

# UC Berkeley

## UC Berkeley Previously Published Works

### Title

An historical review of racial bias in prison-based substance abuse treatment design

### Permalink

<https://escholarship.org/uc/item/4vd005bh>

### Journal

Journal of Offender Rehabilitation, 56(8)

### ISSN

1050-9674

### Author

Kerrison, Erin M

### Publication Date

2017-11-17

### DOI

10.1080/10509674.2017.1363114

Peer reviewed



# An historical review of racial bias in prison-based substance abuse treatment design

Erin M. Kerrison 

University of California, Berkeley School of Social Welfare, Berkeley, California, USA

## ABSTRACT



This study leverages critical race and legal epidemiological frameworks to illustrate the race-based historical evolution of U.S. rehabilitation paradigms directed at imprisoned heroin and opioid users. What began as a racist early-20th-century federal antinarcotic trafficking effort has since assumed a state-based treatment agenda whose programmatic operations are largely based in correctional settings disproportionately reserved for poor substance abusers of color. Even in contemporary carceral facilities, where incarcerated populations are teeming with White addicts, in the aggregate, White drug abusers have been protected from the depraved, incorrigible, and inherently pathological drug-using caricature assigned to their non-White counterparts. This historical examination demonstrates how links between broader drug policy and prison-based drug treatment support a legally codified White supremacist narrative that erodes health and wellbeing for program participants of color, and the communities to which they inevitably return.

## KEYWORDS

Critical race theory; heroin/opioids; legal epidemiology; prison-based programs; substance abuse treatment

## Introduction

In the last decade, the public health problem of opioid addiction has grown to involve millions of individuals across all demographic strata (Manchikanti et al., 2012). In addition to the fatality risks associated with opioid abuse, intravenous heroin use is one of the major routes of transmission of serious communicable diseases, such as HIV and Hepatitis C, in the general population. Furthermore, prescription opioid abuse carries a significant risk of transition to intravenous heroin use (Compton, Jones, & Baldwin, 2016) and recently observed decreases in the abuse of prescribed synthetic opioid narcotics, largely the result of increased enforcement efforts, are associated with increases in heroin usage (Cicero, Ellis, & Harney, 2015). From 2002 to 2015 there was a 2.8-fold increase in the estimated total number of deaths attributed to opioid overdose (National Institute on Drug Abuse, 2017). The indirect risks to health and safety include epigenetic endocrine, metabolic, and cognitive abnormalities (Nestler, 2014), as well as the cultivation of a chaotic

**CONTACT** Erin M. Kerrison, PhD  [kerrison@berkeley.edu](mailto:kerrison@berkeley.edu)  University of California, Berkeley School of Social Welfare, 120 Haviland Hall, MC #7400, Berkeley, CA 94720-7400, USA.

© 2017 Taylor & Francis

lifestyle often culminating in criminal justice system involvement (Ropelewski, Mancha, Hulbert, Rudolph, & Martins, 2011).

Notwithstanding the unchallenged consensus that the heroin and synthetic opiate epidemic is alive and well, we have yet to revive a “War on Drugs” the likes of which have historically wreaked havoc in urban, majority Black and Latinx communities. Specifically, the passage of legislation that includes the Comprehensive Addiction Recovery Act of 2016 (CARA)<sup>1</sup>—one of the more celebrated legal strategies levied against the growing contemporary opioid addiction crisis—was not authored by the same proponents of “tough on crime” mandates of yesteryear. Instead, the new legal movement designed to combat heroin and opioid addiction in the 21st century is characterized by a much more therapeutic, rather than punitive, orientation. Coincidentally, all that has changed in the nation’s addiction-related public health crisis is the skin tone and socioeconomic status of the addict. Increasingly, heroin addiction and prescription opioid abuse have taken hold of White, middle-class youth and professionals (Martins et al., 2015). As such, what Netherland and Hansen (2016) have cleverly dubbed “the War on Drugs that *wasn’t*,” may evidence that the state’s revised approach to curtailing addiction is directly tethered to the race of the subjects negotiating the constructed problem.

History demonstrates that the extent to which the law seeks to medicalize or penalize substance abuse is not a colorblind phenomenon. To be clear, abuse of heroin, alcohol, marijuana, and a host of other substances has always been an American enterprise sustained by users across racial, ethnic, and socioeconomic groups. The likelihood of reconciling legally codified punishment in response to that substance abuse, however, has always been a deeply racialized trend. Through a multidecade exploration or “punitive prohibitionism,” or legislation aimed at narcotic trafficking and abuse, Doris-Marie Provine offered that “the demonization of these drugs, my analysis suggests, could not have occurred without a sustained effort to cultivate White anxieties about specific racial and ethnic groups” (Provine, 2007, p. 65). In other words, the centrality of racism and preserving White supremacy in the development of American drug-control policy cannot be exaggerated. Not only were efforts to limit narcotic trafficking by racial minorities deliberate, but also the state has maintained a longstanding commitment to providing normalizing and reintegrative treatment to White substance abusers, above and beyond any rehabilitative benefits conferred by their counterparts of color.

This study examines the historical legacy of prison-based heroin and opioid treatment programs designed to privilege White treatment participants. The following arguments leverage critical race and legal epidemiological frameworks to demonstrate not only that contemporary White inmates navigating opioid addiction recovery occupy a privileged status relative to similarly situated non-White incarcerated individuals, but that the practice of legal

institutions unevenly distributing health care among even the least popular of society's members, is a longstanding White supremacist practice.

### Critical race theory

The critical race theoretical (CRT) tradition is a dynamic interdisciplinary framework used to identify, analyze, and challenge the ways that racial constructs and racism intersect with multiple forms of subordination to shape the experiences of people of color (Crenshaw, Gotanda, Peller, & Thomas, 1995). Many sociolegal scholars have established that legal institutions—the criminal legal system, in particular—reify White supremacist agendas and disadvantage racially minoritized populations. Research suggests that across the United States, racial discrimination against Black, Latinx, Asian, and indigenous alleged offenders unfolds at every stage of criminal justice processing including stop-and-frisk (Redner-Vera & Galeste, 2015), arrest (Duran & Pasadas, 2016), conviction (Bushway & Piehl, 2001; Kutateladze & Andiloro, 2014), and sentencing (Owens, Kerrison, & Santos Da Silveira, 2017).

Through a critical race theoretical framework, in this essay I will demonstrate how the medicalization of drug use in carceral institutions arose in response to mounting concerns about White drug users' health—a shift in response that has been historically punitive and retributive for other racial groups. I will also show that following interdiction and the categorization of substance use as a punishable offense, the correctional facilities' treatment paradigms aimed at curtailing those behaviors advantage White inmates and leave inmates of Color less prepared for lasting recovery and reentry into their communities.

### A note on White privilege and White supremacy

I want to be clear on why I have chosen to highlight the reach of *White supremacy* or *White dominance* as opposed to their subsequent and observable machinations of *White privilege*. First, the origins of White privilege as we see it manifest in everyday life, are in fact born of White supremacy. Individuals who are constructed as White (Painter, 2010; Saperstein, Penner, & Light, 2013) would not enjoy the benefits of that label and status were it not for the ideological foundation propping up the assertion that Whiteness is superior and justifies an unearned merit that individuals constructed as other races are not owed (McIntosh, 2015). Second, to entertain a discussion about colorblindness absent an examination of how normalizing and standardizing notions of White supremacy insidiously permeate our social institutions—even the darkest among them, including the carceral state—undermines our aspirational efforts towards social justice. As Bonds and Inwood (2016)

suggested, we cannot remedy the problem of racism and racial injustice in the United States without first naming its foundation: White supremacy. Similarly, Leonardo (2004) and Leonardo and Manning (2017) encouraged critical, racial justice advocates to redirect their focus to the platform (White supremacy) that gives rise to the process or manifestation (White privilege), and not to mistake the symptoms of White dominance for its philosophical and sociopolitical root causes.

Further, it is my aim to demonstrate that because one of White supremacy's objectives is to present White dominance as universal and natural, a reflection of "White" individuals' assumed superiority, those who are constructed as White are permitted to believe that their realities constitute an ontological baseline. That is to say, our institutional and social scaffoldings exist to support and advance their needs and values. Given this ubiquitous influence, even the design and carrying out of contemporary punishment will still privilege the needs and experiences of White people. Unsurprisingly, ostensibly colorblind agendas work to naturalize White supremacy and the privileges that flow from it, because it fails to critique a status quo that has always existed to benefit White people and affirm their identities. Simultaneously, policymakers and others who Duncan, Nicholson, White, and Ellis-Griffith (2014) refer to as "moral entrepreneurs," rely on racially coded references to location and geography to support punitive drug policies that target ethno-racial minority groups. In response to this practice, I will demonstrate how prison-based substance abuse rehabilitation programming perpetuates a White supremacist creed.

