

Drug War Dragnet: Surveillance, Criminalization, and Drug War Logic within and beyond Community Supervision



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Introduction

Since President Richard Nixon launched the contemporary “war on drugs” fifty years ago, decision-makers have responded to people who use drugs with punishment, racial profiling, and stigma, not compassion or evidence-based treatment. The punitive reflex has infected nearly every level of society, transforming what could be opportunities for support into battlegrounds of policing, surveillance, and coercion. This paper will examine the multilayered dynamics behind the drivers of overdose deaths, criminal legal-system involvement, and the drug war infiltration of people’s everyday lives—especially for people under community supervision.

The myriad individual, community, and societal harms of the war on drugs in the United States are well documented.¹ Since 1971, there have been more than forty-one million drug arrests.² Today, drug offenses remain among the leading causes of arrest, with one million arrests each year for drug law violations.³ Incarceration for drug offenses has declined slightly in recent years, but still nearly one in five of the almost two million people in prisons and jails are incarcerated for drug law violations.⁴

Despite the federal government channeling billions of dollars to local and state law enforcement to eliminate drug sales and possession, drug use rates have remained steady.⁵ Yet due to an unregulated and increasingly unpredictable drug supply, drug overdose mortalities have skyrocketed.⁶ Over one million drug overdose deaths have occurred in the United States since the onset of the crisis, and overdose is currently the leading cause of accidental death in the country.⁷

Both drug enforcement and overdose deaths are highly racialized. Despite similar rates of use and sales across races and ethnicities, Black, Indigenous, and Latine people are targeted and arrested, charged, and incarcerated at higher rates than white people.⁸ Racial and ethnic disparities in overdose deaths are stark. American Indian and Alaska Native people have the highest rate of drug overdose mortality of any racial/ethnic groups in the United States.⁹ Black people have the fastest-growing rates of overdose mortality of any racial or ethnic group: between 1999 and 2019, their drug overdose death rates tripled,¹⁰ and drug overdose is now the fourth leading cause of death for Black women.¹¹ While Latine people have consistently had lower drug overdose mortality rates than most racial/ethnic

groups in the United States, between 2010 and 2021, the average annual percentage change for drug overdoses was 3% higher among Hispanic than non-Hispanic populations.¹²

In the same period that incarceration skyrocketed five-fold, the population on probation and parole, already vast, grew almost fourfold, also along racialized lines.¹³ While incarceration receives more media and academic attention because of its particular cruelty, almost twice as many people—3.7 million, or one in every sixty-nine U.S. adults—are under community supervision, with people on probation making up about three-quarters of that number.¹⁴ Probation (a period of supervision served in the community in place of prison or jail) and parole (a period of supervision following a term of incarceration) are not “alternatives to incarceration” or positive reforms but rather extensions of the harshness of the correctional system.¹⁵

The Harms of Supervision

The conditions of probation and parole differ from being behind bars, yet people on supervision face similar harms to those associated with incarceration.¹⁶

Health Harms of Probation and Parole

People on supervision fare worse than the general population as measured by myriad health metrics.¹⁷ Research has found probation and parole are associated with increased mortality and morbidity, and decreased health care utilization.

People on probation die at over twice the rate of the general population.¹⁸ People who have been incarcerated, including those on parole, are at significantly higher risk of death following release, including deaths due to drug overdose, suicide, and liver and cardiovascular disease.¹⁹

As the leading cause of death among people recently released from prison or jail, drug overdose demands particular attention.²⁰ A 2023 review of studies on drug-related deaths among adults released from prison found that in the first two weeks following release, opioid overdose deaths were twenty-seven times higher than expected in the general population; in the first year post-release, opioid overdose deaths remained more than fifteen times higher than expected; and any time post-release, opioid overdose deaths were almost seven times higher.²¹

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In addition to a higher risk of death, people under community supervision have poorer physical and mental health outcomes than the general population. They are less likely to access outpatient health care and to have a primary care physician, and they are at higher risk of being uninsured.²² They make disproportionate use of emergency departments for routine health care needs and have a higher risk of preventable hospital admissions.²³ The health consequences of incarceration are well documented: past incarceration is associated with an increased risk of infectious and cardiovascular disease, hypertension, tuberculosis, major depressive disorder, and worsened mental health generally.²⁴ Until recently, more attention has been given to the health of incarcerated and formerly incarcerated people than to people on probation.²⁵ But recent studies have found that people on probation also experience increased risk of infectious disease and report higher rates of heart conditions, kidney disease, and mental health and substance use disorders.²⁶

