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Exploring how prison-based drug rehabilitation programming shapes racial disparities in substance use disorder recovery

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ABSTRACT

Prison-based therapeutic community (TC) programming is derived from the perspective that drug addiction is primarily symptomatic of cognitive dysfunction, poor emotional management, and under-developed self-reliance skills, and can be addressed in a collaborative space where a strong ideological commitment to moral reform and personal responsibility is required of its members. In this space, *evidence* of rehabilitation is largely centered on the client's relationship to language and the public adoption of a "broken self" narrative. Failure to master these linguistic performances can result in the denial of material and symbolic resources, thus participants learn how to use TC language to present themselves in ways that support existing institutionalized hierarchies, even if that surrender spells their self-denigration. This research examines the interview narratives of 300 former prisoners who participated in a minimum of 12 months of prison-based TC programming, and described how programming rhetoric impacted their substance abuse treatment experiences. While many of the respondents described distressing experiences as TC participants, White respondents were more likely to eventually embrace the "addict" label and speak of privileges and reintegrative support subsequently received. Black respondents were more likely to defy the treatment rhetoric, and either fail to complete the program or simulate a deficit-based self-narrative without investing in the content of those stories. The following explores the significance of language and identity construction in these carceral spaces, and how treatment providers as well as agency agendas are implicated in the reproduction of racial disparities in substance abuse recovery.

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1. Introduction

The US criminal legal system has emerged as one of the largest dedicated providers of substance use disorder (SUD) treatment for American citizens (Tiger, 2011; Wolff et al., 2013), which may prove problematic for several reasons. First, one of the dominant SUD treatment models adopted in prison sites is a mutated form of the therapeutic community (TC) treatment modality, which is based on the premise that drug addiction is primarily symptomatic of individual-level cognitive dysfunction, poor emotional management, and underdeveloped self-reliance skills. Second, the emphasis placed on personal responsibility, over a recognition that sociostructural factors serve as predictors and perpetuators of SUD trajectories, creates a treatment mismatch for historically disadvantaged participants. This is important because much of the incarcerated population in the US is navigating an acutely

marginalized social status (Binswanger et al., 2011; Potter, 2015). These individuals occupy an intersectionally marginal status, which Collins (2015, p. 2) defines as a state in which "class, gender, sexuality, ethnicity, nation, ability, and age operate not as unitary, mutually exclusive entities, but rather as reciprocally constructing phenomena" that when negatively compounded, produce exponential disadvantage. As such, the prison-based TC may not be the most appropriate for this multiply-disadvantaged population if it serves to reinforce stigmatized norms, including the social weight of the "addict" label. Third, 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 (De Leon et al., 1993; Melnick et al., 2011), the gulf between prison-based TC operational mechanisms and the needs and post-release outcomes of non-White, non-male TC participants have not yet been empirically addressed. Consequently, this form of TC may actually mediate or even exacerbate racial inequalities in SUD recovery, particularly due to racial

differences in social norms and mores surrounding substance abuse, the cultivation of recovery tools that are validated by the mainstream, and one's willingness to comply with institutional mandates that impose what might be perceived as misplaced personal blame. This study will explore the extent to which differences emerge between Black and White former TC participants' adoption of what might emerge as racialized treatment, sobriety, and identity narratives.

2. What does prison-based therapeutic community treatment look like?

Within the US, the criminal legal system has endorsed a three-stage therapeutic community intervention designed to suit clients' shifting correctional supervision status: intensive, communal supervision while incarcerated; transitional work-release where clients obtain employment in the free community but return to the residential *family setting* to spend nonworking hours in prison or a community correctional facility; and aftercare while under parole or probationary supervision. This study will focus primarily on experiences unfolding during the initial prison-based clinical design aimed at exposing incarcerated individuals to "recovering addict" role models, prosocial values, and initiating a process of understanding the addiction cycle.

