

# The Criminalization of Addiction: Privilege and Recovery

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## Introduction

Attaining abstinence and sustaining long-term recovery is vastly more difficult for people who lack financial security, education, health insurance, and a strong support system of family, friends, and colleagues. These resources make up key aspects of a person's "recovery capital," or the amount of internal and external assets that can be utilized to attain and sustain recovery.<sup>1</sup> Access to medical detoxification, treatment, and peer support services differs based on the presence or absence of these factors. Those in a position of privilege are better positioned to access treatment and recovery support services.

Privilege is a set of benefits that inherently accompany being part of a particular group, including but not limited to race, class, ethnicity, nationality, sex, gender, or religion and is best illustrated through examples. This paper will focus on racial and economic privilege.

An example of economic privilege comes from my own experience with the criminal justice system. As a defendant facing federal felony charges, I was initially unable to afford a lawyer and was assigned a court appointed attorney. My court appointed attorney advised me that there was little chance I would be released on bail and he did not return my family's calls for information about when the bail hearing would be. He told me he didn't see much point in even requesting a hearing, as he viewed it as hopeless, and immediately suggested that I consider a guilty plea. At this point, my attorney and I did not even know the full scope of the government's evidence against me. I realized my attorney was unwilling to provide me with a vigorous defense. Fortunately, family resources allowed me to hire expensive private counsel and within hours I was released on bail. A hearing became unnecessary due to the strong

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<sup>1</sup>White, W. & Cloud, W. "Recovery Capital: A primer for addictions professionals," Counselor, 2008, p. 22-23.

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advocacy by my attorney and the utilization of his professional working relationship with the prosecutor. As soon as I hired expensive private counsel, my entire experience with the criminal justice system dramatically changed.

My privilege allowed me to get out of jail to continue focusing on my recovery, working and preparing for my pending trial from home rather than a cell. Because I was released from jail, I was able to attend several peer-to-peer recovery support meetings each week and meet with my sponsor and sober friends as needed and desired. In jail, these resources are incredibly limited at best. For example, we only had one recovery meeting per week in two of the jails I was in, and one prison where I was held had none. Furthermore, had I taken my initial court appointed attorney's advice to plead guilty so early, I would likely have received close to a ten-year sentence, rather than the 33 month sentence I served. I would have just recently been released from prison, rather than having graduated from college and law school and passing the bar exam. These are the differences privilege can make when a person with a substance use disorder becomes justice system involved.

An example of racial privilege is the fact that as of 2013, black children were four times as likely to be committed to a juvenile correctional facility than white children,<sup>2</sup> despite the fact that evidence does not suggest black children commit crimes at higher rates.<sup>3</sup> White children are less likely than black, Latino, or Native American children to have negative interaction with law enforcement, including arrests.<sup>4</sup> One way this inequality manifests itself is in public schools. Inner cities are more likely to have police officers stationed in the schools. The natural result of law enforcement presence in schools is that issues normally resolved by students, teachers, and parents, are more often turned

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<sup>2</sup> Rovner, J. "Racial Disparities in Youth Commitments and Arrests," The Sentencing Project, April 1, 2016.

<http://www.sentencingproject.org/publications/racial-disparities-in-youth-commitments-and-arrests/>

<sup>3</sup> *Id.*

<sup>4</sup> *Id.*

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over to law enforcement, thus leading to more criminal justice system involvement. While detention, suspension, or traditional parental consequences, such as grounding, are generally the response to particular behaviors in schools without a police presence, the same behavior is often sanctioned with citations and arrests, when law enforcement is directly involved.

### History and Background

Understanding the history of the criminalization of addiction in the United States is central to understanding the role privilege plays in access to treatment and peer recovery services, as well as sustaining recovery. During the nineteenth century, cocaine, opiates, and other drugs were widely used in mainstream medicine.<sup>5</sup> Drug prohibition began late in the century, but policies leading specifically to mass incarceration and particularly to racially disparate rates of incarceration did not fully emerge until well into the twentieth century.