### Legal epidemiology

Scholars investigating the intersections of law's influence on health have recently identified the utility of a legal epidemiological (LE) framework for understanding how law, like any other social institution, can shape wellbeing at micro and macro scales. The LE framework props up the theoretical assumption that legislation, legal processes, and legal institutional processes operate as determinants of health, and that the causes, distribution, and prevention of disease and injury can be attributed to law and legal institutions (Burris, Ashe, Levin, Penn, & Larkin, 2015).

Within this framework, legal etiology is a less-developed concept than legal prevention and control in the cultivation of safe and health environments. Its importance, however, cannot be overstated. Burris et al. (2015, p. 140) aptly pointed out that "not all law that influences health falls within the traditional boundaries of 'health law.' Most laws are proposed, enacted, and enforced with little or no thought to health, but many laws and policies can have a powerful health impact." Examples include the deregulation of the dual mortgage market, which gives rise to economic instability and affects fertility

(Schneider, 2015) and exposure to lead poisoning (Sewell, 2016). One could argue (perhaps) that the adverse health effects sprung from the ghettoization of Federal Housing Administration loans (Kimble, 2007) was unintentional, but the impact that the Department of Housing and Urban Development, its parent agency, has had on Black health, however, cannot be disputed. Levitsky (2013) argued that law shapes our environments, behaviors and beliefs, the level and distribution of health in a community, and our understanding of personal responsibility for health outcomes. It follows, then, that researchers committed to reducing health disparities must turn to legal etiology and a focus on how law differentially affect community members.

Through normative and doctrinal analysis, previous critical sociolegal scholarship does a fine job of demonstrating that the construction and enforcement of laws are animated by racial constructions and racist ideology (Gómez, 2010; Han, 2015; Harris, 1993). However, as law's prominence in American public health began to swell in the 1960s, social scientists with legal training focused increasingly on the impact of specific legal interventions on health (Burriss & Anderson, 2013). Gostin (2000), a public health law scholar, argued that "statutes, regulations, and litigation can be pivotal tools for creating the conditions for people to lead healthier and safer lives" (p. 2,837). Those structures can also undermine health and wellbeing. Currently, less is known about how the legal agendas and the institutional animus preceding those written laws and policies are directly responsible for poor health and disparate health outcomes. This work seeks to address that gap in the discourse by using the LE framework to examine the ways in which prison-based rehabilitation agendas perpetuate long-standing, race-based legal mandates and processes that engender racial health disparity—in this case, substance use disorder (SUD) recovery.

### **Medicalization of drug abuse**

Social scientists have consistently demonstrated that the prescribed social control modality applied to an identified deviant has less to do with the problematic act committed, and instead far more to do with an arbitrary assessment of the defendant's demographic characteristics (Zuberi & Bonilla-Silva, 2008). These discriminatory practices are sustained among healthcare providers, too. Despite repeated findings suggesting that substance use and abuse are prevalent practices among offenders of all racial groups, White s are routinely afforded protection from the criminalization of that practice (Heitzeg, 2015). For example, nationally based self-report data from high school students surveyed between 1975 and 2011 indicated that White students were more likely to have used an illicit substance in the past 30 days than their Black counterparts (Johnston, O'Malley, Bachman, & Schulenberg, 2012a). Data suggest that the same trend exists within adult samples, as well

(Johnston, O'Malley, Bachman, & Schulenberg, 2012b; Welty et al., 2016). These users faced relatively minimal criminal legal sanctioning, if any at all. Instead, the drug-using habits of White men and women, both in juvenile, college student, and adult pools, are *medicalized* (Netherland & Hansen, 2017).

Conrad (1979) defined medicalization as, “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (p. 3). He also identified three general forms of medical social control. *Technology*, he began, consists of the tools through which treatment is administered, most commonly presented in the form of prescription drug and psychosurgery. Secondly, *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. Miller's (2014) contemporary research underscores the myriad of ways in which social welfare and criminal justice actors collude to manage poor Black people in a way that is not conducive to their wellbeing. Third, *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. Permission to relinquish personal responsibility is a gift more often bestowed upon White drug users. Daniels's (2012) content analyses of *Intervention* television episodes revealed that addiction narratives for White users are protective and valorize the potential for White success. In this way, medical institutions, their tools, and the auxiliary language associated with their practices, operate to minimize, eliminate, and normalize deviant behavior, but only for the most privileged.

Medicalization confers benefits to some and effects deleterious outcomes for others, and the likelihood of who stands to gain more from a medicalized response is not an arbitrary trend. Smith's (2010) conceptualizations of ethnoracial differences in institutional trust include a treatment of the impacts that discrimination, neighborhood context, and socialization have on the emergence and prolonged gulf trust that exists between disenfranchised groups and the institutions that relegate them to the margins. The relationship between the state's administration of healthcare and Black wellbeing can be described as tenuous at best. Numerous studies illustrate not only that Black men and women have less access to regular healthcare than their White counterparts (Phelan & Link, 2015), 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 healthcare (Griffith, Allen, & Gunter, 2011; Sewell, 2015; Shavers, Klein, & Fagan, 2012). Furthermore, the proportion of Black community members who are under criminal justice 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 (Prins, Osher, Steadman, Robbins, & Case, 2012). This is particularly problematic when coupled with research findings highlighting that the systemic implicit bias held by physicians, healthcare administrators, and patients lead to underestimations of poor health, and a subsequently subpar provision of care (Abdou & Fingerhut, 2014; Matthew, 2015; Sanchez & Vargas, 2016). The absence of quality healthcare delivery for patients of Color is a crisis that may steer members of these groups away from effective treatment that they need and deserve.

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 criminal justice involved populations of color, however (notable exceptions include: (May, 1997; Sewell, Jefferson, & Lee, 2016; Thompson, Newell, & Carlson, 2016). In a historical moment increasingly marked by the racialized medicalization of substance abuse, it is important to examine the emergence of these manifestations and how the implications for substance abuse among those who are criminal justice supervised and politically disenfranchised are, and have always been immense.

### **Prison-based drug rehabilitation**

The impulse to levy a punitive response against possessors and distributors of illicit substances is not a contemporary phenomenon. The criminal justice system has incorporated drug rehabilitation programming into its correctional agenda for decades (Ghatak, 2010). Historically, the extent to which the punitive chord associated with this healthcare provision affects lasting harm for inmate–patient–clients, however, varies with the race of that subject and the community context to which they return (Brown, 1981). The following chronicles the historical carceral response to drug-addicted prison inmates and an illustration of how these prison-based programs have always better served the needs and social contexts of White addicts, more so than those of their counterparts of color.

### ***Federal narcotic farm, 1935–1974***

The Progressive Era was marked by an ascendance of federal regulatory power over drug use and drug trade among ethnoracial minority groups. The call for federal limits on the distribution of cocaine and opium at the time was lobbied by politicians 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 (Hickman, 2000; Musto, 1999). Similarly, interest in the distribution of marijuana cemented with the



emergence of Mexican and Mexican-American control of its trade (Lassiter, 2015). The passage of the Harrison Narcotics Act of 1914<sup>2</sup> placed the prescription and dispensing of narcotics under the purview of federal supervision, and represented the first comprehensive criminalization of opiate use. The strict enforcement of the Harrison Act drove opiate-seeking middle- and upper-class White women to underground markets (Kandall & Chavkin, 1991), and the majority of substance abusers filling prisons in the 1920s and 1930s were poor and working-class men (Acker, 2002).

Prison wardens were vexed by the influx of a population that they were ill equipped to serve and called for the passage of the Porter Narcotics Farm Act of 1929.<sup>3</sup> This legislation allowed for the construction of hospitals that fulfilled two purposes: facilities were intended to both provide effective medical treatment to and conduct addiction research on substance abusers; and quarantine those classified as the nation's most dangerous addicts, many of whom were feared to serve as recruiters into the country's drug world underbelly (Baumohl, 2011). The Narcotic Farm, jointly conceived of by the Bureau of Prisons and the Public Health Service, was erected in 1935 in Lexington, Kentucky and signaled the emergence of federally funded prison-based substance abuse programming. It was here that the first civil commitments by the state were imposed and at the behest of troubled wardens and social progressives, drug-addicted "inmate-patients" received treatment in a correctional space dedicated to addressing substance addiction, exclusively (Campbell, Olsen, & Walden, 2008). This was the first time that criminally enmeshed drug users were classified as ill and in need of care. Chief Medical Officer and Assistant Surgeon General Kolb (1939) wrote:

Addiction is a weakness that needs treatment, rather than a crime calling for punishment. Unreasonable punishment and prison association add to the weakness that causes the addiction; and the stigma of prison operates to prevent the released addict from getting employment which, after all, is the salvation of cured addicts. The crimes for which addicts are convicted are mostly the illegal possession or selling of narcotics. Many of the sellers sell only small quantities in order to provide themselves with funds to keep up their own personal supply which, for the time being, is necessary to prevent suffering. They should, as a rule, be treated as users and given the benefit of hospital treatment on probation. (p. 101)

The treatment modalities provided, however, were not the most effective for the population they were meant to serve.