Economic Harms

People on supervision are already more likely to be low-income than the general population. As with people who have been incarcerated, the addition of a criminal record saddles those on supervision with lifelong consequences, including lost educational opportunities, denial of public benefits, and barriers to obtaining safe, well-paid employment and stable housing.²⁷ Along with those penalties, many people on probation and parole must pay monthly fines and fees for their supervision.²⁸

Drug War Surveillance and Community Supervision

The drug war's impact extends far beyond prisons and jails.²⁹ The surveillance of people under community supervision—both those who have been convicted of drug-related offenses and those who have not—demands far more attention.

Estimates suggest that people on supervision have rates of substance use disorder two to three times higher than the general population.³⁰ Especially because of mandated periods of abstinence, people on probation and parole are at heightened risk of overdose.

Yet, despite being a population with a greater need for addiction services, people under community supervision often receive surveillance rather than evidence-based treatment and care.³¹ While probation and parole are commonly understood as “alternatives to incarceration” or “lenient sentences,” people on supervision must endure constant monitoring, perpetually under the threat of incarceration.³² Regardless of someone's original sentence, abstinence from drugs, drug testing, submission to warrantless searches, and court-ordered treatment are routine features of supervision. Drug-related violations are among the top reasons that lead to revocations of probation or parole.³³ Consistent with drug arrest data, Black and Native people are more likely than white people to garner a supervision violation for using or possessing drugs, despite similar

rates of drug use across all races and ethnicities.³⁴ Nationally, around one in eight people in state prisons and one in five people in jails are there for technical violations of probation or parole.³⁵

While a small number of people may benefit from services accessed through probation or parole, this “coercive care” comes at a cost.³⁶ To access services such as housing or treatment—both of which may be substandard—people under supervision must adhere to other burdensome requirements.³⁷ For some, the experience is so coercive that they would prefer a short term of incarceration over a longer period of community supervision.³⁸

Drug war policies and practices have profoundly shaped probation and parole. The putative goal of community supervision is to ensure successful reintegration; yet drug war surveillance enacts extensive barriers, making health, financial security, and overall well-being far harder to obtain.

Drug Testing

Common requirements of supervision include frequent, and sometimes random, drug testing. A drug test measures whether or not a drug metabolite is present in a person's body, indicating previous use. Drug tests cannot specify how much of a drug someone has used, whether the person is currently intoxicated or impaired, nor if they have a substance use disorder. Drug tests shed no light on whether drug use will impact a person's daily life or if a person presents a safety risk to themselves or others. Some people report feeling that their probation or parole officer cares more about a positive test than what might have led to their drug use in the first place—factors such as physical pain, emotional distress, or trauma—or what supports could be put in place to help stabilize them or make their use safer.³⁹ The use of drug testing has not been found to reduce recidivism rates or facilitate access to care for people who use drugs.⁴⁰

A positive drug test, being found with drugs, or even missing a drug test appointment can all lead to a supervision violation or legal proceeding. In many jurisdictions, a report alone can lead to someone being (re)incarcerated on a technical violation. Return to drug use is recognized as an inherent part of recovery for many people, but remanding someone into prison or jail will not decrease drug use or reduce the risk of overdose death.⁴¹

Even if someone does not use illicit drugs, submitting to routine drug testing can be onerous, expensive, and humiliating.⁴² People on supervision often must pay for each drug test—a particular burden for people on probation or parole who are more likely than the general population to be unemployed or low-income.⁴³ People might be administered a drug test with little to no inquiry into how they are doing physically, emotionally, or financially.

Substance Use Disorder Treatment

The criminal legal system plays a significant role in substance use disorder treatment by often requiring

completion of treatment as part of participation in a drug court, as part of a sentence, or as a condition of release from incarceration. One in four clients in publicly funded treatment was referred from the criminal legal system as a condition of their probation, parole, or diversion program.⁴⁴ The source of referral profoundly shapes treatment.

