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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 underdeveloped 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

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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 non-compliant (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

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