Referred to locally as, "NARCO," the Lexington farm's first cohorts were comprised of a diverse mix of men coming from east of the Mississippi River and second Narcotic Farm built in Fort Worth, Texas in 1938, housed drug-addicted inmates who were identified west of the Mississippi River. The men who were involuntarily housed there, all charged with drug-related possession and/or property offenses and sentenced to mandatory correctional treatment,

largely belonged to poor Black, Mexican, and Puerto Rican urban communities (Courtwright, 1992). Campbell et al. (2008) reported instead that it was in these spaces that poorly orchestrated resocialization practices took hold. These facilities offered recreational activities in pastoral, isolated rural settings that were cut off from the lures of urban vice, but also from any meaningful social attachments these incarcerated individuals may have previously cultivated. Additionally, under the guise of receiving therapeutic physical rehabilitation and learning the value of cooperative occupational skills, the imprisoned were required to labor in prison manufacturing industries, netting substantial profits for the federal government and the continuation of penal development (Conley, 1980). The proposed therapeutic value of these work assignments would be more believable if these inmates did not serve indeterminate lengthy sentences that precluded them from community reentry during the years in which they could meaningfully contribute to the labor market.

In addition to the quarantine labor force gained by the Bureau of Prisons, a great deal of anatomical and psychiatric research was conducted on these disenfranchised inmate-patients. A critical element of the NARCO agenda was to understand the mechanisms to which sustained addiction were attributed, and to develop a cure for prisoners suffering from the disease. To satisfy that aim, the Addiction Research Center (ARC) was a lab site housed on the NARCO campus (Campbell, 2006). Research efforts involved experimentation on inmates, including procedures like the “re-addiction” to an opiate, followed by a forced substance withdrawal and the administration of new drugs to see how effective they were in ameliorating withdrawal symptoms. In addition to their unethical nature, these studies that reintroduced illicit substances in inmate-patients’ systems led to relapses that would lengthen their sentences. Dr. Victor Vogel of the Lexington campus asserted:

By legal definition, an addict patient is not cured until he has regained the power of self-control with regard to the use of drugs. This involved not only “kicking the habit” to rid himself of a physical dependence to the drug but the opportunity for regular living without drugs, and perhaps for psychiatric treatment to build up a resistance to an underlying emotional desire for drugs which may persist strongly for months. (Vogel, 1948, p. 46).

It was not until the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (1978) recommended the prohibition of nearly all prisoner research, that prison institutions were held accountable for upholding standards of bioethical accountability in their treatment of incarcerated research subjects (Cislo & Trestman, 2013). Regrettably, however, for those drug-addicted inmates struggling with recovery, the majority of whom were poor men of color with scant social capital, spending

years on a work farm that did little to effectively address their opiate addiction proved detrimental for their life-course trajectories and the communities to which they returned.

As federal antinarcotic law is drafted with colorblind language, its marginalizing and disadvantaging agenda is concealed. The micro and macro outcomes connected to federal substance-abuse related penal responses remain the same, however, and the argument that this rehabilitation program privileged the White participant, despite its universal harms, still holds. White drug users, even those subjected to criminal justice intervention, were less likely to be subjected to the same lasting harm that participation in federal narcotic farm programs imposed upon life chances for incarcerated individuals of Color. The disparity in reentry experiences was due, in large part, to the absence of rehabilitation-oriented political and organizational resources in communities of color and the lack of social supports needed to bolster families that had been irrevocably disrupted by the lengthy incarceration sentences imposed upon men of color (Block, 1979; Courtwright, 1992). For instance, while the Nation of Islam was one of the most prominent organizations to campaign against narcotic sale and use in Black communities (Sanders & Powell, 2012), the resources needed to support the growing number of community members confronting opioid abuse recovery and criminal records were limited. As such, relapse and recidivism outcomes for non-White men, eclipsed those of their White counterparts and lent support for the non-White criminal addict stereotype. Throughout the second half of the 20th century the expansion of narcotics control increasingly became a state-based mandate, and state prison facilities began to implement similarly disadvantaging rehabilitation programs.

### ***Narcotics Anonymous (1953–present)***

Although the widely accepted and celebrated community-based Narcotics Anonymous (NA) fellowship did not hold its first publicly announced meeting in California until 1953, Addicts Anonymous meetings were held weekly at the federal NARCO farm in Lexington, Kentucky in as early as 1947. Upon being transferred in 1948, a former NARCO inmate started a New York NA fellowship in the New York State prison system, and other prison chapters soon emerged in Texas, Virginia, and California (Kelly & White, 2014). Law enforcement of the 1950s was animated by a fair amount of “get tough” narcotic regulation. With the passage of mandatory sentencing laws that included the Boggs Act of 1952<sup>4</sup> and Narcotic Control Act of 1956<sup>5</sup> (which increased minimum prison sentences to 2–15 years for possession of heroin, cocaine, or cannabis), the emergence of “loitering addict” laws under which known addicts could be arrested or have their probation/parole violated for simply associating with each other in public, state prisons were

suddenly crowded with drug-addicted individuals (White, Budnick, & Pickard, 2013)—and the need for prison-based support groups was quite pronounced.

In 1954, the first NA publication was printed and titled the “Little Yellow Booklet,” which contained the 12 traditions, or steps of recovery from drug dependence. In large part, the “12 Steps,” as they are colloquially referenced, emphasize the importance of social support, subjective mental states, and spirituality in the journey of substance abuse recovery (Best et al., 2016). While seemingly innocuous and universally appreciated positive recovery anchors, this orientation does not necessarily confer identical benefits across racial groups. For instance, NA operates with the assumption that recovery pathways are initiated and maintained by a change of social networks, which allows for the cultivation of a new sober identity that will supplant the destructive addict identity. Findings derived from General Social Survey polls, however, indicate that Black Americans are more likely to be meaningfully connected to incarcerated individuals, making distance from the criminal justice involved world less likely, and even undesirable (Lee, McCormick, Hicken, & Wildeman, 2015).

In addition, sociological arguments that privilege the significance of social networks in recovery work (Sampson & Laub, 1993), do not address the *intersectional* influence of social roles and network for marginalized individuals navigating recovery from substance abuse. For example, qualitative research findings illustrate that for some contemporary samples of drug-involved incarcerated women, navigating the role and corresponding responsibilities of parenthood can communicate stigma and exacerbate the recovery journey (Gunn, Sacks, & Jemal, 2016; Kerrison, Bachman, & Paternoster, 2016; Leverentz, 2011). For multimarginalized individuals living in concentrated disadvantage, beyond the proximity of prosocial network members and/or inadequately empowered to fully participate in a prosocial network, lasting recovery is less likely to begin with positive influences and lessons gleaned from their most proximate network members.

I am not arguing that the establishment of prison-based NA fellowships is inherently problematic for non-White participants who are more often connected to networks that lack mainstream notions of social capital (for arguments that challenge the race-based construction of social and human capital, see Piquero, Jennings, Piquero, & Schubert, 2014; Yosso, 2005). Rather, my aim is highlight how this program ignores the intersectional disadvantages reconciled by so large a segment of inmate populations. It is the continued endorsement of prison rehabilitation programming that better supports White participants who are more likely to have access to social networks that are recognized or constructed as more supportive that I identify as problematic. More recent research acknowledges the temporal importance of identity change preceding social network change, and suggests that policy

that emphasizes the significance of initial identity change is better suited for demographically diverse drug-addicted offending groups (Bachman, Kerrison, Paternoster, O'Connell, & Smith, 2016; Paternoster, Bachman, Kerrison, O'Connell, & Smith, 2016). Although the NA fellowship is accessed primarily in community settings, it is foundational to the prison-based therapeutic community and mindfulness modalities discussed next.

### ***Therapeutic communities, 1958–present***

One of the most frequently adopted substance abuse treatment modalities found in criminal justice settings is the therapeutic community (TC). The correctional TC originated in the 1958 at a time when medical and psychiatric substance abuse treatment programs like the aforementioned NARCO types proved unsuccessful at “curing” addiction. The guiding approach of the TC’s client-centered therapy is to provide drug-addicted inmates with a substance-free environment and intensive cognitive behavioral therapy, marked by an orientation that blends tenets of personal responsibility and public support or accountability (De Leon, 2000). Because cognitive behavioral therapeutic modalities within the TC setting are based on the assumption that cognitive deficits are learned rather than inherent, programs emphasize individual accountability and the importance of developing ways to identify and correct deficient thought and decision-making patterns (Lipsey, Landenberger, & Wilson, 2007).

The principal goal around which prison-based TC programming is designed is to provide a holistic, inclusive, and protected space where substance abusing participants can confront their poorly rationalized coping patterns and put an end to the destructive behaviors that manifest as a result of that condition. Inciardi, Martin, and Butzin (2004) 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. [Emphasis in original]

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.

