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“HOPE FOR EVERY ADDICTED AMERICAN”

An Opioid Epidemic in the Age of Ethopolitics:
Implications for U.S. Drug Policy and Governing Problematic Subjects

By

ELIZABETH NEWCOMER

A master's thesis submitted to the Graduate Faculty in Political Science in partial fulfillment of the requirements for the degree of Master of Arts, The City University of New York.

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ABSTRACT

“HOPE FOR EVERY ADDICTED AMERICAN”

An Opioid Epidemic in the Age of Ethopolitics:
Implications for U.S. Drug Policy and Governing Problematic Subjects

By

Elizabeth Newcomer

Advisor: Professor Alyson Cole

The United States is in the midst of an unprecedented drug epidemic instigated by overprescribed pain relievers and cheap, accessible heroin. Beyond its immense scope, what makes this opioid epidemic distinctive is a widespread awareness of its effects among privileged populations and a political consensus that it cannot be effectively addressed with existing, punitive drug policies. Building upon analyses of the drug addict identity and policy change as well as critical addiction studies, I critically examine the discourses of the opioid epidemic, considering their impact on U.S. drug policy since 2000 and analyzing the implications of these changes for governing – in a Foucauldian sense – people labeled drug addicts. I demonstrate that the epidemic has brought what I term the “normalized sympathetic addict” (or NSA) to the forefront of public discourse. This empathetic figure is juxtaposed against the “marginalized threatening addict” (or MTA), the typical menacing drug addict. Focus on the NSA of the opioid epidemic has lent authority to the discourses of addiction disease and recovery, which are informed by ethopolitical and advanced liberal governmental logics, making possible novel modes of government through the “recovering addict” identity. The “progressive” public health policies inspired by these discourses allegedly offer equal opportunities to both NSAs and MTAs to engage in recovery. However, I argue that recovery’s individualizing and privatizing logic enables these policies to perpetuate the discriminatory effects of the War on Drugs by obscuring

inequalities and displacing blame for biased outcomes onto addicts' individual choices to accept or reject recovery. Thus, despite significant changes in discourse inspired by the opioid epidemic's NSA, drug policy remains a useful tool for managing problematic subjects through their identities and maintaining the hegemonic political order, even as it claims to be more humane and less discriminatory.

Keywords: opioid epidemic; drug policy; addiction recovery; critical addiction studies; discourse analysis; ethopolitics

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I. INTRODUCTION

According to the Centers for Disease Control and Prevention (CDC), “[t]he United States is in the midst of a prescription painkiller overdose epidemic” (CDC 2015d). The Department of Health and Human Services (HHS) calls this overdose epidemic “unprecedented” (HHS 2013), the Department of Justice (DOJ) calls it a “true national crisis” (Bureau of Justice Assistance 2014), and the Office of National Drug Control Policy (ONDCP) calls prescription drug abuse “a major public health and public safety crisis” (ONDCP 2011a). Experts and the media characterize the current opioid epidemic as “the worst drug epidemic in our history” (Sifferlin 2015) a title not unwarranted as the White House reported in 2011 the epidemic had already killed more people than the two most recent drug epidemics – crack cocaine in the 1980’s and heroin in the 1970’s – combined (Young 2011).

The opioid epidemic is typically described as originating from systemically overprescribed prescription opioid pain relievers such as hydrocodone, oxycodone, morphine, and methadone (CDC 2015b). Partially in response to demands to treat chronic pain, partially the product of aggressive marketing campaigns by pharmaceutical companies (Bell and Salmon 2009; Hansen and Roberts 2012; Kolodny et al. 2015); between 1999 and 2013 the number of opioid prescriptions in the U.S. quadrupled even though the amount of pain reported by the population did not increase (CDC 2015b). During that same period, opioid-related overdose deaths also quadrupled killing 16,000 people in 2013, surpassing car crashes as the leading cause of injury death in the U.S (Ibid). Rates of heroin use – a naturally occurring opioid – have also risen in recent years as regulatory controls have reduced the availability of prescription opioids (CDC 2015a) and heroin has become cheaper, more potent, and more widely available (Jones et al.

2015). As a result, heroin overdose rates nearly quadrupled between 2002 and 2013, and nearly doubled between 2011 and 2013 alone (Jones et al. 2015).

The epidemic first gained media attention in local newspapers in Maine and Ohio in 2000 (Ordway 2000; Whelan and Asbridge 2013). Prescription opioids were nicknamed “hillbilly heroin” for their prevalence in rural areas in the Northeast, Appalachia, and the South (Tough 2001). However this phenomenon quickly spread nationwide, and prescription drug abuse was declared a national epidemic in 2011 by the CDC (CDC 2011). That same year the ONDCP released a four-fold strategy to address the epidemic through education, tracking and monitoring prescriptions, proper disposal of unused pharmaceuticals, and enforcement (ONDCP 2011a). An overabundance of opioids in the U.S. – particularly in rural and suburban areas where opioids were not previously plentiful (Wood 2014) – has triggered a shocking drug epidemic unlike any other in U.S. history, and policymakers and experts have scrambled to respond. For example, former West Virginia Representative Nick Rahall (D-WV) stated in a Congressional hearing in 2012, “The toll of destruction and devastation heaped upon America’s families and our economy by this epidemic demands the United States Congress must act, and act swiftly” (Rahall (WV) 2012, 21). Former Representative Mary Bono Mack (R-CA) echoed this urgency, stating, “Simply put, we are in the midst of an American tragedy” (Mack (CA) 2012, 22).

Beyond its immense scope, what makes the contemporary opioid epidemic distinctive is an acute awareness of its effects among privileged socioeconomic and racial groups typically thought to be insulated from “hard” drug use and associated problems, problems typically ascribed to urban, poor neighborhoods and people of color. CDC data shows that prescription overdose deaths are most likely among those ages 25-54, non-Hispanic whites, and men, though women’s rates of opioid overdose are rising at a faster rate than men’s (CDC 2015f). Heroin use

and overdose is also most common among young adults age 25-34, non-Hispanic whites, men, and people living in the Northeast and Midwest (HHS 2015, 3). Although the data shows that poor, rural, white individuals are the most likely to die from opioid overdoses (CDC 2015e), much of the public dialogue has focused on rising rates of opioid use and overdose among middle-class, suburban white people, particularly young people (Achenbach 2014). The opioid epidemic “cuts across class, race, and demographic characteristics” (Bureau of Justice Assistance 2014), defying stereotypes about drug addiction and demanding a “coordinated...government-wide response” (ONDCP 2014b, 2).

It is well-established that actual or perceived demographic changes among those using drugs affects popular and political discourses about drug use and addiction and subsequently public policy (Acker 2002; Campbell 2000; Cooper 2004; Courtwright 1982; Hickman 2007; Musto 1987). Dual conceptions of the addict operating in tandem – one sympathetic for the dominant class, one menacing for the underclasses – have been a consistent feature of the figurative drug addict (Hickman 2007; Dawn Moore 2007) since the concept’s inception (Reith 2004; Sedgwick 1993). The distinction between the two has historically been based on the individual’s position in hierarchies of socioeconomic status, race, immigration status, gender, and sexuality (Acker 2002; Campbell 2000; Hickman 2000), and the attributed source of the addict’s problem, either an illness or an inherent moral or personality flaw (Cooper 2004; Courtwright 1982). Studies of past drug epidemics show that greater public attention to one or the other construction of the drug addict has contributed to policy changes alternately emphasizing treatment or incarceration for drug users (Acker 2002; Campbell 2000; Cooper 2004; Courtwright 1982; Hickman 2007; Musto 1987).

In this case, public awareness of the opioid epidemic’s impact in middle- and upper-class, suburban neighborhoods and among white young and middle-aged people has elevated what I term the “normalized sympathetic addict” (or NSA) to the forefront of drug policy discussions. This addict is distinguished by their privileged identity and is described as having the capacity to recover from the disease of addiction through treatment. The NSA is constructed in contrast to what I term the “marginalized threatening addict” (or MTA) who is distinguished by their stigmatized identity and their supposed aversion to treatment and recovery. The contemporary opioid epidemic – the material reality of skyrocketing numbers of people using, overdosing, and dying from opioids – and the popular and political discourse surrounding the epidemic – animated by the NSA and the discourse of addiction disease and recovery – are being strategically deployed to change the tone of U.S. drug policy from a nearly exclusive “War on Drugs” criminal justice and incarceration approach to a professedly “balanced, compassionate, and humane” approach that incorporates limited public health interventions without abandoning traditional law enforcement tactics (ONDCP 2013c, 1). Such public health policies include those crafted in response to the opioid epidemic such as expanding access to the overdose antidote naloxone and Medication Assisted Treatment (MAT) like methadone and buprenorphine. Some of the broader drug policy changes in the last fifteen years have also been influenced by these discourses, such as removing or reducing mandatory minimum drug sentences, expanding alternatives to incarceration, and broadening addiction treatment coverage through the Affordable Care Act (ACA). These policy changes are described as scientifically informed and evidence-based responses to the public health and safety risks associated with addiction because they provide treatment for the addict rather than – or in conjunction with – punitive measures, offering them an opportunity to begin the process of recovery from addiction. Changes in the

U.S. approach to drug policy since the turn of the century are typically attributed to drug war fatigue, the pursuit of cheaper alternatives to mass incarceration, a general decline in the crime rate since the 1990's, and reduced public concern about drug use (Apuzzo 2014; Desilver 2014; Gottschalk 2007; Neill 2014; Pew Research Center 2014). These remain important factors but I find the opioid epidemic and its main character, the normalized sympathetic addict, and the supporting discourses of addiction as a disease and particularly addiction recovery have also made critical contributions to these modifications.

Beyond these immediate changes to drug policy, the discourses of the opioid epidemic also have wider political effects and have altered how addicts are governed – in a Foucauldian sense – through their identities (Foucault 1981). I investigate these broader implications by conducting a critical discourse analysis, considering what these discourses generate, allow, and require as well as what they forbid and render invisible and unspeakable, with a specific focus on how addicts are further differentiated and governed through the discourse of addiction recovery. I find the discourses popularized by the opioid epidemic, particularly the ethopolitical discourse of addiction recovery, advances the objectives of advanced liberal government by compelling addicted subjects to adopt new modes of behavior under the guidance of experts in order to reinvent themselves toward ideals of freedom, happiness, and health. In pursuit of these goals, recovering or potentially recovering addict subjects are rendered governable through their “free” recovery-consumer choices, choices curated by the state through the regulation of experts and which ultimately align with the reproduction of the existing political hierarchy (Rose 1999, 2007). The discourse of addiction disease and contemporary legal norms of justice and equality require that recovery ostensibly be available to all addicts, eradicating past dichotomous governing strategies for sympathetic and threatening addicts that discriminated against

subordinated groups. Therefore, recovery makes possible new distinctions among addicts that crosscut the MTA and NSA identities. Addicts are further distinguished by their status as recovering addicts, potentially recovering addicts, or addicts refusing to recover, and through these designations they are more precisely – and allegedly more justly – governed. Indeed, the policies and practices of recovery do appear to be empowering for some self-identified recovering addicts who are using this discourse to organize and advocate for their social, political, and health rights. Recovery also allows some addicts to disassociate from their stigmatized addict identity and assume a more socially acceptable identity in recovery. However, the obligation to recover and the addict's inability to make choices in their own best interest while in the throes of their addiction also legitimates coercive and punitive tactics to induce recovery and enforce compliance, justified as being in the addict's own best interest, even if applied over their own objections.

Finally, the advanced liberal logic of recovery ignores structural barriers that prevent marginalized populations from succeeding in recovery and instead attributes failure to individual, freely made choices to reject a benevolently provided opportunity to reintegrate into society through recovery. Thus, the political work accomplished by recovery discourse is akin to what Cole found in contemporary anti-victimist discourse that in its “unremittingly privatizing and therapeutic” logic thereby “displaces or translates issues of institutional power and social inequity into matters of character” (Cole 2007, 19). In this case, the discourse of recovery displaces blame for disparities in the criminal justice and addiction treatment systems from institutional biases and highly unequal distribution of resources to personal failure, justifying ostracism and incarceration for the intransigent addict. Thus, professedly progressive drug policies relieve pressure on the state to provide security and ensure health more equitably by

individualizing social problems related to drug use, and disguise drug policy's continued role in differentiating deviance and reproducing the hegemonic political order through dehumanization and incarceration.

Structure

I begin by briefly reviewing the existing literature on discourse and drug policy, describing the approach I take to studying governmental rationalities, subject formation, and discourse analysis, and defining key terms. In the following section I analyze the discourses of the opioid epidemic in policy documents, government hearing testimony, statements by advocates and experts, and media coverage. I identify the NSA's prevalence in these public narratives, the supporting discourses of addiction as a disease and addiction recovery, and how these discourses are employed to further policy change. In the fourth section I review some key changes to U.S. drug policy in the last fifteen years and identify the discursive role of the NSA, addiction as a disease, and addiction recovery in shaping and legitimating these changes. I then analyze the political and governmental implications of these discourses and the policies they animate, particularly their role in governing subjects through the addict identity, differentiated by their responsiveness to recovery. I conclude by considering broader implications of this inquiry and future areas of research.

II. METHODOLOGY

This study draws on two main bodies of literature. First, examinations of the drug addict identity and its role in policy change (Acker 2002; Cooper 2004; Courtwright 1982; Hickman 2007; Musto 1987; Neill 2014), and second, research in the “critical addiction studies” tradition (Reinarman and Granfield 2015) which analyzes medical, therapeutic, criminal justice, and political discourses about drug addiction and drug policy’s role in managing deviance and shaping governable subjects (Bourgeois 2000; Bunton 2001; Campbell 2000; Hansen and Roberts 2012; Kaye 2013; David Moore and Fraser 2006; Dawn Moore 2007, 2011; O’Malley and Valverde 2004; Tiger 2015; Valverde 1998; Vrecko 2010). My approach to these literatures is informed by Foucauldian studies of government, particularly the works of Nikolas Rose.

