Michelle Smirnova

THE PRESCRIPTION-TO-PRISON PIPELINE

THE MEDICALIZATION AND CRIMINALIZATION OF PAIN

THE PRESCRIPTION-TO-PRISON PIPELINE

THE PRESCRIPTION-TO-PRISON

Duke University Press *Durham and London* 2023

PIPELINE

THE MEDICALIZATION

AND CRIMINALIZATION OF PAIN

Michelle Smirnova

DUKE
UNIVERSITY
PRESS

Printed in the United States of America on acid-free paper ∞
Project Editor: Liz Smith
Designed by Courtney Leigh Richardson
Typeset in Portrait and Trade Gothic by Westchester Publishing Services

Library of Congress Cataloging-in-Publication Data
<to come>

Cover art: <credit to come>

CONTENTS

ACKNOWLEDGMENTS

This book project began with Jennifer Owens. As two newly minted assistant professors, Jena and I sat next to each other on the orientation bus on our first day employed at the University of Missouri–Kansas City. We chatted about our respective moves from Washington, DC, and St. Louis, MO; about the pleasant surprise of housing costs and walkable commutes to school; and then asked each other about what we were up to: our research. Jena's dissertation had focused on methamphetamine use and production among women. I had been working on a broad assortment of projects, ranging from studies of political humor as resistance to the medicalization of youth. She asked me what I meant by medicalization, as she was curious about this novel concept. She asked if it included prescription drugs. Many of the women she had interviewed had told her she should be paying attention to prescription drugs rather than illicit ones—they were the real problem these days. We chatted about this—I offered some theories why that might be the case—but then we changed the subject to discuss more important things, such as where to get good Korean food in Kansas City.

Later that year, Jena walked into my office and asked whether I'd be interested in working on a project with her. She wanted to go into prisons and ask women about prescription drugs. She knew that I was a trained methodologist given both my graduate preparation as well as my two years of working in the qualitative research center at the United States Census Bureau, so she thought I could help design the surveys and interview instruments as well as collect the data. I was interested. We drafted several grants and began the long Institutional Review Board (IRB) process for approval. Over the next three years, we applied for five grants, interviewed eighty incarcerated people, surveyed over five hundred individuals, and made many, many long car trips together. During these trips,

we processed our interviews, discussed politics and books, and questioned how *America's Funniest Home Videos* was still in existence after the advent of YouTube and TikTok. Jena has since left the higher education world, but I cannot imagine how I would have set off on this project without her. She is one of the most detail-oriented research partners, and she taught me how to be a more attentive researcher and scholar.

Jena and I were part of a UM system program called the Faculty Scholars, through which we went on retreats to develop our research, apply for grants, and learn new teaching techniques. It was on this retreat that I met other faculty whom I could laugh and commiserate with, including Amanda Grimes, Debra Leiter, Jamie Hunt, David Thurmaier, Jason Martin, Sarah Marie Martin, and Lori Sexton. I am grateful to the UM system for providing this program, which helped connect me with other new professors who ultimately became part of my support (read: survival) network in my early years as an assistant professor. The university was not equally supportive of all of us, and, in witnessing those inequities, I think about how we might change structures and cultures to change that every day.

Lori Sexton is the type of colleague and friend who will convince you that there is brilliance and humor on even the greyest days. Our regular coffeeshop dates have helped me process my research, teaching, and life in invaluable ways. Lori read an early version of this manuscript and offered thoughtful feedback. Given her extensive research in prisons and focus on restorative justice, she helped frame this book in important ways.

Jenny Huberman managed to read the entire first draft of this book and provide comments in less than a week's time. Jenny has been my across-the-hall mentor and one of my closest friends since starting at UMKC. Jenny and Jeff welcomed me into their home and family from the moment I arrived in Kansas City and gave me the first sense of community. Not only has Jenny helped me process this research at its many stages of development, but she is also responsible for making Kansas City feel like home.

Others at UMKC who helped the book come to be include Debbie Smith, the chair of the sociology department during these six years. She was supportive of the project from the beginning and wrote in support of me for several grants and awards related to the project. The Women's and Sexualities Studies Department provided two crucial early grants to start this research and the Funding For Excellence Grants secured us enough funding to bring this project to fruition. Makini King and Sandy Rodriguez shaped my thinking at the later stages of this work—when I was already revising the manuscript—but I am immensely grateful for their friendship and intellectual guidance.

To Gisela Fosado, Ale Mejía, and the entire Duke editorial, production, and marketing teams: this book would not be here were it not for your tireless labor. Gisela, in particular, saw value in my project from its inception, fought for its publication, and was my biggest advocate and supporter throughout the process. Ale made the process clear, seamless, and expedient and was always a pleasure to work with. The two of them were also responsible for identifying and working with the two anonymous reviewers of this manuscript who provided invaluable feedback. Each of the reviewers, along with Gisela, seemed truly invested in growing this book into its best possible form. I am incredibly grateful for their meticulous and thoughtful readings and their copious constructive and transformative commentary. I know this labor is uncompensated and often thankless, but I can truly say that this book would not be what it is without you, so I am most appreciative that I was able to benefit from all your labor and investment in this project.

While friends and mentors from graduate school did not all read this book, it often felt like they were sitting in the room as I typed, reminding me to be thoughtful and careful with my analyses and interpretations. Aleia Clark was one of my closest graduate school comrades. I pegged her as my friend on the first day of the program and am grateful she didn't completely rebuke me, as I'm not sure I would have survived without her. I called Aleia many times while I worked on this book, and as always, she was able to see clearly though all the haze, helping me make important theoretical connections and practical decisions. Melissa Milkie has been a mentor and a close friend for the past fifteen years. Everyone should find their "Melissa" (though it's unlikely the knockoff version will be as good as the original). She is notorious among graduate students (and professors and friends) as being an unwavering source of support and motivation. I don't think I could have made it through graduate school or completed this book without her support. Her work on gender, parenting, and the self has also influenced my work and life in enduring ways. Melissa encouraged me to get involved with the Sociologists for Women in Society, and those conferences have felt like a retreat from this world—where we biked, hiked, and danced our way through mountains, sessions, and research projects.

People often say that once you learn sociology, it is difficult to "unsee" it. I feel the same way about Patricia Hill Collins, fondly known as "PHC," and her groundbreaking work on intersectionality and the matrix of domination. She has shaped my worldview and research in ways that become increasingly apparent over the years. I am grateful for her patience and humor as a professor and a mentor. Laura Mamo, Emily Mann, Carolina Martin, and Valerie Chepp are other inspiring sociologists who shaped my thinking during graduate school

and shaped this book. Laura Mamo first introduced me to medical sociology and science and technology studies, and it's hard to imagine this book without those classes I took early in graduate school. Emily Mann read an early version of one paper that served as the backbone for this project and provided attentive feedback as well as generously connected me to other scholars doing similar work. Carolina Martin was a buoy through graduate school as well as the years that followed. Valerie Chepp showed me how it was possible to juggle more than I thought was possible.

In addition to my academic community, there are many others in my life who shaped this book. My friends in DC: Natalie, Lena, Sara, Jimmy, Jon, Emmy—I am eternally grateful for your friendship, love, and inspiration to fight for a more just and equitable world. Julia and Aliza, while we haven't lived nearby since college, I'm so energized each time we visit or get off the phone. Although I didn't know anyone in Kansas City prior to starting my position at UMKC, CDV, an important connector in our lives connected me to Quinton—a fellow Wash U alum who also lived in KC. We met on a job visit and immediately hit it off. Q is one of the wittiest, smartest and most welcoming people out there, and he introduced us to half the people we know in KC today. Debates about drug policy, homelessness, and medicalization were common dinner table conversation with Meghan, Jeff, Caety, Matt, Katherine, and Q, as were they around the fire pit with Matthew, Louisa, Becca, and Jordan. Each of you shaped my thinking in important ways. To Mary, Kevin, Jennifer, Ryan, Chris, Darin, and Maggie, thanks for bringing hilarity and joy to our lives. To all of our Kansas City family, thank you for welcoming us with open arms and making this city feel like home.

Lauren and Jess, my two longest friends and my chosen sisters, I am forever grateful to have you as family and to have you there to lift me up when I need it the most. You remind me to celebrate my victories and are always there to assist in that endeavor. You both challenge and inspire me and I always look forward to being able to process the world with you.

Thank you to my mom, who is similarly there to shower me with love and support and who has served as a role model of how one might persevere through all the challenges of life—emigrating to a new country as a refugee, learning to speak a new language, and building a new community and career. As she always reminds me, find something that you love and fight for it.

AJ, you are that something. I'm so grateful for you now and always. You are brilliant, kind, and more humble than anyone else I know. You inspire, support, and love me in a way that makes me aspire to be my best self. You and Zev keep me grounded and full of love. I love the way you see and engage with the

world, and I always appreciate your thoughtful reflections and feedback. I just wish you'd read Marx already.

Finally, I'd like to thank the individuals who participated in the surveys and interviews. Thank you for trusting me with your stories and for offering your candid insights and reflections. Without you, this book would not exist. I hope this book does justice to your lives and that it effects positive changes that you experience firsthand.