In order to facilitate rehabilitation, prison-based TC serves as a total treatment environment where for a minimum of generally 12 months "residents" are housed separately from the rest of the incarcerated population, disruption, and access to contraband, that is characteristic of prison life. Within this community, activities are shaped by a hybrid "community as method" orientation that blends tenets of personal responsibility, public support, accountability, and reintegration (De Leon, 1997; Stevens, 2013). The principal goal around which prison-based TC programming is designed, is to provide an inclusive and protected space where substance abusing inmates can identify the triggers that lead to substance abuse and antisocial behavior, and provide mutual help in putting an end to the destructive behaviors that manifest as a result of those flawed reasoning processes (Linley et al., 2010). Inciardi et al. (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" (p. 90, emphasis is original). In essence, TC programming, they argue, is oriented around accountability and responsibility for one's self, and participants are subjected to increased surveillance, accountability, and public confrontation by TC personnel and fellow participants, in order to address those individual flaws. For example, incarcerated TC members must participate in "encounter groups," or compulsory biweekly or triweekly group-based meetings marked by "push-ups" or affirmations for behavior that exemplifies TC norms, as well as the harsh public shaming of community members who are accused of maladaptive conduct deemed inconsistent with TC norms (Broekaert et al., 2004; Warren et al., 2013a,b). 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 individual choices and negative behaviors have netted them the life circumstances that produced a host of harmful consequences. 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 in recovery themselves (De Leon, 2000).

Importantly, prison-based TC participant adherence and success is measured by the extent to which community members 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. Though consistent with a typical degradation ceremony imposed upon those subjected to criminal justice supervision (Gustafson, 2013), this requirement might be illogical for structurally disadvantaged inmates whose individual "failings" are really permutations of the social contexts that they have learned to survive. For intersectionally-marginalized substance abusers of Color participating in prison-based TC programming, there is scant acknowledgement of the concentrated poverty and intergenerational trauma that play a nontrivial role in the cultivation of illicit substance use habits (Nikulina and Widom, 2014; Stevens-Watkins et al., 2012).

These requirements of deference and defeat can appear dangerous to subjects navigating intersectional disadvantage, as studies demonstrate that resistance to peer-based SUD interventions are sometimes derived from a panic about how to reconcile persistent stigma and isolation (Gunn and Canada, 2015; McCorkel, 2013; Woods and Joseph, 2015) and the negative consequences associated with being subsequently deemed noncompliant (Comfort et al., 2015). Additional research suggests that White SUD treatment patients, however, are encouraged to align themselves with the goals of an intervention that emphasizes the root cause of addiction as individualized, but in a *medicalized* fashion. Findings suggest that adopting what Parsons (1951) identified as the "sick role", allows White SUD treatment clients to enjoy the rights and pardons that accompany that status (Kerrison, 2015; Netherland and Hansen, 2016, 2017). For instance, Parsons (1951, 1975) contended that the rights of a sick person include exemption from normal social roles as well as a lack of personal responsibility for their condition. In addition, the obligations of a sick person include the responsibility to try to get well and to make a concerted effort to seek technically competent help. It could be the case that although White SUD treatment clients relinquish some autonomy in adopting the "addict" identity, that could be precisely the title that an otherwise disenfranchised White drug user could take advantage of in ways that further marginalizes disenfranchised drug users of Color. This illness related status could confer a new protective title that allows its bearer to eschew culpability and receive more inclusive, less inherently blame-laden care. "Strong-arm rehab" (Gowan and Whetstone, 2012) on the other hand – or state-mandated rehabilitation marked by long residential stays, ubiquitous surveillance, and intense character reform – might be reserved for poor SUD patients of Color, instead, and could stand to "amplify [y] the taint of addiction into a new biologization of poverty and race" (p. 69).

Whether these disparities exist in SUD treatment outcomes for incarcerated individuals, however, remains unknown. This study seeks to fill that gap in the discourse by exploring how former Black and White prison-based TC clients describe the program's aims, the ways in which they navigated the treatment mechanisms and mandates of "addict" identity construction, and how they felt the program shaped their subsequent treatment, sobriety, and recovery outcomes.

3. Methods

3.1. Sample

This study is based on data collected from 304 in-depth interviews with a contemporary mixed race, mixed gender cohort of approximately 1250 drug-involved former prisoners (Bachman et al., 2013). Respondents were randomly selected from the larger

multi-phase longitudinal study, which included an analysis of official arrest and incarceration patterns for the cohort, over a 30-year observation period. All study participants were released from several state prisons in Delaware between 1990 and 1996 and four waves of extensive survey data were collected, including basic demographics, offending and drug use history, substance abuse treatment history, housing arrangements, sexual behavior, physical and mental health indicators, and various attitudinal measures.

