



## Article

# Is There “Hope for Every Addicted American”? The New U.S. War on Drugs

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**Abstract:** The U.S. has been waging a War on Drugs for the last forty years. But in the mid-2010s, a series of reforms have rejected this militant approach. How did these policies manage to break through a gridlocked Congress? What is the nature of these reforms, and what are their political implications? Using critical discourse analysis, I demonstrate that a new policy framework of “addiction recovery” defines the political crises of the opioid epidemic, the failure of the War on Drugs, and mass incarceration in terms of disease, attributing Drug War injustices to prejudice against “addiction,” rather than a constellation of institutional racism, sexism, nativism, and economic exploitation enacted through drug policy. I conclude that characterizing recent reforms as a decisive break with the War on Drugs obscures the ways in which drug policy continues to perpetuate injustice by offering a personal, rather than political, solution in the “hope” of recovery.

**Keywords:** critical discourse analysis; critical addiction studies; drug policy; drug addiction; addiction recovery; War on Drugs

## 1. Introduction

Since the early twentieth century, the United States has been waging recurring wars on drugs (Courtwright 1982). Like its predecessors, the most recent Drug War declared in the 1970s has failed to eradicate drug use, sales, and trade (Musto 1987). Evidence of this failure has been available for decades but policymakers only began to reverse course in the last several years. How did drug policy reform manage to break through a gridlocked Congress? Why would the former director of the Office of National Drug Control Policy (ONDCP) eschew the title “Drug Czar,” claiming it “connotes this old ‘War on Drugs’ focus to the work that we do . . . ” that “ . . . has been all wrong” (Pelley 2015)? The conventional explanation is that the costs of mass incarceration, a decline in the crime rate since the 1990s, and a movement to rectify the War on Drugs’ racially disparate impacts have triggered this change (Apuzzo 2014; Desilver 2014; DPA 2016; Gottschalk 2015). These are important factors, but I argue that a shift in how drug use is framed has also played a critical role. This development was decades in the making, but has crystallized into policy change in the last several years because of the current opioid epidemic,<sup>1</sup> a shift in the typical “drug addict” portrayed in the media and political discourse, a new policy framework put forth by “addiction recovery” advocates, and the ONDCP incorporating this framework into the national drug strategy.

<sup>1</sup> “Opioid” describes drugs derived directly from the opium poppy (traditional “opiates” e.g., heroin), semisynthetic, modified opiates (e.g., oxycodone), and synthetic drugs, which have neurochemical effects similar to opiates (e.g., methadone) (Hernandez and Nelson 2010). I use the term “epidemic” here to reflect the CDC’s declaration that opioid use and overdose in the U.S. currently constitutes an epidemic (CDC 2011).

I trace how these reforms came to pass, critically analyze the discourses informing them, and consider their political implications. I find the domestic demand-reduction<sup>2</sup> policy framework has shifted from a militant, incarceration-first approach to a “balanced, compassionate, and humane” approach (ONDCP 2013, p. 1) that offers “hope for every addicted American” in the prospect of recovery (ONDCP n.d.d). I suggest that recovery discourse has engendered some significant reforms at the state and national levels, but there is little evidence of a “revolution” in drug policy as the ONDCP has claimed (Gardner 2012). I argue this is because the logic of recovery legitimizes maintaining punitive drug policies alongside new, recovery-oriented policies, precluding more comprehensive reform. I conclude that recovery discourse enabled these reforms to break through legislative gridlock because it provides a politically convenient explanation for the failure of the War on Drugs, while perpetuating Drug War injustices under the sign of progressive reform.

## 2. Literature Review

In their theory of policy change and stability, Baumgartner and Jones characterize U.S. policymaking as a system of “punctuated equilibrium,” where policy stability is a product of powerful policy monopolies, and moments of sudden change result from a shift in the dominant policy image and/or policy venue at the core of those monopolies (Baumgartner and Jones 2009, p. 38). In this model, a primary site of political struggle is among policy entrepreneurs and elites who seek to define issues in order to maintain or disrupt existing monopolies. This framework informs my analysis of drug policy development as part of a complex process of competition and redefinition of policy problems and solutions.

My analysis is also informed by the historical literature on U.S. drug policy. This scholarship has established that drug epidemics, and actual or perceived demographic changes among people who use drugs, affect the discourses about drug use and public policy (Acker 2002; Campbell 2000; Cooper 2004; Courtwright 1982; Hickman 2007; Musto 1987). Dual conceptions of the figurative “drug addict” operate in tandem—one sympathetic for the dominant class, one unsympathetic for the underclasses; and these figures’ alternating prominence in public discourse is linked to changes in drug policy emphasizing treatment or incarceration, respectively (Acker 2002; Campbell 2000; Cooper 2004; Courtwright 1982; Hickman 2007; Musto 1987). Lassiter has argued this bifurcated policy pattern can develop simultaneously, with treatment advocated for white, young, suburban drug users and punishment for the Black or Latino “drug pushers” who “prey” upon them (Lassiter 2015). There has been some media attention to a similar dynamic developing in response to the opioid epidemic (Godfrey 2014; Seelye 2015; Young and Hobson 2015). But to date, there has been little scholarly work linking the opioid epidemic and recent drug policy developments (Neill 2014).