Historically, the United States has responded to drug addiction differently depending on the race, socioeconomic status, and even politics of the perceived users. For example, Commissioner Harry Anslinger<sup>6</sup> of the Federal Bureau of Narcotics from 1930-1962 warned:

*“There are 100,000 total marijuana smokers in the U.S., and most are Negroes, Hispanics, Filipinos and entertainers...This marijuana causes white women to seek sexual relations with Negroes, entertainers and any others.”*

This “reefer madness” hype of the early twentieth century was perpetuated by propaganda that marijuana use would make black men force themselves on or otherwise become sexually involved with white women. Marijuana use was largely

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<sup>5</sup> Kandall, S. “A History of Women and Addiction in the United States- 1850 to the Present,” 1996, p. 33. [https://archives.drugabuse.gov/pdf/DARHW/033-052\\_Kandall.pdf](https://archives.drugabuse.gov/pdf/DARHW/033-052_Kandall.pdf)

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considered a “black problem” and associated with jazz. Another purported concern was that use would be spread to whites, particularly white women, and threaten the social order and cultural makeup of the United States. Fear tactics were also employed to subvert progressive countercultures. The racist anti-drug rhetoric expanded to include political views during the Vietnam War era, the ends of which had nothing to do with the eradication of drugs or combating addiction. In reflecting back on the 1968 Nixon Presidential campaign, senior Nixon advisor, John Ehrlichman<sup>6</sup>, once said:

*“You understand what I’m saying? We knew we couldn’t make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin and then criminalizing both heavily, we could disrupt those communities,” Ehrlichman said. “We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.”*

Today’s heroin epidemic is not the first in the United States. In fact, many soldiers became addicted to heroin during the Vietnam War and the addiction followed some of the service members back home, where the drug remained readily available.<sup>6</sup> This era marked the beginning of the tough on crime approach to drugs, which included the birth of the Drug Enforcement Administration<sup>7</sup>, and later the Rockefeller drug laws, which ushered in stiff mandatory minimum sentences for drug offenses, limiting judicial discretion.<sup>8</sup> During this era, the perception was that the vast majority of drug users were hippies, minorities, and “blue-collar” people.

The 1980’s marked the peak of the crack cocaine epidemic in the United States, which

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<sup>6</sup> “Heroin History,” Narconon.

<http://www.narconon.org/drug-information/heroin-1900s-more.html>

<sup>7</sup> “DEA History,” <https://www.dea.gov/about/history.shtml>

<sup>8</sup> “Background on New York’s Draconian Rockefeller Drug Laws,” Drug Policy Alliance. Laws, <http://www.drugpolicy.org/resource/background-new-yorks-draconian-rockefeller-drug-laws>

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was generally viewed as an inner city issue.<sup>9</sup> The federal government responded to the epidemic with the passage of the Anti Drug Abuse Act of 1986.<sup>10</sup> This law made penalties for crack cocaine one hundred times greater than for powder cocaine, despite the fact that they are simply different forms of the same drug, cocaine. Possession of five grams of crack triggered a mandatory minimum five-year sentence in federal prison, whereas five hundred grams of powder cocaine was required to trigger the same mandatory minimum. Powder cocaine was largely viewed as being used by stockbrokers, college students, and other “white collar” professionals whereas crack was viewed as an inner city drug. In other words, white people were viewed as the users and purveyors of powder cocaine and people of color were viewed as the users and purveyors of crack cocaine and much harsher punishments were instituted for crack than for cocaine.

Selectively increased enforcement and racially based longer sentences greatly contributed to the dramatic increase in the prison and jail populations, which now stand at roughly 2.3 million,<sup>11</sup> up from approximately 338,000 in 1970.<sup>12</sup> The United States now incarcerates more people than any other nation on earth, both per capita and in raw numbers,<sup>13</sup> and the racial disparities in incarceration statistics are glaring. One out of three black males born in 2001 can expect to be incarcerated at some point during his life, while only one out of seventeen white males and one out of every 111 white

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<sup>9</sup> Massing, M. “Cracks Destructive Sprint Across America,” The New York Times, October 1, 1989.

<http://www.nytimes.com/1989/10/01/magazine/crack-s-destructive-sprint-across-america.html?pagewanted=all>

<sup>10</sup> “H.R.5484 - Anti-Drug Abuse Act of 1986 99th Congress (1985-1986),”

<https://www.congress.gov/bill/99th-congress/house-bill/5484>

<sup>11</sup> Wagner, P., Rabuy, B. “Mass Incarceration: The Whole Pie 2016,” Prison Policy Initiative, March 14, 2016, p.1. <https://www.prisonpolicy.org/reports/pie2016.html>

<sup>12</sup> “The Punishing Decade: Prison and Jail Estimates at the Millennium,” Justice Policy Institute, May 2000, p. 1. [http://www.justicepolicy.org/images/upload/00-05\\_rep\\_punishingdecade\\_ac.pdf](http://www.justicepolicy.org/images/upload/00-05_rep_punishingdecade_ac.pdf)

<sup>13</sup> “Criminal Justice Facts,” The Sentencing Project.