TC implementation unfolds in multiple stages, all oriented around accountability and responsibility for one’s self. First, participants 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. Relative to the incarcerated individuals housed in the facility’s general population, TC participants are subjected to increased surveillance and public confrontation by TC personnel. For example, TC members must participate in “encounter groups,” or compulsory biweekly and triweekly TC group-based meetings marked by participant denigration and harsh confrontation among other inmates (Broekaert, Vandeveld, Schuyten, Erauw, & Bracke, 2004). The rationale for this programming element is to require participants to do the uncomfortable work of articulating their emotions and publicly admitting and accepting that their choices and negative behaviors have netted them the life circumstances that resulted a host of harmful consequences. Acampora and Stern (1992) offered the following description:

There is usually a brief silence, a scanning appraisal as to that is present, and a kind of sizing one another up. Then, the group launches into an intense emotional exchange of personal and collective problems. A key point of the sessions is the emphasis laid on extreme uncompromising candor about one another. No holds or statements are barred from the group effort at truth seeking about problem situations, feelings, and emotions of each member of the group (...) This often left them with a clearer view and a greater knowledge of their inner and outer world. (p. 3)

These sorts of encounters are a critical element of TC programming and newer residents are socialized into the norms of these practices by older residents and TC personnel, many of whom are recovering addicts themselves (Curtis & Eby, 2010; De Leon, 2000).

Importantly, TC participant adherence is measured by the extent to which patients employ deferential and respectful postures, and refrain from exhibiting cynicism. In other words, the drug-addicted inmate will not be assessed as making progress until they relinquish the impulse to resist full personal responsibility for their life circumstances (Kerrison, 2017). These requirements of deference and defeat can appear dangerous to subjects navigating intersectional disadvantage, as studies demonstrate that resistance to peer-based drug treatment interventions are sometimes derived from a panic about how to reconcile persistent stigma and isolation (Gunn & Canada, 2015). Despite the fact that the cultural relevance of TC programming has been long debated and proponents of its methods have admitted that the modality is best suited for White male opiate abusers (Melnick et al., 2011), the gulf between the TC operational mechanisms and the needs and postrelease outcomes of non-White, nonmale TC participants have not yet been addressed. In the meantime, research has shown that White drug abuse treatment patients are encouraged to align themselves with the goals of this medicalized intervention because adopting the “sick role” (Parsons, 1951) allows them to enjoy the rights and pardons that accompany that status (Netherland & Hansen, 2016, 2017).



For poor Black TC participants who reject the addict label, their access to the already limited addiction-related healthcare resources available to them in the community is further diminished. The rejection of the addict label precludes eligibility for diversionary programming, positive evaluation of drug treatment participation and completion, leniency in urinalysis testing, and the dispensing of Supplemental Security Income (SSI) benefits for diagnosed drug abuse related disabling conditions. These are the very supports that facilitate prisoner reentry substance abuse recovery (Garner, Scott, Dennis, & Funk, 2014), and are already poorly matched to the needs of patients of color (Thompson et al., 2016). While I am not suggesting that Black inmates who prefer to maintain their autonomy should instead forfeit their agency and comply with the TC programming rhetoric, I think it is important for readers to consider the possibilities for recovery that might be known to them if they actually felt safe adopting a status that would allow them access to meaningful treatment. Although evaluators report that some of the intensity and bleakness traditionally associated with TC programming has decreased in recent years (Vanderplasschen et al., 2013), until the rhetoric and requirements of compliance no longer require that multimarginalized people admit to and embrace their vulnerability, the potential for parity in prison-based TC recovery experiences across racial groups may be stifled.

### ***Medication-assisted treatment, 1964–present***

Unlike abstinence-based treatment models that eschew all pharmaceutical use, medication-assisted treatment (MAT) is a treatment approach that integrates behavioral therapy and the administration of medication aimed at correcting the neurological abnormalities associated with addiction (Center for Substance Abuse Treatment, 2012). Although relatively few jails and prisons offer comprehensive MAT services, there are generally three MAT options offered in opioid treatment program (OTP) programs made available to incarcerated substance abusers. Opioid agonists and mixed agonists-antagonist modalities, or agents with an effect profile similar to the abused substance, are widely used—the most popular of which include methadone and buprenorphine, respectively (Novick, Salsitz, Joseph, & Kreek, 2015). The third most-frequently used MAT offered to inmates is the antagonist naltrexone. Of the three categories, only naltrexone is an unscheduled medication that any physician or certified nurse practitioner can prescribe, and it is only naltrexone that is not associated with the negative cognitive and medical side effects or pronounced risks of abuse known to exist with the other MATs (Volkow, Freiden, Hyde, & Cha, 2014). Naltrexone is an oral or implantable opioid antagonist, which binds to one's opioid receptors but neither activates them nor allows opioid agonists to activate them. This prevents the abused



opioids from producing their physiological effects, even if taken. The provision of injectable extended-release naltrexone has recently become available in some prison settings and its use as an addiction and health-focused criminal justice intervention eliminates several problems that complicate the use of more traditionally used MATs in prison facilities (Gordon et al., 2015).

Despite—or perhaps because of—its promising outcomes, the administration of naltrexone is costlier than that of pre-existing MAT modalities (Williams & Bisaga, 2016) and more difficult to administer in prison settings than what is required for methadone buprenorphine provision (Center for Substance Abuse Treatment, 2014; Levin, Bisaga, Sullivan, Williams, & Cates-Wessel, 2016). Barring comprehensive health insurance coverage or involvement in a state sponsored carceral program, poor drug abusers of color currently do not have the same access to more effective MAT care as their White counterparts. Moreover, regardless of whatever pharmacological developments emerge in the expansion of MATs in general, treatment provision evaluation data suggest that opioid dependent individuals who are referred to MAT by the criminal justice system are more likely to face delays in admission than other types of referrals (Friedmann et al., 2012; Gryczynski, Schwartz, Salkever, Mitchell, & Jaffe, 2011).

The fallout related to these barriers is reflected in reentry, recidivism, and desistance outcomes, too. Sentencing disparities research demonstrates that White drug abusers' convictions lead to community-based supervision, more often than the custodial status disproportionately confronted by their similarly situated non-White counterparts (Omori, 2017). As a result, the likelihood that non-White addicts in recovery who can either only access the less costly and less effective prison-based MAT options or underfunded community-based treatment mandates will relapse may be greater. That a discourse around neurologically based treatment options exists absent a meaningful recognition of how racially informed structural schema shape MAT outcomes (Hansen & Roberts, 2012; Mitchell et al., 2014) is a reflection of persistently colorblind treatment administration, carried out by legal entities that bolster White supremacy.

### ***Mindfulness-based interventions, 1971–present***

Although TC programming and cognitive behavior psychotherapies aimed at modifying negative or unhelpful thought patterns are still widely used in prison settings, increasingly, correctional facilities are moving toward the incorporation of mindfulness elements into their drug rehabilitative agendas. Kabat-Zinn (2003, p. 145) described mindfulness as “the awareness that emerges through paying attention on purpose, in the present moment, and

nonjudgmentally to the unfolding of experience moment by moment.” Mindfulness-based relapse prevention combines mindfulness strategies with relapse prevention techniques to help people with substance use disorders increase their awareness of, and ability to resist craving by paying attention to thoughts, emotions, and environments that lead to using substances (Bowen et al., 2014). In the effort to address some of the reluctance to internalize the admonishment that accompanies the perceived “problem-based” cognitive behavioral therapy modalities, mindfulness foregrounds personal responsibility and agency, and the agent is empowered by their capacity for growth, rather than shame.

There are three kinds of meditative programs offered to incarcerated individuals: transcendental meditation (TM), mindfulness-based stress reduction, and in-facility Vipassana retreats (Himmelstein, 2011). The most commonly implemented of the three, TM, involves approximately 20 mins of daily focused breathing and calls for a quieting of the mind and body’s distractions. This enables individuals to tap into their own reservoirs of peace and undisturbed creative energy. The result allows for a natural state of restful alertness, where those who practice TM learn to recognize their autonomy and infinite individual power. Mindfulness-based stress reduction (MBSR) programming requires those who practice to focus on their ongoing mental processes and self-management (Glasner et al., 2017; Kabat-Zinn et al., 1992). As MBSR drives students to envision their mind at work and the ways in which they pilot their own experiences and decision-making, this practice has the possibility to improve mood states within incarcerated populations confined to the restrictions of a total institution and may help develop healthier psychological functioning. Mastery of this practice can contribute to better results in other rehabilitative programs that require choice-making consciousness and accountability. Vipassana residential retreats last for 10 days and require that participants move in silence, focusing exclusively on their feelings and how to regulate their impulses, rather than having those feelings steer their actions. Participants learn to recognize the impermanence of what was believed to be a ubiquitous hold on the body, and can therein free themselves from cravings, and addictions that seemed insurmountable prior to Vipassana (Cohen, Jensen, Stange, Neuburger, & Heimberg, 2017). The result is a newfound freedom from psychological attachment and hedonic, or pleasure-related stimuli—the primary basis of many substance abusers’ plight (Garland, Howard, Zubieta, & Froeliger, 2017).