The Drug Addict Identity and Policy Change

Systems of domination through differentiation (Gilmore 2002) including racism, sexism, heterosexism, and capitalism have shaped the drug addict identity throughout the history of U.S. drug policy. Drug use exceeding social acceptability in the U.S. has been present across all sociopolitical groups and in order to explain and address drug use among these differently valued groups, at least two distinct constructions of the drug addict have developed. The primary subjects of drug addiction discourse, the NSA and the MTA, are the product of interconnected political, medical, psychological, criminal justice, and public health discourses designed to differentiate between valued and disposable drug users.

First, what I term the NSA is the constructed figure most often used to describe drug addicts among the privileged classes. I use the terms normalized and sympathetic to reflect how the NSA is described as being akin to the ideal advanced liberal political subject and the dominant social group, and the emotional response this figure is designed to elicit. Their problem

has long been psychologized or medicalized, at times described as an attempt by respectable people to cope with the pressures of modern life (Hickman 2000) or simply the physiological result of an irresponsible doctor establishing an addiction to legal medications in an unsuspecting victim (Courtwright 1982; Hickman 2000, 2007). The NSA identity has typically been assigned to members of the dominant classes, middle- or upper-class, educated, straight white men. White upper-class women have been considered particularly susceptible to addiction because of their weak disposition but even these privileged women experience more dire social consequences than men for using drugs, often ostracized as failures of pious womanhood and motherhood (Campbell 2000; Hickman 2007). Despite their benign disposition, drug use among NSAs still poses a serious problem for society and policy makers. Addiction among this class has been framed as a serious threat to racial hegemony and white female purity (Hickman 2007), to American international dominance and security (Campbell 2000), and to the prevailing political order. Therefore a range of experts is compelled to intervene in these failing citizens' lives. Policies have typically provided treatment for NSAs and exempted them from criminalization (Acker 2002; Hansen and Roberts 2012; Hickman 2007).

In contemporary discourse the NSA is an individual who without their addiction would otherwise be part of a dominant social group and would adhere to the requirements of contemporary political subjectivity. Their problem is understood as a disease, some combination of a preexisting genetic or neurochemical susceptibility and a biological reaction and physical dependence to specific addicting substances. They are assigned little blame for having a disease though they are expected to engage in the process of recovery and adopt a range of state-incentivized and expert-guided "techniques of the self" through which they can be restored from their diseased state to a healthy one (Foucault 1997; Rose 1999, 245). NSAs are considered

otherwise good people who want to recover but are mercilessly controlled by their disease. Fortunately, with the help of experts they can regain their capacity to perform the necessary functions of good citizenship and go on to lead productive, respectable lives.

In contrast, the MTA is a menacing “Other” against which the dominant social order must be protected. They are typically depicted as part of maligned sociopolitical groups, the poor and working-class, immigrants, people of color, women, gender nonconforming people, and sexual minorities. In the past the MTA was commonly described as having “freely chosen to enter into the company of degenerates” by using drugs, rather than becoming addicted involuntarily through physician-prescribed medication (Hickman 2000, 82); or as an ominous minority of “psychopaths, neurotics, and criminals” that need to be tightly controlled or institutionalized (Courtwright 1982, 142). Historically these addicts were understood as being incurable because their drug use was a symptom of innate immorality or fatal character flaws (Acker 2002; Hickman 2000). However, efforts to medicalize addiction have altered the image of the MTA. These addicts are no longer strictly pathologized as they were in the past, rather they are understood to be treatable with expert interventions into their misdirected desires, poor decision-making skills, and bad habits (Acker 2002; Hickman 2000). Though the MTA shares a medical condition with the NSA, the marginalized addict is still less trustworthy than their normalized counterpart. Unmanaged, they are irrational, dangerous criminals who will do anything to feed their addiction; but with the right interventions, the threat they pose to society can be neutralized. This understanding of the MTA grew out of disciplinary concerns in the wake of the politically tumultuous 1960’s and 1970’s and a simultaneous growing complex of state-funded medical knowledge about addiction and neurochemistry (Acker 2002; Bourgois 2000; Hansen and Roberts 2012). Interventions developed for the threatening addict such as methadone

maintenance treatment were designed to control crime and the spread of disease, and are accompanied by close state surveillance and social stigma (Ibid). Because the threatening addict rarely submits willingly to treatment, coercion is often required to keep them motivated to pursue recovery. Thus therapeutic interventions designed to treat the MTA's addiction remain embedded in the criminal justice system despite addiction being described as a disease (Tiger 2015). However, the marginalized addict's disease is not an excuse for illegal or antisocial behavior, a tendency Dershowitz derided in *The Abuse Excuse* (Dershowitz 1994). Their illegal acts may be described as a result of their disease of addiction but they are no less responsible for those actions. They are held accountable for their transgressions through the criminal justice system and are simultaneously compelled to take responsibility for managing their disease through closely monitored and enforced recovery (Tiger 2015).

Producing MTAs by criminalizing the use of drugs associated with a specific group delineated by race, ethnicity, or nationality is a common political tactic in the U.S., often in an attempt to resolve sociopolitical and economic tensions by repressing minorities and alleviating white fear (Musto 1987). According to Hickman the circular logic of the racialization of drug addiction operates such that for the privileged subject "to be an addict is to be *like*" the racialized Other – that is, to lose race, class, and other privileges – but also that to be a racialized Other is "to be *like* an addict" whether or not one uses drugs (Hickman 2000, 72). This logic concludes that when a racialized Other uses drugs they do so as an expression of their essentialized, stigmatized identity (Ibid). Therefore even if the MTA's addiction can be arrested, the racialized addict's subjugated condition always makes them more similar to the failing addicted subject than to the ideal political subject (Ibid). The same is true for women. As Campbell documents, drug policies have been crafted to target women when their increasing autonomy threatens the

misogynist sociopolitical order (Campbell 2000). Their alleged dissimilarity to the ideal political subject also sets them apart and requires them to be more closely managed whether or not they are identified as a drug addict and even if they successfully end their drug use (Ibid). Therefore even in recovery the MTA remains a marginalized Other as Hickman described, an individual whose racialized, gendered, or classed identity makes them always *like* an addict and therefore needing to be controlled, either through closely policed recovery or through their other stigmatized identities. Criminalizing drug use and associating it with marginalized social groups continues to be used to govern addicts and groups conflated with addicts. For example, Zerai and Banks document how the demonization of “crack moms” in the 1980s and 1990s drove the drug policy agenda and how this identity was key to governing women who used drugs specifically and to scapegoat low-income black women generally for social and political crises (Zerai and Banks 2002). Thus the MTA and NSA identities are shaped by political, behavioral, psychological, and medical discourses, practices, and contests; and these identities and their predominant elements affect public policy.

Studies of past drug epidemics show that immigration patterns, moments of cultural, economic, or political crisis (Hickman 2007; Zerai and Banks 2002), developments in the science and treatment of addiction (Courtwright 1982; Hansen and Roberts 2012; Kolodny et al. 2015), changes in the perceived or actual populations of drug users (Cooper 2004; Courtwright 1982) and competing discourse coalitions (Stevens 2007), among other factors, have influenced the content and context of these binary constructions, their alternating prominence in popular and political discourse, and thus drug policy. Most recently, Neill analyzed how the perception of drug addicts has influenced policy outcomes from the earliest attempts to control availability of narcotics at the turn of the 20th century to the present. Neill finds that since 2000 a range of

factors have contributed to a more compassionate perception of the drug addict as needing treatment rather than incarceration including marijuana legalization, relatability of prescription drug use and abuse, and the clear failure of the War on Drugs (Neill 2014). In relation to the contemporary opioid epidemic, other scholars have investigated professional discourses, specifically pain management experts (Bell and Salmon 2009) in comparison with addiction medicine specialists (Whelan and Asbridge 2013) and how each profession differentiated between drug addicts and legitimate pain patients. Similarly, Whelan, Asbridge, and Haydt compared coverage of OxyContin, one prescription opioid intimately connected with the epidemic, in medical journals and North American newspapers focusing on public depictions of OxyContin as a “problem drug” or a medication with a legitimate medical purpose (Whelan, Asbridge, and Haydt 2011). Others have examined public discourses of the epidemic and found a correlation between popular media coverage of the epidemic and overdose death rates (Dasgupta, Mandl, and Brownstein 2009) and an overemphasis in local media coverage in Kentucky of prescription opioids’ connection to crime (Tunnell 2005).

Missing in this burgeoning literature on the discourse of the opioid epidemic is an investigation of the relationship between the depiction of opioid addicts and contemporary policy changes, particularly in light of developments in the discourses of addiction disease and recovery. There has been some public discussion about the connection between the two, such as at the 2014 Harm Reduction Conference in Baltimore, Maryland. Peter Davidson, a medical sociologist at the University of California, San Diego, reportedly noted the role the opioid epidemic and its effects among the middle class have had in furthering a harm reduction agenda in the U.S., stating “[l]egislators are much more interested in the arguments [made by middle-class parents] than they are in evidence” (Godfrey 2014). Will Godfrey, editor-in-chief of

Substance.com summarized Davidson's point: "the experience of opioid-related overdoses across all layers of US society in recent years has won harm reduction new advocates of the sort – white and rich – that lawmakers tend to listen to" (Ibid). But to my knowledge the discourse of the opioid epidemic and its role in policy change and projects of government has yet to be examined.

Governing the Drug Addict

I also build on an extensive literature about drug policy and its role in larger projects of government (Bourgeois 2000; Campbell 2000; Hansen and Roberts 2012; Vrecko 2010), particularly attempts to reconstitute viable, governable subjects out of drug addicts (Bunton 2001; Donohue and Moore 2009; Kaye 2013; Dawn Moore 2007; Reith 2004), because of the specific threat drug addiction poses to contemporary norms of subjectivity (O'Malley and Valverde 2004; Sedgwick 1993; Valverde 1998). I use the term "government" here in the Foucauldian sense, as in "modes of action, more or less considered or calculated...to structure the possible field of action of others" (Foucault 1982). Appropriate methods of government are informed by the prevailing logics of governmentality and political rationality. 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 2007, 2010; Rose, O'Malley, and Valverde 2006). I find Nikolas Rose's concepts of ethopolitics and advanced liberal government most useful in understanding the prevailing logics of contemporary modes of government.

I refer to Rose's concept of "ethopolitics," where the capacities of the population are managed through "sentiments, beliefs, and values; by acting on [the] ethics" of the subject (Rose 2007, 27). "Techniques of the self" – including personal desires, values, and judgments about

oneself and who one can become – are aligned with governmental objectives for the orderly reproduction of the socioeconomic and political order (Rose 1999, 2007, 11). This should not be misconstrued for some type of totalitarian mind control or a deeply ingrained false consciousness, but rather as an alignment of the goals of governmentality and self by “bringing the varied ambitions of political, scientific, philanthropic, and professional authorities into alignment with the ideals and aspirations of individuals, with the selves each of us want to be” (Rose 1999, 217).

I also cite Rose’s concept of “advanced liberal” society, an intensified version of traditional “liberalism” and its constant economic interrogation of the functions of government. Advanced liberalism informs a state “that will govern without governing ‘society’...by acting on the choices and self-steering properties of individuals, families, communities and organizations” (Ibid, xxiii). The state, rather than providing for or directly intervening in society or individuals’ lives, instead is charged with “create[ing] freedom and those capable of inhabiting it” (Ibid); or creating ethopolitical subjects who can be governed as autonomous and responsible consumers who, “through acts of free but responsabilized choice” among the vast – yet not unlimited – options of “lifestyle” and personal identity expression, are governed through those choices and identities (Ibid). Therefore the government of persons takes place largely outside of the state’s immediate purview, in the interactions between ethopolitical subjects and a variety of “experts” with whom they must consult to inform and guide the choices they are compelled to make (Ibid). This allows state authorities to “govern at a distance” through “techniques of government that create a distance between the decisions of formal political institutions and other social actors,” specifically through the regulation of experts and the shaping of autonomous, “free” choice (Rose 1996, 53–54).

Ethopolitics and advanced liberal government thus provide the ideological means through which the drug addict is known and intervened upon, determining which practices are most appropriate to achieve desired ends, how the efficacy of those practices should be measured, and thus the design and implementation of drug policy in order to optimize the qualities of the population. The discourses about drug addiction are shaped by these rationalities as are the subjectivities afforded to drug addicts through which they are governed (Dawn Moore 2007). Therefore, studying how drug addicts are governed is also an inquiry into a specific manifestation of contemporary governmental and political rationalities.

I consider contemporary drug policy through Rose's "critical biopolitics of control" which questions "what are the benefits, what are the dangers, what are [the] gains, and to whom, and what are the costs and to whom, of strategies of control that seek to identify and govern biologically risky individuals in the name of public protection?" (Rose 2007, 251). My approach is also similar to Moore's in *Criminal Artefacts* in that I am interested in studying the drug addict identity in order to "gain important insights into a system whose functioning depends in part on constituting such figures as problems of order in need of solutions" (Dawn Moore 2007, 2). Similar critical inquiries into contemporary drug policies, the drug addict identity, and projects of government include Moore's *Benevolent Watch*, an investigation of drug treatment courts and blended strategies of government (Dawn Moore 2011), and Kaye's consideration of "therapeutic communities" and the modes of government employed to rid drug offenders of their "drugs lifestyle," making possible new types of docile agency (Kaye 2013, 213). Also Campbell's analysis of the long history of U.S. drug policy's utility in governing women (Campbell 2000) and Zerai and Banks' analysis of the "crack mom" and "crack baby" in U.S. drug policy discourse and these figures' role in governing low-income Black women during a time of

economic and social destabilization (Zerai and Banks 2002). Building upon these literatures I examine the discourses of the opioid epidemic, considering their effects on U.S. drug policy and discourse since 2000 and the political and governmental implications of the changes provoked by these discourses. By investigating this case I also seek to contribute broader insight into how problematic subjects in general are governed in the advanced liberal, ethopolitical era of the contemporary U.S.