<http://www.sentencingproject.org/criminal-justice-facts/>

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women are likely to be incarcerated.<sup>14</sup> The main contributing factor to racially disparate incarceration rates is that laws are not equally enforced in all communities and among all races.<sup>15</sup> For example, black people and white people use marijuana at roughly the same rates, but black people are 3.73 times more likely to be arrested for marijuana possession than whites.<sup>16</sup> This is because affluent communities, particularly affluent white communities, are insulated from regular police interaction, while low-income people and communities are not.<sup>17</sup> Policing techniques such as “stop and frisk” are rarely implemented in affluent communities, but are regularly utilized in inner cities, therefore less people are found with drugs in affluent communities and avoid justice system involvement despite engaging in the same illegal activity.

Beyond the constitutional and basic human rights issues associated with a racially and economically discriminatory criminal justice system, the system also negatively impacts low-income people generally, and minorities specifically, when it comes to achieving and maintaining recovery. In the words of two of my mentors, “Poor kids go to jail and middle class and rich kids go to Florida,”<sup>17</sup> referring to the large number of treatment centers in Florida that are often inaccessible for minorities and low-income people, but offer a refuge to the affluent.

The justice system, including jail and prison, has become the nation’s largest mental health and substance use “treatment provider.” When a person receives treatment from behavioral health professionals, the experience and consequences are vastly different than those the justice system provides. For example, one of the ongoing results of completing a private treatment program is access to an alumni network and ongoing

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<sup>14</sup> *Id.*

<sup>15</sup> La Vigne, N., Lachman, P., Rao, S., Matthews, A. “Stop and Frisk: Balancing Crime Control with Community Relations. Washington, DC: Office of Community Oriented Policing Services,” United States Department of Justice, 2014, p. 1.

<https://ric-zai-inc.com/Publications/cops-p306-pub.pdf>

<sup>16</sup> “The War on Marijuana in Black and White,” American Civil Liberties Union, June 2013, p. 4.

<https://www.aclu.org/files/assets/aclu-thewaronmarijuana-rel2.pdf>

<sup>17</sup> Burki, A., Burki, R., personal communication, Bern, Switzerland, October 2016.

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support from trained professionals. One of the ongoing results of justice system involvement is a criminal record that negatively impacts nearly all aspects of a person's chances in life, indefinitely. Jail, prison, probation, trial, plea bargains, etc., are all incredibly stressful experiences and the exact opposite of the therapeutic setting treatment in the outside world provides. The privilege of avoiding, minimizing or mitigating justice system involvement greatly impacts recovery and long term success in life.

### **The Current Opioid Epidemic and the Gentler Approach to the War On Drugs**

In contrast to the “reefer madness” days of the early twentieth century, the “black” heroin epidemic<sup>18</sup> of the 1960's and 1970's, and the crack epidemic of the 1980's, the current opioid epidemic is considered by many to be a public health issue rather than solely a criminal justice issue. For the first time, affluent whites are dying in large numbers as a result of a drug epidemic and the more humane governmental and societal response clearly reflects this.

Instead of the highly punitive federal response to the crack epidemic, Congress currently appears more interested in working on bills promoting prevention, treatment, and recovery.<sup>19</sup> States are also following suit, by implementing progressive and innovative programs that divert people away from the criminal justice system and toward treatment and other services. For example, in Seattle, Law Enforcement Assisted Diversion (LEAD) allows people arrested for low-level drug offenses or prostitution, which is often related to drug addiction, to elect to be assigned a case manager and develop a plan to address their addiction in lieu of prosecution.<sup>20</sup> In

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<sup>18</sup> Cohen, A. “How White Users Made Heroin a Public Health Problem,” The Atlantic, August 12, 2015, p. 1-3.

<http://www.theatlantic.com/politics/archive/2015/08/crack-heroin-and-race/401015/>

<sup>19</sup> Cherkis, J. “Congress Finally Passes Bipartisan Legislation To Address Opioid Epidemic,” The Huffington Post, July 13, 2016.