Mindfulness-based and meditation programming support existing modalities offered in prison settings by helping to develop the toolkit needed for coping with triggers and negative affect, as well as an overall condition of wellbeing (Bowen et al., 2006). Additionally, as other prison-based treatment modalities discussed earlier have encouraged prayer and individualized self-reflection, arguably both treatment providing personnel and incarcerated

individuals from varied cultural backgrounds are primed to adopt mindfulness-based programming that neatly aligns with that treatment history (Kabat-Zinn, 2003). Orme-Johnson's (2011) findings suggest that meditation-based programs may increase positive psychological states, such as hopefulness optimism, as well as decrease negative psychological states, such as obsessive-compulsive behavior and hostility. Meditation-based programs also signal decreased self-reported substance use in some correctional populations (Perelman et al., 2012) and lower criminal offending and recidivism rates upon release from prison (Alexander et al., 2003) and jail (Malouf, Youman, Stuewig, Witt, & Tangney, 2017).

These modalities appear promising for proponents of racial justice in correctional substance abuse treatment, though there is still work to be done. First, the influences that impede treatment compliance and adherence for the other modalities among participants of color, may decrease if they are exposed to what they perceive to be a more empowering treatment orientation. Second, meditative therapy is an individual practice that can take place anywhere upon release from prison, with little to no operational expense. Even the operational costs of this nonpharmacological prison-based intervention are relatively nil, as many of the MBI facilitators provide classes at the facilities on a volunteer basis (Lyons & Cantrell, 2016) and incarcerated individuals across racial groups teach the practice to one another (Suarez et al., 2014).

Despite our knowledge of the disproportionate numbers of racially minoritized individuals serving sentences in prisons, there is a dearth of research that explores the needs of mindfulness-based practice participants of color. Research conducted by Amaro et al. (Amaro, 2014; Amaro, Spear, Vallejo, Conron, & Black, 2014; Vallejo & Amaro, 2009) indicates that although the original MBSR practice had been adapted for universal use by women navigating SUD, chronic stress, and histories of trauma, what is required for parity of intervention adherence, compliance, and impact across White, Black, and Latinx groups in those populations is still unknown. Newer efforts at accommodating treatment population's ethnoracial heterogeneity have been made by widening MBI access to marginalized groups including those who cannot afford mental health treatment (Burnett-Zeigler et al., 2016; Burnett-Zeigler, Schuette, Victorson, & Wisner, 2016), confront LGBTQ-related discrimination and stress (Ingraham et al., 2016; Seelman, Adams, & Poteat, 2016), and are working through the challenges of interpersonal violence victimization (Kelly & Garland, 2016). Still, little is known about how the interventions operate for incarcerated participants across racial groups and further research is needed.

That the mounting purchase of MBI modalities for SUD treatment in correctional settings coincides with the swelling of numbers of middle-class White individuals navigating SUD recovery cannot be ignored. As yoga

practice is a mainstream recreational activity in the United States, particularly among educated middle-class Whites (Birdee et al., 2008), their integrating postprison MBI recovery with societal reintegration will be a far less stigmatizing experience and administrative burden than what daily trips to the local methadone clinic tend to provoke (Gryczynski et al., 2011; Peterson et al., 2010). That is not to discount that regardless of race, formerly incarcerated individuals under community supervision must negotiate a host of reentry challenges. Rather, as this study merely aims to underscore how the benefits of treatment modalities offered to incarcerated individuals are conditioned by race, the timeliness of growing support for MBI intervention coinciding with the growing proportion of Whites to whom it is offered, is somewhat suspect.

## Conclusion

In exploring the historical legacy of tacit White supremacist drug treatment programming in prison settings, this study demonstrates how one legal institution—U.S. prisons—works to steer health outcomes in favor of White wellbeing. This examination also makes clear that even when exploring the state's health care provision for White Americans who occupy the lowest rungs of the ladder, those recipients are still met with treatment modalities that reflect their majority status, values, and experiences. In this context, the law serves two purposes: narcotic regulation is symbolic insofar as it defines and reiterates the norms of the majority who maintain social dominance; and the letter of the law is instrumental in the dispatching of police power levied against the stigmatized behavior. That the law functions in this way and affects health outcomes that do not “cure” addiction for non-White mandated-treatment recipients is a pyrrhic defeat. By constructing an incorrigible, racially othered addict subject, the state also maintains a belief that this subject is inherently criminal.

That these practices and motivations are animated by a commitment to legal colorblindness is no accident either. As Provine (2007) aptly argued, “the prevailing ideology of color blindness protects officials from having to acknowledge and deal with the blatant racial and class inequalities in the punishment system” (p. 164). Making a case for race neutrality, despite overwhelming evidence of unequivocal race-based health disparities in prison care, is a calculated act of racial injustice. When the moral and health panic is directed inward, however, history evidences that White Americans (even those who have been convicted of crimes and sentenced to state prison) do not meet the same specter of punishment and relegation. Instead, the law's control of healthcare provision for incarcerated populations, still operates to further the wellbeing of White SUD treatment participants, and racial health disparities among opiate and opioid abusers persist.

## Notes

1. Pub. L. 114–198.
2. Pub. L. 63–223, 38 Stat. 785 (repealed).
3. Pub. L. 70–672.
4. Pub. L. 82–255.
5. Pub. L. 728–84.

## Funding

This work was supported by the University of Pennsylvania.

## ORCID

Erin M. Kerrison  <http://orcid.org/0000-0003-1300-3983>

## References

- Abdou, C. M., & Fingerhut, A. W. (2014). Stereotype threat among Black and White women. *Cultural Diversity and Ethnic Minority Psychology, 20*(3), 316–323. doi:10.1037/a0036946
- Acampora, A., & Stern, C. (1992). The evolution of the therapeutic community. In A. M. Christner (Ed.), *Paradigms: Past, present and future. Proceedings of the therapeutic communities of America. 1992 Planning Conference* (pp. 2–15). Washington, DC: Therapeutic Communities of America.
- Acker, C. J. (2002). *Creating the American junkie: Addiction research in the classic era of narcotic control*. Baltimore, MD: The Johns Hopkins University Press.
- Alexander, C. N., Rainforth, M. V., Frank, P. R., Grant, J. D., Von Stade, C., & Walton, K. G. (2003). Walpole study of the transcendental meditation program in maximum security prisoners III: Reduced recidivism. *Journal of Offender Rehabilitation, 36*, 161–180. doi:10.1300/j076v36n01\_08
- Amaro, H. (2014). Implementing mindfulness-based relapse prevention in diverse populations: Challenges and future directions. *Substance Use and Misuse, 49*(5), 612–616. doi:10.3109/10826084.2014.856624
- Amaro, H., Spear, S., Vallejo, Z., Conron, K., & Black, D. S. (2014). Feasibility, acceptability, and preliminary outcomes of a mindfulness-based relapse prevention intervention for culturally-diverse, low-income women in substance use disorder treatment. *Substance Use and Misuse, 49*(5), 547–559. doi:10.3109/10826084.2013.852587
- Bachman, R., Kerrison, E., Paternoster, R., O'Connell, D., & Smith, L. (2016). Desistance for a long-term drug involved sample of adult offenders: The importance of identity transformation. *Criminal Justice and Behavior, 43*(2), 164–186. doi:10.1177/0093854815604012
- Baumohl, J. (2011). Porter narcotic farm act. In M. A. R. Kleiman & J. E. Hawdon (Eds.), *Encyclopedia of Drug Policy* (pp. 657–659). Thousand Oaks, CA: Sage.
- Best, D., Beckwith, M., Haslam, C., Haslam, S. A., Jetten, J., Mawson, E., & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The social identity model of recovery (SIMOR). *Addiction Research and Theory, 24*(2), 111–123. doi:10.3109/16066359.2015.1075980
- Birdee, G. S., Legedza, A. T., Saper, R. B., Bertisch, S. M., Eisenberg, D. M., & Phillips, R. S. (2008). Characteristics of yoga users: Results of a national survey. *Journal of General Internal Medicine, 23*(10), 1653–1658. doi:10.1007/s11606-008-0735-5