3.2. Interview methods

The current qualitative study findings are derived from a stratified random sample of 304 men and women who were selected for intensive face-to-face follow-up interviews in 2010 and 2011 (for a full discussion of the procedures used to locate respondents, and analyze the narratives, see: Bachman et al., 2016; Kerrison et al., 2016). The purpose of these interviews was to illuminate the mechanisms for change in offending and substance use over time, and to allow respondents to speak directly for themselves about what changes they had undergone over the years since their initial participation in the larger study which began in the 1990s, including the factors that both facilitated and inhibited offending. All respondents had participated in TC programming prior to the prison release that marked their initial participation in the larger study. Each respondent was asked to share their experiences as a participant in that programming, as well as how participating in TC programming shaped their perceptions of SUD recovery.

All interviews that took place at the university office site lasted from 1 to 3 h and were digitally tape-recorded. Informed consent statements were read and signed at each interview, and respondents were compensated $100 for their time and travel expenses. Not surprisingly, sample attrition was an unavoidable problem when attempting to contact study participants years after their last survey. Approximately 11% of the original cohort was deceased, 13% were still incarcerated, 3% were found to be living out of state, and 7% were unreachable by any means. Of the 304 respondents interviewed, the majority was Black (61%), and the mean age was 45 years at the time of the interview. The response rate for those who were successfully contacted and living in Delaware was approximately 96 percent. All qualitative data collection protocols were formally approved by the Institutional Review Board at the University of Delaware.

3.3. Analytic strategy

All interviews were transcribed verbatim and imported into the NVivo software platform for coding. The analytical process of coding involved a number sequential stages that identified ideas and themes as opposed to counts of explicit words or phrases (Namey et al., 2008; Sandelowski et al., 2009). That said, this study provides readers with some enumerative guidance on participant response frequencies, where "few" indicates less than five individuals, "many" indicates greater than twenty individuals, and "most" represents the majority, or greater than 51 percent of those who offered relevant insights. The coding process began with a list of initial categories derived from the existing SUD treatment literature and included such key indicators as relapse, social support, triggers, and program adherence. To facilitate future analyses, all emergent themes were coded, which resulted in more than 20 main categories (e.g., discontent, turning points, incarceration) and more than 100 subcategories used in the coding scheme. Coding theoretically and empirically substantive domains helped to organize the transcripts into meaningful segments, but ultimately all analytical conclusions were based on a holistic reading of the interviews in their entirety, looking for trends in those interviews

that captured how varied elements of treatment programming participation impacted participants across the racial groups. The coding team was comprised of the Principal Investigator of the parent study, two research assistants, and myself (a Co-Investigator of the study). Through eight weekly reliability meetings where members had each coded the same interviews, the team established intercoder reliability ratings that were acceptable (kappa coefficients were generally 0.70 or higher).

4. Findings

Respondent narratives uncovered two principal, racially disparate perceptions of the appropriateness of this prison-based TC approach, and the challenges that the structure and rhetoric used within the program imposed upon prosocial identity construction and SUD recovery. First, while what the program required for determining whether someone was ready to graduate was understood by most, Black respondents were less likely to buy into the program's aims for reasons that they attributed to poor, culturally mismatched design. As a result, most Black respondents did not feel that they could meet the criteria for prison-based TC-defined recovery, and were more likely to distance themselves from SUD treatment altogether. Second, more than their White counterparts, Black respondents expressed feeling not only ill-prepared for reentry and reintegration upon leaving the prisons' TCs, but that the failures were intentional on the part of carceral stakeholders, and that there was no real institutional commitment to their recovery and long-term health. Narratives detailing these experiences are offered below.

4.1. Organizational culture and interpersonal exchanges that further isolate black clients

As is discussed earlier, the hallmark of the ongoing prison-based therapeutic community treatment unfolds in a group-based setting with a counselor and approximately ten to fifteen incarcerated participants. Respondents detailed how encounter groups featured a highly confrontational interaction between group therapy participants, where one patient situated in the center of an enclosed group circle, was verbally abused and humiliated by the surrounding group members. Participants rotated through this ritual until it was decided that they had sufficiently capitulated and publicly recognized that they were in fact broken and needed to be "stripped" before reconstruction could take hold. These sessions were troubling for many respondents across age, race, gender, and criminal history characteristics. Karen, for example, was thrilled to take on a prison job assignment that conflicted with the scheduled encounter group sessions. When asked why she preferred the work assignment to TC participation, she answered:

> I loved it! It would get me out of EG {encounter group} nights, and EG is when everybody is sittin' around in a circle, you sit right in the middle of that circle, and when they call your name you would turn around to 'em and they just blow you right out … Anything that they wanted to say, cuss at you, and all you do is sit up in there and you don't do nothing … When I got that job, I wasn't in that EG thing no more, and I'd be so glad that I didn't go up getting cussed out, called all kinds of names, 'cause I could feel something in me wantin' to jump … It was just time for me to leave from the program … I ended up losing weight in there. I had lost 19 pounds, got down to a {size} 9, came home and ain't nobody know who I was.