[http://www.huffingtonpost.com/entry/congress-passes-opioid-bill\\_us\\_5786ed5ee4b0867123dfac37](http://www.huffingtonpost.com/entry/congress-passes-opioid-bill_us_5786ed5ee4b0867123dfac37)

<sup>20</sup> “Law Enforcement Assisted Diversion.” <http://leadkingcounty.org>

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Gloucester, Massachusetts, the Police Assisted Addiction and Recovery Initiative (PAARI) encourages people with substance use disorders to come to the police station in order to be directed toward treatment. People who come voluntarily can surrender any drugs or paraphernalia without fear or prosecution and immediate attempts are made to place these individuals into treatment when clinically appropriate.<sup>21</sup> In Portland, Maine, the Law Enforcement Addiction Advocacy Program (LEAAP) engages a civilian employee when officers encounter a person suffering from addiction.<sup>22</sup> The civilian employee attempts to diffuse the situation, uncover the underlying issues, and direct the person toward resources.

It is worth noting that these programs focus on vulnerable, rather than privileged, populations that otherwise would likely become or remain justice system involved. Highly privileged drug users largely manage to avoid police contact and justice system involvement all together. When justice system involvement does occur, privileged people often have access to well-connected and resourced attorneys, who can help the individual avoid jail time and sometimes even avoid a conviction and thus a damaging criminal record. During law school, I spent some time practicing law as a student attorney in Maine. My work involved defending children facing criminal charges. Every child I represented came from a low-income family and the number of children I encountered who were people of color was disproportionate to the overall number of minorities in the state. Children from affluent families undoubtedly also break the law, but are largely insulated from police contact, therefore we rarely encountered them in court at all, let alone without counsel and needing our services.

To summarize, when drugs were viewed as a minority problem or a “poor people” problem, many policymakers were addressing an issue pertaining to what could be considered “others,” or people who they knew existed but were not like them and were

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<sup>21</sup> “The Police Assisted Addiction and Recovery Initiative.” <http://paariususa.org>

<sup>22</sup> “Law Enforcement Addiction Advocacy Program.”

<http://www.portlandmaine.gov/1715/Law-Enforcement-Addiction-Advocacy-Progr>



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not a key constituency. The response was almost entirely punitive, decimating some communities. Now that drugs are killing affluent white people in large numbers, the epidemic is suddenly a health issue, where the emphasis is placed on prevention, treatment, and recovery. Having acknowledged this troublesome reality, we must also recognize and seize the opportunity it offers to create inclusive policy changes based on facts rather than fear. Fundamental change will only come through consistent engagement and cooperation by people in the recovery community and their allies as well as prevention, treatment, and recovery professionals and policymakers at all levels of government.

### Privilege and Access to Treatment

White, Hispanic, and black people use drugs at approximately the same rates<sup>23</sup> and have signs of alcoholism, drug abuse, or mental health issues in the prior twelve months at similar rates.<sup>24</sup> However, whites with perceived need for treatment were substantially less likely to lack access to treatment than black people or Latinos.<sup>25</sup> Regarding those within each group with a perceived need for treatment, white people were more likely than black people or Latinos to actually be receiving treatment.<sup>26</sup> Black people and Latinos had less access to care and a greater unmet need for treatment than whites.<sup>27</sup>

### Detoxification

The first step toward recovery is detoxification from the substance or substances the individual seeking help is using. Detoxification is a painful process and challenging experience and when the physical and mental withdrawal symptoms manifest people are highly likely to seek their substance(s) of choice to relieve these painful symptoms.

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<sup>23</sup> “Racial and Ethnic Minority Populations,” Substance Abuse and Mental Health Services Administration. <https://www.samhsa.gov/specific-populations/racial-ethnic-minority>

<sup>24</sup> Wells, K., Klap, R., Koike, A., Sherbourne, C. “Ethnic Disparities in Unmet Need for Alcoholism, Drug Abuse, and Mental Health Care,” *Am. J Psychiatry*, 2001; 158: 2027.

<sup>25</sup> *Id.* at 2029.

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

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One way to mitigate this risk and to increase the safety of the person experiencing withdrawal is to have the person detox in a medical facility under the care of professionals and frequently with the aid of medications. If the person who is actively addicted and seeking help, does not have insurance that the medical facility will accept, the provider may not admit the person as a patient and, if they do, the patient may incur a heavy financial burden. Not only does this impact immediate access to treatment by deterring people who are simply unable to pay or wary of incurring a future financial burden, it can also negatively impact the chances of success in long-term recovery, if the person does accept the services and is later burdened by extensive debt.