- Block, A. A. (1979). The snowman cometh: Coke in progressive New York. *Criminology*, 17(1), 75–99.
- Bonds, A., & Inwood, J. (2016). Beyond White privilege: Geographies of White supremacy and settler colonialism. *Progress in Human Geography*, 40(6), 715–733. doi:10.1177/0309132515613166
- Bowen, S., Witkiewitz, K., Clifasefi, S. L., Grow, J., Chawla, N., Hsu, S. H., ... Larimer, M. E. (2014). Relative efficacy of mindfulness-based relapse prevention, standard relapse prevention, and treatment as usual for substance use disorders. *Journal of American Medical Association*, 311(5), 547–556. doi:10.1001/jamapsychiatry.2013.4546
- Bowen, S., Witkiewitz, K., Dillworth, T. M., Chawla, N., Simpson, T. L., Ostafin, B. D., ... Marlatt, G. A. (2006). Mindfulness meditation and substance use in an incarcerated population. *Psychology of Addictive Behaviors*, 20(3), 343–347. doi:10.1037/0893-164x.20.3.343
- Broekaert, E., Vandavelde, S., Schuyten, G., Erauw, K., & Bracke, R. (2004). Evolution of encounter group methods in therapeutic communities for substance abusers. *Addictive Behaviors*, 29(2), 231–244. doi:10.1016/s0306-4603(03)00092-3
- Brown, L. S., Jr. (1981). Substance abuse and America: Historical perspective on the federal response to a social phenomenon. *Journal of the National Medical Association*, 73(6), 497–506.
- Burnett-Zeigler, I. E., Satyshur, M. D., Hong, S., Yang, A., Moskowitz, J. T., & Wisner, K. L. (2016). Mindfulness based stress reduction adapted for depressed disadvantaged women in an urban federally qualified health center. *Complementary Therapies in Clinical Practice*, 25, 59–67. doi:10.1016/j.ctcp.2016.08.007
- Burnett-Zeigler, I., Schuette, S., Victorson, D., & Wisner, K. L. (2016). Mind-body approaches to treating mental health symptoms among disadvantaged populations: A comprehensive review. *Journal of Alternative and Complementary Medicine*, 22(2), 115–124. doi:10.1089/acm.2015.0038
- Burris, S., & Anderson, E. (2013). Legal regulation of health-related behavior: A half-century of public health law research. *Annual Review of Law and Social Science*, 9(1), 95–117. doi:10.1146/annurev-lawsocsci-102612-134011
- Burris, S., Ashe, M., Levin, D., Penn, M., & Larkin, M. (2015). A transdisciplinary approach to public health law: The emerging practice of legal epidemiology. *Annual Review of Public Health*, 37(1), 135–148. doi:10.1146/annurev-publhealth-032315-021841
- Bushway, S. D., & Piehl, A. M. (2001). Judging judicial discretion: Legal factors and racial discrimination in sentencing. *Law and Society Review*, 35(4), 733–764. doi:10.2307/3185415
- Campbell, N. D. (2006). “A new deal for the drug addict”: The addiction research center, Lexington, Kentucky. *Journal of the History of the Behavioral Sciences*, 42(2), 135–157.
- Campbell, N. D., Olsen, J. P., & Walden, L. (2008). *The narcotic farm: The rise and fall of America's first prison for drug addicts*. New York, NY: Abrams.
- Center for Substance Abuse Treatment. (2012). *Medication-assisted treatment for opioid addiction in opioid treatment programs. Treatment Improvement Protocol (TIP) Series 43*. HHS Publication No. (SMA) 12-4214. Rockville, MD.
- Center for Substance Abuse Treatment. (2014). *Substance abuse treatment for adults in the criminal justice system. Treatment Improvement Protocol (TIP) Series 44* (HHS Publication No. (SMA) 13-4056). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Cicero, T. J., Ellis, M. S., & Harney, J. (2015). Shifting patterns of prescription opioid and heroin abuse in the United States. *New England Journal of Medicine*, 373(18), 1789–1790. doi:10.1056/nejmc1505541



- Cislo, A. M., & Trestman, R. (2013). Challenges and solutions for conducting research in correctional settings: The U.S. experience. *International Journal of Law and Psychiatry*, 36(3–4), 304–310. doi:10.1016/j.ijlp.2013.04.002
- Cohen, J. N., Jensen, D., Stange, J. P., Neuburger, M., & Heimberg, R. G. (2017). The immediate and long-term effects of an intensive meditation retreat. *Mindfulness*, 8(4), 1064–1077.
- Compton, W. M., Jones, C. M., & Baldwin, G. T. (2016). Relationship between nonmedical prescription-opioid use and heroin use. *The New England Journal of Medicine*, 374(2), 154–163. doi:10.1056/nejmra1508490
- Conley, J. A. (1980). Prisons, production, and profit: Reconsidering the importance of prison industries. *Journal of Social History*, 14(2), 257–275. doi:10.1353/jsh/14.2.257
- Conrad, P. (1979). Types of medical social control. *Sociology of Health & Illness*, 1(1), 1–11. doi:10.1111/j.1467-9566.1979.tb00175.x
- Courtwright, D. T. (1992). A century of American narcotic drug policy. In D. R. Gerstein & H. J. Harwood (Eds.), *Treating drug problems, volume 2: Commissioned papers on historical, institutional, and economic contexts of drug treatment*. (pp. 1–62). Washington, DC: National Academy Press.
- Crenshaw, K., Gotanda, N., Peller, G., & Thomas, K. (Eds.). (1995). *Critical race theory: The key writings that formed the movement*. New York, NY: The New Press.
- Curtis, S. L., & Eby, L. T. (2010). Recovery at work: The relationship between social identity and commitment among substance abuse counselors. *Journal of Substance Abuse Treatment*, 39(3), 248–254. doi:10.1016/j.jsat.2010.06.006
- Daniels, J. (2012). Intervention: Reality TV, Whiteness, and narratives of addiction. In J. Netherland (Ed.), *Critical perspectives on addiction* (Vol. 14, pp. 103–125). Bingley, UK: Emerald Group Publishing Limited.
- De Leon, G. (2000). *The therapeutic community: Theory, model, and method*. New York, NY: Springer Publishing Company.
- Duncan, D. F., Nicholson, T., White, J. B., & Ellis-Griffith, G. (2014). A brief history of prohibition and treatment solutions for substance abusers. *International Journal of Criminology and Sociology*, 3, 186–199. doi:10.6000/1929-4409.2014.03.17
- Duran, R. J., & Pasadas, C. E. (2016). The policing of youth on the US–Mexico border: A law enforcement perception of leniency. *Race and Justice*, 6(1), 57–83.
- Friedmann, P. D., Hoskinson, R. A., Gordon, M., Schwartz, R., Kinkock, T., Knight, K., ... Frisman, L. K. (2012). Medication-assisted treatment in criminal justice agencies affiliated with the criminal justice-drug abuse treatment studies (CJ-DATS): Availability, barriers, and intentions. *Substance Abuse*, 33, 9–18. doi:10.1080/08897077.2011.611460
- Garland, E. L., Howard, M. O., Zubieta, J.-K., & Froeliger, B. (2017). Restructuring hedonic dysregulation in chronic pain and prescription opioid misuse: Effects of mindfulness-oriented recovery enhancement on responsiveness to drug cues and natural rewards. *Psychotherapy and Psychosomatics*, 86(2), 111–112. doi:10.1159/000453400
- Garner, B. R., Scott, C. K., Dennis, M. L., & Funk, R. R. (2014). The relationship between recovery and health-related quality of life. *Journal of Substance Abuse Treatment*, 47(4), 293–298. doi:10.1016/j.jsat.2014.05.006
- Ghatak, S. (2010). “The opium wars”: The biopolitics of narcotic control in the United States, 1914–1935. *Critical Criminology*, 18(1), 41–56. doi:10.1007/s10612-010-9098-4
- Glasner, S., Mooney, L. J., Ang, A., Garneau, H. C., Hartwell, E., Brecht, M.-L., & Rawson, R. A. (2017). Mindfulness-based relapse prevention for stimulant dependent adults: A pilot randomized clinical trial. *Mindfulness*, 8, 126–13. doi:10.1007/s12671-016-0586-9



