for prescription drug abuse onset, men and women in the sample offered no significant difference in response. Both men and women respondents attributed the onset of their general drug use to peers, siblings, older cousins, and for women who exhibited late onset patterns, they often identified their partners as the individual responsible for introducing them to drug abuse. Men and women whose stated drug of choice included prescription opioids of some sort, generally attributed that onset to varied psychological disorders. Diagnoses included hyperactivity, anxiety, depression, and chronic pain. A nontrivial proportion of women also cited an effort to limit prescription drug abuse that interfered with their parenting responsibilities.
tion and mental illness. Rather, black men and women surveyed talked a lot about being “hard-headed,” “willful,” “bored,” “defiant,” “rebellious,” and about the desire to pursue their own free will. Dennis is a 52 year-old black man who described himself as his “own worst enemy.” When asked what sorts of things kept undermining his personal growth and mental health, Lawrence replied, “myself.” When asked about how he spiraled out of control and into a life marked by extensive opioid abuse, Roger, a 42 year-old black man, attributed his addiction to a lack of self-discipline:

Interviewer: Why would you fall into what got you into that situation anyway?

Roger: For years and years and years I used my mother’s death as a crutch, as an excuse not to do some things. I didn’t accomplish anything because I didn’t try to. I just didn’t motivate myself . . . I did what I wanted to do, when I wanted to do it, how I wanted to do it, and not tell anybody why I was doing it. I just did it. I felt like the world owed me everything because of the passing of my mother.

Interviewer: So you got mad at the world for a while?

Roger: A long while. Even today I’ve maybe gotten over all that stuff within the last 15 to 20 years. That’s bad, man. You know?

Mourning the death of your mother and of the self-destructive behavior that potentially accompanies that journey does not constitute a scenario where a clinician would cite a lack of self-discipline or low self-control as traits that explain the onset of pharmaceutical substance abuse. Still, for Roger and others like him who experienced trauma (with a frequency that could only lead to Post-Traumatic Stress Disorder for many), they fail to attribute their substance abuse patterns to mental illness. Roger even asks the interviewer to confirm his personal failings. It is as if he refuses to even consider the possibility of sympathy for him or the reasons behind his choices.

White study participants also identified traits of willfulness, disobedience, and a propensity for experimentation with friends as reasons for the onset of their prescription opioid abuse. Many more of them, however, attributed their sustained drug abuse to mental illness and also adopted an “addict” status and identity. Michelle attributes much of the havoc in her life to addiction:

Interviewer: On a scale of one to ten, how much do you think that your drug use impacted your family?

Michelle: It was a ten. I was just nothing but a drug addict.

Interviewer: And on your job, the same number?

Michelle: Yes.

Interviewer: Did you want to ever stop using?

Michelle: Not at that time, No.

Unlike Roger, Peter identified the loss of his oldest brother as the event that triggered the onset of a severe depressive state. He goes on to share that this reaction was unique to him in that none of his other siblings experienced anything quite like it. This overwhelming depression is the root of his addiction:

Interviewer: Okay, so were you influenced by your brothers and sisters and their drug use, too?

Peter: No. Just basically I’m the outcast.

Interviewer: Why is that?

Peter: Because I’m the only drug addict in my house.

Interviewer: Okay, so everybody else had experiences, but you were the only one that was a real drug addict?

Peter: Yeah.

Interviewer: Why do you think that?

Peter: They just fucked my life up. I don’t know. I was just, when my brother passed away it fucked my whole life up. That’s what happened basically.

Interviewer: Why you think it had a different response on you then it did the rest of your family?

Peter: I don’t know.

Black respondents were far less likely to place any significance on the power of addiction and some adamantly denied the label:

Interviewer: Do you think you’re an addict?

Michael: No, I’m not an addict. No.

Interviewer: Let me ask you one question. Did you have any 12-step support treatment? Did you ever attend NA or AA?
Michael: Yes when I was in the Crest I went to a program. The {Treatment Center Name}

Interviewer: Did you go after CREST?

Michael: No, I stopped going. I gave up.

Interviewer: How come?