### Treatment

The most glaring disparity regarding privilege in the continuum of recovery is access to long-term treatment programs of 28 days or more. Many inpatient, partial hospitalization, intensive outpatient, and outpatient treatment centers are private and accept only insurance or cash pay. A 2011 study found that only 13% of non-elderly whites lacked health insurance, compared to 21% of black people and 32% of Hispanics.<sup>28</sup> Some treatment centers provide scholarships for people without resources to afford treatment, but the demand far outweighs the supply. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 90% of the people who need substance use disorder treatment during any given year do not receive it.<sup>29</sup>

Access to, and successful completion of, treatment is an effective and compassionate

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<sup>28</sup> “Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act,” The Henry J. Kaiser Foundation, March 13, 2013.

<http://kff.org/disparities-policy/issue-brief/health-coverage-by-race-and-ethnicity-the-potential-impact-of-the-affordable-care-act/>

<sup>29</sup> “DYING WAITING FOR TREATMENT, The Opioid Use Disorder Treatment Gap and the Need for Funding,” A report by the Democratic Staff of the Senate Committee on Finance, October 10, 2016, p. 2.

<http://www.finance.senate.gov/imo/media/doc/101116%20Opioid%20Treatment%20Gap%20Report%20Final.pdf>

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means of achieving remission from an active substance use disorder. Lacking access to treatment increases the chances of ongoing misuse, which can lead to major disruptions to basic life functions, health issues, justice system involvement, and often death. Further, a short-term, acute model of treatment is often problematic for anyone, particularly people lacking strong recovery capital. Longer-term treatment programs that offer a holistic continuation of care model are even less accessible to people lacking privilege than are standard 30-day or 60-day programs. The belief is often projected to the patient that if he or she fails, it is because they messed up, and not at least partially as a result of systemic dysfunction and inadequate care.<sup>30</sup> Short-term acute treatment is not always the most effective model, particularly for those lacking substantial recovery capital. No other field of medicine places the blame squarely on the patient without thoroughly analyzing the care provided.<sup>31</sup> This is an issue throughout the addiction treatment space, but disparately impacts people of color and low-income.

### Long Term Recovery and Peer Support Services

The relationship between privilege and access to and utilization of formal treatment is straightforward and supported by empirical data showing inequality. However, the relationship between privilege and peer support services is more complex. Alcoholics Anonymous (AA) and other 12-step recovery programs are undoubtedly the most widely utilized peer support recovery programs in the United States. While AA membership was initially comprised largely of middle-aged white men, it has grown to exist in nearly every community in the country and throughout much of the world.<sup>32</sup> Many communities with high minority populations and low-income white populations have vibrant 12-step

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<sup>30</sup> White, W. "Personal Failure or System Failure," Selected Papers of William H. White, December 14, 2013.

<http://www.williamwhitepapers.com/blog/2013/12/personal-failure-or-system-failure.html>

<sup>31</sup> *Id.*

<sup>32</sup> Evans, A., Ichara-Abrahams, I., Lamb, R., White, W. "Ethnic Specific Support Systems as a Method for Sustaining Long-Term Recovery," *Journal of Groups in Addiction & Recovery*, 2012. p. 173.

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communities and other more unique and homogenous peer-to-peer recovery support programs.<sup>33</sup> Religious and cultural revitalization movements promoting recovery within communities of color began hundreds of years ago in Native American communities and during the nineteenth and twentieth century in African American Communities. These movements, or their contemporary counterparts, continue to thrive today.<sup>34</sup>

One area where privilege definitely plays a role in access to peer recovery support and services is at the collegiate or higher level. Privileged white people are much more likely to attend college than are people of color or low-income white people.<sup>35</sup> Collegiate recovery programs are programs that encourage students facing addiction to pursue recovery and offer programming, peer support, and social activities to help facilitate this.<sup>36</sup> Therefore, people attempting to achieve and/or maintain recovery not enrolled in college, lack access to these services. Further, many of the collegiate recovery programs are located on traditional college campuses. Traditional four-year degree programs are often less accessible to minorities and low-income white people, who frequently attend night school at community colleges and other facilities catering to part time students.