Another literature informing my approach is “critical addiction studies” (Reinarman and Granfield 2015, p. 15). This scholarship includes analyses of public and private efforts to name and categorize “drug addicts,” to develop techniques of government<sup>3</sup> to manage them, and thereby to mitigate the threat they pose to the dominant social order (Bourgois 2000; Bunton 2001; Donohue and Moore 2009; O’Malley and Valverde 2004; Reith 2004; Vrecko 2010; Campbell 2000; Hansen and Roberts 2012; Kaye 2013; Moore and Fraser 2006; Moore 2007, 2011; Tiger 2015; Valverde 1998). Several authors have examined the governmental projects made possible by the contemporary “drug addict” identity, therapeutic drug policies, and practices of recovery (Campbell 2000; Hansen and Roberts 2012; Kaye 2013; Moore 2007, 2011; Wilton and DeVerteuil 2006). But none have investigated these

<sup>2</sup> Demand-reduction measures aim to reduce rates of drug use, while supply-reduction measures aim to disrupt drug trafficking and distribution.

<sup>3</sup> I use the terms “govern” and “government” throughout in a Foucauldian sense, as in, “modes of action, more or less considered or calculated . . . to structure the possible field of action of others” (Foucault 1982, p. 790). Thus, the ability to govern—to exercise power—is contingent upon the freedom of the subject.

governing strategies in the context of the opioid epidemic or the effects of recovery discourse on policy development, which is the contribution I make here.

Finally, there is scant work in political science on drug policy development (Fortner 2015), and none that takes a critical discursive approach. Most recent political analyses of drug policy describe it as a tool used to fuel mass incarceration, expand the carceral state, or maintain racial domination (Alexander 2012; Murakawa 2014; Weaver 2007).

Building upon these disparate literatures, I weave together models of policy development, histories of U.S. drug policy, and Foucauldian critical theories, to comprehensively consider drug policy development. I analyze drug policy as a function of changing ideas, practices, and institutions that develop over time, and as a rich site of information about prevailing conceptions of the human and governmental techniques for managing the population.

A final note on terminology: “addict” is the most common term used to describe a person whose drug use exceeds social acceptability, but it is being phased out by the increasingly common “substance use disorder.” The DSM-V changed the terminology for people who use drugs to substance use disorders of varying levels of severity (SAMHSA 2014), but the National Institute on Drug Abuse (NIDA) still uses the term “addiction,” which they consider interchangeable with “substance use disorder.” NIDA describes their neuroscientific model of “addiction” as:

... a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain—they change its structure and how it works. These brain changes can be long-lasting, and can lead to the harmful behaviors seen in people who abuse drugs. (NIDA 2014, p. 5)

Disease models of “addiction” have existed for centuries (Courtwright 1982). NIDA’s neuroscientific model currently prevails, but still competes with the “allergy” disease model advanced by some therapeutic discourses (White 2014). Importantly, both models frame “addiction” as a disease that the “addict” cannot be faulted for having. The “addict” cannot be cured by willpower alone, rather they need medical treatment to get well. These models also make the concept of recovery possible, claiming that changes in the brain are reversible or that the allergy can be arrested through abstinence. Yet, “addicts” still face serious stigma, and as I argue in the discussion section, recovery discourse engenders new varieties of stigma.

The definition of “addiction recovery” is contentious, but the ONDCP’s definition includes its most common elements:

Recovery is a process of change and growth through which people with substance use disorders stop using, and reestablish friendships and family ties, build positive social networks, and become productive and responsible citizens. It is characterized by health, wellness, a sense of purpose, and productive involvement with family and community. Recovery can occur at the individual, family, and community levels. (ONDCP n.d.c)

I explore the tensions over the use and definition of recovery in the discussion section.

Finally, I use the phrase “people who use drugs” when referring to all individuals who ingest mind- or mood-altering substances. I employ the term “addict” when referring to people self-identified, or identified by experts, as “drug addicts.” This distinction is analytically necessary because not all people who use drugs are labeled “addicts.” When using the term “addict,” I am referring to a political category of persons and the specific bundle of social, cultural, and political meanings attached to that identity.

### 3. Materials and Methods

My findings are based on an analysis of the political, biomedical, psychological, legal, and public health discourses used by the media, policymakers, experts, and advocates to describe “addiction,” the

typical “addict,” effective treatments, the practices of recovery, and public policies. I employ critical discourse analysis because the objects of my investigation are linguistic constructions and associations, which are best considered through close examination of rhetorical artifacts. My analysis consisted of examining materials about U.S. drug policy spanning from 1999–2016, focusing on those related to the opioid epidemic. I gathered more than 200 media articles from Lexis Nexis, the EBSCO host periodicals database, and Google News, by searching for “opioid epidemic,” as well as reviewing key articles referenced by authors, in news articles, and by lawmakers. I also searched the Congressional Record for “opioid epidemic,” reviewing eight committee hearings and thirteen other items including floor remarks, hearing reports, and the language of proposed and passed bills. I analyzed more than 100 reports, webpages, policy statements, public remarks, and other materials produced by government agencies ranging from the Department of Justice (DOJ) to the Centers for Disease Control and Prevention (CDC), elected officials at the local, state, and national level, research organizations, professional associations including medical and treatment specialists, and advocacy groups, regarding the opioid epidemic specifically and drug policy in general. As I examined these resources, I tagged recurring frames, themes, phrases, and terms, and recorded changes over time. The sources cited in this essay are included as paradigmatic examples of the discourses I repeatedly encountered throughout my analysis.