Discourse Analysis

In order to identify the discourse of the opioid epidemic, addiction disease, and addiction recovery and their political and government effects, I analyze the discourses of the opioid epidemic and drug policy generally. This includes political, medical, psychological, criminal justice, and public health discourses used by the media, policy makers, experts, and advocates to describe the opioid epidemic, the drug addict, the drug addict's problem, potential solutions to that problem, and policy responses manifesting those solutions. Specific sources include a sampling of media coverage – primarily national but also local – of the opioid epidemic since 2000 (gathered by searching “opioid epidemic” everywhere and “opioid” in the headline in Lexis Nexis and Google News searches of “opioid epidemic”) as well as reviewing landmark articles referenced by other authors, in other news articles, and by lawmakers. I also searched the Congressional Record for mentions of the opioid epidemic by lawmakers, experts, officials, and advocates in committee hearings and floor remarks, and in the language of proposed and passed bills. I reviewed materials produced by government agencies tasked with addressing the opioid epidemic and implementing drug policy including the U.S. Department of Justice (DOJ), the U.S. Department of Health and Human Services (HHS), particularly its subsidiaries the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for

Disease Control and Prevention (CDC), and the National Institute on Drug Abuse (NIDA), and a thorough review of materials produced by the Office of National Drug Control Policy (ONDCP). Finally, I reviewed materials produced by research and advocacy groups including the Drug Policy Alliance (DPA), the Legal Action Center (LAC), Faces and Voices of Recovery (FAVOR), and the FED UP! Coalition.

While the governing strategies of ethopolitical and advanced liberal democracies are concerned with limiting state interference in society, I focus on state policies and discourses as one point of entry to understand how the state “from a distance” enables both state and non-state actors to intervene in drug addicts’ lives through the practices of psychology, psychiatry, biomedicine, neurochemistry, behavioral therapy, criminal justice, and public health. I follow Campbell’s approach to critical policy analysis that examines “policy-making...as a discursive practice” which has “material effects that shape the experience and interpretation of addiction” including the practices of experts operating outside the state (Campbell 2000, 6). This approach also “reads’ public policy for what it can tell us about contemporary political culture” and “examines the structures of political exclusion, social isolation, and economic marginalization” manifest in policy that reflect the reigning “governing mentalities” often overlooked in typical policy analysis (Ibid, 7-8). Thus, I examine how policy discourse shapes strategies of neutralizing “threatening others” by “governing the ‘known facts’ about them” (Ibid, 14) and in this case, informing interventions that are simultaneously stigmatizing and compassionate.

Terminology

Finally, a note about terms. I use the term “drug addict” as it is the most commonly used term to describe a person whose drug use exceeds social acceptability. While the newly revised Diagnostic and Statistical Manual V (DSM-V) has changed the diagnostic terminology to

“substance use disorders” of varying levels of severity (SAMHSA 2014b), NIDA still uses the term addiction, which they consider equivalent to the DSM’s definition of substance use disorders (NIDA 2014, 5), and in my analysis I found the most commonly used terms remain “addict” and “addiction.” Since my analysis focuses on the significant of terminology, I am precise in noting certain organizations or individuals that use the term “substance use disorder” rather than “addiction” and note patterns of use. NIDA currently defines 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 (Ibid, 5).

I also use the term “recovery” – as in recovery from drug addiction – as it is also a commonly used term in the discourse particularly among advocacy organizations and service providers. Recovery is defined differently among these parties, but the definition used by the ONDCP encompasses the most common elements in popular usage:

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.).

Finally, my interest here is not whether drug addiction or recovery are “real” – i.e. biological, psychological, or behavioral phenomena – but rather to consider the personae constructed by these terms, the network of experts and interventions targeting these figures, and the political work they accomplish. I understand drug addiction and recovery as socially constructed identities that are often imposed upon individuals for purposes of government, while they are simultaneously identities claimed by some who find them politically or socially useful. Therefore, the observations and conclusions I make in the following analysis should not be

construed as dismissing the objectives or experience of groups or individuals claiming these identities for political or personal reasons. An identity shaped in a context of unequal power relations is not necessarily or purely a tool of government used to control the individual to which that identity is applied or claimed. As Foucault astutely noted regarding “madness,” though the concept was founded in a network of medicalized power relations, “[t]his fact in no way impugns the scientific validity or the therapeutic effectiveness of psychiatry: It does not endorse psychiatry, but neither does it invalidate it” (Foucault 1997, 296). I similarly seek to investigate the “games of truth” and the multidirectional systems of power at work in the novel identities and practices made possible by recent innovations in the discourse of drug addiction and policy, without assuming that truth and identity only operate in the interests of unidirectional, hegemonic power (Ibid).

III. DISCOURSE ANALYSIS OF THE OPIOID EPIDEMIC

The opioid epidemic is described primarily through three interconnected discourses that explain why the epidemic is happening, describe the people it affects, and indicate potential solutions. These discourses are not only changing popular conceptions of who the drug addict is – and therefore drug policy as past studies would indicate – they are also intentionally being used to support progressive policy changes. The first discourse is the NSA described in contrast to the MTA.

The Normalized Sympathetic Addict and the Marginalized Threatening Addict

First, the main character of the opioid epidemic is the NSA. This figure is the most commonly referred to by lawmakers, experts, and the media when discussing the epidemic and proposed policy responses. This character is the typical NSA found in past analyses, usually white, middle- or upper-class, straight, most often young, usually men but sometimes women. In this discourse, the NSA/MTA binary is operationalized when the sympathetic addict is described in relief to the silently assumed image of the threatening addict.

The NSA is described as a “citizen who would not ordinarily be associated with the term addiction” (Levin (MI) 2000, S9113). They are rarely described as criminals or malicious individuals but rather as “everyday people” who have become “victims” trapped in “the grips of addiction” (Portman (OH) 2014, S5701). They are “someone who has hopes and dreams, someone who at some point made a mistake, and now that mistake threatens those dreams and often devastates their family” (Ibid, S5702). Their lives are contextualized and relatable; they are described as an otherwise “good productive citizen” (Bradley 2012, 85), a “fellow American” (ONDCP 2011b, iii) and a lawmakers’ constituent (Lynch (MA) 2012, H5532; Rogers (KY) 2012a, 17). They are family members, neighbors, and colleagues like any other; including “old

people, lawyers, doctors, teachers...veterans com[ing] back after protecting us” (Carroll 2014) and “homemakers, professionals, students, and laborers” (Lynch (MA) 2012, 30).

Every time the NSA of the opioid epidemic is referred to as not the “typical” drug addict or someone who would not normally be pictured as a “junkie,” the MTA is invoked with all of its attendant racialized, gendered, and classed connotations. A recent piece by TIME magazine illustrates the juxtaposition of the sympathetic and the “typical” threatening addict: “This is not a story about dark alleys and drug dealers. It starts in doctors’ offices with everyday people seeking relief from pain and suffering” (Calabresi 2015). The binary is also present when the epidemic is described as failing to “distinguish between socioeconomic lines or gender lines or geographic lines. It’s indiscriminate in its path of destruction” (Rogers (KY) 2012b, H5530), and when the refrains “addiction does not discriminate” (American Society of Addiction Medicine 2014, 1; Bradley 2012, 86; Lynch (MA) 2012, 30) and addiction is an “equal opportunity illness” (Samuels and McCaffrey 2015) are invoked by lawmakers, advocates, and the media. These statements reflect the cultural assumption that addiction usually occurs among marginalized social groups and not among privileged groups. Statements like this are common and reinforce the larger narrative that drug use, particularly opioid use, was “once almost exclusively an urban problem” but is quickly “spreading to small towns and suburbs” (Volkow 2014, 9). It is present among “every racial, geographical, and socio-economic group” and therefore warrants widespread concern among lawmakers, experts, and the public (Udall (NM) 2014, 1).

The prevailing, culturally produced image of the crazed criminal drug addict – who is most likely a poor person of color living in the inner city and who deserves incarceration because of their obstinacy – makes the NSA figure of the opioid epidemic both possible and necessary. Thus the NSA only exists in relation to its opposite; without the assumed image of the MTA there

would be no need to distinguish the sympathetic addict as an otherwise normal person with a relatable story who has fallen victim to the disease of addiction and whose predicament deserves a compassionate public response. In this way the focus on the sympathetic addict reinforces the image of the threatening addict, even when it is unspoken. The fact that the NSA is described as white, male, upper-class, suburban, and educated, the opposite of that figure – a person of color, a woman, the poor and working class in urban neighborhoods – are de facto associated with the MTA, the “typical” addict that the normalized addict is not.

The common narrative of the NSA is that they are introduced to opioids through an injury or other ailment requiring opioid pain relievers, resulting in a “drug addiction [that] often begins in our medicine cabinets, rather than on the streets” (Udall (NM) 2014, 1). When the prescription runs out, this otherwise normal person resorts to seeking out pills on the black market and “people who would never have dreamed of shooting up, like suburban moms and middle-class professionals, seek respite from the pain of withdrawal” by intravenously injecting opioid pills or heroin (Calabresi 2015). These individuals are found all across the country, “primarily outside of the central city – in the suburbs, and in rural areas. Middle class America, affluent America” (CBS 2013). A big part of the problem is that prescription opioids are easily abusable, readily available, and “so very addictive” (Fitz 2015, 58). Most dangerously they “do not carry the social stigma associated with all other drug abuse” because they are prescribed by a doctor and assumed to be safe (Bradley 2012, 85). Those most susceptible to opioid abuse are “so-called naive users in the 35-to-64 age group—mostly baby boomers, with their aching bodies and their long romance with pharmaceutical chemistry” (Kluger 2010) or “naïve” young people (Potter 2014) who through a doctor’s prescription or typical teenage experimentation get hooked on drugs much more powerful than they realize (Tough 2001). These pills “quickly turn people

without any real emotional or physical problems into desperate people suddenly facing life-or-death struggles” (Mack (CA) 2012, 22). Lawmakers have taken it upon themselves to educate the public about the opioid epidemic and its sympathetic victims in an effort to promote public health policy solutions to the crisis. As Representative Stephen Lynch (D-MA) wrote in submitted testimony to a 2012 House Subcommittee hearing on prescription drug abuse:

There is a misperception about substance abuse that prevents many people from identifying it as the problem it is. That in turn makes it more difficult to find a real solution. My colleagues and I are here today to refute that misperception, to testify that this is not an inner city problem or a problem that affects only those who have made the wrong choices in life (Lynch (MA) 2012, 29–30).

The effects of the opioid epidemic on valued citizens – described as NSAs – has been the primary concern voiced by policymakers and experts in the last several years and their stories animate calls for policy change.

In tandem with the NSA, typical MTAs distinguished by socioeconomic, race, gender, and sexual identities are still present throughout the discourse of the opioid epidemic; they are not the central figure, rather they are the Other. The MTA of the opioid epidemic is most often poor, rural, and white. Rural Appalachian and Rust Belt towns marked by “high unemployment and low self-esteem” (Reynolds 2015) are “havens for prescription drug abuse” (S. S. Brown (OH) 2011, S6592) that is “shredding the social fabric...creating a Wild West-like anarchy in many communities” (Mishra 2001). Much of the initial media coverage and public concern about the epidemic was focused on the criminal, sometimes violent activity of these MTAs (Tough 2001). This figurative addict is typically poor, bilking Medicaid and the taxpayer by complaining of false ailments to unscrupulous doctors who “prescribe...opioids like candy” (Murphy (PA) 2015, 10). These addicts frequently “‘doctor shop,’ or seek care from multiple physicians” pretending to be in pain to get their opioid fix (Sensenbrenner (WI) 2012, 2). They also abuse the treatment

systems intended to help them, such as MAT, which some addicts use not to support their recovery but rather to “get a month’s supply of buprenorphine to use whenever they can’t get heroin. It tides them over, enabling them to remain in their active addiction” (Murphy (PA) 2015, 6). Their behavior can only be changed under threat of force or imprisonment, as Governor Peter Shumlin described in his 2014 State of the State address as he declared a public health emergency in Vermont as a result of the opioid epidemic:

...let’s do a better job of convincing drug users who wind up in our criminal justice system that getting help is a better path than addiction. This too is not easy work. Drug addicts are the best deniers and the best liars you will ever meet. Some will do just about anything to continue using. But all the research tells us that an addict is most accepting of treatment right after the bust (Shumlin (VT) 2014, 6).

The common narratives of MTAs are limited to their immediate problems, their irrationality, and desperation; their current state is only contextualized to pointedly demonstrate their failure to be a responsible individual and therefore their stories are typically not relatable to the general public (Seelye 2013). Threatening addicts, unlike their sympathetic counterparts, pose a violent criminal threat to their communities and are a drain on common resources (Butterfield 2002; Ordway 2000).

Pregnant women in particular are demonized for their opioid use, and Neonatal Abstinence Syndrome (NAS), a range of symptoms experienced by newborns exposed to opioids including “breathing problems, fever, tremors, stiff limbs, difficulty feeding, and preterm birth” (Clark and Patrick 2015) has reportedly increased threefold over the last decade (ONDCP 2014f, 78). The all-too-common tactic of displacing the country’s problems onto poor women of color has resurged with states criminalizing drug use during pregnancy (Zerai and Banks 2002). Punishing pregnant women for using drugs is justified because of the alleged dire medical effects on their

fetuses. NIDA warns that some children born with NAS likely “will need educational support in the classroom to help them overcome what may be subtle deficits in developmental areas such as behavior, attention, and thinking” and that developmental problems may continue into adolescence (NIDA 2014, 22). These claims echo the alarmist predictions of so-called “crack babies” growing up to be violent, dysfunctional adults that were prevalent during the crack epidemic but have since been debunked (Zerai and Banks 2002). Criminalization is also described as a necessary deterrent to drug use and motivation for pregnant women to initiate treatment. For example, Tennessee passed a law in 2014 allowing assault charges to be brought against a woman whose baby tests positive for drugs, with the caveat that she may not be charged if she is enrolled in a drug treatment program (Boucher and Gonzalez 2015). Despite the law’s seemingly treatment-focused intention, health care providers and advocates argue these laws actually push women away from prenatal care for fear of prosecution (Ibid). These laws also ignore the fact that most women whose babies experience NAS symptoms are already receiving MAT – typically methadone or buprenorphine – the medically preferred option for stabilizing opioid-dependent pregnant women that prevents detox and a potential miscarriage (Gluck 2015). In contrast with the sympathetic addict of the opioid epidemic whose drug use is contextualized and whose value to society is assumed, pregnant women who use opioids and their children are dehumanized in the public discourse. For example, Sullivan County, Tennessee District Attorney Barry Staubus described his area of the state as “drowning in...these children” with NAS (Gonzalez 2014), and according to state Representative Terri Lynn Weaver (R-Lancaster) who sponsored the Tennessee bill, women who use drugs during pregnancy “have no business being parents” (Ibid). She refuted claims that the bill would push women away from prenatal care, saying:

These ladies are not those who would consider going to prenatal care. These are ladies who are strung out on heroin and cocaine and their only next decision is how to get their next fix...These ladies are the worst of the worst. Again, I want to emphasize what they are thinking about, and that is just money for the next high (Gonzalez and DuBois 2014).