First, while people under community supervision do have higher rates of substance use disorder compared to the general population, many people who use illicit drugs do not use problematically. Some who are forced to complete treatment as a condition of their probation or parole might not actually need treatment. As the United States faces high rates of substance use disorder in the general population and a chronic shortage of available treatment for people who are actively seeking it, devoting precious treatment slots to people who do not struggle with their use is an ineffective use of resources.

Second, the criminal legal system limits the quality of treatment received. Only a small fraction of those who access treatment receive interventions backed by scientific research.⁴⁵ Among all people who access treatment, less than half actually complete it. In the criminal legal context, where there is a documented lack of evidence-based care that is known to increase treatment engagement, patients face steeper odds getting treatment that is scientifically backed.⁴⁶ Only 5% of people with opioid use disorder who were referred to treatment by the criminal legal system received either methadone or buprenorphine, the gold standard of medications for opioid use disorder (MOUD).⁴⁷ By comparison, 40% of people in treatment who were self-referred or referred by another source received methadone or buprenorphine.⁴⁸ This discrepancy likely has negative health consequences;⁴⁹ MOUD cuts the risk of overdose in half.⁵⁰ Further, forced abstinence can put someone at greater risk of overdose, since overdose risk is higher following an extended period without use. A recent systematic review and meta-analysis of mandatory abstinence programs found that these programs were associated with being twice as likely to ever have a non-fatal overdose compared to people who never attended these programs, and more than 3.5 times more likely to have a non-fatal overdose, in the past six to twelve months.⁵¹

Third, even for people under community supervision who do receive MOUD, being referred to treatment from the criminal legal system is one of the strongest risk factors for discontinuing MOUD treatment before the recommended minimum period of six months.⁵² Some probation and parole officers might restrict the amount of time that a client can use methadone or buprenorphine.⁵³ Treatment discontinuation could also be due to a lower need or desire for treatment among people referred to treatment by a criminal legal entity compared to those who are self-referred.⁵⁴ Even those with the best intentions of attending and completing a treatment program may struggle to do so because of structural barriers, including cost, treatment requirements (such as submission to drug tests, abstinence maintenance, and counseling session attendance), lack of

transportation, childcare responsibilities, and employment.⁵⁵ These barriers are heightened for people of color, pregnant people, sex workers, unhoused people, and disabled people.⁵⁶

While access to treatment should be expanded, especially for those with criminal legal involvement, treatment should never occur through the threat of sanctions or incarceration for non-compliance or non-completion. The focus for justice-involved people and the general population should be on mitigating factors that exacerbate risks for people who use drugs through evidence-based and effective care.

Compounding Harm

Connections among health care and treatment providers, criminal legal system actors, and other service providers can, in theory, serve to better coordinate care. In practice, communication between these entities can also heighten the surveillance and punishment of people under supervision. Treatment providers monitor client compliance and abstinence through mechanisms such as observed, routine drug tests. Providers are often in regular contact with referral sources and service agencies, including probation and parole officers, about a client's progress in treatment. Any drug use or negative progress reports can be used as grounds to sanction someone on supervision. An allegation of drug use can also serve as a justification for removing children from custody or evicting a person from their housing. Any one of these outcomes—technical violations and sanctions, family separation, and loss of housing—can exacerbate problematic drug use and directly or indirectly lead to incarceration.⁵⁷

Adherence to drug-related supervision requirements can conflict with other supervision conditions. For example, maintaining stable employment can be challenging when a person also has to report for regular meetings with their probation officer, attend counseling sessions as a part of their treatment program, or take unplanned hours out of their day for a random drug test. Avoiding the presence of alcohol and drugs can be difficult if a person needs their friend or family member (who might use drugs or alcohol) to watch their child as they attend a supervision appointment. People under supervision must adhere not only to the conditions of their probation or parole but also to the conditions of the programs or services they access. For instance, if someone arrives late to their treatment program, they might not receive MOUD. Or if someone tests positive for drugs in a treatment program, they could also lose their housing if it is accessed through their program.

Each day, people under supervision navigate a web of surveillance, sometimes avoiding sites of potential support—such as health care and social services—because those sites trigger additional surveillance. Drug war surveillance and coercion lead to profound social isolation and stigmatization, making community supervision not an alternative to punishment but an extension of it.