- Gómez, L. E. (2010). Understanding law and race as mutually constitutive: An invitation to explore an emerging field. *Annual Review of Law and Social Science*, 6(1), 487–505. doi:10.1146/annurev.lawsocsci.093008.131508
- Gordon, M. S., Kinlock, T. W., Vocci, F. J., Fitzgerald, T. T., Memisoglu, A., & Silverman, B. (2015). A Phase 4, pilot, open-label study of VIVITROL (extended-release Naltrexone XR-NTX) for prisoners. *Journal of Substance Abuse Treatment*, 59, 52–58. doi:10.1016/j.jsat.2015.07.005
- Gostin, L. O. (2000). Public health law in a new century—Part I: Law as a tool to advance the community's health. *Journal of the American Medical Association*, 283(21), 2837–2841. doi:10.1001/jama.283.21.2837
- Griffith, D. M., Allen, J. O., & Gunter, K. (2011). Social and cultural factors influence African American men's medical help seeking. *Research on Social Work Practice*, 21(3), 337–347. doi:10.1177/1049731510388669
- Gryczynski, J., Schwartz, R. P., Salkever, D. S., Mitchell, S. G., & Jaffe, J. H. (2011). Patterns in admission delays to outpatient methadone treatment in the United States. *Journal of Substance Abuse Treatment*, 41, 431–439. doi:10.1016/j.jsat.2011.06.005
- Gunn, A. J., & Canada, K. E. (2015). Intra-group stigma: Examining peer relationships among women in recovery for addictions. *Drugs: Education, Prevention and Policy*, 22(3), 281–292. doi:10.3109/09687637.2015.1021241
- Gunn, A. J., Sacks, T. K., & Jemal, A. (2016). “That’s not me anymore”: Resistance strategies for managing intersectional stigmas for women with substance use and incarceration histories. *Qualitative Social Work*, 147332501668028. doi:10.1177/1473325016680282
- Han, S. (2015). *Letters of the law: Race and the fantasy of colorblindness in American law*. Stanford, CA: Stanford University Press.
- Hansen, H., & Roberts, S. K. (2012). Two tiers of biomedicalization: Methadone, buprenorphine, and the racial politics of addiction treatment. In J. Netherland (Ed.), *Critical Perspectives on Addiction* (Vol. 14, pp. 79–102). Bingley, UK: Emerald Group Publishing Limited.
- Harris, C. I. (1993). Whiteness as property. *Harvard Law Review*, 106(8), 1707–1791. doi:10.2307/1341787
- Heitzeg, N. A. (2015). “Whiteness,” criminality, and the double standards of deviance/social control. *Contemporary Justice Review*, 18(2), 197–214. doi:10.1080/10282580.2015.1025630
- Hickman, T. A. (2000). Drugs and race in American culture: Orientalism in the turn-of-the-century discourse of narcotic addiction. *American Studies*, 41(1), 71–91.
- Himmelstein, S. (2011). Meditation research: The state of the art in correctional settings. *International Journal of Offender Therapy & Comparative Criminology*, 55(4), 646–661. doi:10.1177/0306624x10364485
- Inciardi, J. A., Martin, S. S., & Butzin, C. A. (2004). Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison. *Crime and Delinquency*, 50(1), 88–107. doi:10.1177/0011128703258874
- Ingraham, N., Eliason, M. J., Garbers, S., Harbatkin, D., Minnis, A. M., McElroy, J. A., & Haynes, S. G. (2016). Effects of mindfulness interventions on health outcomes in older lesbian/bisexual women. *Women's Health Issues*, 26-S1, S53–S62. doi:10.1016/j.whi.2016.04.002
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012a). *Monitoring the future: National survey results on drug use, 1975–2011: Vol. 1. Secondary school students*. Ann Arbor, MI: Institute for Social Research, The University of Michigan.
- Johnston, L. D., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2012b). *Monitoring the future: National survey results on drug use, 1975–2011: Vol. 2. College students and adults ages 19–50*. Ann Arbor, MI: Institute for Social Research, The University of Michigan.

- Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice*, 10(2), 144–156. doi:10.1093/clipsy.bpg016
- Kabat-Zinn, J., Massion, A. O., Kristeller, J. K., Peterson, L. G., Fletcher, K. E., Pbert, L., ... Santorelli, S. F. (1992). Effectiveness of a meditation-based stress reduction program in the treatment of anxiety disorders. *American Journal of Psychiatry*, 149(7), 936–943.
- Kandall, S., & Chavkin, W. (1991). Illicit drugs in America: History, impact on women and infants, and treatment strategies for women. *Hastings Law Journal*, 43, 616–643.
- Kelly, A., & Garland, E. L. (2016). Trauma-Informed mindfulness-based stress reduction for female survivors of interpersonal violence: Results from a Stage I RCT. *Journal of Clinical Psychology*, 72(4), 311–328. doi:10.1002/jclp.22273
- Kelly, J. F., & White, W. L. (2014). Broadening the base of addiction mutual-help organizations. In J. D. Roth, W. L. White, & J. F. Kelly (Eds.), *Broadening the base of addiction mutual support groups: Bridging theory and science to contemporary trends* (pp. 4–24). New York, NY: Routledge.
- Kerrison, E. M. (2017). Exploring how prison-based drug rehabilitation programming shapes racial disparities in substance use disorder recovery. *Social Science & Medicine*. doi:10.1016/j.socscimed.2017.08.002
- Kerrison, E. M., Bachman, R., & Paternoster, R. (2016). The effects of age at prison release on women's desistance trajectories: A mixed-method analysis. *Journal of Developmental and Life-Course Criminology*, 2(3), 341–370. doi:10.1007/s40865-016-0039-0
- Kimble, J. (2007). Insuring inequality: The role of the federal housing administration in the urban ghettoization of African Americans. *Law and Social Inquiry*, 32(2), 399–434. doi:10.1111/j.1747-4465.2007.00064.x
- Kolb, L. (1939). The United States public health service narcotic hospitals. *American Journal of Medical Jurisprudence*, 2(2), 100–103.
- Kutateladze, B. L., & Andiloro, N. R. (2014). *Prosecution and racial justice in New York County*. New York, NY: Vera Institute of Justice.
- Lassiter, M. D. (2015). Pushers, victims, and the lost innocence of White suburbia: California's war on narcotics during the 1950s. *Journal of Urban History*, 41(5), 787–807. doi:10.1177/0096144215589945
- Lee, H., McCormick, T., Hicken, M. T., & Wildeman, C. (2015). Racial inequalities in connectedness to imprisoned individuals in the United States. *Du Bois Review: Social Science Research on Race*, 12(2), 269–282. doi:10.1017/s1742058x15000065
- Leonardo, Z. (2004). The color of supremacy: Beyond the discourse of “White privilege.” *Educational Philosophy & Theory*, 36(2), 137–152. doi:10.1111/j.1469-5812.2004.00057.x
- Leonardo, Z., & Manning, L. (2017). White historical activity theory: Toward a critical understanding of White zones of proximal development. *Race Ethnicity and Education*, 20(1), 15–29. doi:10.1080/13613324.2015.1100988
- Leverentz, A. (2011). Being a good daughter and sister: Families of origin in the reentry of African American female ex-prisoners. *Feminist Criminology*, 6(4), 239–267. doi:10.1177/1557085111414859
- Levin, F. R., Bisaga, A., Sullivan, M. A., Williams, A. R., & Cates-Wessel, K. (2016). A review of a national training initiative to increase provider use of MAT to address the opioid epidemic. *The American Journal on Addictions*, 25(8), 603–609. doi:10.1111/ajad.12454
- Levitsky, S. R. (2013). Integrating law and health policy. *Annual Review of Law and Social Science*, 9(1), 33–50. doi:10.1146/annurev-lawsocsci-102612-133949
- Lipsey, M. W., Landenberger, N. A., & Wilson, S. J. (2007). Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews*, 6, 1–27.

- Lyons, T., & Cantrell, W. D. (2016). Prison meditation movements and mass incarceration. *International Journal of Offender Therapy and Comparative Criminology*, 60(12), 1363–1375. doi:10.1177/0306624x15583807
- Malouf, E. T., Youman, K., Stuewig, J., Witt, E. A., & Tangney, J. P. (2017). A pilot RCT of a values-based mindfulness group intervention with jail inmates: Evidence for reduction in post-release risk behavior. *Mindfulness*, 8(3), 603–614.
- Manchikanti, L., Standiford Helm, I. I., Fellows, B., Janata, J. W., Pampati, V., Grider, J. S., & Boswell, M. V. (2012). Opioid epidemic in the United States. *Pain Physician*, 15, ES9–ES38.
- Martins, S. S., Kim, J. H., Chen, L.-Y., Levin, D., Keyes, K. M., Cerdá, M., & Storr, C. L. (2015). Nonmedical prescription drug use among US young adults by educational attainment. *Social Psychiatry and Psychiatric Epidemiology*, 50(5), 713–724.
- Matthew, D. B. (2015). *Just medicine: A cure for racial inequality in American healthcare*. New York: New York University Press.
- May, E. T. (1997). *Barren in the promised land: Childless Americans and the pursuit of happiness*. Cambridge, MA: Harvard University Press.
- McIntosh, P. (2015). Extending the knapsack: Using the White privilege analysis to examine conferred advantage and disadvantage. *Women & Therapy*, 38(3/4), 232–245. doi:10.1080/02703149.2015.1059195
- Melnick, G., Duncan, A., Thompson, A., Wexler, H. K., Chaple, M., & Cleland, C. M. (2011). Racial disparities in substance abuse treatment and the ecological fallacy. *Journal of Ethnicity in Substance Abuse*, 10(3), 226–245.
- Miller, R. J. (2014). Devolving the carceral state: Race, prisoner reentry, and the micro-politics of urban poverty management. *Punishment & Society*, 16(3), 305–335. doi:10.1177/1462474514527487
- Mitchell, S. G., Gryczynski, J., Kelly, S. M., O’Grady, K. E., Jaffe, J. H., Olsen, Y. K., & Schwartz, R. P. (2014). Treatment outcomes of African American buprenorphine patients by parole and probation status. *Journal of Drug Issues*, 44(1), 69–82. doi:10.1177/0022042613491106
- Musto, D. F. (1999). *The American disease: Origins of narcotic control (3rd Edition)*. New York, NY: Oxford University Press.
- National Commission for the Protection of Human Subjects of Biomedical, & Behavioral Research. (1978). *The Belmont report: Ethical principles for the protection of human subjects of research*. Washington, DC: National government publication.
- National Institute on Drug Abuse. (2017). *Overdose death rates*. Retrieved from <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>.
- Nestler, E. J. (2014). Epigenetic mechanisms of drug addiction. *Neuropharmacology*, 76, 259–268.
- Netherland, J., & Hansen, H. B. (2016). The war on drugs that wasn’t: Wasted Whiteness, “dirty doctors,” and race in media coverage of prescription opioid misuse. *Culture, Medicine, and Psychiatry*, 40(4), 664–686.
- Netherland, J., & Hansen, H. (2017). White opioids: Pharmaceutical race and the war on drugs that wasn’t. *BioSocieties*, 12(2), 217–238.
- Novick, D. M., Salsitz, E. A., Joseph, H., & Kreek, M. J. (2015). Methadone medical maintenance: An early 21st-century perspective. *Journal of Addictive Diseases*, 34(2–3), 226–237. doi:10.1080/10550887.2015.1059225
- Omori, M. (2017). Spatial dimensions of racial inequality: Neighborhood racial characteristics and drug sentencing. *Race and Justice*, 7(1), 35–58. doi:10.1177/2153368716648461
- Orme-Johnson, D. (2011). The use of meditation in corrections. *International Journal of Offender Therapy & Comparative Criminology*, 55(4), 662–664. doi:10.1177/0306624x10371803