Studies have found that women whose babies experience NAS symptoms are predominantly white, young, poor, and living in rural areas (Gluck 2015). Media coverage is mixed, depicting Black, Latina, and white women as mothers with babies who experience NAS (Desiderio 2014; Gonzalez and DuBois 2014). Babies born with NAS are described as “the youngest victims of our nation’s battle with the prescription drug epidemic,” victimized by their drug using mothers. They are also a drain on public resources, as a recent study asserted that the rising number of infants experiencing NAS from 2000 to 2012 were treated at a cost of “an estimated \$1.5 billion in health care expenditures; 80 percent of that is paid for with Medicaid dollars” (Clark and Patrick 2015).

Despite renewed interest in criminalizing pregnant women who use drugs, the public narrative about the opioid epidemic has been focused primarily on the sympathetic addict and their plight to access treatment in the face of stigma. Stories of threatening addicts are the assumed and accepted narratives of opioid use, particularly heroin use. Criminalizing MTAs, such as pregnant women, continues to be an effective method of controlling poor women and blaming them for social ills such as child behavioral and developmental problems, ballooning health care costs, and huge deficits for public programs such as Medicaid. These MTAs persist in the public conversation because they are the assumed figurative drug addict and their stories reinforce the narrative that “most” drug addicts are threatening, and that the opioid epidemic requires immediate attention precisely because it defies the typical pattern of drug use and addiction, posing a real threat to white upper-class hegemony. In order to address the opioid

epidemic and its privileged victims, new stories are being told to justify policies that treat drug addicts as people whose lives are valuable and deviate from the traditional War on Drugs approach. These stories are primarily NSAs who have a disease of addiction and are capable of recovery.

The Disease of Addiction and Addiction Recovery

Addiction has been characterized by medical experts as a disease for decades. NIDA has produced research supporting the brain disease model of addiction since the 1970's (Courtwright 2015). However, the current medical model of addiction as a brain disease and the "emerging view of addiction as a public health issue" (Lofgren 2011, 802) has gained popularity among policymakers only in the last several decades (Leshner 1997; McGinty et al. 2015) after considerable resistance from politicians, the criminal justice establishment, and social scientists (Courtwright 2015). In this model, the source of addiction is found in a combination of the individual's genetic, psychological, neurological, and behavioral functioning. Social and environmental circumstances are acknowledged as contributing but not determining factors. Though the disease manifests itself in the brain, it is not an immutable characteristic, therefore pharmaceutical or behavioral "evidence-based" treatment (NIDA 2014, 25) is available to remedy the "underlying brain disease" (Leshner 1997) and restore normal functioning.

This understanding of addiction is echoed by all the major federal agencies that deal with drug use (CDC, SAMHSA, ONDCP) and virtually all mainstream medical and therapeutic organizations refer to addiction as a "chronic relapsing brain disease" (Leshner 1997). Normalizing addiction by comparing it to other chronic illnesses is a common strategy used to promote this concept. Experts regularly compare addiction to relatable chronic illnesses such as diabetes or heart disease and argue that equitable long-term medical care must be the standard

treatment for chronic addictions (Chen 2014; Lupkin 2013). If addiction is a disease like any other, it can likewise be treated and successful recovery is possible. Former Representative Dennis Kucinich (D-OH) made this clear during his opening statement for a 2010 House Domestic Policy Subcommittee hearing titled “Treating Addiction as a Disease: The Promise of Medication-Assisted Recovery.” He stated:

...scientific research definitively shows that addiction is a treatable medical condition. Like people with any other medical condition, drug-addicted individuals need to have access to medications to treat the disease” (Kucinich (OH) 2010, 2).

However, addiction is unlike other chronic diseases in that it undermines one’s free will by “hijacking” the brain and disrupting normal social functioning. Dr. Nora Volkow, Director of NIDA, described this aspect of addiction in that same hearing:

...[drug addiction] affects fundamental areas of the brain that enable us, for example, to exert control over our desires and emotion, which explains why a person that is addicted will compulsively take the drug despite catastrophic consequences to that person and their family (Volkow 2010, 4).

Dr. Thomas McLellan, then-Deputy Director of ONDCP, also described the effects of drug use as “ultimately eroding inhibitory control, turning drug-seeking into a compulsion, and erasing motivation for normally pleasurable human relationships” (McLellan 2010, 3).

Addiction as a brain disease requiring medical treatment factors significantly into the discourse of the opioid epidemic where there is an immediate need to respond to the public health crisis of opioid-related deaths. Opioids are one of the few drugs for which medications have been developed to treat overdoses and dependence, lending itself to an understanding of opioid addiction as a disease and the normalized sympathetic opioid addict as needing MAT to support their “long-term recovery” (Botticelli 2014, 11). The argument that MATs support recovery by addressing the physiological components of the disease of addiction is common. By “helping individuals start and remain in behavioral therapy and achieve long-term recovery,”

MAT is a critical element of effective treatment and therefore supported by many lawmakers and nearly all addiction experts (Kucinich (OH) 2010, 2).

The concept and discourse of addiction recovery also has a long history. Treatments promising cures for drug addiction emerged along with the addict identity, particularly for NSAs (Campbell 2000; Courtwright 1982; Hickman 2007). Contemporary addiction recovery discourse has proliferated from its origins in the modern treatment industry and is gaining mainstream acceptance as never before, due partially to its promotion by influential governmental agencies, medical experts, and a novel type of advocacy group. In my analysis of official documents and legislative history, I found the contemporary language of recovery used by government agencies goes back at least to the 1990's when SAMHSA began celebrating "National Alcohol and Drug Addiction Recovery Month" in 1998 (SAMHSA n.d.). In his 2003 State of the Union (SOTU) address, former President George W. Bush shared a "message of hope" with all "Americans who struggle with drug addiction" declaring "the miracle of recovery is possible, and it could be you" (Bush 2003). The funding the President announced in his SOTU address eventually became the "Access to Recovery" program, a voucher system to help low-income people access treatment (ONDCP 2002, 3, 2004, 6). This program marks the initiation of contemporary recovery language at the ONDCP, and SAMHSA defined recovery for the first time in 2005 (SAMHSA n.d.).

Among government agencies, SAMHSA and ONDCP lead the recovery narrative. ONDCP defines recovery for those with a substance use disorder as necessarily ending drug use but also as an exhaustive personal overhaul of rebuilding, reclaiming, and transforming one's life. Because addiction is a loss of personal control, recovery offers the restoration of willpower whereby addicts can "stop abusing drugs and resume productive lives" (NIDA 2014, 25). It is

“characterized by health, wellness, a sense of purpose, and productive involvement with family and community” (ONDCP n.d.) and requires “active involvement in satisfying work and play, joyful relationships, a healthy body, and a safe living environment” (SAMHSA 2014a).

Recovery is also resuming one’s rightful social and political roles, as recovering addicts are reintegrated into their community as “responsible parents, neighbors, and citizens” (ONDCP 2011b, 37). According to the mainstream treatment industry both addiction and recovery have “psychological, social, and spiritual components” which medical treatment alone cannot address (Seppala 2015, 38). Therefore, according to Dr. Marvin Seppala of the Hazelden Betty Ford Foundation, the “keys to recovery that last” include efforts to “improve psychosocial functioning, enrich relationships, and foster a healthier lifestyle” (Ibid).

Though recovery often requires a team of experts including “doctors, physician assistants, nurses, counselors, social workers, recovery peer support counselors, and other specialists” to guide the addict in recovery, motivation to recover must come from the addict themselves (ONDCP 2014f, 19). SAMHSA declares “self-determination and self-direction are the foundations for recovery” and the addict is charged with “mak[ing] informed choices” about the treatment they receive in order to “regain control over their lives” (SAMHSA 2012, 4). Thus the state should not limit the types of treatment available to people with an addiction. According to Representative Jim Jordan (R-OH), government must “support individual choices in the type of treatment that is most beneficial” as determined by each individual choosing from a variety of recovery options (Jordan (OH) 2010, 3). Neither does the state endorse any type of treatment, as ONDCP asserted in the 2010 National Drug Control Strategy (NDCS), claiming there are “countless other pathways to recovery” and that it is less important how a person recovers than the fact that “they have recovered, and their achievements should be celebrated and built upon”

(ONDCP 2010, 44). The only requirement for treatment is effectiveness. It must be “a reliable pathway not just to cessation of drug use, but to sustained recovery, meaning a full, healthy, and responsible life” (Ibid, 8). And it is an undertaking that lasts a lifetime as “services may need to continue indefinitely, as relapse can be a lifelong risk” (ONDCP 2012b, 1).

Finally, those who have succeeded in their arduous and ongoing journey in recovery must “share the gift of recovery with others in need” (ONDCP 2011b, 37). According to SAMHSA one of the key elements required for successful recovery is hope or “the belief that recovery is real” because it “provides the essential and motivating message of a better future” for the addict who is just starting on their recovery journey (SAMHSA 2012, 4). ONDCP is particularly adamant that recovering people be publicly visible so they might “instill hope that recovery is possible for every American, even those with the most severe cases of addiction” (ONDCP 2010, 44). Therefore recovery from addiction is much more than just stopping drug use or arresting the disease of addiction, it is the ultimate ethopolitical intervention to reconstruct a responsible, independent, choice-making citizen out of the broken addict by compelling them to act in the interest of the person they want to become.

The possibility of recovery for the NSA has been a significant element in the discourse of the opioid epidemic. Critically, these addicts are capable of recovery as Dr. Harry Chen of the Vermont Department of Health testified in 2014 at a Senate Judiciary Committee hearing:

I, along with just about every other parent of young adults, know several of their classmates who were well-adjusted kids with caring parents whose lives were taken over by the horrors of opiate addiction. Thankfully, nearly all are now in recovery and doing well (Chen 2014, 2).

Even amid the “death and destruction” of the epidemic there is hope for recovery through which “people who are able to stop their use of illicit drugs...can return to vibrant and productive lives” (Westreich 2015, 44, 47). Dr. Andrew Kolodny, an addiction treatment specialist, suggests that

even for the millions affected by the opioid epidemic “with treatment, sustained remission and recovery is possible” and those treated can expect to “go on to lead fully productive lives” (Kolodny 2014, 5). Addictions are “terribly costly. They ruin lives. They ruin communities” and yet, according to McLellan, “there's hope. There are 20 million people now that label themselves as being in stable recovery...Treatment ought to lead to recovery, and it can” (McLellan 2010, 12).

Discourse and Policy Advocacy

The popular narratives of the opioid epidemic’s NSA victims, the fact that they have a disease, and their potential for recovery are being deployed professedly to destigmatize addiction and treatment, to inspire hope in those with addiction to pursue recovery, and to secure progressive policy changes that include public health strategies rather than exclusively criminal justice strategies. Tactics used to reach these goals include changing the language used to refer to the drug addict, educating the public that addiction is a disease and is treatable, and highlighting the experiences of those who have successfully recovered. The beneficiary of policy efforts promoting recovery is often the NSA of the opioid epidemic. Because the sympathetic addict’s problem is understood as a disease and they are more likely to be considered amenable to recovery, they are the figure most often invoked in arguments for policy change. This strategic approach is supported by public opinion data. The authors of a recent poll investigating public opinion about addiction, mental health, treatment, and recovery bemoan the prevalence of the MTA figure, or “street drug users in bad economic conditions” often portrayed in the media, rather than the NSA figure, people “in the suburbs who have become addicted to prescription painkillers after struggling with chronic pain” or “inspiring stories of people who, with effective treatment, are able to overcome addiction and live drug-free for many years” (Desmon and

Morrow 2014). They recommend combatting negative public perceptions about the nature of addiction and treatment effectiveness by “educat[ing] the public that [mental illness and drug addiction] are treatable conditions” and thus increasing support for compassionate policy responses (Ibid).

Government agencies, advocates, and experts seeking to change public opinion and policy take precisely this approach. ONDCP states the problem and solution as they see it in the 2014 NDCS: “Stigma, rooted in the misperception that a substance use disorder is a personal moral failing rather than a brain disease, is a major obstacle to drug policy reform” (ONDCP 2014f, 19). Therefore “reducing the stigma surrounding these medical conditions is a particularly important component of drug policy reform,” a challenge ONDCP is actively working to address (Ibid, 2). Toward that end, ONDCP dedicated an entire section of the NDCS 2014 to “The Importance of Language: Reducing the Stigma Surrounding Substance Use Disorders” (Ibid). In this section they recommend concerted changes to the discourse of addiction, avoiding terms such as “substance abuser” which “evokes less sympathy” for the individual and instead using the term “substance use disorder...thereby reducing the stigma” of addiction and “encouraging these individuals to seek help at an earlier stage in the disease” (Ibid). SAMHSA has also worked intentionally to change the public discourse about addiction. The agency held a summit of treatment and recovery experts in 2005 to create the first national consensus on what recovery is and what recovery-focused treatment should look like, with one of the primary goals being to develop “new ideas to transform policy, services, and systems toward a recovery-oriented paradigm” (SAMHSA 2005, 1). Dr. H. Westley Clark, then-Director of SAMHSA’s Center for Substance Abuse Treatment (CSAT) was quoted in the summit report suggesting “the Federal government can play a critical role by crafting messages that treatment works, that recovery is

real and that peers play a critical role in fostering resilience and embodying a message of hope” (Ibid, 5). SAMHSA has taken on this role by launching a public awareness campaign to educate the public about recovery as part of their 2011-2014 strategic initiatives (SAMHSA 2011).

Leading medical associations including the American College of Physicians also recognize the need to change “public perceptions of the drug user” in order to secure public health policies and greater access to treatment (Kirschner, Ginsburg, and Sulmasy 2014, 11). Submitted testimony from Dr. Patrice Harris of the American Medical Association (AMA) to a House Subcommittee hearing on the opioid epidemic read:

Similar to patients in pain, we should not use terms such as ‘addict’ or ‘junkie’ or ‘user’ because these terms carry with them damaging psychological stigma. Patients who need care are ‘patients,’ and deserve our care and compassion (Harris 2015, 5).