The larger issue regarding peer support and privilege is that many people of color and low-income white people never make it to the point of engaging peer support services because they are unable to successfully make it through the initial stages of detoxification necessary to comprehend and utilize these programs and services. Without the foundation of recovery often found through successfully completing a detoxification and treatment program, many people who might otherwise be able to

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<sup>33</sup> White, B. "The Color of Recovery," Selected Papers of William White, April 22, 2016, p. 1. <http://www.williamwhitepapers.com/blog/2016/04/the-color-of-recovery.html>

<sup>34</sup> Evans, A. Ichara-Abrahams, I., Lamb, R., White, W., p. 174.

<sup>35</sup> Ryan, C. Bauman, K. "Educational Attainment in the United States: 2015," United States Census, March 2016, p. 1. <http://www.census.gov/content/dam/Census/library/publications/2016/demo/p20-578.pdf>

<sup>36</sup> "The Collegiate Recovery Movement: A History," Association of Recovery in Higher Education." <http://collegiaterecovery.org/the-collegiate-recovery-movement-a-history/>

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utilize peer support programs, do not obtain sufficient stability and clarity to do so.

Further, when people lack recovery capital such as housing, transportation, and family support, utilizing peer support services successfully is vastly more difficult.

### Conclusion and Path Forward

Addressing disparities in access to treatment will require a fundamental shift in the way addiction is perceived and addressed in the United States. A substantial increase in funding and accessible programming will be required. We will need to respond to addiction the way we respond to other health epidemics, if there is to be any chance of truly addressing and mitigating this tragedy. For example, Congress allocated 5.4 billion in emergency funding to address the Ebola virus in the United States for fiscal year 2015,<sup>37</sup> but provided no emergency funding to address the opioid epidemic. During the same year, 52,404 people in the United States died from drug overdoses,<sup>38</sup> while zero people died as a result of the Ebola virus, and only one death resulted from Ebola during 2014.<sup>39</sup> It may have been completely appropriate to invest this much money in preventing the further spread of Ebola, but it is equally important to address an epidemic that is already raging. The fact that Congress did not is discriminatory and reflective of the deep stigma still surrounding addiction.

In attempting to promote peer recovery resources and services in communities of color and low-income white communities, the first step is determining what resources and services already exist. The next step is talking with social, political, and faith leaders in

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<sup>37</sup> Kates, J., Michaud, J., Wexler, A., Valentine, A. “The U.S. Response to Ebola: Status of the FY2015 Emergency Ebola Appropriation,” The Henry J. Kaiser Family Foundation, December 11, 2015.

<http://kff.org/global-health-policy/issue-brief/the-u-s-response-to-ebola-status-of-the-fy2015-emergency-ebola-appropriation/>

<sup>38</sup> “More than 50,000 overdose deaths: A grim tally soars to all-time U.S. high,” The Chicago Tribune, December 8, 2016.

<http://www.chicagotribune.com/news/nationworld/ct-us-overdose-deaths-20161208-story.html>

<sup>39</sup> “Ebola Fast Facts,” CNN, December 26, 2016.

<http://www.cnn.com/2014/04/11/health/ebola-fast-facts/>

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these communities to hear their ideas and concerns. It would be counterproductive to assume that models implemented in affluent white communities are the best fit for low-income or minority communities. Attempting to impose such systems would likely prove ineffective and would be disrespectful. Listening to the needs of the impacted people and then assisting with necessary resources that include planning, organizing, funding, and implementation is essential. Many communities of color have rich traditions of embracing and directly supporting recovery. Learning about these traditions while also sharing, but not imposing, programs that have proven successful in affluent white communities is vital.

To summarize, access to treatment and peer recovery support and services is vastly more difficult for people who lack racial and economic privilege. The justice system, rather than the behavioral health system, becomes the de facto care provider for many, and often leaves a wake of ongoing destruction in the lives of those that it touches. Fundamental changes in how addiction is viewed and treated by policymakers and the general public is essential to ending the discrimination and stigma that prevent adequate resources being devoted to addressing substance use disorders. Every community would benefit from the presence of a recovery center where people can go to seek treatment, peer support, employment and educational opportunities, and simply a healthy environment to get and stay well. This support must be available to all, regardless of race or income. Active inclusivity of low-income people and people of color must become a fundamental aspect of the recovery movement and increased communication and collaboration between all stakeholders is necessary.