INTRODUCTION

QUICK FIXES TO ENDURING PROBLEMS

I met Lyndsey when she was forty-five years old. A petite blonde woman with bright blue eyes, she sat across a table from me, taking up half of an aluminum metal chair. For the duration of our conversation, she sat folded in upon herself, her hands clasped around her crossed legs, gently rubbing one thumb over the other. She responded to most questions with an affirmative "yes ma'am" while looking me in the eyes, or "no, ma'am," looking down. We sat in an undecorated office that looked like it could have been anywhere in corporate America. But its door was much heavier and it did not lock, unlike the prison cell down the hall where Lyndsey had spent the last three years serving a sentence for operating a motor vehicle while under the influence of pharmaceutical drugs that had not been prescribed to her.

While her life was not always easy, no one expected Lyndsey to end up in prison. Lyndsey developed leukemia at a young age and spent a lot of time in the care of doctors. Despite this harrowing, potentially fatal diagnosis, symptoms of her illness were slow to develop, especially in her youth. While she tried to keep an optimistic outlook—which was evident as she described her aspirations for college and travel upon completion of her sentence—her life always felt precarious. It was unclear how long she would have or which milestones she would live to see. Lyndsey dreamed of a big wedding, followed by a big family, attending college to become a teacher—then therapist, then social worker.

Despite these ambitions, she knew better than to live for the future when the present was perpetually uncertain. Lyndsey grew up poor in a household where she was regularly abused both physically and sexually. Her father terrorized her mother and siblings, often pitting them against each other so that the fear permeated the house even when he was absent. Two of her sisters were removed by Child Protective Services; though for reasons unknown to Lyndsey, she and

her other siblings remained within her father's custody. Guilt, fear, and anger were emotions that Lyndsey became familiar with at an early age.

As a result of this upbringing, Lyndsey was elated when she found out she was pregnant at seventeen years old. She had always dreamed about starting a family of her own, and she and her boyfriend had decided to get married and raise their child. The baby meant she could escape her father, the abuse, and her diagnosis of leukemia. She loved being pregnant—with a child and with dreams of hopeful future. But then, at eight months pregnant, Lyndsey's red blood cell count dropped to worrisome levels. The doctors performed an emergency cesarean section in order to save her child. The baby survived the delivery, but his lungs were underdeveloped. He was transferred to the NICU, where he spent several months, but his lungs continued to collapse even with the additional support. At three months old, Lyndsey's baby developed pneumonia and died.

Lyndsey was devastated. She had lost her son. The marriage soon fell apart as well. Everything began to unravel again. While she had had a difficult childhood and battle with leukemia, her pregnancy and potential marriage had given her hope for a better life. When her baby died, she was shattered.

In the wake of her baby's birth, Lyndsey was prescribed Xanax to manage her anxiety, depression, and persistent panic attacks. She was also prescribed Vicodin to moderate the pain from her C-section. Although she had been prescribed pain medication many times before for surgeries and chronic pain related to her leukemia, this time, she had trouble coming off them. She continued to experience both physical and psychological pain, and she found that the Vicodin helped provide her with energy, which helped her hold down a job and support herself. The prescriptions were keeping her going.

But after some time, seemingly out of nowhere, her doctors stopped refilling the scripts. Lyndsey didn't know what to do; the withdrawal was torture, and without the medications, she couldn't motivate herself to get out of bed. One friend connected her with someone to sell her Xanax to help manage withdrawal symptoms. Another suggested she try methamphetamine instead of the Vicodin to give her energy. Medicating herself with these cobbled prescriptions, Lyndsey was able to hold down her job, support and care for her family, and spend time with friends. Things were looking up. But then she was pulled over and her car was searched. They found a pill bottle that didn't have her name on it. Arrested and sentenced to five years in prison, Lyndsey told me her story.

Seven in ten adults in the United States take a prescription drug on a daily basis.[1] One in five take at least one prescribed psychotropic drug, and one in three has been prescribed an opioid painkiller.[2] Psychotropics are substances that change brain chemistry and affect the functioning of the central nervous

system. They include a broad range of prescription drugs including tranquilizers that are used to manage anxiety and panic disorders (e.g., benzodiazepines, Xanax), stimulants used to amplify perception (e.g., Adderall), and sedatives or hypnotics used to treat insomnia (e.g., Ambien). They are prescribed with increasing frequency to anyone exhibiting psychiatric distress (as defined by health professionals) and are increasingly likely to be prescribed by primary care doctors rather than psychiatrists.

Opioid pain killers are prescription medications that have the ability to quell pain. The morphine molecule—the primary chemical compound in opium—is designed to overwhelm our bodies' mu-opioid receptors, which produce a pleasurable sensation similar to that which is produced when natural endorphins are released in the body. As psychotropics are increasingly used as a cure-all for psychiatric distress, opioids are seen as a panacea for treating physical pain.

The ubiquity and normalization of prescription drug consumption has contributed to what anthropologist Joseph Dumit has termed "drugs for life."[3] Instead of being used to treat visible symptoms or prevent death, pharmaceuticals are being used to increase and augment quality of life. The power of medicine and drugs has expanded with the increased medicalization of the social world, whereby previously nonmedical experiences, such as sadness or addiction, came to be defined as medical problems, illnesses, or disorders. In doing so, the medical model locates problems in the bodies of individuals rather than social contexts, relegating responsibility (and blame) to those individuals rather than to policies, laws, or social inequalities.[4]

This process is what sociologists often refer to as "medicalization"—the process by which nonmedical problems are transformed into biological issues to be treated with medical intervention. Just as many endemic social problems are being medicalized and treated with *medical* substances, *nonmedical* substance use is being increasingly criminalized and treated with incarceration or other forms of institutionalization.

In the last forty years, the number of people incarcerated on drug charges has risen tenfold—from 40,900 in 1980 to 452,900 in 2017[5]—due to sentencing policies that were developed as part of what is often termed the "War on Drugs." Today, half a million people are behind bars on any given night for a drug law violation—ten times the number in 1980.[6] Specifically, 56 percent of women and 47 percent of men in federal prisons are serving time for drug-related offenses.[7] Fifty-eight percent of those in juvenile correctional facilities are also there because of drug-related charges.[8] Even those who do not serve time in jail or prison for a drug conviction suffer potential social, economic, and political consequences for their record in many states, including the loss of child

custody, employment, student aid, public housing, public assistance, and the right to vote. Fifty-eight percent of federal prisoners and 47 percent of state prisoners are parents.[9] As a consequence, millions of children in the United States grow up without a parent as a result of incarceration. The vast majority of those parents (two-thirds) are incarcerated for nonviolent offenses, such as drug law violations.[10]

Drug use is often treated as deviant behavior that occurs outside of mainstream society, despite the fact that pharmaceuticals are prescribed by doctors at historic rates and that a significant proportion of people (one in five in the United States) have used an illicit substance in the past year.[11] In 2018, almost seventeen million people in the United States had used a prescription psychotherapeutic drug without the oversight of a doctor in the past year, which constitutes illegal use.[12] According to the Controlled Substances Act, prescription drugs are classified as a controlled substance; therefore, if used "in a manner or amount inconsistent with the legitimate medical use," this use of prescription drugs is considered "drug abuse" and thereby is punishable by law.[13]

The use of prescription drugs without a doctor's supervision is considered to be *nonmedical*. The qualifier "nonmedical" denotes the fact that these substances are used without the direct oversight of a doctor as is assumed with *medical* prescription drug use.[14] Some nonmedical use involves substances that were prescribed by a doctor but are used in greater quantities than prescribed or consumed in a different mode than prescribed (i.e., crushed and snorted or injected intravenously to produce a more potent and immediate effect). Other times, nonmedical use refers to the fact that the pills were obtained from sources other than a doctor, including family members or acquaintances.

The term *nonmedical use* is used in this book rather than *abuse* given that *abuse* implies harm, an assumption that is used by the medical and legal establishments to justify coercive treatment or punishment for this behavior. While substance use under a doctor's supervision is considered to be beneficial at best and harmless at worst, independent substance use is exclusively constructed as harmful, even when the specific modality, quantity, or purpose of use is identical to that occurring under a doctor's supervision, as was mostly the case with Lyndsey and others interviewed for this book. The power of medical and carceral systems lies in their ability to define and thereby control populations. This occurs through individual actors, such as doctors or judges, but also through institutionalized classificatory systems, such as the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), which is used by psychiatrists to diagnose and treat psychiatric disorders.

In this book, I argue that medicalization and criminalization work together to intensify harm among already marginalized individuals like Lyndsey. This intensification occurs in a number of ways. It begins with the classification of certain behaviors as harms that warrant surveillance and intervention. In so doing, we lose the opportunity to understand the motivation or purpose of a behavior as it has been simplistically reduced to a disease or a crime. We listen to representatives of medical and legal institutions to diagnose and pass judgment without entertaining the possibility that the patient or defendant has a greater perspective on the context and on their embodied experience. Once a person is labelled an "addict" or a "criminal," their agency and trustworthiness diminish. The medicalization and criminalization of a behavior justifies medical and legal intervention, control, and punishment, all of which can be accomplished under the guise of benevolence, of helping or "treating" individuals. Yet the individual is rarely listened to or treated as a collaborator in their own care.