Michael: You can learn things yourself if you got that willpower. You can stop on your own. You don't need a program.

Interviewer: Was it useful to you?

Michael: Yeah, I paid attention and learned new things about the addiction.

Interviewer: Let me ask you, from a time that you were in the CREST, because it looks like your violations are for using... So is it safe to assume that ever since you started smoking weed, you kind of never really stopped except for maybe that one month or so after CREST?

Michael: I kind of never look at it as... I use it for pain. You know what I mean?

Interviewer: Pain for?

Michael: For my head injury.

Michael is an example of a black CREST participant who agrees that the program is useful, that he learned quite a bit about addiction and how to overcome it, but does not see those tools or lessons as applicable to his struggle. Instead, though he does not consider himself drug-addicted, he rationalizes his reliance upon a daily cocktail of marijuana and varied prescription opioids as a means to ease the pain of a longstanding, undiagnosed head injury.

It is critical to add that both black and white respondents battling addiction also found that their relapse was connected to legitimate, but poorly monitored prescriptions from doctors and pain clinic personnel. Loretta was clean for some time before she relapsed after a liver failure treatment:

Loretta: I was all right. Then I started an interferon treatment because I have a liver condition.

Interviewer: Oh, okay.

Loretta: So I started that and once I started that I got hooked on opiates. I was taking morphine for the pain because treatment is no joke. That stuff's no joke. So boom, I'm back in the [methadone] clinic.
Madeleine also shared that what began as a toothache treatment, turned into a full-blown relapse within weeks:

Interviewer: Okay, take me back to that point. You were doing good... What's going on, what happened? What was going through your mind?

Madeleine: I had a toothache. I had a toothache and I've always had a big, huge fear of dentists. I always had beautiful teeth so I never really had to worry about it much but then this tooth started hurting... It was swelled and I was crying... Well my older brother had some pain pills.

Interviewer: So you took your older brother's pain pills?

Madeleine: Yup.

Interviewer: How many would you say you were taking?

Madeleine: I only started out with one. One pain pill for 8 hours and that was a weak pain pill – Tramadol. So then after the toothache went away, I realized I liked the way Tramadol made me feel. I was starting to work long hours at {Restaurant Name}, it was a very busy, very successful restaurant, very hot spot. So by then the kids were getting older and I was working a lot and I guess I started getting tired and the pain pills gave me energy. So I thought I was superwoman.

Interviewer: Did you think at any time, when you were starting to take them and you were liking how you were feeling, they were giving you energy that this was, should I be doing this? I don't know?

Madeleine: Yeah! I was thinking, 'I really need to be careful.' Because I was still going God's way by then and I didn't know what was going on at the time but the Lord was actually convicting my heart. You know, I was starting to feel bad. You come in here and you're trying to do this and that and now you're taking a pill a day which ended up being so I would buy like 30 a month, from the door. From whenever he got them.

Interviewer: So they were prescriptions for him and you were just buying?

Madeleine: Yup, I would buy 30. He would call me, a dollar a piece or something.

Interviewer: So what did that lead you to do?

Madeleine: So I did that for like a year... But then I had two or three different people and I was no longer doing Tramadol. I was
doing Percocets, mostly the 10 milligrams. And you know it just got worse.

Interviewer: Where were you getting it from?

Madeleine: People.

Interviewer: Friends?

Madeleine: Friends. Friend of a friend. A couple of times I went to the dentist or the doctor and they would write me out a prescription but that wasn’t very much.

For months, Madeleine fueled her habit by illegally buying drugs from within her social network but also via legitimately prescribed drugs authorized by her dentist. Scott is a 47 year-old white male who shared that he snorts crack cocaine to help alleviate his chronic back pain until his doctor can refill his prescription:

Yeah because you see right now, today, until I die I got back pains. Doctor can’t do anything about it. I mean they give me Percocets but when the drug wears off then there is pain. They used to give me 10s but I don’t see my doctor until next month and he’s going to give me a stronger medicine.