Karen went on to talk at length about how both the trauma that she faced while confined to the "hot seat" during encounter group

sessions, and the experience of bearing witness to others' degradation ceremonies affected her appetite, sleep, blood pressure, and tendency to exhibit paranoiac behaviors. For an exercise that was ostensibly designed to stimulate healing, Karen and other participants suggested that these practices affected noticeable health declines.

Not only did Black clients report frustration with the rhetoric and its delivery in the prisons' encounter groups, but the counselors leading the program also aggravated them. Rather than operating as positive, nurturing role models, Black respondents instead reported that many of the counselors were Black and former prisoners themselves, and were perceived as particularly accusatory and demanding that Black participants admit to their inferiority. Jonathan, for example, recalled confronting his EG counselor, reminding him, "You're no better than me or any of the rest of us. I know you. I know where you come from. I know what you are." More than their White counterparts, Black respondents also shared that they suspected that these counselors with their own unresolved identity matters, clung desperately to a constructed collective victimhood requiring that all Black "addicts" admit to harboring a shared pathos that was widespread, rather than a feature of their own individual shortcomings.

At the time of the interview, Jason was a 42 year old Black man who revealed not only that the TC program was prematurely and hastily implemented, but that the counselors were poorly trained and encouraged by prison administration and program leadership to denigrate drug-involved inmates during EG sessions, particularly those who were especially resistant. As both a TC alumni and former prison-based TC counselor, he shared:

> Well, looking back on it, I think they was kinda trying to get the program started and then expanded into different areas of the system … I think the best way they {prison administration} could deal with being granted permission to start that process was to take the path of least resistance as far as getting us guys out to help … because I don't really think I was in the Key [prison-based TC programming] 6 months before they paroled me to the Work Release thing just to help build the Crest [community-based aftercare TC/work-release hybrid]. And, it was guys that had already been in the Key from July '88 and there it was '90 and they was still getting smacked down {insufficiently "healed" and still subjected to EG degradation}! And, they was still dealing with issues, you nah'mean? And, I really didn't really get an opportunity to deal with no core issues, you nah'mean? And, that's the stuff that keeps people sick and suffering, you nah'mean? Everybody was learning how to identify with and deal with issues … but they was trying to get us to get other people to do it before we did it ourselves.

In contrast, many White respondents cited the value of the "tough love" exhibited by TC staff and that the severity of the program tone was what steered them toward meaningful self-reflection and recovery. When Monica, for example, was struggling to understand the purpose of the encounter group's denigration practices, she reached out to her counselor who she credits with guiding her to a "rebirth":

> I told them I didn't really know the deal. I mean I knew the drug concept but I told them I really needed to get deeper. He {Monica's counselor} was like, "you just come in here and tell me." I mean me and my counselor became real close, you know what I mean? And I started talking to him about everything, everything that was going on. There was so much release and letting go. I never did that before.

Aside from any critique offered here about the quality of the help she received, what is notable here is that White clients like Monica, more than her Black counterparts, were reportedly able to find mentorship and guidance from counselors who they could relate to, and in whom they felt safe confiding. The majority of Black clients seldom reported being afforded a space in which they could enjoy that measure of safety, and for some, consequently altogether avoided cultivating meaningful relationships with counselors who were suspected of working to undermine their recovery. Linda, a 41 year old Black woman, expressed a deep desire to develop that trust, but ultimately shared that her effort to cultivate a personal connection with others in the TC program, proved unsuccessful:

> Interviewer: What about recovery don't you like, or don't you think is useful?
>
> Linda: I love it now.
>
> Interviewer: You say you love it, but you say you couldn't find your place [before]. What was problematic about it?
>
> Linda: For me, the main part of recovery is having connections with people. But there I had a problem with it … this is my business and they don't understand, you know? Where really, they probably do, of course they do, but there's a lot of messed up people {TC alumni} out there. I always felt isolated and scared.

Despite a desire to experience the unburdening and self-reflection that Monica enjoyed, Linda believed that the risks associated with opening up were too great — both derived perhaps from stereotype threat or admitting to Black failure, and opening up to counselors who themselves had not found peace — and so she kept to herself and did not experience the mutual support and catharsis that she sought.