Former Representative Patrick Kennedy (D-RI) made a particularly pointed argument for an intentional shift in language in a 2010 House hearing. Kennedy argued that the key to changing policy and securing effective treatment is changing the perception of the drug addict by focusing on the NSA, specifically the combat veteran. Kennedy recognized that this figure would be understood as having a disease and needing treatment which would further the goal of securing research and investment in effective treatments for addiction. He advises:

We shouldn't at all in this hearing be talking about criminal justice, you know, all of these stigmatized drugs...This has nothing to do with crack addicts in California driving buses or prisoners in prison. This is about our American heroes [veterans]. Let's keep it that way. Because, if we do, we can move forward on this (Kennedy (RI) 2010, 8–9).

In response to Kennedy’s statement, McLellan agreed that Kennedy had “terrific precedent on your side,” asserting the legal methadone program in the U.S. in the 1960’s-70’s was developed “to treat the then opiate problems of returning veterans from a foreign war. If that hadn't happened, there would have been no political will to create that system” (McLellan 2010, 9).

This exchange demonstrates the power of the NSA and the intentionality exhibited by experts and policymakers to make the sympathetic addict the face of public health policy change.

In addition to leading its own public awareness campaigns and advocating for shifts in language, ONDCP is “spreading the promise of recovery across the Nation” (ONDCP 2014f, 3) by reaching out to, supporting, and promoting the stories of people who identify as being in recovery from drug addiction. In 2009 ONDCP founded “the first-ever Recovery branch” under its Office of Demand Reduction in order “to support the 23.5 million Americans in recovery” (ONDCP n.d.). According to ONDCP this represents “an unprecedented commitment to support individuals in recovery” and a promise to “continue to support their cause and celebrate their success” (ONDCP 2013c, 79). The Administration describes this commitment further as:

...working to lift the stigma associated with addiction by partnering with the recovery community to speak out about their successes and encourage others to seek treatment; and reviewing and reforming laws and regulations that unfairly target those with substance use disorders and impede recovery from addiction, including those laws and regulations that restrict access to housing, employment, and attaining a driver’s license or student loan (ONDCP 2013a, 3)

Working directly with recovering addicts is a new approach for ONDCP. Recovery has been in the agency’s vocabulary for at least a decade but bringing public attention to recovery by raising the visibility of recovering addicts has only been part of their official strategy for the last several years. ONDCP implores recovering addicts to be the public, living proof to addicts and non-addicts alike that “recovery is not only possible, but is a positive force that transforms individuals, families, and communities” (ONDCP n.d.). Politicians have echoed ONDCP’s reverent tone for recovering addicts such as Representative Paul Tonko (D-NY) speaking at an Oversight and Investigations hearing in 2015:

The individuals of the addiction recovery community, in my mind, through their courage, determination, and conviction are truly heroes. Bearing witness to the joy and rebirth that recovery has brought to their lives leaves me no doubt that

complete recovery to a substance-free life is, and should be, our goal for every person who is struggling in the throes of addiction; a disease (Tonko (NY) 2015, 22).

For ONDCP this is not just rhetoric. The newest “Drug Czar” Michael Botticelli, acting ONDCP director since 2013 and confirmed as director in 2015, identifies publicly as being in recovery from addiction and directly connects his openness about his recovery with efforts to change policy and public perceptions of individuals with “substance use disorders.” In his post on the White House blog announcing his confirmation as director, he 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 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. By putting faces and voices to the disease of addiction and the promise of recovery, we can lift the curtain of conventional wisdom that continues to keep too many of us hidden and without access to lifesaving treatment. It is time to make a simple, yet courageous decision to be counted, to be seen and to be heard (Botticelli 2015b).

The New York Times reported on Botticelli’s confirmation noting he “is the first person in substance-abuse recovery to hold the position” and his identity “far from the liability it once may have been, is considered evidence that the government is moving toward addressing drug abuse more through healing than handcuffs” (Schwarz 2015). Botticelli is the ultimate normalized sympathetic addict in recovery. He has been in recovery for over 25 years, is a white, well-educated man, and he has dedicated his professional life to spreading the promise of recovery and advocating for other addicts. While it is notable that Botticelli also identifies publicly as a gay man, not the prototypical normalized addict, his identity remains congruent with contemporary idealized citizenship rendering him a model homonormative subject (Puar 2007). In fact, Botticelli compares the stigma faced by those with substance use disorders to that experienced by LGBT-identified people, and refers to the mainstream LGBT movement’s

success in “decreasing the shame and stigma surrounding gay folks” by raising their public visibility and suggests “the substance-abuse field should take cues from the gay rights movement” and adopt these proven tactics (Schwarz 2015).

Long before Botticelli and ONDCP put out the call to recovering addicts to stand up and be counted, advocacy groups have been using the discourse of recovery and the recovering addict identity as organizing principles. The role of one organization in particular – Faces and Voices of Recovery (FAVOR) – is worth considering at length because of its role in shaping the ethopolitical discourse of recovery along with ONDCP and others. People who use drugs or who identify as drug addicts or as being in recovery from addiction are typically “a voiceless, under-represented constituency” (Ollove 2013). Until recently, addicts lacked the “patient advocacy groups” formed by those with cancer or AIDS that typically advocate for better treatment and attempt to destigmatize their illness by speaking out publicly (O’Keeffe 2010, 16). There are currently a variety of organizations doing policy advocacy and political organizing about drug use and addiction and they each use different organizing strategies and discourses to support their work. FAVOR is one of the few groups and the most prominent that explicitly uses the discourse of addiction recovery to organize and to advocate for addicts’ political, social, and health care rights.

Founded in 2001, FAVOR is a group “dedicated to organizing and mobilizing the over 20 million Americans in recovery from addiction to alcohol and other drugs” so that they and the “23 million Americans who have yet to recover” can “lead new lives, free from addiction to alcohol and other drugs”(FAVOR 2011a). Their work includes organizing the burgeoning “grass roots social justice movement” of “courageous addiction recovery advocates [who] have come out of the shadows” (ManyFaces1Voice.org n.d.) and politically empowering recovering addicts

so they can advocate for federal and state policies that support recovery and remove “discriminatory barriers” preventing people from recovering or from “moving on to better lives” once they are in recovery (FAVOR n.d.). One of their primary goals is to change the discourse about drug addiction including the language used to describe them and the assumed knowledge about them in order to change public perception and policy. They do so by calling on their constituents in “long-term recovery” – FAVOR’s poll-tested, preferred terminology – with the responsibility to speak publicly about their experience in order to break down stigma and to expand access to treatment for others in, or not yet in, recovery (FAVOR 2013a, 1). For FAVOR, long-term recovery is abstinence from all drugs and alcohol as well as an opportunity for drug addicts to “reclaim their lives” (FAVOR 2013b, 6). Even Botticelli uses FAVOR’s recommended language to describe himself in his official ONDCP biography as being “in long-term recovery from a substance use disorder” (ONDCP n.d.).

According to FAVOR, the visibility and activism of people in recovery are critical to changing public opinion and public policy because they can demonstrate that recovering addicts are successful ethopolitical subjects. By sharing their personal stories and working with experts to produce empirical evidence about addiction recovery, FAVOR demonstrates that treatment works and people in long-term recovery indeed go on to “lead full, productive, and healthy lives” (Laudet 2013, 9). For example, FAVOR’s 2013 “Life in Recovery” survey found that “contrary to the stigmatizing stereotype society has of the individual in active addiction or recovery” people in recovery experience “dramatic improvements in all areas of life” (Ibid, 1-2). Addicts in long-term recovery are less likely to be involved in the criminal justice system or contract infectious diseases and more likely to be positively involved in their families, communities, and civic duties, to be gainfully employed and financially stable (Ibid). In other words, long-term

recovering addicts are self-regulating, responsible, and healthy persons who meet the requirements for advanced liberal citizenship. FAVOR uses this evidence to support their claims to political, social, and health rights:

...recovery is good not only for the individual, but also for families, communities, and the nation's health and economy. The [Life in Recovery Survey] findings emphasize the call for policies, services, and funding to help more people initiate and sustain recovery, and for additional research to identify effective and cost-effective recovery-promoting policies and services (Ibid, 2).

All of these discourses – the opioid epidemic and its NSA, addiction as a disease and addiction recovery – interlock to build a public narrative where political organizing is possible and policy change is needed. In the next section I demonstrate how these discourses have in fact animated some recent discursive and material changes in U.S. drug policy.

IV. U.S. DRUG POLICY IN THE 21ST CENTURY

As described in section II, changes in the demography of drug users, understandings of drug addiction, and possible solutions to drug addiction have demonstrable effects on policy. Consistent with previous studies, I find that actual and perceived changes in the typical drug using population as a result of the opioid epidemic, state and expert understanding of addiction as a disease, and a growing consensus that recovery from addiction is possible, have likewise had an effect on U.S. drug policy. Politically powerful groups affected by the opioid epidemic have pressured the state to take policy actions that prioritize saving the lives of opioid addicts and providing them with more effective treatment. Public focus on the NSA thus contributed to forming the political will to embrace the discourses of addiction disease and addiction recovery because they explain why the opioid epidemic is affecting populations not “typically” subject to widespread drug abuse and justify changes to drug policies providing these privileged addicts with opportunities for recovery rather than punishment.

Resulting policy changes include public health approaches that aim to save lives and prevent the spread of disease as well as demand reduction measures such as treatment and recovery support services. Of course, these policies are integrated into the predominant War on Drugs criminal justice approach of supply and demand reduction through law enforcement and incarceration. Yet, policies with little political clout in the past such as naloxone access and more accessible and less stigmatized MAT, as well as general policies to expand alternatives to incarceration (ATIs) and roll back mandatory minimum sentencing have been justified by the discourses popularized in the contemporary opioid epidemic. For example, Representative William Keating (D-MA) invoked the NSA when he described the opioid epidemic as crossing “every social and economic boundary that exists,” forcing Congress and the public to recognize

that drug addiction is “by no means just a criminal issue..It is, indeed, a public health issue, and for this reason Congress needs to step in” (Keating (MA) 2012, H5531). Likewise, former Senator Daniel Moynihan (D-NY) advocated for public health policies in response to the “chronic, relapsing disease” of addiction when he spoke from the Senate floor in 2000 in support of expanding access to MAT (Moynihan (NY) 2000, S9113). He went on: “What we are talking about is not simply a law enforcement problem, to cut the supply; it is a public health problem, and we need to treat it as such” (Ibid). And finally a letter by Senator Robert Portman (R-OH) and Senator Tom Udall (D-NM) of the Senate Caucus on International Narcotics Control praised “hybrid approaches” such as ATIs for “fully integrat[ing] criminal justice with public health” an appropriate response to the disease of addiction and one that supports recovery (Udall (NM) and Portman (OH) 2014, 1).

Policies Addressing the Opioid Epidemic

Policy change in response to the opioid epidemic includes dramatically expanding access to naloxone in the last several years. Naloxone is a drug that can reverse the effects of a deadly opioid overdose; it is nonabusable and is incredibly effective in reducing mortality rates where available (DPA 2015b). With increased funding and resources from the federal government, states have led the way in distributing naloxone widely (Bureau of Justice Assistance 2014). The Drug Policy Alliance (DPA) reports that 34 states have increased access to naloxone (DPA 2015b), usually by providing training and the antidote to first responders or changing regulations to allow pharmacists to distribute naloxone directly to opioid users and their friends and family (DPA 2015d, 2). The DOJ also equipped federal officers with naloxone in 2014, citing the 10,000 overdose reversals enabled by the drug since 2001 and the need for immediate action to address the “public health crisis” of opioid overdoses (DOJ 2014). The spirit of naloxone

policies is summed up by Botticelli's response to a question about naloxone "enabling" opioid users to continue their addiction, where he declared "[e]very life is worth saving" (DeMio 2015), refuting the notion that all addicts are unvalued individuals. ONDCP has been a vocal supporter of increased naloxone access because of its proven effectiveness to save lives and to provide a point of contact for treatment referral. Numerous politicians have spoken in support of naloxone access including Representative Michael Burgess (R-TX), medical experts such as Dr. Patrice Harris of the AMA, and law enforcement including Colonel Thomas L'Esperance of the Vermont Police Department (Burgess (TX) 2015, 90; Harris 2015, 2; L'Esperance 2014, 3). Despite the egalitarian rhetoric from Botticelli, there is evidence that NSAs are benefitting most from naloxone policies. A recent CDC study found "naloxone was most likely to be administered to women, people between the ages of 20 and 29, and people living in suburban areas" (CDC 2015c). While these results are preliminary, they do indicate that certain types of NSAs – women and young people living in suburban areas – are more likely to benefit from naloxone expansion policies than other addicts.

Second, legislation and policy expanding access to MAT has been a recurring theme since the early days of the epidemic. MAT includes traditional methadone maintenance treatment but recent efforts have focused on expanding access to buprenorphine, an opioid maintenance medication that has lower abuse potential than methadone and fewer bureaucratic hurdles attached to its distribution (Jaffe and O'Keeffe 2003). Expanding access to MAT is praised as an evidence-based solution to the opioid epidemic by medical experts such as Dr. Harris of the AMA because it accurately treats addiction as a disease (Harris 2015, 2). It is celebrated by HHS for saving lives by reducing the risk of overdose and death (HHS 2015, 6) and by the media for its public health and safety impacts, reducing rates of HIV and Hepatitis C transmission and

“reduc[ing] crime while enabling addicts to join the workforce and resume their roles within families” (Ollove 2013). Importantly, MAT can help restore addicts’ free will damaged by addiction by “enabling opioid-addicted persons to regain control of their health and their lives” as explained by Dr. Volkow (Volkow 2014, 11). Policies expanding access include the Drug Addiction Treatment Act of 2000 (DATA 2000) which officially approved buprenorphine for prescription in private doctor’s offices, making MAT available in some rural and suburban areas underserved by existing methadone clinics; and DATA 2005, which raised the limit on buprenorphine patients for physician group practices (R. S. Brown (OH) 2005, H6679). However, this medication can still be difficult to access in rural areas. Many providers have extensive waitlists of people who want the medication but cannot find an available provider and it is much more expensive than methadone making it inaccessible for many without health insurance. DATA 2000 effectively created bifurcated treatment systems for treating opioid dependence (Jaffe and O’Keeffe 2003). Methadone clinics are highly regulated and primarily serve poor, minority, urban, often intravenous heroin users, while buprenorphine prescribers operate in a more loosely regulated, private system that is integrated into general medicine and primarily serves middle-class, white, most often opioid painkiller users (Hansen and Roberts 2012). In fact, Hansen and Skinner found that buprenorphine users were “92 percent white, over half employed at baseline, over half with at least some college education, and 75 percent prescription opiate addicted” while methadone users were “only 53 percent white, 29 percent employed at baseline, and 19 percent with some college education, most of whom injected heroin (Stanton et al. 2006)” (Hansen and Skinner 2012, 176). Once again, the discourse and policy of the opioid epidemic disproportionately benefit addicts who more closely resemble the NSA than

the MTA, and medication treatment in particular further differentiates and governs addicts according to those identities.