It was not uncommon for study participants to seek out both legal and illegal means to fuel their habits and acquire pharmaceutical drugs. Race and class, however, condition access to healthcare institutions that dispense legitimate prescriptions. Communities of color that are marked by concentrated disadvantage not only see poorer health outcomes, but also lack access to the resources and facilities that would help address those issues. The abuse of legitimately prescribed drugs is more likely to unfold as a phenomenon among white addicts of means, or at least with some social capital.

Not dissimilar from Conrad’s assertions about the associations that exist between the state and medical ideology, we can see how health narratives, and addiction rhetoric in particular, may come to steer correctional programming, too. Who benefits most from aligning themselves with


75. Several white respondents spoke of knowing a family doctor who more willingly dispensed prescriptions to them because they had established a lengthy rapport with that physician.

76. The proliferation of diversionary Drug Courts, Mental Health Courts, and privatized correctional substance abuse programming has resulted in a contemporary merger of healthcare reform and state surveillance. Increasingly, penal policy reflects a growing interest in strengthening healthcare provision’s support of social control. Diversion from conviction is often contingent upon the successful completion of rehabilitative programming and many substance abuse treatment initiatives
that medicalized state intervention, appears to vary by race. More than their black counterparts, white CREST participants were more likely to adopt the “sick role” and to enjoy the rights and pardons that accompany that status. It could be the case that although white addicts relinquish their autonomy in adopting the “addict” identity and portraying themselves as operating beyond their control, the outcome may not be as stigmatizing and deleterious as one might assume. Instead, this illness related status could confer a new protective title that allows its bearer to eschew culpability and receive objective, embracing care.

There exists a long and enduring legacy whereby the state consistently imposes privacy intrusions in the lives of society’s most marginalized and subjugated. For example, Professor Roberts’s research exposes the ways in which drug-addicted black women are systematically denied their rights to autonomous motherhood, despite the fact that punishing pregnant black addicts violates the Equal Protection clause of the fourteenth amendment and places an undue burden on the rights of these women to carry out their pregnancies to term. For poor Americans of color, the persistent presence of the state and its interventions in their lives are not uncommon, and these men and women are hyper-aware of the state’s ubiquity and often fearful of its compelling interest in regulating their behavior. As such, Roberts reported that drug addicted pregnant women of color hesitate to seek out help from healthcare institutions for fear of being reported and forced to abort their pregnancies; and facing the criminal sanctions associated with their prenatal conduct. Roberts writes, “[t]hey have punished women who use drugs during their pregnancy by depriving these mothers of custody of their children, by jailing them during their pregnancy, and by prosecuting them after their babies are report directly to Community Corrections offices around the country. The “inmate-patient” roles overlap with greater frequency and the result leads to greater administrative scrutiny that entraps more and more incorrigibly “sick” citizens in need of state care and supervision. The further the reach of corrections into healthcare, the greater the medicalized description of inmates and more pervasive and indeterminate the prognosis. For studies that explore this movement, see Teresa Gowan & Sarah Whetstone, Making the Criminal Addict: Subjectivity and Social Control in A Strong-Arm Rehab, 14 PUNISH. SOC. 69-93 (2012); Jennifer M. Kilty, “It’s like they don’t want you to get better”: Psy control of women in the carceral context, 22 FEM. PSYCHOL. 162-82 (2012); David E. Smith, Editor’s Note: The Medicalization of Therapeutic Communities in the Era of Health Care Reform, 44 J. PSYCHOACTIVE DRUGS 93-95 (2012).

77. Rights of a sick person include: (1) exemption from normal social roles and (2) a lack of responsibility for their condition. Obligations of a sick person include: (1) responsibility to try to get well and (2) making the effort to seek technically competent help. For full discussion, see Talcott Parsons, Illness and the Role of the physician: A Sociological Perspective, 21 AM. J. ORTHOPSYCHIATRY 452-60 (1951).


For many, revealing one's illness spells the relinquishment of their already meager protections against the abuse of intrusive government power.