Of course, there were also many White respondents who shared that the program was problematic, that they did not buy into the rhetoric, the collective surveillance, or the confrontational delivery practices, and that they said what they believed counselors wanted to hear so that they could move on and get out. Due to her discomfort with the group-based setting where it was required that participants make themselves vulnerable, Stacy very plainly admitted to her inauthentic surrender:

> [In] the group settings I felt very uncomfortable and I felt like they would take it and tell somebody that told somebody … and I'm thinking, "Damn, I'm in a group, a room with addicts and inmates and you want me to reveal my deep dark secrets?" Not me. So, I did the program and I told them what I thought they wanted to hear but I would never get truly deep down.

Upon release from prison, however, Stacy did not completely abandon SUD treatment as many of her Black counterparts who "faked it" did. Instead, she recognized that the prison-based TC setting was problematic for her, so she immediately secured regular community-based care from a family therapist, the expenses of which were covered through her husband's health insurance benefits. Black clients who "faked it" like Dianne, for example, left the carceral setting so put off by the idea of treatment personnel and the language that they used, that they failed to see the value in exploring an alternative setting or modality altogether, particularly if doing so would present another economic hardship for them. When asked about the likelihood that she would participate in other outpatient programs, repulsed by the idea Dianne exclaimed, "You've seen one, you've seen them all, and I don't have time for the

lies, the bullying, or the nonsense." Dianne also "faked it" through the program and graduated, but she never sought SUD treatment again.

To be clear, there were a few Black TC participants who did embrace the program rhetoric and shared that their ability to build and access a coping toolkit that was cultivated while in TC treatment was instrumental to their long-term recovery. Brenda, for instance, admitted that she initially resisted the TC curriculum, but later accepted that her former identity was inherently damaged and in need of rebuilding. She shared:

> Let me tell you, it didn't help then. But all you have to do is take the information that they gave back then … if you just use the information, just use it … the program is just for that. The program will tell you how to be yourself, tell you how to be, what to do. We just gotta use the tools.

Brenda credits her recovery successes to teachings and methods that she picked up while in prison-based TC. However, Brenda was a middle-class, socially and economically established Black woman, which was an exception rather than the norm for this sample. She was convicted of a drug possession charge that was deemed a felony because she was arrested in a school district. Respondents who were more deeply entrenched in criminal lifestyles, with fewer retrievable strands of social capital at their disposal, were less likely to embrace a method that reduced them to even less than what they could already barely claim. For the majority of Black TC participants interviewed, the absence of patient-centered, patient-inclusive treatment that prioritizes patient needs and values was sorely felt.

4.2. Structural racism, the exacerbation of mismatched treatment programming, and the subsequent development of coping strategies

Most of the Black treatment clients interviewed shared that following their release from prison, they resided in isolated, economically unstable deindustrialized regions, and lacked access to empowering healthcare resources. White treatment participants wrestling with the grips of poverty, still tended to be less geographically removed from structural resources and pockets of social capital, than Black study participants. For example, many Black respondents bemoaned the reporting requirements of post-prison release TC programming. The critique reflected an exhaustion by the volume of time and travel devoted to fulfilling those mandates. Several described public transportation routes from their homes to the reporting center, that elapsed an excess of two or more hours and interrupted the work day. Brandon described how difficult it was to juggle the demands of simultaneously reporting to TC aftercare personnel and rebuilding his life and employment record:

> They overwhelmed me, man. Just ridiculousness. They put too much stuff on me at one time. You got a lot going on, you know? You got a lot of making up to do, you got all these appointments and you got to take off work, and lose hours from work. You got a lot of stuff going on. You can't be two places at once, man.

Post-prison TC compliance requires intensive and multiple treatment episodes as well as strong personal and community resources to support that commitment. These appeared to be untenable treatment contingencies for many of the disenfranchised Black clients expected to thrive in this program.