My approach to discourse analysis is Foucauldian. I examine discourse—words, texts, associative meanings, practices, and specialized knowledges—as sites of “power-knowledge relations” that shape ways of knowing and being (Foucault 1977, p. 27–28). In this case, expert knowledge about drugs and people who use them, the practices of policymaking, treatment, and legal sanction, and the experiences of people who use drugs, are all elements of the discourse about drug use and “addiction.” Experts in the medical, scientific, and policy fields are often able to assert their knowledge as definitive (Campbell 2000), but the subjects of these knowledges are not just passively constituted by discourse. They produce their own knowledges, as well as contest or deploy existing discourses to their own ends. Systematic analysis of the aforementioned range of data allowed me to investigate the development of discourse through these struggles, including how competing causal narratives are constructed and how policies are framed to implicate certain solutions (Fischer 2003). Included in this data are materials produced by organizations created by and for people who identify as being in “addiction recovery.” This population is distinct from all people who use drugs and from all people who identify as “addicts.” It is likely that populations not affiliated with these organizations employ the discourses of “addiction” and recovery to different personal and political ends than I find in this study, if they use them at all (Radcliffe and Stevens 2008; Rødner 2005). Comparing the use of these discourses among different groups of people who use drugs is a promising topic for future study. However, because this study is focused on the impacts of these discourses on policy change, my analysis is centered on how elites—experts, policymakers, and advocates—deploy these discourses to advance their policy agendas.

In the discussion section, I explore how the governmental logics of ethopolitics and advanced liberalism (Rose 1996, 1999, 2007) shape the discourses about “drug addiction,” the identities assigned to “addicts,” and how they are made governable through drug policy (Moore 2007). Rose’s concept of ethopolitics is a mode of governmentality<sup>4</sup> where the capacities of the population are managed through “sentiments, beliefs, and values; by acting on [the] ethics” of the subject (Rose 2007, p. 27). In this mode, “techniques of the self”—including personal desires, values, and judgments about oneself and who one can become—are aligned with the reproduction of the sociopolitical order (Foucault 1977, p. 87). This should not be misconstrued for false consciousness, rather, it is a harmonization of the goals of self and government, conjoining the directives of authorities and “the ideals and aspirations of individuals”

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<sup>4</sup> Modes of governmentality are the conceptual and practical directives for exercising power upon and through the population; these overlap and intertwine with political rationalities or the modes of thought dictating the proper exercise of political sovereignty (Foucault 2010, 2007; Rose et al. 2006).

(Rose 1999, p. 217). The quest for personal fulfillment is a point of leverage for experts and the state, but these aspirational identities can also provide a paradigm for political organizing (Rose 2007). In addition, Rose's conception of advanced liberal political rationality, an intensified and expanded version of classical liberalism and its economic interrogation of governmental practices with the aim of shrinking and redirecting the state's power, also shapes these discourses. In this model the state, rather than providing for or directly intervening in the lives of its citizens, is charged with "creat[ing] freedom and those capable of inhabiting it" (Rose 1999, p. xxiii). That is, creating subjects who can be governed as autonomous and responsible consumers who, "through acts of free but responsibilized choice," discover and express their true selves through their consumer choices (Rose 1999, p. xxiii). In an ethopolitical context, this includes the state structuring consumer lifestyle markets by regulating the experts with whom subjects consult as they make "free" personal choices (Rose 1999).

As a scholar concerned with the lives of people who use drugs and enacting justice in all its forms, this approach allows me to make two points: first, to raise questions as to whether the U.S. is truly adopting humane drug policies as claimed, by examining the effects of the implicit exclusions in the discourses animating reform; second, to make a methodological argument that critical discourse analysis offers insight into the intertwined processes of policy development and projects of government, an important contribution to the political science literature.

## 4. Analysis

### 4.1. Development of the Discourse

U.S. drug policy has been shaped by recurring panics over drug "epidemics" (Chitwood et al. 2009). Since the crack epidemic of the late 1980s—which fueled the most recent War on Drugs—there have been several other "epidemics" including ecstasy in the 1990s and methamphetamine in the 2000s (Chitwood et al. 2009). I focus on the opioid epidemic because it has been far more devastating than the previous two. First declared an epidemic in 2011, between 1999 and 2013 there has been a four-fold increase in opioid-related overdose deaths, surpassing car crashes as the leading cause of injury death in the U.S. (CDC 2011, 2015a, 2015c). Further, this epidemic is notable because of widespread public awareness of its effects among privileged socioeconomic and racial groups. Although CDC data shows that people who are poor, white, male, and live in rural areas are the most likely to die from opioid overdoses (CDC 2015a, 2015b), much of the media coverage and policy discourse has focused on rising rates of opioid use and overdose among middle-class, suburban white people, particularly young people (Achenbach 2014; Seelye 2015).

Based on my analysis of the discourses of the opioid epidemic, I make four claims: first, the present epidemic has been critical in redirecting public attention toward a more sympathetic "addict" figure who suffers from a disease; second, focus on a sympathetic figure has affected the dominant images associated with drug policymaking; third, advocates have used these changes to promote their preferred policy frame; and fourth, the ONDCP has incorporated this frame into their demand-reduction approach.