Federal and State Drug Policies, Generally

The discourses popularized by the opioid epidemic have also influenced U.S. drug policy generally. The overall approach to controlling illegal drug use in the U.S. has not changed dramatically in the last fifteen years as measured by enacted federal funding for supply (58%) versus demand reduction (42%), which still favors enforcement (ONDCP 2013b, 19). The U.S. also continues to incarcerate people at the highest rate in the world (ONDCP 2014f, 25), and a vast network of punitive drug laws remains largely undisturbed beneath new piecemeal public health drug laws. However, there has been a significant change in the discourse about federal drug policy. Former ONDCP Director Gil Kerlikowske described the Obama Administration's approach in 2012 as "nothing short of a revolution in how we approach drug abuse" (Gardner 2012). More recently, Botticelli described the 2014 NDCS as a collection of policies that "signal a paradigm shift toward a 21st century drug policy that treats addiction as a disease, not a crime" (ONDCP 2014d). The NDCS 2014 is described as being explicitly informed by a neuroscientific understanding of addiction as a disease that can be treated and from which one can recover, a fact that is "the foundation for the Obama Administration's drug policy strategy and guides the Administration's decision-making on public health and safety" (ONDCP 2014c, 1). It is described as "restoring balance to U.S. drug-control efforts by coordinating an unprecedented government-wide public health and public safety approach to reduce drug use and its consequences" that avoids the extremes of either the War on Drugs or drug legalization (ONDCP n.d.). The Obama Administration's approach is restructuring state mechanisms and developing bodies of knowledge to change drug policy by "aligning criminal justice policies and public

health systems to divert non-violent drug offenders into treatment instead of jail, funding scientific research on drug use, and, through the Affordable Care Act, expanding access to substance abuse treatment” (Ibid). It is an approach based on “science and evidence” (ONDCP 2013b, 7) that “demonstrates a real commitment to a smarter, more humane approach to drug policy in the 21st century” (ONDCP 2014a). Lawmakers have also voiced support for a “multi-pronged approach” to drug policy including “law enforcement, treatment, education, and research” (Rogers (KY) 2012a, 12). Politicians finally appear to be acknowledging that the U.S. “can’t arrest our way out of this crisis” as Senator Charles Grassley (R-IA) put it in his opening statement of a Senate Caucus on International Narcotics Control hearing on the opioid epidemic (Grassley (IA) 2014, 2). The sentiment that drug addiction cannot be effectively addressed by law enforcement alone has also been echoed by other lawmakers, federal agencies such as the Drug Enforcement Administration, and multiple District Attorneys in Congressional hearings and the press (Associated Press 2015; Coffin 2014, 4; Leahy (VT) 2014, 1; Rannazzisi 2014, 4).

Therefore, even though changes have been modest to policy and particularly funding for the drug war, contemporary drug policy is self-referentially described as radically changing course because it is informed by the discourses of addiction disease, recovery, and the NSA. The narrative of a fundamentally new approach to drug policy – without extensively changing policy – allows politicians, experts, and state agencies to concur with public opinion that the War on Drugs has failed and claim that new rhetoric, pilot programs, and minimal funding changes signal they are taking a new approach, while leaving the vast majority of drug laws intact. The discourse of addiction as a disease conveniently explains why previous policy frameworks failed and why new interventions will solve the problem of socially unacceptable drug use. Past policies that responded to drug use solely with incarceration were unsuccessful because they did

not address the underlying disease of addiction. Now armed with policies that properly blend law enforcement, treatment, recovery support, and incarceration when necessary, lawmakers and government agencies can assure the public that the problem will be more effectively addressed.

Though there has been no revolutionary change in drug policy as the rhetoric of ONDCP and others would suggest, the important changes made to drug policy in the last decade and a half have been justified at least in part by the three discourses popularized by the opioid epidemic. These changes include reducing mandatory minimum sentences, expanding alternatives to incarceration, and revising some policies that discriminate against drug addicts including expanding treatment coverage through the ACA.

The most significant changes in the traditional drug policy landscape in the last several decades have been the removal or reduction of mandatory minimum sentences at the federal level and in at least 29 states across the country since 2000 (Subramanian and Delaney 2014). Federal sentencing reform passed in 2010 as the Fair Sentencing Act, reducing the infamous crack/powder cocaine sentencing disparity from 100:1 to 18:1 (ACLU n.d.). In 2013 Attorney General Holder also changed the DOJ's policies to avoid charging people accused of low-level, nonviolent drug offenses with crimes that carry a mandatory minimum sentence (Holder 2013). These changes have frequently been animated by discourses of justice and racial disparity due to the demonstrated racial bias in the application of mandatory minimum sentences (DPA 2015c, 1). However, Lofgren found in debates at the state level to reform mandatory minimum sentences in New York, California, and Arizona, the most frequently cited factors were reducing state costs for incarceration and drug offenders needing medical treatment rather than incarceration (Lofgren 2011). Similarly, Attorney General Holder speaking on the federal sentencing changes in 2013 said of the nearly 100,000 federal inmates incarcerated for drug-

related crimes “many have substance use disorders” and recommended the objectives of drug policy should be “deterrence and rehabilitation,” including “diversion programs – such as drug rehabilitation and community service initiatives” and reentry programs so that “formerly incarcerated individuals [can] successfully rejoin their communities; [and] become productive members of society” (Holder 2013). However, these changes do not address the more fundamental biases in policing and criminal justice practices that cause people of color to be disproportionately “stopped, searched, arrested, convicted, harshly sentenced and saddled with a lifetime criminal record” for drug policy violations (DPA 2015c, 1).

The second set of major changes to federal and state policy are exactly what Attorney General Holder suggested, expanding alternatives to incarceration (ATI) for drug offenders particularly Drug Treatment Courts (DTCs) and diversion programs. DTCs are the best-known, best-funded, and most widely available ATI for drug offenders. According to the National Association of Drug Court Professionals, there are nearly 2,800 drug courts in all 50 states (NADCP n.d.). These courts reach approximately 120,000 people each year (ONDCP 2013c, 2). DTCs typically require regular court appearances with a specific DTC judge, random drug testing, swift punishment for failed drug tests or rule violations, and strict accountability for progress in areas essential to recovery such as employment, housing, and interpersonal relationships. The court suspends drug-related charges against the individual pending successful completion – or “graduation” – from the DTC program, upon which the charges against the graduate are usually dropped or reduced.

Other ATIs are also gaining popularity across the nation, particularly at the state level. The DOJ has supported at least 17 states in “direct[ing] funding away from prison construction and toward evidence-based programs and services” including diversion programs (Holder 2013).

Innovations at the state level include “pre-trial diversion, the use of risk assessment tools, drug courts, enhanced probation and parole protocols, the expansion of treatment (including medication-assisted treatment), and reentry support” (ONDCP 2014e, 25). In addition to these “enhanced probation”-type programs, there are a few programs based on harm reduction principles designed to divert people out of the criminal justice system entirely through pre-booking diversion, steering them instead to social services. These programs also use the threat of criminal charges and incarceration to motivate “client” compliance, but importantly they do not require abstinence or many of the stringent requirements often required in DTCs and intense probationary programs (Beckett 2014).

ATIs are praised for diverting “nonviolent offenders” out of the criminal justice system, addressing the offender’s underlying substance use disorder, providing an opportunity for recovery, reducing recidivism, and being more cost-effective than incarceration (ONDCP drug policy for the 21st c webpage). Treatment is often the “better and less costly approach” as Senator Patrick Leahy (D-VT) noted in a Senate Judiciary Committee hearing in 2014 and it frees up law enforcement resources to focus on more pressing issues by leading to “fewer cases landing on detectives’ and prosecutors’ desks” (Leahy (VT) 2014, 2). Senator Robert Portman (R-OH) also cited treatment’s reduced costs to taxpayers as a reason to support DTCs, but just as importantly, ATIs can lead addicts to “not just get over their addiction and not be committing crimes but become productive citizens and taxpayers themselves,” contributing to the tax base rather than drawing from it (Portman (OH) 2014, S5701).

However, ATIs and particularly DTCs are commonly critiqued for “cherry picking” only nonviolent first-time offenders – typically described as sympathetic addicts – who are less likely to recidivate than serial offenders (DPA 2011; Tiger 2015). Access to DTCs is also disparate by

race. According to a 2008 survey, 62% of drug court participants are Caucasian, 21% African American, and 10% Hispanic or Latino (Szalavitz 2015), despite the well-documented fact that African Americans and Latinos are disproportionately arrested for drug offenses (DPA 2015c). Successful graduation rates also favor the privileged, as Kerwin Kaye, a sociologist who studies drug policy, explained in a recent media article:

The 50 percent who fail [in DTCs] ... are the most disadvantaged, most likely to be black, the least educated, and the most in need, so it's a way of allowing more privileged white people off the hook (Szalavitz 2015).

A final site of general drug policy change is ONDCP's review and refinement of policies that discriminate against recovering addicts. These policies "unfairly target those with substance use disorders and impede recovery from addiction" and therefore must be changed (ONDCP 2013a, 3). Toward this goal, in 2013 ONDCP and the Department of Education developed a document explaining Federal Student Aid (FAFSA) eligibility for people with drug convictions including a clarification of the law that allows those who have a prior drug conviction but were not receiving financial aid at the time they were charged to be eligible for federal aid (ONDCP 2014e, 23). Most substantially, ONDCP has celebrated two recent public health policies that "for the first time in history – end discrimination against people with substance use disorders" by requiring health insurance companies to cover addiction treatment as a disease (ONDCP 2013a, 2), claiming the agency's role implementing these changes as a key part of their work "lifting the stigma of addiction" and removing barriers to treatment (ONDCP 2012a). These federal policy changes were the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) which requires insurance coverage for substance use disorder and mental health treatment to be equitable to that provided for general medical care, and the ACA which declared substance use disorder treatment an "Essential Health Benefit" requiring all health plans in the marketplace to

cover mental health and substance use disorder treatment and to comply with the parity law (Beronio et al. 2013, 2). HHS has described these changes as “one of the largest expansions of mental health and substance use disorder coverage in a generation” (Ibid, 1). However, disparities in healthcare access persist even as the ACA is implemented, particularly for racial minorities and poor individuals, and especially in states that did not expand Medicaid (Evans 2015). Media reports also suggest that rules to enforce parity provisions have not yet been written, allowing limits placed on MAT access by private insurers and some state Medicaid programs to persist (Ollove 2013). Therefore, without universal health coverage and enforcement of the parity rule, low-income people continue to be disproportionately denied access to effective treatment.

Further Policy Implications

The discourses of the NSA, addiction as a disease, and addiction recovery have supported and made possible numerous policy changes at the local, state, and federal levels. At the same time they have also precluded discussion of certain policy options and undermined other approaches to drug policy that do not conform to the current U.S. model.

First, the objective of recovery and the “struggle” of those in recovery are used to undermine certain drug policies that politicians oppose. For example, the ONDCP opposes drug legalization because it “runs counter to a public health approach to drug control” and would “undermine prevention activities, hinder recovery support efforts, and pose a significant health and safety risk to all Americans, especially our youth” (ONDCP 2011b, 22). This statement ignores the results of Portugal’s 2001 drug decriminalization policy which did not significantly increase rates of drug use while successfully increasing rates of treatment and considerably decreasing new HIV/AIDS cases and drug overdose deaths (DPA 2015a). Marijuana legalization

also poses a threat to recovery by providing “confusing messages” that “perpetuate the false notion that marijuana use is harmless” which “hampers the struggle of those recovering from addiction” (ONDCP 2011b, 21). By this logic, if marijuana is legalized, recovering addicts may think it is safe for them to use and thus jeopardize their recovery, putting themselves and their community at risk.

Second, despite many efforts to define recovery broadly, the discourse of recovery often conflicts with harm reduction approaches that value moderation and mitigation of risk. This causes many effective harm reduction tactics to be dismissed out of hand because they do not conform to the idea of recovery as an entire lifestyle overhaul or they are described as sending the wrong message to addicts that it is acceptable to continue to use drugs rather than recover. MAT is often criticized in this way, such as Representative Tim Murphy’s (R-PA) mostly rhetorical question to a panel of experts at a House Oversight and Investigations Subcommittee meeting in 2015 illustrates:

What should be the aim of treatment for opioid addiction: reduce the intake of illicit drugs by these individuals to more moderate levels? Or should the aim be to place patients on a path to detoxification and ultimately a full recovery, ending all illicit uses and removing the need for lifelong opioid maintenance recovery?
(Murphy (PA) 2015, 9).