Perhaps black CREST participants resist the "sick role" because doing so may prove similarly dangerous. First, the response of criminal legal system personnel to drug-using people of color has been overwhelmingly punitive rather than rehabilitative. For drug-using black Americans, for instance, adopting an illness narrative and revealing that condition to a healthcare provider could lead to incarceration far sooner than it would any sort of relief or support. Second, for many black men and women returning to hostile communities, the politics of survival prohibit their adoption of a "sick role" persona that would position them in a relatively vulnerable place. Jill McCorkel's research identifies two reasons for which many drug-involved TC participants resist the inimical "addict" status: as an act of defiance against the disrespectful, abusive, and denigratory nature of the disease model; and to blatantly provoke staff so that they would be expelled from the program with their sense of self still intact. The refusal to be "broken down" is a radical attempt at self-preservation for men and women of color returning to community contexts that swallow weaker victims whole.

Several respondents in this study expressed a need to stay vigilant and fend off threats from criminally-involved acquaintances who would take advantage of them if given the opportunity. As many of these TC participants are returning to the very same streets together, it is important that inmates always posture with strength, as they are likely to come head-to-head with those same people once again, absent the protections of programming staff and mediation protocols. The integrity of the promise of trust, empathy, and support extended to TC participants exposing themselves within a therapeutic circle is already weak, at best. It certainly does not protect participants moving through the community long after their sentences are served. To navigate that world with a demonstrably "broken" spirit could spell one's demise. Finally, perhaps black respondents in the sample rejected the "addict" identity in order to distance themselves from the disease model's pathologized antisocial citizen and the persistent iconography of the incorrigibly drug-dependent, "self-serving" black American. When asked about why he did not consider himself an addict, one respondent asserted that he was "better than that." Ironically, among even the most resistant TC participants, there is consensus among them that is consistent with the disease model teachings—many of these people wholeheartedly believe that words do possess power.

80. Id. at 1430.
81. Gowan and Whetstone, supra note 76; Kenneth B. Nunn, Race, Crime and the Pool of Surplus Criminality: Or Why the War on Drugs Was a War on Blacks, 6 J. GEND. RACE JUST. 381-445 (2002); Provine, supra note 18; Rodriguez, supra note 44; Roberts, Punishing Drug Addicts Who Have Babies, supra note 78.
82. For a wonderful ethnographic illustration of inmates' resistance to Therapeutic Community programming, see Jill A. McCorkel, Breaking Women: Gender, Race, and the New Politics of Imprisonment (2013).
IV. CONCLUSIONS

This research holds immediate contemporary significance for at least three reasons. First, the medicalization of drug use for men and women under criminal justice system supervision has significant implications for community correctional sanctioning. The benefits conferred by white users who adopt the "addict" identity, include eligibility for diversionary programming, positive evaluation of drug treatment participation and completion, leniency in urinalysis testing, and Supplementary Secure Income (SSI) for diagnosed disabilities. Perhaps if a greater proportion black drug-addicted defendants and convicts were treated as unwell instead of criminally deviant, they, too would see better reentry outcomes. Second, the themes raised by these respondents' stories underscore the need for increased access to healthcare within poor communities of color. Perhaps with the implementation of the Patient Protection and Affordable Care Act, more black and brown drug users will seek the treatment that they too deserve. Finally, if hyper-marginalized black men and women like the ones who courageously shared their stories, living in the bleakest of conditions, do not believe in their own innocence and right to redemption, what does this mean for the possibility for change and reform? We must consider the ways in which white ownership of citizenship, innocence, and inclusion, further isolates people of color who are caught up in intergenerational matrixes of subordination. If blacks don't believe in their right to care, who will? The medicalization of drug abuse cannot be selectively applied. Rather, widespread drug abuse is a public health concern that must be addressed at multiple institutional levels.

83. Mark A. R. Kleiman, Justice Reinvestment in Community Supervision, 10 CRIMINOL. PUBLIC POL'y 651-59 (2011).

84. Several white respondents talked at length about their SSI benefits and how they were able to supplement their addiction using those funds. Albeit a less than lucrative source of income, SSI did net these men and women enough income to cover their legitimate monthly living expenses as well as irresponsibly and illegally, support their drug habits. These practices fly directly in the face of the young black "welfare queen" narrative that too many policymakers cite as an outcome of 'Soft on Drugs/ Crime' policies.