When prescription opioid use was first identified as a growing problem in the early 2000s, it was dismissed as a poor, white, rural phenomenon—"hillbilly heroin" (Tough 2001). As the epidemic worsened, state and the federal governments responded by passing legislation to reign in "pill mills" and "doctor shopping" by people who use drugs (ONDCP 2011b). This legislation made prescription opioids more difficult to access, and by the early 2010s, rates of heroin use and overdose rose. Lawmakers and the mainstream media began warning that heroin, "once almost exclusively an urban problem" was "spreading to small towns and suburbs" (Volkow 2014, p. 9). A 2011 front-page piece in *The New York Times* included pictures of an abandoned downtown storefront that had become a makeshift shrine to some of the young people—all white men—who had died of overdoses in Portsmouth, Ohio (Tavernise 2011). This article included both sympathetic and unsympathetic characters—those who were "victims" of the prescription drug scourge and those who



were described as dangerous criminal “addicts.” Since then, the narrative has turned decisively toward sympathetic “addicts,” who are frequently juxtaposed against the “typical junkie” figure. An NBC *Today Show* series on the epidemic featured the story, “A Teacher’s Addiction and the New Face of Heroin,” which deployed these archetypes as follows:

Say the words “heroin addict” and many Americans will conjure up images of a junkie living under an overpass in the poorest part of town. But addiction doesn’t discriminate. And in recent years heroin has wound its way into American communities and touched people who wouldn’t have considered using it just a decade ago—people like Michelle, a former teacher who almost lost everything to her addiction. (Carroll 2014)

The description of Michelle as a sympathetic “addict” in this passage is only comprehensible because the unsympathetic “junkie” figure is easily summoned in the public imaginary.

During the crack epidemic, the stereotypical “addict” was a menacing, young, Black or Latino/a, urban, poor man or pregnant woman. These figures were blamed for social problems ranging from crime to poor infant health and were deployed to justify the War on Drugs and racial disparities in the legal system (DPA 2016; Zerai and Banks 2002). In contrast, the figurative “addict” of the opioid epidemic is most often a sympathetic, young, white, suburban or rural, citizen, working- or middle-class man or woman—though the sympathy granted white women is more tenuous, especially among pregnant and parenting women (Campbell 2000; Gonzalez 2014a). Crack use by Black and Latino/a people was framed as a legal problem, one that could only be solved by courts and prisons. But opioid use by white, middle-class people is framed as a public health problem. This binary of drug-using populations and corresponding policy frameworks is recurrent in U.S. history, but its current manifestation has important political consequences.

During the height of the Drug War, Democratic and Republican lawmakers alike clamored to prove they were “tough on crime.” But many of those politicians have changed their tone in light of the epidemic, insisting “we can’t arrest our way out of this crisis” (Grassley 2014, p. 2). Focus on the sympathetic “addict” of the opioid epidemic who has a disease and is capable of recovery made this possible. The brain disease model has been popular for decades, but it has received greater political traction recently because opioids are one of the few drugs for which there are effective medications to treat dependence and overdose (NIDA 2014). In response, lawmakers on both sides of the aisle have taken up the cause of the sympathetic opioid “addict,” blaming outdated drug policies on public misperceptions of “addicts” being only people “who have made the wrong choices in life” (Lynch 2012, pp. 29–30). Policymakers have dedicated time and resources to combating these misperceptions and to urge pharmaceutical companies to develop better treatments for opioid use. Consider how former Representative Kucinich (D-OH) framed the problem and solution in a 2010 House subcommittee hearing, “Treating Addiction as a Disease: The Promise of Medication-Assisted Recovery”:

[A] neutral observer would have to conclude that this country’s efforts to reduce drug consumption have largely failed. . . . untreated drug and alcohol addiction overburdens our health care system, and clogs our criminal justice system with people who should be in treatment, not behind bars. . . . Like people with any other medical condition, drug-addicted individuals need to have access to medications to treat the disease. . . . and achieve long-term recovery. (Kucinich 2010, p. 2)

Policymakers refer to the epidemic as pressing them to reform drug policy, because it is “ . . . killing our sons and daughters; brothers and sisters, fathers and mothers” (Murphy 2015, p. 3) and constituents (Schakowsky IL 2015, p. 19). Bipartisan consensus has congealed around a new vision for drug policy as “a collaborative, multi-pronged effort—law enforcement, treatment, education and research” (Rogers 2012, pp. 16–17), with a focus on enhancing treatment and recovery services.

Simultaneously, “addiction” recovery advocates have been promoting a recovery-focused policy framework. Contemporary “addiction” recovery discourse emerged out of the modern treatment

movement in the mid-twentieth century (White 2014). There have been earlier grassroots movements to organize people who identified as being in recovery toward political ends, but one organization leading the current movement is Faces and Voices of Recovery (FAVOR). FAVOR is notable because it self-consciously deploys recovery discourse as an organizing paradigm. FAVOR offers a window into how the discourse of recovery is being used by some of the subjects of the discourse, in contrast to expert and elite usage (Bacchi 2000).