In addition to the demands of community-based reporting requirements, many Black respondents expressed a desire to get out

from under the state's gaze as soon as administratively possible. Continued participation in the TC aftercare program meant extended exposure to the Department of Corrections system. The appeal of prolonging one's treatment participation tenure for the sake of earning a certificate of rehabilitation that could be proudly displayed to prospective employers and landlords, did not possess the same luster that was reportedly enjoyed by White TC graduates. For White graduates the certificate served as a badge. For Black graduates who challenged the milestone's appeal, the certificate lingered as a foul stain and proof of their diseased persona that could resurface at any time. Jeffrey, for example, was a White attorney who was disbarred as a result of alcoholism related misconduct, but made sure to accumulate as many rehabilitation certificates as he could to demonstrate a good faith effort of "getting clean." He called himself "an expert on therapeutic communities" who had mastered TC language, and he admitted to producing whatever empty narratives were needed for him to be awarded a certificate of program completion that he could then take to law firms that were willing to hire him. Jeffrey's description was as follows:

> The bar association sent me to a rehab … and I didn't take it very serious at all — in fact, the opposite. I took it as a joke. I really only went because I thought it would get me out of trouble. So, I immediately went out and drank within 5 minutes of getting released from the rehab … I'm like an expert on the therapeutic communities … I did the Key because I'm just a manipulator and I have abilities to be able to manipulate and so I was able to manipulate my way through the Key program twice and get out in 6 months, which is the minimum. Went in a third time and pulled a rabbit out of my hat and got out of that early, so those programs did not work for me. I get what I need and then get out of dodge.

Experiences like Jeffrey's underscore the benefits of White privilege and class privilege. In an era of increased employer liability, however, Black jobseekers are hesitant to disclose any documentation that confirms the stereotype that they believe employers are already harboring. Black respondents in this sample were also less likely to report even participating in a highly-skilled, service labor market in which they believed that employers were more likely to look past candidates' criminal records.

Desperate from the unending search for viable employment, Corrine, a 47 year old Black woman, lied about her criminal background to secure the only work that prison vocational programming had prepared her for — healthcare provision. She had also completed the Crest program but knew better than to flaunt those credentials during her job search:

> We actually had to go out and apply ourselves for job-seeking. I went up there and I had taken a course while I was in prison for CNA [Certified Nursing Assistant Certification]. So, I had my CNA license, so that made me available to them … I got a license in cardiovascular technician. They never knew. You just write it on the paper [referring to application responses about prior felony convictions] … I mean, in your life you might be doing right, but you still tell some lies along the way to get what you want, for real for real. People don't know that, but we do.

For many Black job candidates in this sample, it was believed that revealing one's addiction spelled the relinquishment of their already meager protections against the abuse of implicit and explicit employer bias. Frustrated by the damage that her certificate of rehabilitation would have caused, Corrine very plainly stated,

"those letters ain't meant for us" and thought it best not to share her recovery efforts with prospective employers who she believed would use those credentials against her.

Finally, these narratives reveal serious implications for Black former prisoners' faith in state-run institutions. The mandated participation criteria of carceral drug treatment programming, they argued, only aggravated their isolation and exacerbated their (re) integration efforts. Lenore was drug-addicted, homeless, and regularly victimized by a long-term romantic partner. She vehemently lambasted the role that the state had played in her reentry failures, and identified how state welfare retrenchment had left her even more vulnerable and likely to break the law. Before the conclusion of her interview she offered this plea to policymakers:

> If this is the end of my tape [the mp3 recording] I want y'all to know that y'all really need to talk to the people in the hierarchy 'cause I don't know why when we get out of jail we will be forced back to a life of crime. Because no matter where we go to try to apply for a job they want to do background check and once they run your background check you can't even get a job. What am I supposed to do?! If I can't get a job how am I supposed to eat?! And then they got so strict that welfare even saying you got a drug conviction so no food stamps and no Medicaid. How do y'all do that? Cause I'm telling you, the system ain't never did nothing for me. Nothing. All these stupid group classes and sessions, being in prison all these years didn't teach me anything.

Additional examples of diminished faith in state institutions and their stake in meaningful (re)integration were captured in testimony like Ronald's. Ronald, a 42 year old Black man, noted that he believed that these institutional failures were intentional. In line with Jason's account of the hasty implementation of Crest programming, Ronald offered that he and other Black peers believed that the prison-based TC program was never designed to help Black people. Rather, he argued that it was installed to ensure Black degeneration:

> I think it was about a particular segment of the government, right, the Department of Corrections, that really didn't want to see our particular population succeed. Even though you might have some people in position that are doing the right thing, they really don't know what's going on behind closed doors … So, you know, it was like nobody wanted the place to succeed … It was like this is maybe like what they want us to be. Useless. Sometimes you get to the point of thinking you an addict! I know me, when I go zero to state in my thought process [meaningfully adopting the deficit rhetoric], I'm done.