The second way that medicalization and criminalization can produce more harm is through techniques that produce the very problems they allege to treat. A great example of this is overdose. While in theory, medical and legal systems aim to *prevent* or *treat* overdose, their practices often *produce* overdose as well. The criminalization of nonmedical substance use forces substances underground, where it can be difficult to account for potency or purity of what one ingests and which forces individuals into secrecy, whereby they use alone or under conditions of duress. Each of these factors increase the likelihood of overdose. People who have been incarcerated are more likely to overdose as they experience forcible withdrawal while in prison and have diminished tolerance upon release. With few support systems in place to assist them back into a world where they experience barriers to housing, employment, and social support, many return to managing problems through medications that their bodies are no longer prepared to handle. This can also result in overdose. In fact, one study finds that in the first two weeks after being released, former prisoners were forty times more likely to die of an opioid overdose than the general population. Even after a year, overdose rates remained between ten and eighteen times higher among the formerly incarcerated than among the general population.[15] These data alone challenge the notion that criminalizing substance use reduces overdose incidence. Instead, it may increase it.

Third, the medicalization and criminalization of "addiction" (established as a primary risk factor for overdose) further exacerbates harm as it extends punishment across the expansive industry of drug courts, rehabilitation programs, and prisons. Under the guise of "therapeutic jurisprudence," the legal system

has joined forces with health-care providers to treat individuals deemed "at risk" of overdose. In so doing, one's risk factors for addiction—substance use, unemployment, failure to pay a bill—become signs of medical and criminal risk. This warrants simultaneous medical and legal intervention to protect the individual from harm, despite the fact that the programs themselves produce greater harm by convincing individuals that they are "irresponsible addicts," forcibly removing them from their families and communities, and permanently marking both their medical and legal records, thus thwarting access to employment, housing, and education, all of which are directly correlated with positive health outcomes.

Finally, the dominant paradigm in the United States of punitive approach to substance use only intensifies all the harms outlined above. Previous scholarship has challenged the notion that drug courts and rehabilitation programs offer more humane alternatives to incarceration.[16] In fact, they extend and exacerbate punishment as people who participate in drug courts and mandatory rehabilitation programs often serve longer prison sentences than those who do not and are subject to psychological punishment in addition to isolation and traditional penal practices.[17] As outlined as the first exacerbating factor, perpetual surveillance can create a self-fulfilling prophecy. Prior to incarceration, as part of mandatory rehabilitation programs, or after release, as part of probation and parole requirements, individuals are also subject to regular state surveillance, which intensifies anxiety and stress as the looming threat of reincarceration accompanies otherwise mundane experiences such as getting stuck in traffic on one's way home from work in time for their court-mandated curfew. They also bear the cost of their incarceration, as individuals must pay for GPS ankle monitors, drug and alcohol monitoring bracelets, and other biometric and surveillance technologies. The financial, social, and psychological effects of isolation are further intensified by new techniques of rehabilitative punishment that convinces individuals that they are fundamentally flawed and in need of psychological transformation. As a consequence, punishment is intensified not only in terms of breadth, via extended prison sentences and state surveillance, but also in terms of depth, as they must internalize the punishment process as panoptic prisoner-patients.[18]

This book builds upon this scholarship by foregrounding the narratives of eighty incarcerated individuals who experienced the effects of having their lives both medicalized and criminalized. Bearing witness to their stories, it becomes clear how medical and legal systems often work in ways that intensify—rather than ameliorate—endemic social problems. In doing so, they both produce and exacerbate inequalities along the lines of race, class, and gender. This is not to put

blame on the shoulders of medical or legal professionals as many people who go into these fields do so with the intention of helping rather than hurting. The problem is that social issues like those covered in this book—including child abuse; poverty; unemployment; interpersonal violence; inequities in education, health care, or wages; racism in policing and incarceration; and lack of affordable childcare or support for new mothers—should be attended to through structural rather than individual-level solutions. In the United States, such issues are often presented as individual-level problems and thereby treated with individual-level solutions. And yet individual-level solutions, such as medication, treatment, or incarceration, often only make matters worse.

In this book, I trace how nonmedical prescription drug use may be seen as the result of the intersection of three social processes: (1) structural inequalities in the US system that simultaneously produce unequal levels of pain and unequal access to health care, (2) the medicalization and pharmaceuticalization of pain, and (3) an ongoing War on Drugs that produces and maintains axes of inequality along the lines of race, class, and gender through the criminalization of substance use in addition to inequitable policing and incarcerating practices. Using the narratives of incarcerated persons who used prescription drugs nonmedically, I illustrate how they did (and do) so in order to cope with an unequal system, but also to resist institutions that classify, diagnose, treat, and punish.

The Power of Contradictions

Regulation of prescription drug use in the United States involves a number of contradictions, which effectively challenge fundamental assumptions that are used to justify legislation. For example, many licit prescription drugs are almost identical in chemical construction to other substances classified as *il*licit (e.g., opioids versus opium, amphetamines versus methamphetamines). Prescription drug use is deemed legal and safe when used in certain contexts, but illegal in others: an individual can use a substance legally if it is prescribed by a doctor, but if they continue to use that drug or obtain it from a source other than a doctor, it is illegal and punishable by law. "Off-label" prescribing, where doctors prescribe a drug for a condition other than the one approved by the US Food and Drug Administration, is legal and common. And yet, nonmedical prescription drug use among nonlicensed persons is criminalized. The same decade that the World Health Organization (WHO) declared "freedom from pain" as a universal human right,[19] warranting liberal prescription of pain medication, the United States declared its War on Drugs, thereby criminalizing all other substance use. A drug is considered to be *abused* if one intends to use it for pleasure;

however, opioids and other pharmaceutical drugs are designed specifically to activate endorphins or block the reuptake of serotonin—mechanisms to promote the biological production of pleasure. Substance use has been historically criminalized in the United States when the majority of those locked up were poor or nonwhite. As more white people are being incarcerated, we have witnessed a "therapeutic turn" from punishment to treatment of substance use, illustrating how colorblind legislation continues to be implemented in racially unjust ways.

These contradictions raise important questions. If the boundaries between pleasure and productivity, use and abuse, and licit and illicit substances are much more amorphous than we are led to believe, how are we to police or legislate them? How does the shift from measurable harm to perceived risk cause disadvantaged "at risk" groups to come under greater scrutiny, surveillance, and punishment for the same actions committed by "nonrisky" groups? How do these contradictions produce unequal outcomes for individuals using prescription drugs?

These contradictions might also be perceived to be intentional as they position institutions and authorities to be the arbiters of truth and the associated consequences. People in power get to answer these questions and codify them in new laws, policies, and practices, while those directly impacted by these decisions are rarely consulted in serious or meaningful ways.

This book expands beyond the well-worn narrative of the opioid or overdose crisis by encouraging policy makers, politicians, and the voters who elect them to see the crisis as a social—rather than biological or pharmaceutical—problem. The term *opioid epidemic* implies that (1) we are dealing with a new problem that is caused exclusively by opioids, and (2) opioids are exclusively harmful. Yet opioids are not new. Opium, as derived from opium poppies, has been used to both quell pain and produce joy for millennia.[20] Morphine was first synthesized from opium in 1805 and was subsequently prescribed for everything ranging from pain to respiratory illness to cough to diarrhea. While more limited in application, opiates continue to be considered beneficial and are widely encouraged in medical settings. Further, most negative outcomes associated with opioids are the product of poly drug use rather than opioids in isolation. Framing the situation as an opioid crisis is reductionist, and it also misdirects our attention to the "simple" issues of purity and potency and distracts "from the social, political, and economic conditions that make overdose deaths more likely in some situations and less likely in others."[21]

In other words, the language of "epidemics" obscures endemic social conditions that produce harm. If opiates or other substances were the exclusive—or

even primary—cause of these harms, eliminating them would be the solution. And yet, we see how opiates and other prescription drugs are not outlawed, how they continue to be prescribed by doctors, and how those in pain benefit from their use. We also find that the outlawing of opiates—or other substances—does not reduce poverty, incarceration, unemployment, or overdose. In fact, policing, legislating, and punishing substance use only *increases* these harms. The true causes of these harms—endemic structural poverty, racism, genderism, and sexism—are rendered *invisible* by the language of opioid and overdose crises. Those who navigate what sociologist Celeste Watkins-Hayes terms "injuries of inequality" on a daily basis are ignored until they end up in hospitals, rehab centers, prison, or graves.[22] Only then do they receive interventions or support—or, at least, they make a news headline as a statistic. Further, much of the media coverage of the "opioid epidemic" specifically centers rural white and middle class communities, deflecting attention from urban communities of color that have been subject to policing, incarceration, and overdose for decades with little media attention, empathy, or push for meaningful policy reform.[23] Historically, drug policy has done more to harm than to protect communities of color in the United States.[24]

The language of epidemics and crises "misrepresents the duration and scale of the situation," given that the issues raised are in fact *ordinary* rather than *extraordinary* features of US society. To borrow the language of cultural theorist Lauren Berlant, many of these individuals had long been enduring a "slow death" prior to the statistical crisis of an overdose or arrest. The term *slow death* refers to "the destruction of bodies by capitalism in spaces of production and in the rest of life,"[25] such as the injuries, stress, and traumas produced by long hours, insufficient wages, and precarious conditions of capitalist work and life that often disproportionately impact "vulnerable populations, which include people of color and the aged, but more broadly, too, the economically crunched."[26] For such groups, slow death is the result of society defined by inequality and the objectification of one's labor and body. Rather than an aberration or "epidemic" caused by a substance, such exploitation and its health consequences are a "defining condition of their experience and historical existence."[27] Treating such structural inequality as a novel event is a strategy for mitigating guilt or shame by a society that is complicit in that harm by not engaging in the "heroic agency a crisis seems already to have called for."[28]

The issues bundled in the "opioid epidemic" are not limited to overdose and death, but also include incarceration, unemployment, chronic pain, depression, anxiety, trauma, abuse, and violence. These are not the product of a disease, disaster, or isolated injury, they are a product of structural inequities. As

science historian Nancy Campbell argues, they reflect a "a human-made disaster exacerbated by denial and disavowal of responsibility by those who structured and maintained distinctions between legal and illegal drugs, 'patients' and 'addicts,' and physiological and existential pain."[29] However, these issues are also the responsibility of those who participate in and uphold a society that fails to provide individuals who suffer from these issues with dignity or provide them with appropriate care.