Founded in 2001, FAVOR describes their mission as “organizing and mobilizing the over 23 million Americans in recovery from addiction to alcohol and other drugs . . . to promote the right and resources to recover . . . ” (FAVOR n.d.). Their policy goals include “reduc[ing] the discrimination that keeps people from seeking recovery or moving on with their lives once they achieve it” (FAVOR n.d.). Their main strategy is to change the discourse about “addiction” by having their constituents in “long-term recovery”—their poll-tested terminology—to publicly speak about their recovery (FAVOR 2013, p.1). FAVOR works with academics to produce empirical evidence demonstrating that people in long-term recovery go on to “lead full, productive, and healthy lives,” and then use this evidence to support their claims for political, social, and health care rights (Laudet 2013, p. 2, 9). They also run a network of “Recovery Community Organizations,” providing training and resources for community-based recovery support services (FAVOR n.d.). Notably, FAVOR does not define recovery nor does it promote a specific disease model of “addiction.” Instead, they advise their constituents to go “straight to our message . . . of hope” in recovery, a message that “*describes rather than defines* recovery” (FAVOR 2013, p. 3, emphasis in original). This savvy media and organizing strategy opens their organization to people who define “addiction” and recovery in different ways. But an aversion to defining “addiction” has not kept FAVOR from lobbying for policy change that treats it as a disease.

FAVOR has claimed victory for helping pass the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA)—which require that “addiction” treatment be covered on par with other medical care, and that it be included in all health plans as an “Essential Health Benefit”—constituting the largest expansion of “addiction” treatment in a generation (Beronio et al. 2013, p. 1). They also take credit for the “elevation of recovery as a new organizing paradigm at ONDCP and . . . the first inclusion of recovery within the National Drug Strategy” (FAVOR 2016). If FAVOR’s claims are accurate, they have played an essential role in shaping the framework animating federal drug policy.

This leads to a final point, that the ONDCP has incorporated this recovery framework into its demand-reduction strategy. The ONDCP was founded in 1989 and charged with creating the National Drug Control Strategy (NDCS), which sets the tone and goals for the federal government’s drug policies (ONDCP n.d.a). The ONDCP has used the term recovery at least since 1999 (ONDCP 2002, p. 3), but the political discourse of recovery—that is, recovery as a policy goal and people in recovery as a constituency—was only integrated into the ONDCP’s strategy in 2009 when they established an official “Recovery Branch” (ONDCP n.d.a; Fields 2009). Former ONDCP Director Gil Kerlikowske and former Deputy Director Thomas McLellan are credited with leading the reorientation of the national approach toward recovery (Dokoupil 2014). They were instrumental in securing “addiction” treatment coverage in the ACA, contributing to the shift in venue of demand-reduction policy from criminal law to health care. Furthermore, the most recent director, Michael Botticelli, was a powerful symbol of the ONDCP’s new approach. Botticelli was the office’s first leader to publicly identify as being in “long-term recovery” (ONDCP n.d.b).<sup>5</sup> Announcing his Senate confirmation on the White House blog, Botticelli proclaimed:

There are millions of people in recovery in the United States leading meaningful, productive lives full of joy and love and laughter—and I am one of them. . . . I am open about my recovery

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<sup>5</sup> Botticelli resigned on 19 January 2017 (Botticelli, Michael. 2017. Transition).

not to be self-congratulatory, I am open about my recovery to change public policy. . . . I hope that many more of the millions of Americans in recovery like me will also choose to “come out” and to fight to be treated like anyone else with a chronic disease. (Botticelli 2015a)

Botticelli’s confirmation solidified the optics of the Obama Administration’s change in approach (Schwarz 2015), which he described as follows:

The [*National Drug Control*] Strategy is a 21st century plan that outlines a series of evidence-based reforms that treat our Nation’s drug problem as a public health challenge, not just a criminal justice issue. It moves beyond an outdated “war on drugs” approach and is guided by what experience, compassion, and science demonstrate about the true nature of drug use in America. (Botticelli 2014, p. 1)

An integral part of the ONDCP’s reform strategy is to change the language used to describe people who use drugs—from “addict” or “substance abuser” to someone with a medical condition or “substance use disorder” (ONDCP 2014b, p. 2).

In total, this evidence suggests that the four elements of my argument are linked—a trigger event, a change in policy image, strategic deployment of that image by policy entrepreneurs, and a change in policy venue. Even Botticelli has drawn a connection between the epidemic, advocacy organizing, and a changing policy frame:

Because the demographic of people affected are more white, more middle class, these are parents who are empowered . . . They know how to call a legislator, they know how to get angry with their insurance company, they know how to advocate. They have been so instrumental in changing the conversation. (Seelye 2015)

#### 4.2. Policy Impacts

Policy changes in response to the epidemic include reforms that aim to save lives, prevent the spread of disease, and improve access to treatment. There have been consequential drug policy reforms unrelated to the epidemic in recent years—most notably reform and repeals of mandatory minimum sentences—but even these have been credited partially to the changing image at the core of drug policy (Subramanian and Delaney 2014; Lofgren 2011; DOJ 2013). In this section, I consider several national policies animated by recovery discourse and crafted in response to the epidemic as examples of recent policy changes seen at all levels of government.

First, access to naloxone—a drug that can reverse the effects of an opioid overdose—has dramatically increased in the last several years. Federal funding is now offered and at least 34 states have adopted policies to buy and train people to use naloxone including first responders, people who use opioids, and their friends and family (Bureau of Justice Assistance 2014; DOJ 2014; DPA 2015b). Naloxone access has been praised by the ONDCP, politicians of all political stripes, and law enforcement (Burgess 2015, p. 90; Harris 2015, p. 2; L’Esperance 2014, p. 3). It is predicated on the assumption that “every life is worth saving,” reflecting the discourse of the sympathetic “addict” figure whose life is valuable (DeMio 2015).