- Owens, E., Kerrison, E. M., & Santos Da Silveira, B. (2017). *Examining racial disparities in criminal case outcomes among indigent defendants in San Francisco*. Philadelphia, PA: Quattrone Center for the Fair Administration of Justice, University of Pennsylvania Law School.
- Painter, N. I. (2010). *The history of White people*. New York, NY: W. W. Norton.
- Parsons, T. (1951). Illness and the role of the physician: A sociological perspective. *American Journal of Orthopsychiatry*, 21(3), 452–460.
- Paternoster, R., Bachman, R., Kerrison, E., O'Connell, D., & Smith, L. (2016). Desistance from crime and identity: An empirical test with survival time. *Criminal Justice and Behavior*, 43(9), 1204–1224. doi:10.1177/0093854816651905
- Perelman, A. M., Miller, S. L., Clements, C. B., Rodriguez, A., Allen, K., & Cavanaugh, R. (2012). Meditation in a deep south prison: A longitudinal study of the effects of Vipassana. *Journal of Offender Rehabilitation*, 51(3), 176–198. doi:10.1080/10509674.2011.632814
- Peterson, J. A., Schwartz, R. P., Mitchell, S. G., Reisinger, H. S., Kelly, S. M., O'Grady, K. E., ... Agar, M. H. (2010). Why don't out-of-treatment individuals enter methadone treatment programmes? *International Journal of Drug Policy*, 21(1), 36–42. doi:10.1016/j.drugpo.2008.07.004
- Phelan, J. C., & Link, B. G. (2015). Is racism a fundamental cause of inequalities in health? *Annual Review of Sociology*, 41(1), 311–330. doi:10.1146/annurev-soc-073014-112305
- Piquero, A. R., Jennings, W. G., Piquero, N. L., & Schubert, C. A. (2014). Human but not social capital is better able to distinguish between offending trajectories in a sample of serious adolescent Hispanic offenders. *Journal of Criminal Justice*, 42(4), 366–373. doi:10.1016/j.jcrimjus.2014.05.002
- Prins, S. J., Osher, F. C., Steadman, H. J., Robbins, P. C., & Case, B. (2012). Exploring racial disparities in the brief jail mental health screen. *Criminal Justice and Behavior*, 39(5), 635–645. doi:10.1177/0093854811435776
- Provine, D. M. (2007). *Unequal under law: Race in the war on drugs*. Chicago, IL: Chicago University Press.
- Redner-Vera, E., & Galeste, M.-A. (2015). Attitudes and marginalization: Examining American Indian perceptions of law enforcement among adolescents. *Journal of Ethnicity in Criminal Justice*, 13(4), 283–308. doi:10.1080/15377938.2014.984043
- Ropelewski, L. R., Mancha, B. E., Hulbert, A., Rudolph, A. E., & Martins, S. S. (2011). Correlates of risky injection practices among past-year injection drug users among the US general population. *Drug and Alcohol Dependence*, 116(1–3), 64–71. doi:10.1016/j.drugalcdep.2010.11.025
- Sampson, R., & Laub, J. (1993). *Crime in the making: Pathways and turning points through life*. Cambridge, MA: Harvard University Press.
- Sanchez, G. R., & Vargas, E. D. (2016). Language bias and self-rated health status among the Latino population: Evidence of the influence of translation in a wording experiment. *Quality of Life Research*, 25(5), 1131–1136. doi:10.1007/s11136-015-1147-8
- Sanders, M., & Powell, J. (2012). Multiple pathways of recovery for African American men. *Alcoholism Treatment Quarterly*, 30(3), 315–325. doi:10.1080/07347324.2012.690697
- Saperstein, A., Penner, A. M., & Light, R. (2013). Racial formation in perspective: Connecting individuals, institutions, and power relations. *Annual Review of Sociology*, 39(1), 359–378. doi:10.1146/annurev-soc-071312-145639
- Schneider, D. (2015). The great recession, fertility, and uncertainty: Evidence from the United States. *Journal of Marriage and Family*, 77(5), 1144–1156. doi:10.1111/jomf.12212
- Seelman, K. L., Adams, M. A., & Poteat, T. (2016). Interventions for healthy aging among mature Black lesbians: Recommendations gathered through community-based research. *Journal of Women & Aging*, 1–13. doi:10.1080/08952841.2016.1256733

- Sewell, A. A. (2015). Disaggregating ethnoracial disparities in physician trust. *Social Science Research, 54*, 1–20.
- Sewell, A. A. (2016). The racism-race reification process: A mesolevel political economic framework for understanding racial health disparities. *Sociology of Race and Ethnicity, 2*(4), 402–432. doi:10.1177/2332649215626936
- Sewell, A. A., Jefferson, K. A., & Lee, H. (2016). Living under surveillance: Gender, psychological distress, and stop-question-and-frisk policing in New York City. *Social Science & Medicine, 159*, 1–13. doi:10.1016/j.socscimed.2016.04.024
- Shavers, V. L., Klein, W. M. P., & Fagan, P. (2012). Research on race/ethnicity and health care discrimination: Where we are and where we need to go. *American Journal of Public Health, 102*(5), 930–932. doi:10.2105/ajph.2012.300708
- Smith, S. S. (2010). Race and trust. *Annual Review of Sociology, 36*(1), 453–475. doi:10.1146/annurev.soc.012809.102526
- Suarez, A., Lee, D. Y., Rowe, C., Gomez, A. A., Murowchick, E., & Linn, P. L. (2014). Freedom project: Nonviolent communication and mindfulness training in prison. *SAGE Open, 4*(1), 215824401351615. doi:10.1177/2158244013516154
- Thompson, M., Newell, S., & Carlson, M. J. (2016). Race and access to mental health and substance abuse treatment in the criminal justice system. *Journal of Offender Rehabilitation, 55*(2), 69–94. doi:10.1080/10509674.2015.1112867
- Vallejo, Z., & Amaro, H. (2009). Adaptation of mindfulness-based stress reduction program for addiction relapse prevention. *Humanistic Psychologist, 37*(2), 192–206. doi:10.1080/08873260902892287
- Vanderplasschen, W., Colpaert, K., Autrique, M., Rapp, R. C., Pearce, S., Broekaert, E., & Vandavelde, S. (2013). Therapeutic communities for addictions: A review of their effectiveness from a recovery-oriented perspective. *The Scientific World Journal, 2013*, 1–22. doi:10.1155/2013/427817
- Vogel, V. H. (1948). Treatment of the narcotic addict by the U.S. public health service. *Federal Probation, 12*, 45–50.
- Volkow, N. D., Frieden, T. R., Hyde, P. S., & Cha, S. S. (2014). Medication-assisted therapies: Tackling the opioid-overdose epidemic. *New England Journal of Medicine, 370*(22), 2063–2066. doi:10.1056/nejmp1402780
- Welty, L. J., Harrison, A. J., Abram, K. M., Olson, N. D., Aaby, D. A., McCoy, K. P., ... Teplin, L. A. (2016). Health disparities in drug- and alcohol-use disorders: A 12-year longitudinal study of youths after detention. *American Journal of Public Health, 106*(5), 872–880. doi:10.2105/ajph.2015.303032
- White, W., Budnick, C., & Pickard, B. (2013). Narcotics Anonymous comes of age: A 60th anniversary Professional tribute. *Counselor, 14*(50), 54–57.
- Williams, A. R., & Bisaga, A. (2016). From AIDS to opioids: How to combat an epidemic. *New England Journal of Medicine, 375*(9), 813–815. doi:10.1056/nejmp1604223
- Yosso, T. J. (2005). Whose culture has capital? A critical race theory discussion of community cultural wealth. *Race, Ethnicity, and Education, 8*(1), 69–91. doi:10.1080/1361332052000341006
- Zuberi, T., & Bonilla-Silva, E. (2008). *White logic, White methods: Racism and methodology*. New York, NY: Rowman & Littlefield Publishers.