The extent to which other Black respondents agree with Ronald was not explicitly measured in this study. However, when operations in "correctional" spaces that are designed to ready clients for the world outside, mimic the very institutional strains that contributed to their landing inside those walls, arguments like Ronald's may appear more often than not.

5. Discussion

It is often the case that studies focusing on SUD treatment outcomes focus on individual characteristics instead of the contexts and institutional conditions that impose a substantial influence on recovery outcome trends (Grella et al., 2007). In examining experiences unfolding in a hostile carceral setting, however, it is important that researchers explore the environment and how its occupants navigate the mandates of that space. While this study includes an analysis of how self-identified Black and White men and women describe the prison-based TC program experience, it also interrogates how cultural racism (or the implicit routinization and normalization of values held by the dominant race) intersects with what Finney et al. (2011) identify as the mismatch between institutional recovery process and adherence metrics. Specifically, the mastery of both "sick talk" language and performance in this setting, and the benefits gleaned from efforts toward that mastery, appear to be unequally distributed across racial groups.

The narratives reveal that both Black and White study respondents were often uncomfortable with the programing rhetoric used in these particular TC sites. However, those who resisted the adoption of self-denigrating language were more often Black, and those rejections extended to collective animus toward treatment outlets beyond the prison-based TC walls. These findings cannot offer a counterfactual suggestion that if Black participants aligned themselves with TC sober scripts, they would enjoy the benefits of the "sick role" and disability status with which White participants were reportedly more familiar. In fact, if the history of racialized, state-sanctioned medical injury in the United States provides any indication of what could potentially unfold (Pryma, 2017; Washington, 2006), it is unlikely that Black TC graduates would enjoy the same benefits as those gleaned by their Whites counterparts. What is important to underscore here, however, is that Black respondents shared that TC participation was profoundly destabilizing, so much so that Danny, a two-time Black TC participant, declared that he "wouldn't wish this on his worst enemy."

Drug rehabilitation clients are often characterized as pathologically inferior and dependent (Kimberly and McLellan, 2006), which situates them in a particularly undesirable position during a sociohistorical moment of welfare retrenchment, neoliberalism, and self-sufficiency. In addition to navigating the burdens of an economically constrained context, racially minoritized drug users must also reconcile the added stigma associated with addiction and how that "illness" label is compounded with assignments of merit and personal responsibility (Gunn and Canada, 2015). White respondents were more likely to eventually accept the "addict" label and speak of privileges and access to recovery aid received as a result of embracing that label. Black respondents were more likely to defy the treatment rhetoric, and either fail to complete the program or fake a "diseased" self-narrative without investing in the content of those stories or fully addressing the criminogenic effects of their substance use habits. These narratives illustrate the operational schema implicated in the reproduction of racial disparities in prison-based SUD recovery experiences, and explore how and why Black participants challenged that framework.

6. Conclusions and policy implications

As the pursuit of SUD recovery is largely socially negotiated (Bachman et al., 2016; Best et al., 2016), there are evidence-based interventions that assist SUD patients in identity and social network construction that support the recovery process. As is noted earlier, there is considerable evidence that drug use and socially constructed "addiction" habits are heavily stigmatized across racial groups. However, because stigma in health and healthcare is a multi-faceted phenomenon (Clair et al., 2016; Pescosolido and Martin, 2015), this study highlights how Black "addicts" frequently believe themselves to be more severely impacted, and as a result, must negotiate their outward recovery performances in ways that their White counterparts are less likely to have to navigate. Black inmates may (or may not) comply with the TC programming rhetoric; still, it is possible that recovery from substance use disorder may be more effective and efficient if they perceived

the "addict" label as a safer status to adopt when accessing necessary treatment.

These study findings highlight the applicability of two theoretical frameworks in health disparities research — Critical Race and Critical Disability Studies — to examine whether there are racial differences in aspects of the TC experience: (1) the TC process which includes the meeting content and rhetoric delivery; and (2) the TC metrics for success which primarily include how recovery is determined. Based on these findings, I hypothesize that there will be racial patterns in these two aspects such that Black treatment clients will more often report dissatisfaction with the medicalization model as it unfolds in this space, compared to their White counterparts. I also believe that these patterns will persist across similarly medicalized contexts that endeavor to address drug abuse patterns across racial groups. As such, a commitment to acknowledging Critical Race and Critical Disability Studies tenets in efforts to reduce these SUD treatment disparities, could prove beneficial.