Access to medication-assisted treatment has also significantly expanded during the epidemic, lending credence to the concept of “addiction” as a disease. Buprenorphine was approved as an opioid maintenance medication in 2000 to be dispensed in private doctor’s offices, making it accessible to some suburban and rural communities underserved by already-existing methadone clinics (Jaffe and O’Keeffe 2003). Demand has been high for this less-stigmatized alternative to methadone, and access was expanded by law in 2005 and with an HHS rule change in 2016 (HHS 2016). These medications are praised for being evidence-based treatments for opioid dependence that enable recovery and enhance public health and safety (Harris 2015; HHS 2015). Critically, medication-assisted treatment also restores the “addict’s” free will, “enabling opioid-addicted persons to regain control of their health and their lives” (Volkow 2014, p. 11).



The Protecting Our Infants Act (POIA) was passed in 2015, ordering an HHS study on neonatal abstinence syndrome (NAS)—the name for symptoms experienced by some newborns exposed to opioids, ranging from fever to preterm birth (Clark and Patrick 2015). The Act requires HHS to develop a strategy to address gaps in research about NAS, recommendations for treating it, and to identify barriers to treatment for pregnant people who use opioids (PL 114-91 2015). Notably, the discourse from the White House regarding POIA has consistently framed NAS as a public health issue (Botticelli 2015c), in contrast to the intense demonization of women of color during the so-called “crack baby” era (Zerai and Banks 2002).

In 2016, Congress passed the Comprehensive Addiction and Recovery Act (CARA). In name, CARA is the largest expansion of prevention, treatment, and recovery services in decades. It extends grant-making capacity to HHS for access to naloxone and medication-assisted treatment, to support Recovery Community Organizations, and enables the DOJ to expand alternatives to incarceration (PL 114-198 2016). Alternatives to incarceration—such as drug courts and diversion programs—are praised for redirecting “nonviolent offenders” out of the legal system and into treatment, supporting recovery, reducing recidivism, and being more cost-effective than incarceration (NADCP n.d.; ONDCP 2014a). CARA also calls on the Government Accountability Office to produce a report on the “collateral consequences” for those convicted of drug offenses, and suggestions for mitigating those consequences for those in recovery (PL 114-198 2016). Despite its progressive promise and bipartisan support, CARA’s funding ultimately fell prey to partisan conflict, with the Republican-controlled Congress including only a fraction of the funding required for these initiatives, leaving the rest to be allocated through the appropriations process each year (Sullivan 2016). Temporary funding for some of CARA’s initiatives was allocated later in 2016 via the 21st Century Cures Act, a massive healthcare bill including one billion dollars for states combating the epidemic (PL 114-146 2016). But CARA still has no permanent funding allocation, and it remains to be seen if the bill will live up to its lofty aims.

These three substantial bills—POIA, CARA, and the Cures Act—broke through a gridlocked Congress in part because, as Senate Majority Leader Mitch McConnell (R-KY), one of the introductory sponsors of CARA, said on the Senate floor, “drug abuse isn’t a partisan issue” (McConnell, Senate Majority Leader Mitch 2015). The geography of the epidemic has made bipartisanship possible. Kentucky has been hard-hit by the epidemic, as have other conservative strongholds such as West Virginia, swing states such as Ohio, and early presidential primary states such as New Hampshire (Zezima 2016). These practical political factors combined with a growing overdose epidemic, intense public focus on a sympathetic “addict” figure, advocates armed with a new policy framework, and the ONDCP incorporating this policy framework into its national strategy, aligned to puncture a decades-long policy equilibrium. U.S. drug policy has always been a contested site, particularly between medical experts and legal authorities, but these policy developments have moved demand-reduction policy decisively toward medicalization, and specifically, recovery-oriented care.

These reforms mark a departure from the War on Drugs’ incarceration-first framework. But the overall approach of U.S. drug policy—as measured by federal funding for supply- versus demand-reduction measures—has changed only marginally in the last fifteen years, still slightly favoring law enforcement and interdiction over treatment and prevention (ONDCP 2015, p. 21). In the next section, I consider the governmental implications of this new policy framework, offering insight into why the rhetoric of drug policy has changed dramatically while federal funding has remained static.

## 5. Discussion

Recovery discourse identifies “addicts” as failed subjects because their pursuit of drugs over social norms such as health and employment constitutes a “disease of the will” (Valverde 1998). The idealization of freedom in advanced liberal society and the “insufficiently free” will of the drug “addict” (Sedgwick 1993, p. 137) deems them problematic subjects who must be reformed or ostracized. The ethopolitics of recovery discourse provides a set of “techniques of the self” through which “addicts” are taught how to be autonomous, responsible individuals, choosing among state-sanctioned

recovery lifestyles (O'Malley and Valverde 2004; Foucault 1977, p. 87). This model encompasses both historical types of “addicts”—those who threaten society by their antisocial behavior, and those whose disease threatens their privileged place in society. Both are characterized as having a medical disease. But within recovery discourse there is a new typology of “addicts.” In a break with the past, treatment is no longer provided based on their social, economic or political status. Instead, all “addicts” are now governed according to their “recovery status”—as recovering, potentially recovering, or refusing to recover. While some “addicts” can be successfully governed through the normative appeals of recovery, others are more resistant. Expert knowledge “knows” their disease manifests in criminalized behavior, is concealed by denial, and carries a high risk of relapse. The potentially recovering person often needs the “incentive” of incarceration to keep them motivated in treatment. Thus, recovery-oriented policies are state-funded, expert-directed interventions that blend medical and therapeutic treatment with criminal sanctions to ensure “addicts” *choose* to internalize the ethopolitical practices of recovery—and to punish those who refuse. This approach is part of a larger policy trend away from comprehensive social programs or strictly punitive criminal policies to therapeutic, managerial interventions that make the individual responsible for their own rehabilitation (Moore 2007); and in this case, their recovery.