Drug War Dragnet in Other Systems

The effects of the drug war expose people to punitive actions through other systems, such as education, employment, family policing, public benefits, housing, and immigration. The cumulative effect of these cascading impacts across people's lives can include recidivism or new criminal legal system contact, due to facing insurmountable barriers to secure employment in the formal economy, cover basic food necessities, obtain housing, and care for one's children.

Additionally, collaborations between law enforcement and legal and civil systems can ensnare people who are under community supervision. Along with drug-related surveillance, systems frequently surveil other individual behaviors—including parenting, work status, and attending mandated interventions—as part of a “package” of state-mandated interventions. This punitive surveillance can take the form of mandatory reporting requirements that impact families, nuisance laws that target neighborhoods and communities, or behavioral modification interventions for people on supervision. Drug surveillance also then serves a gatekeeping role to systems that provide services such as nutritional support, employment, housing, health care, and education.

Given that Black, Latine, and Indigenous people are overrepresented in the criminal legal system for drug offenses, members from these communities disproportionately confront the impact of these bans.⁵⁸ As scholar Virginia Eubanks writes: “Marginalized groups face higher levels of data collections when they access public benefits, walk through highly policed neighborhoods, enter the health-care system, or cross national borders. That data acts to reinforce their marginality when it is used to target them for suspicion and extra scrutiny. Those groups seen as undeserving are singled out for punitive public policy and more intense surveillance, and the cycle begins again. It is a kind of collective red-flagging, a feedback loop of injustice.”⁵⁹

Recommendations

Drug testing: Drug testing is not an effective monitoring strategy for care and support and is more often a punitive tool of surveillance. Policymakers, probation and parole officers, and practitioners should work to end drug testing of people on supervision as well as of those who interact with other systems such as hospitals, family policing, and employment. If the practice cannot be eliminated, a positive drug test should not justify revocation of probation or parole. Individuals should at very least have the right to understand the implications of drug testing and provide explicit consent for the test.

Treatment: Clinicians, practitioners, and policymakers should focus on expanding access to voluntary, evidence-based treatment. No one should be forced to complete a treatment program as a condition of supervision and in order to stay out of prison or jail. People in a treatment program should determine their course of treatment with

clinicians—without influence from the criminal legal system—and have access to access to methadone and buprenorphine; no one's supervision status should be in jeopardy if they take MOUD. A person's treatment charts or medical information should never be accessed by corrections or criminal legal system staff or other referral sources, given that patient records can be used in punitive decisions about clients and their families. Until this practice is eliminated, providers can take steps to protect their patients in drug treatment from the overreach of the drug war by being intentional and judicious about any documentation of treatment progress or recurrence of use (also called relapse).

Services and support: A person's drug use or conviction history should never be a condition of receiving services and support, including housing, employment, and public benefits. Those on supervision should have direct linkages to health care and service providers and receive support in care navigation. At local, state, and federal levels, people should advocate for well-resourced, non-punitive social supports and care systems that help to change the conditions leading to problematic drug use and criminalization.

Conclusion

People whose drug use has been criminalized often cycle through treatment programs. They may have tried to talk openly with their health care providers about their use—and been rebuffed. They may have sought housing and education—and been turned down. They also may have decided to avoid these supportive services altogether because they are not available, attractive, or affordable. And many family members and friends, often well-intentioned, feel they have run out of options for their loved ones struggling with drug use.

Care should never come through surveillance or be tied to a threat of criminalization and incarceration. No one should have to adhere to ten to twenty rules each day in order to, if they're lucky, get on a waitlist for supportive housing. No one should have to submit to regular drug tests in order to access treatment that may not even offer medications for opioid use disorder. There is extensive research on what works to help people who use drugs and have substance use disorders: we need to treat drug use as a public health issue, provide access to evidence-based and effective drug treatment and care for those requesting it, and craft policies and practices to buttress protective factors such as housing, employment, and family and community connections.

Coercion is not care; surveillance is not support; and for many, drug use is not the root of the problems they face. It is a lack of affordable, safe housing, well-paid employment, affordable health care, and transportation that keep people from being healthy and economically stable. If our goal is for people under supervision to be able to move forward with their lives and reintegrate into their communities, we must identify and remove the barriers that are making it harder for people to get back on their feet—far too often with deadly consequences.

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