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. In this research context, the move from overt state-sanctioned retribution to the medicalization of substance use disorder does not in fact signal a paradigmatic shift from punishment to rehabilitation. Instead, this evidence suggests that punishment has simply been *repackaged* as rehabilitation, and poor, racially minoritized citizens bear the brunt of these punitive mandates (McCorkel, 2013; McKim, 2017; Miller, 2014; Phelps, 2011). Critical Disability Studies (CDS) interrogate social constructions of ability, impairment, and normalcy (Vehmas and Watson, 2014). The findings offered above broaden the discussion of how (dis)ability and race are conflated (Block et al., 2001; Dilts, 2012), and the extent to which ableism and intersections of marginality disproportionately affect women, queer, poor, and nonwhite individuals, by including the experiences of formerly incarcerated individuals.

It should not shock readers to learn that the consumption of SUD treatment and the adoption of the "sick role" might vary across racial groups, when so many of the adverse effects that our existing disability policies have on poor Black people navigating disabling conditions, are a reflection of larger exclusionary social attitudes and values (Dorfman, 2017; Pokempner and Roberts, 2001). It follows, then, that just as discrete carceral and SUD treatment policies mimic the larger landscape of racial hierarchy (Hansen & Netherland, 2016), we must explore trust and faith in healthcare provision for individuals who are socially-constructed as disabled, as macro-level phenomena, too (Bullock, 2011; Campos-Castillo et al., 2016). This analysis suggests that the medicalization and the construction of pathology in this prison-based TC site are racialized phenomena that carry lasting implications for our understandings of bias and experiences of SUD treatment in state-funded carceral contexts. Situated within a CRT and CDS lens, this study emphasizes the significance of politicized language in constructing access to power, and an analysis of the ways in which the racialization of individual responsibility conditions the adoption of institutionally-authored sober scripts and identity narratives.

Alternatives to TC modalities and the metrics of adherence that legitimate its racially hierarchical operation include: mindfulness based therapies that empower clients from various backgrounds to develop self-sustaining healthy coping mechanisms (Amaro et al., 2014); culturally-informed training curricula for SUD treatment counselors who must develop consensus around recovery metrics (Asad and Kay, 2015; Neale et al., 2016; Tervalon and Murray-García, 1998) and deploy more productive therapeutic exchanges that reject perverse incentives to monitor client language (Carr, 2010); discharge preparation that bolsters clients' access to supportive and productive healthcare provision (Duffy and Baldwin, 2013); motivational and strengths-based interviewing (Hall et al., 2016); and a willingness to develop structural competency and challenge the institutional violence that these punitive contexts create (Metzl and Hansen, 2014; Metzl and Roberts, 2014). Simultaneously availing multiple client-centered, culturally-validated treatment modalities can also mitigate weaknesses in the methods that emerge for certain social groups and not others (Marchand and Oviedo-Joekes, 2017). Ultimately, meaningful SUD treatment reform that addresses racial disparities in treatment experiences, must be a multi-pronged, multi-level effort.

I acknowledge that this study is not without its limitations. Despite the richness that qualitative data offer the research community, there is always some degree of measurement error. For example, the demonstration of desirability bias among respondents asked to disclose their engagement in deviant and illegal behavior is expected. Still, I believe that this work makes a contribution to the substance abuse, punishment, Critical Race, and Critical Disability Studies discourses. These analyses examine how a mixed-race, mixed-gender cohort of drug-involved former prisoners makes sense of navigating the politics of survival in a punitive rehabilitation era.

This research is innovative because the analysis presented traces the decline of the rehabilitative ideal among public health providers and identifies the social, political, and institutional currents that give rise to new forms of racialized punishment and supervision. This study deepens our understanding of the convergence of racial bias and health inequality, because it examines the implications of new systems of control for criminal justice involved "addicts" and details their efforts to combat racialized institutional challenges to dignity and sustained wellbeing. These research findings also remind us of the importance of, and need for intersectional scholarship that further investigates how prison-based TC "sick talk" intervention and the required self-devaluation, exacerbate recovery experiences for the growing population of already traumatized Black men and women exposed to these treatment contexts. Finally, these findings set the stage for internationally relevant future research, policy, and advocacy agendas focused on adopting coping mechanisms that are self-initiated, self-sustaining beyond a treatment setting, and are seen as culturally relevant and empowering. These trends have implications for racial disparities and inequities in carceral supervisory compliance, lasting substance abuse recovery outcomes, and trust in healthcare-providing institutions.

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