We are all implicated in this system of inequality and its casualties. This is not to say that it is everyone's responsibility and therefore, effectively no one's. Quite the opposite. Those of us with greater privilege and power—by virtue of our skin color, gender, wealth, job, or influence over institutional policy and action—are more culpable and therefore must engage in more extensive undoing. But we all perpetuate such inequalities in some ways at ideological or institutional levels and therefore it is a collective project. Above all else, constructing these issues as individual rather than collective or structural is at the heart of the problem. This is often accomplished through the medical and legal institutions of our society and is why they are the focus of this book.

At Risk of Social Control: Medicalization of Structural Inequalities

Philosopher Michel Foucault argued that contemporary power—what he terms "biopower"—is productive rather than repressive.[30] It produces bodies, identities, and new ways of processing the world. It establishes new standards, new ways of knowing about human life, and new aspirational goals. It comes to determine what is a (good) life, and what is not. Biopower is enacted via modern state institutions that collect and legislate upon population-level data, but it is also internalized by individuals who come to understand themselves through biopolitical discourse. In so doing, it has subsumed the structure-agency balance of power, whereby individuals perceive themselves to be thinking and acting independently and distinctively. The aim of biopolitical power is to increase productivity of the body and society in tandem, quantified by such epidemiological population measures as birth, morbidity, and mortality rates as well as economic measures of gross domestic product (GDP) and employment rates.[31]

This quest for productivity is facilitated by the medicalization process that supports or thwarts behaviors, bodies, and ideas based on their alignment with contemporary notions of productivity. The term *medicalization* was first used in the 1970s by sociologist Irving K. Zola and medical philosopher Ivan Illich to describe how previously nonmedical experiences, such as sadness or addiction, came to be defined as medical problems, illnesses, or disorders.[32] From their

perspective, health care had become a "sick-making enterprise" in which doctors and medicine are responsible for *producing* rather than *curing* diseases.[33] In doing so, many problems become medical rather than social, political, or financial. Individuals are transformed from citizens and community members into lifelong patients dependent upon the services of doctors, medicine, and health care. Medicine is not merely a source of treatment, but it is a source of identity. This is made particularly possible through prescription drugs.

Prescription drugs are a medical technology, not unlike the giant machines hooked up to patients in hospital beds.[34] These small pills have reconstituted health care and medicine both within and outside the clinical setting. People take pills with their morning coffee or before brushing their teeth at night. They occupy our most intimate spaces—bedside tables, purses, desks drawers at work. They are ubiquitous to contemporary US life. Yet, while they require self-administration, self-diagnosis, and self-treatment, both remain prohibited. They require the internalization of medical discourse and the medical gaze, whereby an individual must surveille and treat their body and brain according to how health professionals deem fit.[35] Yet, this surveillance of body and mind and associated medication or treatment are often experienced as a personal decision or ambition, as medical treatment becomes a type of identity work. This is particularly true with pharmaceutical drugs.

Pharmaceuticalization refers to the redefinition and reconstruction of social or structural problems as having a pharmaceutical solution,[36] such as the prescription of antianxiety medication to soldiers returning from war or restless children being prescribed Ritalin to help them sit still in school. Pharmaceuticalization has been made possible by the rise of autonomous consumer-patients,[37] the availability of more products over the counter without a doctor's oversight,[38] the use of certain prescription drugs for "enhancement" purposes (e.g., Viagra),[39] and the increasing marketing influence of pharmaceutical companies, amid lighter media regulation.[40]

Pharmaceutical drugs are used more widely in the contemporary United States than in any other geographic region or historical period.[41] This is also the result of the ever-expanding realm of conditions and experiences that have become pharmaceuticalized. By constructing social problems as biological ones, pharmaceutical companies, scientists, doctors, and legislators offer pharmaceuticals and psychotropics as solutions.

Medicalization and pharmaceuticalization often refer to the reduction of complex, multicausational social problems into simplistic corporeal ones. Addiction and drug abuse are two such problems that lie at the intersection of both medicalization and pharmaceuticalization.

These two processes establish health care, pharmaceutical companies, and the criminal legal system as the arbiters of legal and healthy substance use and as the sources of treatment for illegal and unhealthy use. And yet, many of the very substances that are outlawed or identified as the source of addiction are produced by intensifying medicalization and pharmaceuticalization processes that are substantially funded and supported by laboratories, legislation, and discourse produced and supported by the state.

A central mechanism of biopower is the successful internalization of an individualized civic duty to live long, healthy, productive lives.[42] It requires believing in and living a life aligned with the scientific discourse and expertise that dictate acceptable and desirable ways of being. In so doing, individuals need not be diagnosed, policed, or labeled by medicine or the carceral system, as they do this work all on their own. They *aspire* to be their "best self": wealthy, healthy, fertile, self-sufficient, and productive, which just so happens to conform to the images put forth by these dominant institutions. In accordance with these aspirations, power is rendered invisible as it is experienced productively: *inspiring* individuals to behave in certain ways, rather than threatening them.

This neoliberal imperative directs attention away from institutions and practices that effectively *maim* individuals, thwarting their productive efforts. In her book *The Right to Maim: Debility, Capacity, Disability*, queer theorist Jasbir Puar disrupts the traditional binary between ability and disability by asking us to interrogate the relationship between disability, capacity, and *debility*. She asks us to consider how "some bodies may not be recognized as or identify as disabled," despite being "debilitated, in part by being foreclosed access to legibility and resources as disabled."[43] For example, those who are raised in underfunded school districts may be debilitated in terms of their educational resources. However, they are not recognized as disabled in the traditional sense as their disadvantage is structural rather than biological. Rather than biological features of the body, debility and capacity are the direct result of institutional (mis)recognition and structural in- or exclusivity. This explains why "some bodies may well be disabled but also capacitated,"[44] such as those with recognized learning disabilities that result in institutional accommodation. Many bodies are debilitated by our culture but are not recognized as disabled and therefore receive neither individual- nor group-level accommodations, nor do they mobilize collective effort for structural change.

Such debilitation has resulted in underfunded and overpoliced communities that increasingly feel more like prisons themselves. The lines between prison and such communities are increasingly blurred and have resulted in what sociologist Loïc Wacquant has termed a "carceral continuum."[45] This

term refers to the increasingly formalized carceral net that entangles more and more people under the guise of diversion or rehabilitation. As sociologist Kerwin Kaye argues in *Enforcing Freedom*, the entire model of therapeutic jurisprudence, including drug courts, is to eradicate the "drugs lifestyle" and prepare marginalized populations for low-wage labor and further exploitation and systemic abuse. Many who find themselves ensnared in the carceral system of drug courts, mandated rehabilitation programs, supervision, and parole often have only minimal involvement with substances yet have been deemed to be *at risk*—locating the problem in the body and the brain rather than the environment. Accordingly, the solution is "rehabilitation" of the individual psyche rather than addressing the "host of social and political problems—unemployment, housing instability, hunger, race and class discrimination, barriers to education, police harassment, among many others."[46] It also fails to account for the fact that the same individuals who are more likely to have problems medicalized and treated with drugs under a state surveillance program are also more likely to have that substance use criminalized and punished through the carceral system.

Prescription drugs exist at the liminal space between the *productive* and the *at risk*. When following the direction of doctor, prescription drug use is productive. When used independently, it is risky. While the risk is argued to be epidemiological (impact on one's health), in practice, the risk is institutional (arrest or incarceration).