In this statement Murphy denigrates harm reduction and distinguishes between “full recovery” and “opioid maintenance recovery,” a seemingly lesser accomplishment and suboptimal outcome. His description assumes that “true” recovery is total abstinence and that anything short of that ideal is unacceptable. Despite overwhelming evidence presented to Murphy at this hearing that MAT is the most successful treatment for opioid addicts and does not constitute a “replacement” addiction, his puritanical understanding of recovery was unwavering, a common attitude among those who define recovery as complete abstinence. Policy allegedly informed by

science also regularly ignores data supporting several harm reduction policy reforms that could save lives and stop the spread of disease such as Needle Exchange Programs (NEPs) and Supervised Injection Facilities (SIFs). While ONDCP has advocated for NEPs because of their proven public health and safety benefits (ONDCP 2014e, 21), there is currently a federal funding ban against them, a ban that was briefly lifted in 2010 but reinstated in 2011 by a Republican dominated Congress (HRI 2011). Some states have moved to provide emergency needle exchanges in response to specific outbreaks of HIV and Hepatitis C as a result of the opioid epidemic (Schwarz and Smith 2015), but concerns about encouraging or enabling drug use by making clean needles available to those who use them has prevailed over effective policy. Similarly, SIFs – facilities where people can legally inject drugs with sterile equipment under the supervision of medical staff – have been shown to reduce drug overdose death rates and HIV transmission rates, promote safe injecting practices, and provide a critical point of contact for drug using individuals to seek treatment if they want it (DPA 2014, 1). However, no SIFs exist in the U.S. and the possibility is rarely discussed in the mainstream media much less among lawmakers or in official ONDCP documents. A final proven harm reduction tactic is stabilizing opioid addicts by prescribing them heroin or other opioids rather than methadone or buprenorphine. This approach was successful in Sweden with individuals prescribed heroin improving their social functioning in areas from criminal activity to employment and psychological wellbeing more than addicts maintained on methadone or morphine (Bourgois 2000). Unfortunately, providing prescription heroin to opioid dependent people is outside the realm of consideration for most U.S. policymakers despite evidence that it could address the issue of inconsistent strengths of illicit heroin, a primary source of opioid overdoses, and thus reduce the unprecedented rates of opioid-related deaths.

Finally, U.S. drug policy discourse has international implications, potentially hampering the spread of effective harm reduction and public health tactics that the U.S. does not support. The new American approach is already being promoted by the U.S. government as an example for the world to adopt; at the 2012 World Forum Against Drugs, the U.S. “presented a document to the international community that sets forth the principles upon which the Administration’s approach to drug policy is based” including addiction is a disease requiring treatment and recovery is possible with proper support (ONDCP 2013c, 1). Adopting this view is not an option, in the NDCS 2013, ONDCP demanded that “all countries must view drug policy as a public health and public safety issue that requires a modern, evidence-based response” (ONDCP 2013a, 3). U.S. drug policy has set the tone for international drug policy for decades, and it is quite likely that the global policy climate will continue to reflect the U.S. model rather than adopting more effective harm reduction and decriminalization policies developed in other countries.

This section has demonstrated that the discourses popularized by the opioid epidemic – the NSA, addiction as a disease, and addiction recovery – have supported some of the important adjustments made to U.S. drug policy in the last fifteen years and have inspired a “revolutionary” change in drug policy discourse. In the next section I consider my final question: What are the political and governmental implications of these changes?

V. IMPLICATIONS FOR GOVERNING PROBLEMATIC SUBJECTS

As illustrated in the previous section, drug policy and discourse have demonstrable effects on how drug addicts are governed. In this case, the discourses popularized by the opioid epidemic and the policies informed by these discourses further distinguish between and attempt to more effectively govern addicts through their identity as failing subjects. In other words, the opioid epidemic, its primary character the NSA, and the popular authority it has provided to the discourses of addiction disease and recovery have made possible novel variations in the knowledges and interventions – therapeutic, medical, and criminal justice – applied to people labeled drug addicts through drug policy.

I find the discourse of recovery in particular provides a set of ethopolitical interventions for the failing addict subject through which they must remake themselves into advanced liberal subjects who can be regulated through their freedom (Rose 1999, 2007). By this I mean that recovery provides the means and an ethical imperative for the addict to act on their own techniques of the self under the guidance of experts in order to improve themselves toward culturally specific yet personally valued goals of health, fulfillment, and quality of life (Rose 2007). At the same time, recovery compels the addict to become an autonomous, responsible, choice-making subject whose individually tailored lifestyle aligns with advanced liberal ideas about self-regulation and appropriate government from a distance (Ibid, 43). The doctrine of addiction disease declares the addict's compulsive use of drugs over pursuits of social norms of health, happiness, employment, and sociality constitutes a "disease of the will" (Valverde 1998). The compulsion to freedom in advanced liberal society and the "insufficiently free" will of the drug addict (Sedgwick 1993, 137) deems them problematic subjects who if untreated threaten the health of the population by spreading disease, breeding vice and crime, and undermining the

absolute value of freedom. Though the addict is unable to choose to stop using drugs on their own, they can choose to submit to the process of recovery and the guidance of experts. Their willing submission to treatment is the simple yet indispensable key to initiating recovery. Paradoxically, the discourse of recovery blends medical models of addiction disease with criminological behaviorism so that the addict's biomedical disease can only be arrested through their own active choices to change their behaviors in compliance with directives for recovery (Tiger 2015). Once the addict has acquiesced to recovery, the tenor of subsequent interventions is best described by Moore in the context of DTCs as "not deploy[ing] strategies of brute force or repression nearly as much as they offer 'opportunities' for people...to 'choose to change'" (Dawn Moore 2007, 10). Thus good drug policies are state-supported but expert-directed interventions that first convince potentially recovering addicts to submit to treatment and then provide them with "opportunities" to engage in the ethopolitical project of recovery so they can again be effectively governed through their freedom (Valverde 1998). Simultaneously, policy must also be able to quarantine the addict who refuses to recover and therefore cannot be effectively governed as a free citizen in advanced liberal society.

More than just becoming a typical advanced liberal citizen, the recovering addict must further remake themselves into a biological citizen (Rose 2007). These are subjects whose biology is a source of identity and their health is a source of right and responsibility (Ibid). Through expert knowledge, guidance, and intervention, the biological citizen acts upon themselves for the betterment of their health and as part of a mandated "ethic of active citizenship" in advanced liberal democracies (Ibid, 25). The recovering addict must take on specific techniques of the "care of the self" including constant self-evaluation and self-improvement in order to optimize their health (Ibid; Foucault 1986). The recovering addict has

taken responsibility for their biological identity by seeking expert direction to manage their disease and regain control of their lives and can therefore claim rights to treatment, social acceptance, and political recognition based on their identity as an active, recovering biological citizen.

A full recovery characterized by advanced liberal and biological citizenship is the aspiration for all addicts – both marginalized and normalized – and is professedly offered to all through drug policies designed to convince potentially recovering addicts to take up this ethopolitical order. Recovering and potentially recovering statuses crosscut the MTA and NSA identities, further dividing and distinguishing addicts and allowing more targeted application of governing methods. Keane (2000) describes the recovering addict as not just “the mirror opposite of the addict’s pathological and unenlightened being, but the recovering addict is also the promise of what every addict could become” (Keane 2000, 328). Consequently all addicts are governed through their potential identities as recovering addicts and biological citizens as well as through their existing NSA and MTA identities. In the past, normalized and marginalized addicts were governed through dichotomous strategies and institutions, typically pastoral therapeutic or medical treatment for the sympathetic addict and disciplinary sanctions or incarceration for the threatening addict. However, contemporary drug laws must declaratively treat all addicts equally. In the contemporary discourse both types of addicts are described as having a disease and the solution to their common problem is recovery, therefore policies encouraging treatment and rehabilitation must be applied to both types of addicts. Each addict requires a personalized management strategy to achieve recovery which may include therapeutic, disciplinary, and repressive techniques. Thus, hybrid drug policies integrating public health and existing criminal justice approaches can be effectively and allegedly equally offered to both normalized and

marginalized addicts, those amenable to recovery and those resistant to it, by instituting a continuum of interventions that can be fluidly applied. These mechanisms blend techniques of government allowing precise interventions according to the addicts' amenability to recovery. The state can offer well-behaved, recovery-minded addicts "opportunities for gainful employment, housing, and education" while "saving the most resource-intensive programs for those with the most need and the highest risk of recidivism" or the addicts perceived as most averse to recovery (ONDCP 2014e, 26). Critically, all addicts are described as having an opportunity to recover through these policies and as making a choice to accept that opportunity or squander it.

Thus the government of drug addicts in the current advanced liberal regime of crosscutting identities, egalitarian rhetoric, and blended governmentalities proceeds roughly as follows: The addict is offered the opportunity to engage in the ethopolitical process of recovery, typically in a therapeutic or medical setting, under the guidance of state and expert pastoralism and motivated by the regulatory norm of the successfully recovering addict. Not all addicts are offered the same opportunity to engage in therapeutic recovery, this is dependent upon the addicts' perceived identity and how they encounter the addiction treatment and criminal justice complex, such as through a doctor, an arrest, the type of arrest, criminal history, etc. For those uninterested, unqualified, or deemed incapable of these self-directed techniques, punitive disciplinary power in the criminal justice system is used to deter drug use and enforce recovery. A series of sanctions and incentives are offered to the addict in a restrictive setting. They can choose to comply with these directives or not, and if discipline fails to provoke engagement in recovery, the sovereign power to take life through perpetual incarceration or death are reserved as motivational last resorts and the ultimate punishment for those who refuse to comply. Illegal drug use must remain criminalized and addiction treatment embedded in the criminal justice

system because the threat of incarceration is at times the only sufficient incentive for the addict to agree to manage their peculiar disease through recovery. Addicts unmoved by ethopolitical incentives or punitive deterrents are rightfully punished for rejecting recovery for at every step in this process the addict chooses either to capitulate to recovery or to incur more punishment. If the threat of incarceration or death fails to persuade the addicted subject to surrender then they have brought their fate upon themselves.

Blending modes of government is a common strategy for managing difficult subjects, as Donohue and Moore found in the fluid identities of “offender” and “client” and requisite punitive and therapeutic methods operating simultaneously and co-constitutively to manage people in the criminal justice system (Donohue and Moore 2009). Moore also found integrated disciplinary and pastoral interventions in DTCs (Dawn Moore 2011), and Campbell identified how forced drug treatment for pregnant women is simultaneously compassionate and coercive (Campbell 2000). The result is a range of governmental powers employed simultaneously through policies that blend treatment, sanctions, and incarceration, all toward the goal of directing the addict to adopt ethopolitical technologies of recovery and reshape themselves into a viable advanced liberal subject.

Political Resistance and Identity Reformation

The political implications of the ethopolitical discourse of recovery and supporting public health drug policies are two-fold. An optimistic projection is that they could deliver on their promise and modestly begin to unravel the long history of dichotomous treatment for MTAs and NSAs. It could provide some addicts who would otherwise have been institutionalized, sterilized, incarcerated, or killed with access to resources and treatment they may find beneficial. The discourse of recovery is humanizing and could lead to less stigmatization and reduce social

isolation for people who use drugs, minimizing the harms otherwise caused by criminalization. For these reasons virtually all advocacy groups, even the most critical, agree that recent policy changes, particularly those that take a public health approach, are a significant improvement over strict criminalization policies (DPA 2011).

Recovery discourse could also help build political power among those labeled addicts who are inclined to engage in recovery. The logic of biological citizenship requires recovering addicts to organize and “*become* political” in order to secure their biological rights to effective treatments and cures as well as freedom from discrimination based on their biological status (Rose 2007, 149). This makes it possible to build organizations and perhaps a movement based on the discourse of recovery for addicts to advocate for rights and recognition (Seelye 2015). FAVOR is a prime example of this. Addicts who can claim recovery are able to take advantage of their biological citizenship to advocate for themselves, organize and build political power, and have an impact on public policies that affect them. If recovery advocates are able to effectively claim rights for themselves and change drug policy, it is possible those changes could also have wider benefits for addicts who are not in recovery or people who use drugs who do not identify as addicts or with recovery.

The discourse of recovery also presents a rare opportunity for someone with a stigmatized identity to disassociate from it and assume a normalized identity, albeit through very specific methods and invasive techniques of recovery. Still, the addict can take on a new identity as a recovering addict through which they can avoid incarceration, reintegrate into society, and reap some of the benefits of possessing a valued identity. For a group that has been categorically ostracized and institutionalized for being the antithesis of the ideal subject, being able to claim an advanced liberal subject position may be an effective strategy for advancing addicts’

independence and ability to make decisions about their own lives (David Moore and Fraser 2006). In fact, it is an identity some embrace and are feverishly organizing to support. For example, Kaye found that some addicts enthusiastically claimed new identities afforded by the narrative of addiction and invasive disciplinary drug treatment practices in therapeutic communities because acquiescence offered the promise of reintegration into society, an explanation for past failures, hope for future success, a new type of docile agency enabling low-wage work in the formal economy, and benefits such as job training to assist the addict toward those promises (Kaye 2013). Kaye recommended social scientists studying projects of government not dismiss this phenomenon but instead:

...take seriously the ways in which poor people sometimes take the state up on its offer, such that more than once, individuals I interviewed declared with genuine feeling, *'Thank God I was arrested!'* (Ibid, 210).

Kaye's ethnographic findings exemplify how the discourse of recovery succeeds in its ethopolitical objective by offering addicts a valuable identity, the pursuit of which aligns with the goals of advanced liberal government as addicts are governed from a distance through expert guidance to shape their recovery lifestyles. By following these ethopolitical directives addicts are – perhaps unknowingly – reproducing the system of government that determined they were problematic subjects in the first place. However, Bourgois recommends from a “humanitarian risk reduction perspective” that scholars consider the ways certain drug policies might relieve suffering otherwise caused by criminalization and incarceration even as these policies are used to govern subjects and reproduce existing sociopolitical hierarchies (Bourgois 2000, 190).

Likewise, I suggest the identities afforded by those policies be given similar consideration.

Finally, because power is not totalizing or unidirectional (Foucault 2007), people labeled addicts or recovering addicts can also use those identities for their own purposes, including in opposition

to the hegemonic order. Each novel identity crafted for the purposes of government offers possibilities for compliance and resistance (Dawn Moore 2007) and the discourse of recovery makes it possible for addicts to organize, opening drug policy to new demands and new voices which may prove to be powerful tools of resistance.