As a result, the discourse of recovery provides a paradox of political implications. Research suggests “addiction” disease and recovery discourse evokes sympathy and humanizes people who use drugs (Desmon and Morrow 2014; McGinty et al. 2015). It can also provide some people who use drugs—who in the past have been institutionalized, sterilized (Kaye 2012), or killed (Berlant 2007)—with access to resources and treatment they may find beneficial. For these reasons, even the most radical advocates agree that recent policy changes are an improvement over the War on Drugs approach (DPA 2011). Further, by claiming a recovery identity, people who use drugs may be able to assert their autonomy and minimize the harms they experience from drug prohibition. Most importantly, recovery discourse legitimizes the voices of some people who use drugs in the public arena. Members of advocacy groups such as FAVOR can use recovery discourse and their “biological citizen” identities (Rose 2007, p. 149) as political tools to advocate for policies they see as being in their best interest, improving drug policy’s adherence to normative expectations of democratic policymaking (Fischer 2003).

At the same time, recovery discourse also limits what can be said about drug use. People who do not experience their drug use as problematic are excluded from the public conversation, as are those who eschew the “addict” label. Depictions of recovery also have a distinctly privileged bent. Successful people in recovery featured by the media and advocacy organizations are often the redeemed sympathetic “addict”—that is, white, well-educated individuals from middle-class neighborhoods who defy stereotypes about “addiction” (FAVOR n.d.). For example, in a White House blog post on drug courts, Donovan, a young white man from Kentucky, was described as exemplary of “people who seized the chance to change their lives for the better when they were given the opportunity” (Botticelli 2015b). This is a common framing that emphasizes the individual’s personal commitment to recovery, not the racial or socioeconomic factors that may have enabled them to access treatment. Recovery discourse has also precluded discussion of other policy frameworks. Harm reduction policies are often dismissed because they do not demand complete abstinence, while decriminalization and marijuana legalization are criticized for “undermining” recovery, ignoring evidence that such policies improve public health (DPA 2015a; ONDCP 2011a, pp. 21–22), including medical marijuana being a viable alternative to prescription opioids (Bradford and Bradford 2016).

With these limitations in mind, the underside of recovery discourse emerges. First, recovery discourse can justify cruel coercive practices. Forcing the “addict” into treatment by threatening them with criminal charges or the loss of their home or children is considered a humane alternative to

incarceration. For example, a law passed in Tennessee in 2014<sup>6</sup> allowed for a person who gave birth to a baby that tests positive for drugs to be charged with assault, with the caveat that they could avoid the charges if they enroll in a treatment program (Boucher and Gonzalez 2015). Health care providers condemned the law for pushing pregnant people away from prenatal care, but proponents claimed “the women we have charged would say the law was helpful to them” because it “[led] to better things for them and their children” (Boucher and Gonzalez 2015). This example demonstrates how tenuously women are represented as sympathetic “addicts,” when their children are described as “the youngest victims of our nation’s battle with the prescription drug epidemic”—victimized by their parents who use drugs (Clark and Patrick 2015).

Second, recovery discourse makes possible a new binary of people who are recovering and those who refuse to recover. Just as the sympathetic “addict” of the opioid epidemic is often contrasted with the assumed “junkie,” so too is the recovering “addict” often described in relief to its opposite figure—the “addict” who refuses to recover. As Keane notes, “... the recovering addict is ... the promise of what every addict could become” (Keane 2000, p. 328), thereby becoming the measure against which all potentially recovering “addicts” are compared. For example, FAVOR at times distinguishes between individuals based on “recovery status” and what political and social rights they each deserve (FAVOR n.d.). The ONDCP likewise criticizes laws that “make no distinction between the person who continues to use drugs and the person who is on the pathway to recovery,” and advocates for an “exemption of recovering people” from some legal sanctions (ONDCP 2010, p. 44). While both organizations claim to be working on behalf of all “addicts,” they often champion the person in recovery in contrast to their Other. The recovering person is celebrated as a courageous individual who deserves to be reintegrated into society, while the “addict” who refuses to recover is justifiably outcast from society (Rose 2007).

According to this logic, “addicts” are incarcerated not because the law discriminates against them as a class, or against certain classes of “addicts,” but because individual “addicts” have rejected the opportunity to learn how to “properly” govern themselves. Despite promising a more equitable approach, recovery as an individualized responsibility of each “addict” thereby legitimizes continued disparities in the legal system. For example, some public health and diversion programs have been shown to perpetuate disparate outcomes by race, class, and gender, including medication-assisted treatment (Beeler 2014; Hansen and Roberts 2012; Jaffe and O’Keeffe 2003) and drug courts (Csete and Tomasini-Joshi 2015; DPA 2011; Tiger 2015). Distinguishing among “addicts” based on their allegedly free choices blames them for failing to recover and obscures the barriers often blocking marginalized people from treatment and recovery resources (Cherkis 2015). The Tennessee law further demonstrates this point. The stated intention of the law was to motivate people to enter treatment (Gonzalez 2014b); however, the law did not provide additional funding for treatment centers to accept pregnant or parenting persons, a chronically underserved group (Gonzalez 2014a). Thus, policymakers appeared knowledgeable about “addiction” and motivated by compassion, while in practice, the law subjected predominantly low-income pregnant people to invasive surveillance, criminal sanctions, and the threat of losing custody of their children, without offering additional treatment options.