Stratification via Criminalization

For the first three quarters of the twentieth century, the prison population remained stable in the United States; on average 110 out of 100,000 people were incarcerated each year. But those numbers started to increase in the 1970s, doubling in the 1980s, and doubling again in the 1990s. In 2018, 706 people were incarcerated out of 100,000, almost seven times the rate of 1900–1975.[47] Today, even though the United States is home to only 5 percent of the world population, it has over 20 percent of the world's incarcerated population. This is, in part, the result of legislation passed in the 1980s that established more stringent sentencing for drug-related offenses. Between 1982 and 1994, federal murder sentences decreased by almost 30 percent while drug sentences increased by 45 percent; state-level trends were similar. These laws and policies resulted in a 126 percent increase in drug arrests over the decade, resulting in a prison population larger than anywhere else in the world. This has become so extreme that sociologist Randall Sheldon argues that "it has become progressively more serious to have been caught with drugs than to kill someone."[48]

These policies laid the foundation for what came to be termed the War on Drugs. This "war" was waged by the United States federal government on psychoactive drugs and those who used and distributed them. This was made possible by rendering drugs and people who used or distributed them as dangerous to the social body. Legislation shifted from focusing on drug kingpins to low-level drug offenders. This resulted in an increase in policing given the greater number of potential arrestees, but also resulted in their greater visibility, facilitating identification, arrest, and prosecution, all of which were financially and politically encouraged by the federal government. Drug crimes were increasingly punished with incarceration rather than probation and the length of sentences skyrocketed. The average length of incarceration jumped 153 percent between 1988 and 2012.[49]

The War on Drugs was racialized from the start. Drug policy, in tandem with policing and incarceration practices and the disenfranchisement of incarcerated people in the United States, has reentrenched the racial caste system that was previously upheld by the Atlantic slave trade and, later, Jim Crow segregationist policies. While drug laws do not explicitly mention race, in practice, they result in the disproportionate incarceration of African Americans, relegating them to a permanent second-class status where they are denied the very rights won by the civil rights movement, such as the right to vote, to serve on juries, and to be protected from discrimination in employment, housing, education, and securing social services.[50] This is made possible by the many wires of the "birdcage" of structural racism, including sentencing disparities, mandatory minimums, "zero-tolerance" policies, all-white juries, and so-called colorblind algorithmic surveillance and policing systems that disproportionately target, arrest, and incarcerate Black and Brown communities.[51]

In recent years, mass incarceration has become increasingly diverse. This is not the result of declining incarceration rates among Black and Latinx individuals; instead, it reflects the influx of white prisoners. Civil rights activist and legal scholar Michelle Alexander terms the increasing incarceration of white people by a drug war designed to target Black and Brown people as "collateral damage." As she explains, "in any war, a tremendous amount of collateral damage is inevitable. Black and brown people are the principal targets in this war; white people are collateral damage." She explains, "Saying that white people are collateral damage may sound callous, but it reflects a particular reality." It also allows for the veil of colorblindness to remain over the criminal legal system, whereby not *all* people behind bars are Black or Latinx, just the disproportionate majority.[52]

The influx of prisoners, many of whom are white, for the nonmedical use of prescription drugs reflects collateral damage. This book focuses on the

criminalization of prescription drug use as an example of (1) the ever-widening net of carceral control, and (2) how quickly legislation might change to focus on rehabilitation rather than punishment when the majority of those who are impacted are increasingly white. It also draws attention to this issue as (3) nonmedical prescription drug use and overdose by prescription drugs are increasingly impacting Black and Latinx communities as well. While punishment for illicit substance use was designed to target people of color, access to prescription drugs (often of greater potency than street drugs) has been shaped by white privilege. The convergence of the medical and carceral systems initially impacted those at their nexus—poor, white, communities—but in recent years it has extended its reach well beyond these bounds. Specifically, while initial rates of use and overdose of opioids were higher among white populations who had greater access to medical care and therefore to the prescriptions, rates of overdose for Black and Latinx individuals have skyrocketed in recent years, with some estimates showing a 40 percent increase between 2018 and 2019 so that now rates of overdose are comparable between white, Black, and Latinx individuals.[53]

Medicine and the criminal legal system exert social control through systems of classification that simultaneously allow and encourage the behaviors of some groups and deny and punish the behaviors of others. In doing so, they regulate social morality by designating certain acts illegal, thereby warranting punishment, while deeming certain acts a sign of sickness, warranting treatment.[54] Prescription drugs have become a technology of both institutions as they are simultaneously used to treat sickness and moderate criminality under a single moral economy where the boundary between treatment and punishment is often indistinguishable, such as prisons that heavily medicate institutionalized populations or court-mandated drug treatment programs that employ punishment as a form of treatment.[55] These interrelated systems of medicalization, pharmaceuticalization, and criminalization come together to form a prescription-to-prison pipeline.

The Prescription-to-Prison Pipeline: Where Medicalization and Criminalization Meet

The term *prescription-to-prison pipeline* draws upon a number of pipeline systems and concepts, including the Drug Enforcement Administration's Operation Pipeline, which was part of the Reagan administration's War on Drugs, as well as the *school-to-prison pipeline*, which described the strong association between children who have been removed from schools and subsequent incarceration.

Operation Pipeline was a federal program administered by over three hundred state and local law enforcement agencies to train law enforcement officers to use traffic stops as a pretext to search for drugs and use the drugs as the basis for arrest and prosecution.[56] While the program focused particularly upon traffic violations, the "volume" approach to law enforcement has come to include many other minor infractions, such as loitering, jaywalking, or appearing "suspicious," as defined by a law enforcement officer. While the proportion of searches that yield discovery of illegal substances is low, the logic assumes that more stops eventually result in more arrests.

The school-to-prison pipeline refers to the fact that children who are suspended or expelled from school are disproportionately Black, Latinx, poor, or have a documented disability, and that being removed from school in early childhood increases the likelihood of future incarceration.[57] Despite purporting to be "colorblind" in suspension or expulsion policies, Black students are suspended or expelled at a rate three times higher than white students. This trend begins as early as preschool, where almost half of children suspended or expelled before the age of five are Black.[58] As a result of "zero tolerance policies," children who are suspended, expelled, or otherwise "pushed out" out of the school system are more likely to end up on the street, in the juvenile justice system, or in adult jails and prisons.[59] In fact, young Black men between the ages of twenty and twenty-four who do not have a high school diploma (or GED) have a greater chance of being incarcerated than of being employed.[60] The inverse relationship between education and incarceration is further revealed by the fact that 41percent of those in prison did not complete high school, and the average offender reads at an eighth-grade level.[61] Despite this documented relationship, prison spending in the United States has increased at triple the rate that funding for public elementary and secondary education has.[62] Together, these data illustrate how disparities in funding, discipline, and education can create disparities in policing and incarceration, disproportionately impacting certain communities and individuals over others.

The prescription-to-prison pipeline refers to a similar relationship between communities who receive the least funding and support for quality health care, education, housing, employment, and nourishing environments while facing some of the highest levels of state surveillance, intervention, and control. Health care—including mental health support—is not a constitutional right in the United States. Instead, it is something that has historically been available to those with salaried jobs. As a result, those with inconsistent employment or wage-labor positions often experience fractured and incomplete health-care coverage and support. Sporadic interactions with health-care professionals

can result in dangerous combinations of too-much and too-little medical intervention; this is exacerbated by the fact that psychotropics are increasingly prescribed by a wide range of health practitioners, rather than prescribed by psychiatrists who have medical training and knowledge of substance effects.[63] Increasingly, psychotropics are prescribed without a psychiatric diagnosis. One study found that over 60 percent of visits where a new psychotropic was prescribed did not involve a psychiatric diagnosis.[64] These trends intersect in dangerous ways for those who receive health care as a part of state-mandated care (e.g., foster care, juvenile detention, school counselors, prisons), as medication regimens may be unjustified or uninterrogated. As sociologist Anthony Hatch asks, "What is the boundary between benevolent medicine and malevolent drugging?"[65] The prescription of drugs is always about control, but the question is: Who is the subject and object of that control?

Individuals with less power, specifically those with fewer financial, social, or cultural resources to direct, negotiate, or challenge their treatment, are especially vulnerable to medicine and prisons as twin institutions of control. In fact, administration of psychotropic drugs is the most common and often the only form of mental health care that incarcerated populations receive, sometimes accounting for more of a prison's budget than food.[66] And those subject to incarceration are disproportionately those who come from underresourced communities and families. Adults who live below the poverty line are three times more likely to be arrested than those above, and those earning less than 150 percent of the federal poverty level are fifteen times more likely to be charged with a felony than those above the poverty level.[67] Education is highly correlated with income; therefore it is no surprise that individuals with college education also receive shorter sentences than individuals without.[68] How exactly psychotropics are prescribed by state-enforced institutionalized settings exists in a black box, so it is impossible to fully understand, evaluate, or change the practice.[69] Unlike surveys that trace the use of psychotropics in noninstitutionalized settings, surveys about psychotropic prescription in prisons are administered infrequently, ask questions in different ways on each administration, and do not ask whether prisoners have been forced to take medications against their will—details that negate the possibility for a historical comparative analysis. Hatch argues that this obfuscation is intentional, hiding the ways in which prisons use psychotropics to control incarcerated populations.[70] He argues that many are forced to take these medications in the absence of formal diagnoses, and that "psychotropics are a major element of the policy approach called *technocorrections*, the strategic application of new technologies in the effort to reduce the costs of mass incarceration and minimize the risks that

prisoners pose to society."[71] In other words, the United States would not be capable of incarcerating as many people as it does without psychotropics as a fundamental technology of the carceral system.

The prescription-to-prison pipeline refers to the ways that medicalization and pharmaceuticalization, both inside and outside of institutionalized settings, contribute to incarceration and recidivism among already underserved and overpoliced populations. It includes a wide range of interrelated structures, policies, and discourses that funnel certain groups and individuals into the carceral system. It includes people who were prescribed and used medication for a long duration before having their script abruptly discontinued and being forced to find alternative sources or ways to manage symptoms of withdrawal. It includes people who have experienced trauma and abuse, who were taught to manage their pain pharmacologically, but were later criminalized for that same behavior. It includes people who work for meager wages, who began to use prescription drugs without a prescription as a way to self-medicate, to perform on the job, or to hold families together in the face of compounding injustices. It includes children separated from their families at a young age who were medicated for behavioral issues rather than treated for trauma or reunited with families, only to have harms further compounded when they are criminalized for using those prescriptions in alternative ways. It includes all of these groups and others who have had social, political, and financial problems medicalized directly by health-care practitioners or more broadly by neoliberal, biomedical discourses, but as a consequence of their social location were subjected to greater carceral scrutiny and punishment. The prescription-to-prison pipeline refers to ways that criminalization *and* medicalization are used to reframe social and political problems such as unemployment, housing insecurity, family separation, and other forms of discrimination as *moral* and *biological* problems of substance abuse, addiction, or impulse control. It also justifies an increase in spending on corrections and psychotropic prescriptions and a reduction of spending on education, hospitals and health care, and public welfare.[72]

Hatch argues that the state asserts custodial power through the medicalization and (forcible) administration of psychotropics when it is deemed to be "in the best interest of the prisoner."[73] However, there are many people outside of institutionalized settings who use prescription drugs of their own volition to enact idealized behaviors or identities, because they believe they will make them healthy or make them a "better version" of themselves without realizing how these versions of themselves are those that help sustain existing (stratified) structures of society. This is able to occur in a society where the treatment of one's prescription drug use by institutions of control is not consistent. While some

people's use of prescription drugs confers greater privilege and status (e.g., job promotion), others are further marginalized and oppressed (e.g., incarceration).

Prescription drugs may intensify existing axes of stratification. As is true for all interactions with the carceral system, those arrested or prosecuted for nonmedical prescription drug use are not all treated alike. Treatment by the criminal legal system remains stratified by race, class, and gender. While some are *blamed* for their *abuse* of drugs and told to take responsibility for the associated adverse outcomes, others are viewed as *victims* of the substances, doctors, or adverse situations that precipitated substance use. This is most apparent in the arrest and sentencing disparities between prescription opioids and cocaine. Despite the fact that prescription opioids have greater potential for overdose, there were nearly four times as many arrests for cocaine than opioids in 2016, and individuals found guilty of cocaine-related charges are more often sentenced to prison, whereas those charged with opioid-related offenses are more likely to be sent to inpatient rehabilitation or therapeutic communities, as directed by drug courts. Black people were also more than three times as likely as white people to be arrested on charges related to heroin, opioids, and cocaine in 2016.[74] This reflects persistent racialized disparities in legislation, policing, and sentencing. As such, the harms of these systems remain stratified by race, class, and gender.

The People behind the Numbers and Labels

This book demonstrates that the boundaries between the medical and carceral systems, use and abuse, prescription and illicit drugs, productivity and pleasure, and physical and psychological pain are far more permeable than they are often presented as being, but are preserved to justify medical and legal regulation. These binaries can be used to justify unequal treatment of drug use and maintain systems of control, legitimating the authority of medicine, doctors, and the law to regulate behavior and sort actors into hospitals, homes, or prisons.

This research aims to highlight how the relationship between pain, substance use, treatment, and incarceration is mediated by one's identities. Although data on substance use or incarceration, as presented by the National Institutes of Drug Abuse (NIDA) or the Department of Justice (DOJ), are often spliced by singular identities such as sex, race, or age, the individuals behind those numbers are shaped by multiple, mutually constitutive, identities. For example, it is not particularly meaningful to say that 50 percent of individuals who use prescription drugs are white if we do not know their other identity characteristics, such as gender, class, and education level, but also if we do not know their life histories. Did they experience trauma or abuse? Did they experience an

injury or surgery that resulted in chronic pain? Were they diagnosed (or undiagnosed) with a mental health disorder? Were they in a high-pressure environment with limited social support? In other words, what were the contextual and personal factors that might help us understand why they used prescription drugs nonmedically and what were the subsequent factors that resulted in their incarceration?

Rather than thinking about race, class, and gender as a set of free-standing identities, intersectionality pushes us to interrogate how racism, (hetero)sexism, ageism, nationalism, neocolonialism, neoliberalism, and capitalism structure our experiences, often in mutually intensifying ways.[75] The emphasis upon structures and processes that influence how bodies and behaviors are experienced and treated differently draws attention to the fact that the meanings of identities are socially constructed rather than biological realities.[76] Without such emphasis, it is easy for disparities along such demographic variables to be interpreted as the result of biological propensities to behave differently, rather than differential treatment by social institutions and individuals. So long as race, gender, and other social constructs continue to be treated as objective biological facts rather than social inventions, they may continue to be used to justify inequalities in medicine, housing, education, social class, and the criminal legal system rather than interrogate how those institutions are *producing* those inequalities.[77] As author Ta-Nehisi Coates argues, "Race is the child of racism, not its father."[78]

While racism, classism, sexism, homophobia, and other forms of discrimination impact one's experiences of pain, medicalization, and overdose, these do not occur in uniform ways. While white, middle-class or affluent women may be more likely to be prescribed pills than men, other women are not. But there are also plenty of white, affluent women who are not prescribed pills—those who have been labeled an "addict," "hysterical," "weak," or "strong." In our personal lives, we recognize that we, our friends, and family are not reducible to a series of demographic labels; our lives defy such reductionist explanations. However, institutions that survey and collect data on our life experiences, such as prescribing rates, substance use, and overdose, continue to do so in ways that reify these categories and potentially reverse causal arguments that interpret disparities as the outcome of some biological reality rather than the justification for racial classification. The self-reported race, gender, and age of respondents are included in this book given that individuals are treated differently as a result of discrimination on the basis of perceived identities. However, these details should be treated as contextual information in understanding the life stories of the individuals in this book. My goal is to examine why certain bodies

and populations are at greater risk of being medicalized, criminalized, or both. It is not the intention to locate this risk in bodies or populations themselves, but to draw attention to the structural violence that produces such inequities.

This book draws upon eighty interviews, each an hour long, conducted with people currently incarcerated in Missouri for a variety of charges (e.g., illicit drugs, theft, forgery, or homicide).[79] It draws upon the perspectives of the incarcerated in part because they are simultaneously invisible and hypervisible in society, but also because they are trapped in this nexus of increasing medication and regulation. It also centers the voices of those omitted from most nationally representative studies of drug use. For example, the National Institute of Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have measured the severity of nonmedical prescription drug use in terms of overdose incidence. These data, while purportedly nationally representative, do not sample from institutionalized populations such as those in prisons or treatment centers. As a result, nonmedical prescription drug use—most often referred to by these agencies as "prescription drug misuse" or "abuse"—is considered a problem only in so far as it contributes to drug overdose. In doing so, it casts the issue in limited terms, measuring consequences exclusively in terms of overdose numbers but also locating the cause of the problem in the drug or the individual using the drug rather than the social and political environment that created the initial untreated pain.

While each of the issues has been explored separately—the medicalization of everyday life, how medical and carceral systems work together to control populations, the impacts of therapeutic jurisprudence, factors that have contributed to rises in opioid use and overdose, and how the War on Drugs has institutionalized racism, classism, and sexism[80]—this book brings into focus how these processes work together to produce a prescription-to-prison pipeline. Building upon the work of these scholars, I tease out the multiple factors that motivate nonmedical prescription drug use, the stratified treatment of that use, and the broader structural and institutional factors that construct the meanings of *nonmedical use*, *substance abuse*, *addiction*, and the *user* or *addict* that similarly distract us from place and context by focusing on individual willpower, brain science, and chemical compounds. Further, I draw attention to how such discourses are rendered "colorblind" while simultaneously contributing to racial disparities in treatment and outcomes. In so doing, I highlight how colorblind racism plays a central role in how similar situations of substance use are treated differently by medicine, science, and the law.[81] I show this by adopting an intersectional approach that takes into consideration interviewees' different social identities and how social locations impact how those identities are treated. As

much as possible, I situate their perspectives in relationship to personal life experiences and structural conditions that shape how they perceive and interact with both medical and carceral systems.

This book centers the perspectives of the incarcerated given that they are one of the most marginalized populations. In her book *Are Prisons Obsolete?*, revolutionary philosopher Angela Davis critiques the US criminal justice system, arguing that the prison has come to function "ideologically as an abstract site into which undesirables are deposited, relieving us of the responsibility of thinking about the real issues afflicting those communities from which prisoners are drawn in such disproportionate numbers." In doing so, "it relieves us of the responsibility of seriously engaging with the problems of our society, especially those produced by racism and, increasingly, global capitalism."[82] This has increasingly become the case with the nonmedical use of prescription drugs.

The experiences of the incarcerated affect us all. Almost half of all people living in the United States have experienced the incarceration of a parent, spouse, sibling, or child. More than five million children in the United States have had a parent incarcerated. Forty-five percent of men aged twenty-four or younger in state or federal prisons are fathers, and 48 percent of women in federal prison, and 55 percent in state facilities, are mothers. In the state of Missouri, 7 percent of children (98,000 children) have grown up with an incarcerated parent.[83] Black adults are twice as likely as white adults to have an immediate family member incarcerated, and those relatives are three times more likely to be imprisoned for over a year. Latinx individuals are 70 percent more likely than white individuals to be locked up for more than a year.[84]

As harrowing as the national statistics are, trends in Missouri, where the vast majority of the people interviewed grew up, are even worse. Missouri has the eighth highest incarceration rate out of the fifty US states. Rates of juvenile custody are also higher in Missouri than the average juvenile custody rates in the United States. Specifically, Missouri has the seventeenth highest juvenile custody rate out of the fifty US states.[85] Further, Missouri has the fourth highest prescribing rate of benzodiazepines (e.g., Xanax, Klonopin, and Valium).[86] This is particularly concerning given that before August of 2021, Missouri was the only state that did not enforce a federal law designed to ensure mental health care is covered by insurance providers at the same rate as physical ailments are. Relatedly, Missouri has one of the most acute shortages of mental health specialists,[87] given that many of them were not reimbursed the same way they might be in other states. This fact only exacerbates the fact that the majority of psychotropics are prescribed by primary care doctors.[88] Looking beyond mood stabilizers, in 2012, Missouri averaged 95.4 opioid prescriptions per 100

people,[89] and until 2021, Missouri remained the only state without a prescription drug monitoring system. These are some of the many reasons why this research focuses on the state of Missouri, given that national trends were even more acute at the state level.