More broadly, recovery discourse legitimizes the advanced liberal state’s refusal to equitably provide security and ensure health for the entire population. It supports the narrative that failure to thrive is the result of an individual’s inability to make appropriate choices. Recovery discourse also provides false hope that ending drug use will necessarily improve the life circumstances of a person who uses drugs, ignoring the many factors that contribute to social, economic, and political dislocation.

Finally, the narrative of a new approach to drug policy allows policymakers to acknowledge the War on Drugs has failed without actually admitting defeat. Recovery discourse condemns the

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<sup>6</sup> This law expired in 2016 and was not renewed by the Tennessee legislature (Ebert 2016); however, other states continue to prosecute people who use drugs during pregnancy under criminal or civil child abuse statutes (Guttman Institute 2017).

War on Drugs for favoring incarceration over treatment and treating “addicts” as criminals rather than people with a disease; but it does not condemn the Drug War for systematically incarcerating, disenfranchising, and destroying marginalized communities by targeting young, poor, urban, Black and Latino/a people. “Addiction” is allegedly indiscriminate to race, gender, sexuality, class, geography, or country-of-origin; yet those employing recovery discourse rarely address why racial minorities and marginalized populations are disproportionately affected by punitive drug policies (FAVOR 2011). As drug policy is increasingly framed as a matter of incentivizing recovery, people who use drugs who cannot or will not claim an “addict” identity are rendered invisible and punished under the veneer of protecting public health. This is particularly true for people who sell drugs, who are usually construed as “preying” on “addicts”—rather than as people who use drugs themselves or who have few other economic opportunities (Petska 2015; Zapotosky 2016).

My analysis indicates that drug policy reform made it on to the policy agenda because the individualizing and privatizing discourse of recovery legitimizes humane alternatives to mass incarceration for a privileged few. Reforms diverting first-time, nonviolent offenders out of prison and into treatment placate privileged groups demanding more humane drug policies in response to the epidemic. At the same time, recovery discourse reframes punitive drug policies as themselves part of a larger recovery-oriented approach, designed to keep “addicts” on the path to recovery. This allows the state to control marginalized classes through the carceral apparatus, suppressing demands from below to more thoroughly reform the legal system (Gottschalk 2015; Tiger 2013). Therefore, I find that drug policy reform broke through a gridlocked Congress in part because of the governmental implications of recovery as a policy framework. Recovery discourse defines the political crises of the opioid epidemic, the failure of the War on Drugs, and mass incarceration in terms of disease, attributing these injustices to prejudice against “addiction” rather than a constellation of institutional racism, sexism, nativism, and economic exploitation enacted through drug policy. I conclude that characterizing recent reforms as a decisive break with the War on Drugs obscures the ways in which drug policy continues to perpetuate injustice by offering a personal, rather than political, solution in the “hope” of recovery.

## 6. Conclusions

Drug policy reform has succeeded in an otherwise gridlocked Congress because a new policy image—the sympathetic “addict” of the opioid epidemic—has been championed by recovery advocates, adopted by the ONDCP, and used effectively by constituents to pressure members of Congress. I argue that the “addiction recovery” paradigm has prevailed because it frames demand-reduction policy as hinging on an individual decision made by the “addict” to accept or reject recovery, obscuring the ways in which drug policy continues to perpetuate social, political, and economic stratification.

There are limitations to this study. I primarily examined discourses about the opioid epidemic, not the entire breadth of U.S. drug policy discourse. One area for further study is marijuana legalization. I omitted this issue because the debate is largely over regulating marijuana similar to alcohol and tobacco, rather than rethinking drug prohibition. The global movements for harm reduction, decriminalization, and legalization, and their impacts on U.S. policy development, would also be fruitful areas for further examination. Finally, as mentioned above, a closer examination of how the discourses of “addiction” and recovery are used by the varied populations of people who use drugs is worthy of a full study as well.

The Trump administration has offered mixed signals regarding the future trajectory of U.S. drug policy. The current president may be sympathetic to the discourses of disease and recovery, as he publicly attributes his teetotalism to his brother’s death from alcoholism (Horowitz 2016). Some actions by his administration, including declaring the opioid epidemic a “national public health emergency” and convening a special commission that recommended expanding access to treatment and drug courts in response to the epidemic, reflect this potential (Korte 2017). However, neither of those actions included additional funding, and Trump and the Republican majority in



Congress continue to attempt to dismantle the ACA (Montanaro 2017). At the same time, Attorney General Jeff Sessions has reversed some of the initiatives of his predecessor, restoring the directive to pursue mandatory minimum sentences in drug-related cases (Beckett 2017). Therefore, it is quite possible that the new administration will continue along a similar path to the one paved by the Obama administration—encouraging treatment for privileged people who use drugs—but using more explicitly racialized, xenophobic, and sexist language for those who “fail” to recover. In this political context, drug policy reform advocates may find it expedient to combat retrenchment by championing the sympathetic “addict” figure. However, this article suggests advocates would be wise to take into account the political and human costs this discursive strategy entails, and to consider employing more inclusive discourses in order to more radically challenge the newest iteration of the U.S. War on Drugs.

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