It is not the intention of this book to vilify or exalt any individuals, groups, or institutions over others. Instead, I seek to present the experiences and interpretations from the perspectives of my interviewees and provide a historical and institutional context for such claims. Many interviewees have caused harm to themselves or to others. They described such incidents, for which they felt guilt or shame. However, they were also often victims of considerable harms over their lifetimes. And in many cases, they did not recognize that their experiences were traumatic or that they were not responsible for them. While I do not seek to absolve anyone from responsibility for their actions (nor do I have the power to do so), I also draw attention to broader punitive discourses that cause these individuals to assume full culpability given that they are often trapped at the nexus of intersecting forms of inequality.

While the majority of the people interviewed for this project came from hardship or poverty, or experienced considerable trauma and abuse, it is important to note that the majority of people who experience these things do not end up using prescription drugs nonmedically and do not become incarcerated. Further, many people who use prescription drugs nonmedically do not come from the same type of hardship—in fact, many come from relative privilege, and yet they do not suffer the impacts of medicalization and criminalization of their substance use that our interviewees did.

There is an important interplay between structure and agency that is illustrated by these stories, as there is in all our lives. It is not the intention of this book to portray people as lacking that agency or to imply that their life outcomes are overdetermined, but rather to identify and trace institutional structures and cultural discourses that may limit how events, technologies, and behaviors are interpreted. The goal is to help identify what are the actual problems at play and what might be some tenable solutions.

Organization of the Book

This book argues that the medicalization of endemic social problems in tandem with the criminalization of those problems and their medical solutions exacerbates inequality along lines of race, class, and gender and expands the carceral net. Although not all trajectories progress in the same linear fashion, as people enter the pipeline at different stages, many experience each stage of

this process at some point as the circuit becomes recursive and totalizing. As such, each chapter of this book traces one element of this process. Chapter 1, "The Medicalization and Criminalization of Pain," begins with a discussion of pain itself. Only in recent history has pain been considered to be a medical ailment in and of itself warranting medical and pharmaceutical intervention. The medicalization of pain narrows the scope of prevention or treatment to the corporeal level and blinds us to the structural factors that could wield much greater influence than a tiny (though mighty) pill. By seeing how pain itself is unevenly distributed in the population, it becomes evident that pain is not an individual-level problem but rather, a social one. Situating the medicalization of pain in the broader political and social history of substance use and regulation in the United States, we see how medicalization and criminalization are unevenly patterned across groups in the United States, which entrenches existing axes of inequality. As a consequence, privileged groups and entities are protected from control or punishment for their substance use, whereas marginalized groups are perpetually at risk of having their actions criminalized. Such protection and prosecution are facilitated in large part by legislation that has shielded pharmaceutical companies, doctors, and the well-resourced from serious legal consequences while simultaneously criminalizing marginalized communities and communities of color and legalizing surveillance terrorism of these groups. In recent years, such stratification has been intensified by the medicalization of substance use and abuse. Contrary to the assumption that health-care providers, treatment, and rehabilitation centers offer alternatives to penal institutions, this chapter outlines the ways in which they extend and intensify a carceral net that surveilles, controls, and punishes, and which does little to address pain or adverse outcomes of substance use, but rather, increases their incidence.

Chapter 2, "Prescription: Getting Hooked," explores how the overreliance upon pharmacological solutions often exacerbates endemic social problems such as poverty, gender inequality, abuse, and trauma. Both pain and health care are unequally distributed in US society, and those without access to broader financial, social, and political support systems are more likely to be treated with a prescription pad. This chapter presents the stories of interviewees who were prescribed opioids to manage pain associated with injuries incurred on the job or as a result of violence; psychotropics to deal with childhood abuse, trauma, or hardship; or opioids and psychotropics to assist with pregnancy, childbirth, or early motherhood. Many interviewees were taught early on to medicate their problems, a practice that later resulted in arrest and imprisonment. Their experiences reflect the broader neoliberal imperative and medicalization of society, but

also how this medicalization intersects with criminalization for those who are subject to greater surveillance. This chapter draws attention to systems of marginalization that were intensified by medicalization processes.

Chapter 3, "Pipeline: Sorting Use from Abuse," explores how the sorting and labelling processes involved in policing prescription drugs initiate and perpetuate systems of inequality. Despite the biological language of substance abuse or addiction as a "brain disease," diagnostic criteria of such "disorders" are behavioral and directly linked to existing socioeconomic and social structures, such as one's performance on the job or at school. As a consequence, failure to contribute to a capitalist, neoliberal economy has been transformed into a symptom of addiction or a substance use disorder, warranting medical or carceral intervention. The chapter explores how the regulation of substance use has been tied to the regulation of a race-, class-, and gender-based social structure. In doing so, it highlights how medical practitioners have worked alongside and via the criminal legal system to pathologize substance use for some groups, while simultaneously encouraging substance use among others. Such pathologization most often takes the form of diagnostic and judicial labels such as "addicts" and "criminals," which result in restrictions and heightened surveillance and the increased likelihood of eventual incarceration. Interviewees' stories reveal how medicine and prisons work together to monitor, diagnose, and manage individuals in ways that result in perpetual medical-penal surveillance and, for the already marginalized, the prescription-to-prison pipeline.

Chapter 4, "Prison: From Medicalization to Criminalization," explores how the prescription-to-prison pipeline has contributed to the net-widening effects of the carceral system. Through the experiences of those whose substance use has been medicalized and criminalized, it becomes evident how treatment and incarceration are two sides of the same coin that seeks to control, surveille, and punish those who do not behave or present themselves the way that society has deemed appropriate. While holistic health care can advantage those already advantaged by race, class, and gender, the marginalized may find their situations only made worse through the medicalization process that extends carceral surveillance, control, and punishment.

Contrary to the popular narrative that drug use, poverty, violence, and incarceration are the result of individual choices or biological deficits, this book demonstrates that these social problems are the product of environmental and structural factors, including underfunded school systems, unlivable wages, incompatibility of work and childcare schedules and costs, stratified policing, and overreliance upon pharmacological solutions to social, financial, and political problems. The adverse effects of substance use are tied to a stark divide in

income and wealth in this country, a divide that is directly linked to inequities in health care, education, policing, and incarceration as well as discrimination along lines of race, class, and gender. The conclusion to this book, "When Medicine Becomes a Drug," interrogates how medicalization practices exacerbate preexisting inequalities and have contributed to the prescription-to-prison pipeline, while offering policy solutions and counternarratives. The proposed solutions are broad and far-reaching, given that the prescription-to-prison-pipeline is overdetermined by many interlocking structural factors related to employment, health care, social support, policing, and the political and social economy. In this book, I outline the multiple overlapping and multidirectional ways by which individuals are funneled into the pipeline. Although the title implies a singular pipeline and process, there are multiple avenues by which someone may get pulled or pushed into the system. Once inside, marked by negative medical and legal credentials,[90] it becomes increasingly challenging to escape.

If, as a society, the United States decided to invest in the social services to assist individuals with health care, counseling, employment, and housing, as opposed to more "quick fixes" such as pharmaceutical drugs and prisons, perhaps it could disrupt the prescription-to-prison pipeline, as well as reduce adverse effects associated with substance use and incarceration. Lyndsey did not want to go to prison. She didn't want to hurt her children. She didn't want to spend her life in pursuit of more drugs, only to feel relief for just a short while. She wants to spend time with her children, find steady employment and housing to support them, and have some time to herself every once in a while. But sometimes she feels as though the system is rigged against her. And maybe it is.

NOTES

INTRODUCTION

1 News Network, "Nearly 7 in 10 Americans Take Prescription Drugs."

2 Smith, "Inappropriate Prescribing," 36; Han et al., "Prescription Opioid Use, Misuse."

3 Dumit, *Drugs for Life*.

4 Conrad and Schneider, *Deviance and Medicalization*.

5 Bronson and Carson, "Prisoners in 2017."

6 Reuter, "Why Has US Drug Policy Changed So Little over 30 Years?"

7 Carson, "Prisoners in 2016."

8 Hockenberry, Wachter, and Sladky, "Juvenile Residential Facility Census, 2014."

9 Glaze and Maruschak, "Parents in Prison and Their Minor Children."

10 Western and Pettit, "Collateral Costs."

11 SAMHSA, "Key Substance Use and Mental Health Indicators in the United States," H-56.

12 SAMHSA, "Key Substance Use and Mental Health Indicators in the United States," H-54.

13 Drug Enforcement Administration, "Drugs of Abuse."

14 The terms *abuse* and *misuse* are not used in this book given that they accomplish similar obfuscating effects as the terms *opioid epidemic* and *opioid crisis*. These terms obscure the ways in which nonmedical use can benefit rather than harm by characterizing behaviors in unequivocally negative terms. The terms *abuse* and *misuse* reflect a specific perspective—that of the medical and legal establishments who have the ability to police those boundaries. Pejorative terms such as *abuse* and *addict* impact the reader, but also health-care practitioners and the individual using substances. For example, in a study of five hundred clinicians, researchers John Kelly and Cara Westerhoff found that clinicians who used such labels were more likely to treat their patients punitively than those who did not use these terms. As journalist Maia Szalavitz notes, the terms *substance abuse* and *substance abuser* imply that it is the individual using substances who is abusive and warranting punishment, not the environment that produced pain or harm in the first place.

See Kelly and Westerhoff, "Does It Matter How We Refer to Individuals with Substance-Related Conditions?"; Kelly, Dow, and Westerhoff, "Does Our Choice of Substance-Related Terms Influence Perceptions of Treatment Need?"; Szalavitz, *Unbroken Brain*.

15 Ranapurwala et al., "Opioid Overdose Mortality among Former North Carolina Inmates."

16 Garcia, *Pastoral Clinic*; McCorkel, *Breaking Women*; McKim, *Addicted to Rehab.*

17 In order to participate in a drug court, individuals must plead guilty to full charges—associated with harshest penalties—to enter such programs. While they are spared these penalties if they follow the conditions of "treatment," if they fail—if they are caught with drugs in their system or violate their conditions of probation or parole—they are immediately sentenced to the fullest extent of the law. These sentences are often much more severe than if they had been able to enter into a plea bargain (or been able to successfully defend their innocence in the first place).

18 Garcia, *Pastoral Clinic*.

19 Brennan, Lohman, and Gwyther, "Access to Pain Management as a Human Right."

20 Norn, Kruse, and Kruse, "Opiumsvalmuen og Morfin Gennem Tiderne."

21 Campbell, *OD*.

22 Watkins-Hayes, *Remaking a Life*.

23 Campbell, *OD*.

24 Kaye, *Enforcing Freedom*.

25 Berlant, "Slow Death (Sovereignty, Obesity, Lateral Agency)," 764.

26 Berlant, "Slow Death (Sovereignty, Obesity, Lateral Agency)," 764.

27 Berlant, "Slow Death (Sovereignty, Obesity, Lateral Agency)," 764.

28 Berlant, "Slow Death (Sovereignty, Obesity, Lateral Agency)," 764–65.

29 Campbell, *OD*.

30 Foucault, *History of Sexuality*.

31 Foucault, *Birth of Biopolitics*, 226, 228–30; Puar, *Right to Maim*, xviii, 13.

32 Zola, "Medicine as an Institution of Social Control"; Illich, *Medical Nemesis*.

33 Illich, *Medical Nemesis*, 7.

34 Casper and Morrison, "Medical Sociology and Technology."

35 Armstrong, "Rise of Surveillance Medicine."

36 Williams, Martin, and Gabe, "Pharmaceuticalisation of Society?"

37 Conrad, *Medicalization of Society*.

38 Abraham, "Pharmaceuticalization of Society in Context."

39 Loe, *Rise of Viagra*.

40 Abraham, "Pharmaceuticalization of Society in Context."

41 Ledley et al., "Profitability of Large Pharmaceutical Companies."

42 Rose, "Politics of Life Itself."

43 Puar, *Right to Maim*, xv.

44 Puar, *Right to Maim*, xv.

45 Wacquant, "Deadly Symbiosis."

46 Kaye, *Enforcing Freedom*.

47 Wagner and Sawyer, "Whole Pie 2018."

48 Shelden, *Controlling the Dangerous Classes*, 143.
49 Pew Charitable Trusts, "More Imprisonment Does Not Reduce State Drug Problems."
50 Alexander, *New Jim Crow*, 186.
51 On this last point, see Benjamin, *Race after Technology*; O'Neil, *Weapons of Math Destruction*. On mandatory minimums and all-white juries, see Alexander, *New Jim Crow*, 109–16, 116–20. As an example of sentencing disparities, powder cocaine, commonly used among middle- and upper-class white populations, carries dramatically lighter sentencing guidelines than crack cocaine, which is cheaper and therefore more commonly used by working-class and poor Black populations. Despite it being the same substance, until the Fair Sentencing Act of 2010 passed by the Obama administration, the possession of five grams of crack cocaine was punished at the same severity as for five hundred grams of powder cocaine, resulting in a one-hundred-to-one disparity in legislation that conveniently mapped onto racial differences of substance use. While the Fair Sentencing Act reduced the disparity between the amount of crack cocaine in comparison to powder cocaine that triggers certain federal penalties, it remains at an eighteen-to-one weight ratio disparity. For more, see Provine, "Race and Inequality in the War on Drugs"; United States Sentencing Commission, *2015 Report to the Congress*.
52 Alexander, *New Jim Crow*, 199.
53 Larochelle et al., "Disparities in Opioid Overdose Death."
54 Conrad, "Medicalization and Social Control," 209–32.
55 Chiarello, "Policing Pleasure," 109–39; Hatch, *Silent Cells*, 10–15, 91–93; Garcia, *Pastoral Clinic*; McCorkel, *Breaking Women*; McKim, *Addicted to Rehab*.
56 United States Department of Justice, *Drug Enforcement Administration (DEA) History 1980–1985*; Cole, *No Equal Justice*, 46–49.
57 Heitzeg, "Education or Incarceration."
58 United States Department of Education Office for Civil Rights, "2013–2014 Civil Rights Data Collection Data Snapshot."
59 Heitzeg, "Education or Incarceration"; Witt, "School Discipline Tougher on African Americans"; Wald and Losen, "Defining and Redirecting a School to Prison Pipeline"; Springer, "Interrupting the School-to-Prison Pipeline."
60 Neal and Rick, "Prison Boom."
61 Harlow, "Education and Correctional Populations"; Stipek and Hanson, "Schools vs Prisons."
62 United States Department of Education, "State and Local Expenditures on Corrections and Education."
63 Mark, Levit, and Buck, "Datapoints"; Mojtabai and Olfson, "National Patterns in Antidepressant Treatment."
64 Rhee and Rosenheck, "Initiation of New Psychotropic Prescriptions."
65 Hatch, *Silent Cells*, 23.
66 Hatch, *Silent Cells*, 11–12; Abramsky and Fellner, "Ill-Equipped"; Gottsclich and Cetnar, "Drug Bills at Jail Top Food Costs."
67 Hashimoto, "Class Matters."
68 Schmitt, Reedt, and Blackwell, *Demographic Differences in Sentencing*.

69 Hatch, *Silent Cells*, 15–21.
70 Hatch, *Silent Cells*, 29–41.
71 Hatch, *Silent Cells*, 12.
72 Pager, *Marked*.
73 Hatch, *Silent Cells*, 16.
74 Equal Justice Initiative, "Racial Double Standard in Drug Laws."
75 Crenshaw, "Mapping the Margins"; Collins, *Black Feminist Thought*; Omi and Winant, *Racial Formation in the United States*.
76 Collins, *Black Feminist Thought*.
77 Crenshaw, "Mapping the Margins"; Collins, *Black Feminist Thought*; Omi and Winant, *Racial Formation in the United States*; Rothstein, *Color of Law*; Bonilla-Silva, *Racism without Racists*; Tatum, *Why Are All the Black Kids Sitting Together in the Cafeteria?*; Roberts, *Killing the Black Body*; Duster, "Race and Reification in Science"; Hatch, *Blood Sugar*; Alexander, *New Jim Crow*; Davis, *Are Prisons Obsolete?*
78 Coates, *Between the World and Me*.
79 The interviews are part of a broader study that was approved by the Institutional Review Board and received a Certificate of Confidentiality from the US National Institute of Drug Abuse that protects respondents' survey and interview responses. As of 2018, Missouri remained the only state without a prescription drug monitoring program, which may account for the particularly high rates of both medical and nonmedical Rx drug use.
80 Dumit, *Drugs for Life*; Conrad, *Medicalization of Society*; Conrad and Schneider, *Deviance and Medicalization*; Conrad, "Medicalization and Social Control"; Goffman, *Asylums*; Foucault, *Birth of the Clinic*; McCorkel, *Breaking Women*; Kaye, *Enforcing Freedom*; Campbell, *OD*; Alexander, *New Jim Crow*; McKim, *Addicted to Rehab*; Davis, *Are Prisons Obsolete?*
81 Bonilla-Silva, *Racism without Racists*.
82 Davis, *Are Prisons Obsolete?*
83 Sentencing Project, "State-by-State Data."
84 McCarthy, "Family Member Incarcerated."
85 Sentencing Project, "State-by-State Data: State Rankings."
86 Express Scripts, "America's State of Mind Report."
87 Kaiser Family Foundation, "Mental Health Care Health Professional Shortage Areas."
88 Agarwal and Landon, "Patterns in Outpatient Benzodiazepine Prescribing in the United States," e187399.
89 Centers for Disease Control and Prevention, "U.S. State Opioid Dispensing Rates."
90 Pager, *Marked*.

1. THE MEDICALIZATION AND CRIMINALIZATION OF PAIN

1 Brennan, Lohman, and Gwyther, "Access to Pain Management as a Human Right."
2 Martin et al., *Prescription Drug Use in the United States, 2015–2016*.
3 Centers for Disease Control and Prevention, "QuickStats: Percentage of Adults ≥ 18 Years."