Discursive Preclusions, Requirements, and Biases

At the same time, the discourse of addiction recovery often limits much of what can be said about experiences of drug use. Recovery discourse requires specific stories of addiction and recovery, primarily first-person narratives from addicts telling their personal tale of degradation through addiction and redemption through recovery. Only those who are successfully recovering are invited to share their stories with the media, politicians, and experts, not those who tried to recover and failed. While these stories may vary as to how the person came to recovery or what their recovery looks like, they all require redemption through abstinence and the guidance of experts and their experience must be named recovery from a biological disease of addiction in order to “count.” The stories of those who do not experience their drug use as problematic or do not find themselves needing the techniques of recovery in order to change their drug use are excluded from the public conversation entirely. Those who have used drugs and did not become addicted – the vast majority of people who ever use drugs – are also not included. Though recovery introduces the personal experiences of drug users into the public discourse in a meaningful way it also limits contributions to those that conform to a preexisting narrative of recovery. The “known facts” (Campbell 2000, 14) about drug addicts are controlled primarily by esoteric practices and knowledges of medical, criminal justice, treatment, and recovery experts, and the personal stories promoted in the discourse must confirm these knowledges.

The discourse of recovery also precludes any other understanding of drug use and drug addiction other than social maladaptation and disease. Addiction as a neurobiological disease is the reigning “style of thought” through which the facts about addicts, treatment, and drug policies are formed (Vrecko 2010, 62). Public health drug policies aimed to divert people with drug addictions out of the criminal justice system and into treatment assume that all people who are arrested or encounter expert-identified “problems” related to their substance use have the disease of addiction. The only question asked of the drug offender is whether or not they are ready to embrace recovery, not whether or not their drug use is actually disrupting their life. It flattens all experiences with drugs to one of disorder and disease, ignoring socioeconomic inequalities that contribute to drug exposure and drug use as well as any other reason why people might use drugs, such as for pleasure, recreation, or physical or psychological benefits. It also claims that ending drug use will necessarily improve the addict’s life circumstances, again ignoring the many other factors that could explain one’s social, economic, and political dislocation from mainstream society.

In addition, the successfully recovering addict in these discourses is most often illustrated as a typical NSA. For example, when Botticelli wrote on the ONDCP blog about the success of drug courts his featured case was Donovan, a young white man from Kentucky. Botticelli described Donovan’s story as exemplary of “people who seized the chance to change their lives for the better when they were given the opportunity” (Botticelli 2015a). Similarly, the successful recovery stories most often promoted on FAVOR’s website are those of typical NSAs, white, well-educated individuals from good neighborhoods and families who through recovery have reclaimed a successful position in society (ONDCP n.d.). Stories of normalized recovering addicts are also dominant in the media, particularly in coverage of the opioid epidemic. A 2014

NBC series on the opioid epidemic called “Hooked: A teacher's addiction and the new face of heroin,” featured the story of Michelle, a teacher, mother, and middle-aged white woman living in suburban New York who despite her good job and privileged lifestyle succumbed to prescription opioids and eventually heroin addiction (Carroll 2014). Her recovery also began in a DTC that “motivated me to continue to do the right thing” and she is now an ideal recovering biological citizen, making it her life’s work to help other addicts by working on the “Drug Court Team” for the DTC judge who oversaw her case (Ibid).

A New Binary and the Empty Promise of Recovery

Considering these discursive limits and the strong association between recovering addicts and NSAs, a more critical reading of the implications of recovery discourse suggests it can also be used to justify coercion and demonization of those who do not embrace recovery and to legitimize continued disparities in the criminal justice system. First, in the discourse of addiction disease and recovery, medical and psychological authorities know the truth of the addict – that their willpower is damaged by addiction and they need recovery to repair it – more accurately than the addict knows themselves. As former ONDCP Director Kerlikowske wrote in his closing remarks to the NDCS 2011, addiction “unlike most diseases” is often “obscured by denial” therefore treatment may need to take place in “non-traditional settings, such as the criminal justice system” (ONDCP 2011b, 89). Resistance to treatment is understood as a symptom of the addict’s irrational disease, therefore coerced treatment is justified as being in the addict’s own best interest even if they protest. As Valverde explains, the celebration of the freedom of the recovering addict is easily used “to coerce other alcoholics into locked asylums so that, losing their freedom, they would be given the opportunity to regain it” (Valverde 1998, 16). Reinerman and Granfield similarly warn that promoting the discourse of addiction disease is not a uniformly

effective strategy for changing drug policy because of its tendency to legitimize coercive practices in the criminal justice system (Reinarman and Granfield 2015). For example, the Tennessee law criminalizing pregnant women who test positive for drugs was characterized by local District Attorney Steven Crump as in fact helping women by giving them an incentive to receive treatment and end their drug use:

I think the women we have charged would say the law was helpful to them. Was it a hard time in their life? Yes. But ultimately did it lead to better things for them and their children? Ultimately, I think they'd have to agree to that, too (Boucher and Gonzalez 2015).

The discourse of disease and denial justifies all types of invasive and punitive interventions into the drug addict's life in the name of their future health and wellness in recovery, despite their initial resistance.

Second, recovery discourse also makes possible a new binary of recovering addicts and addicts who refuse to recover. Just as the NSA of the opioid epidemic is contrasted with the often unnamed MTA, so too is the recovering addict often described in relief to its implicit shadow, the addict that refuses to recover. FAVOR at times distinguishes between individuals based on "recovery status" and what political and social rights they each deserve (FAVOR 2011b, 1). In the "Recovery Bill of Rights" FAVOR demands social, political, and health care rights for those who are "no longer misusing alcohol/other drugs and are on the road to recovery" (FAVOR n.d.). Elsewhere they describe their work as "aimed at ending the punishment and incarceration of people for their status as people with histories of addiction" (FAVOR 2012, 7), not necessarily those with ongoing experiences of addiction or drug use. ONDCP likewise criticizes laws that inexcusably "make no distinction between the person who continues to use drugs and the person who is on the pathway to recovery" (ONDCP 2010, 44). The agency suggests these laws should be "either repealed or modified in a fashion that allows exemption of recovering people from

their effects” so that “a greater number of addicted individuals in early recovery will succeed in the long-term goals of becoming healthy and productive members of society” (Ibid). Thus, while both of these groups claim to be working on behalf of all addicts, at times they characterize the recovering addict as someone who deserves rights, treatment, and compassion in contrast to their “Other,” the addict who rejects recovery.

In this binary, the recovering addict is celebrated as a courageous advanced liberal subject whose determined efforts to recover qualify them for social reintegration, while the addict who refuses to recover is an indecent, unthinking subject whose obstinacy makes them a true “anticitizen.” According to Rose, anticitizens are failing subjects who “seem to lack all the self-governing capacities that are at the heart of civilized moral agency in an advanced liberal society” (Rose 2007, 242). They have scorned society’s values and therefore must be purged to protect those values and the population from their corrupting influence (Rose 2000). Therefore, anticitizen addicts are not excluded from society because the law discriminates against addicts as a class, or even against particular classes of addicts, but because those specific individuals chose to reject the opportunity to recover. The grammar of addiction disease and recovery discourse – in which objective medical knowledge informs policies providing equal access to evidence-based treatments and treatment success or failure is the result of individual choice – precludes any discussion of racism, sexism, classism, or any other systematic discrimination manifested in drug policy. Addicts are not disciplined, coerced, and imprisoned by virtue of their identity as addicts, but because they are “intractable individuals unable to govern themselves” (Rose 2007, 249). These are the individuals from which society must be protected; and in the interests of more efficiently managing risk within the population, state and expert resources are directed at

controlling these individuals rather than addicts amenable to recovery who can be taught to manage themselves (Kaye 2013).

Consequently, the individualizing and privatizing logic of recovery obscures structural barriers preventing marginalized populations from accessing recovery resources, ignores the highly uneven distribution of resources to support recovery, and disavows biases in the criminal justice system. Instead, the discourse of recovery attributes persistent disparities in the criminal justice system and in access to MAT, naloxone, ATIs, and health care to the individual choices of addicts to accept or reject recovery. Those who attempt to recover and fail are personally blamed for not sufficiently committing themselves to recovery, no fault is assigned to frequently ineffective or inaccessible treatment (Cherkis 2015), as the case of the Tennessee law further demonstrates. According to the law, women criminalized for drug use during pregnancy can avoid criminal charges by entering treatment, but the law did not provide additional funding for treatment centers to accept pregnant or parenting women, a chronically underserved group (DuBois and Gonzalez 2014). Thus the legislature appeared compassionate and informed by the discourse of addiction disease while offering poor pregnant women a hollow promise of legal amnesty through recovery and subjecting them to further surveillance and disciplinary control.

Despite ONDCP's rhetoric promising "to make our public health and safety policies more effective and more equitable" (ONDCP 2014e, 79), the NSA and the MTA continue to be governed through their identities as either valued or maligned individuals (Dawn Moore 2007). Though both addicts are described as having a disease that needs to be treated, biases against MTAs and in favor of NSAs persist, particularly regarding their access to treatment and recovery resources and the perception of their amenability for recovery. By blending methods of government in hybrid policy mechanisms, the state can appear to be treating all equally while

distinguishing among addicts based on their NSA or MTA identity and their status in recovery and applying interventions accordingly. Thus, drug policies can support the ethopolitical project of recovery for NSAs by allowing private doctors to prescribe buprenorphine, requiring insurance coverage for treatment, and diverting NSAs from the criminal justice system through ATIs, while simultaneously operating as a mechanism of control for MTAs by tightly regulating methadone clinics, failing to ensure adequate access to treatment and lifesaving drugs, and funding surveillance-heavy ATIs that keep MTAs firmly in the orbit of the carceral state (Gottschalk 2007). The end result remains that NSAs have disproportionate access to interventions that include treatment while MTAs are still more likely to receive punitive sanctions and incarceration. Even without strictly dichotomous institutions and policies, MTAs are still systematically directed to sites of disciplinary and sovereign power through the biased practices of the criminal justice, treatment, and recovery complexes. They are no longer categorically pathologized as essentially irredeemable subjects, rather they are targeted as individual subjects who have chosen not to adopt the equally accessible practices of recovery. By rejecting an opportunity to reshape themselves into socially acceptable subjects, they have essentially chosen to exclude themselves from society and therefore deserve the punishment and ostracism they suffer.

Furthermore, even if MTAs are able to successfully recover, they continue to be excluded from sharing equitably in the benefits of mainstream society because of the other stigmatized identities they are assigned. As Hickman noted, the racialized (or gendered, classed, or sexualized) “Other” is always “*like* an addict;” recovery promises integration into mainstream society but that promise is largely empty in a rigidly stratified social system. There may be some opportunity for upward mobility, but the full benefits of privileged advanced liberal citizenship

remain unattainable for most. The disregard for systemic inequalities in recovery discourse may explain why recovery is so attractive to some addicts, such as those quoted in Kaye's study, and why recovery so often fails to deliver on its promise of equal access and true social reintegration. Thus, while some individuals labeled addicts – typically those who already had access to resources and privileges – are benefitting from heightened visibility and support for addiction recovery, others who do not have those privileges are largely excluded from those benefits, and may be further harmed by the discourse of recovery if deemed anticitizens.

Marginalized groups may also be harmed by recovery discourse as it serves the political objectives of advanced liberalism by renouncing the state's responsibility to directly address social problems. Failure to thrive in advanced liberal society is attributed to individual failure to make appropriate choices. By this logic the state is not responsible for poverty, insecurity, or poor health because they result from imprudent, individual choice (Dawn Moore 2007). Accordingly, in the discourse of recovery, social factors contributing to drug use and addiction are often minimized because the solution to the addict's problem is personal rather than political. Through treatment some addicts are able to reach previously inaccessible public benefits, but these are provided as a privilege not a right, and are only provided to enable the addict to become a free and independent subject. Thus recovery discourse relieves pressure on the state to provide security and ensure health equitably by displacing responsibility for addiction – a major source of inequality – onto individual addicts.

It also alleviates the demands put on the state by a privileged sector of the population to address the effects of the opioid epidemic on their valued group. The opioid epidemic's main role in this historical narrative is leading privileged groups to pressure policymakers and experts to respond to the epidemic with new policy tools, contributing to the current prominence of the

discourses of addiction disease and recovery. By implementing public health policies that predominantly serve privileged classes by diverting them from the worst aspects of the criminal justice system, the burden to more thoroughly change that system is relieved. And, by more efficiently monitoring and controlling marginalized classes through ATIs and MAT, pressure from below to address discriminatory drug policies is suppressed at the same time.

Finally, recovery discourse makes possible a new method of executing the drug war and a novel mode of using incarceration to shape identities and sustain inequality. Drug policy and practice continue to be used to identify, categorize, build knowledges about, and thus make governable individuals labeled drug addicts. The discourse of addiction recovery provides new methods of differentiating more precisely among addicts and thereby more efficiently governing deviance through the drug addict identity. While U.S. drug policy has not massively changed since 2000 – despite the insistence of ONDCP and others of a “revolution” in approach – public health policies integrated into the existing complex of criminal policies provide the veneer of a more progressive and just method for addressing addiction among all addicts while primarily serving the privileged. These policies simultaneously mask the continuous, targeted effects of punitive drug policy on the underclasses (Tiger 2015) and blame the marginalized for their failure to succeed in a system that is built upon their suppression (Campbell 2000).

Therefore, I find the current arrangement of drug policy inspired by the opioid epidemic and the discourse of recovery is qualitatively different, though not necessarily less oppressive, than that employed during the War on Drugs. Rather, these seemingly “progressive” policies may succeed primarily in allowing the most privileged, sympathetically constructed addicts to avoid incarceration while simultaneously distracting from the carceral state that continues to ensnare the most marginalized through racialized, classed, and gendered drug policies. Thus drug

policy remains a useful tool for managing problematic subjects and perpetuating the effects of the War on Drugs, even as it claims to be more humane and less discriminatory.

VI. CONCLUSION

The opioid epidemic and the NSA have changed the discourses about drug addiction in the U.S. in the 21st century, bringing the discourses of addiction as a neurobiological disease and addiction recovery into mainstream policy and practice. I have demonstrated that these changes have contributed to official disavowals of the War on Drugs approach and the incorporation of public health policies at the state and federal level. Consistent with past findings, a drug epidemic among a privileged group of addicts has led to change in discourse and thus change in drug policy, and these new policies reflect contemporary governmental logics. These logics inform novel methods of governing addicts through their identities, in this case through the ethopolitics of recovery; and I have argued that this mode of government emphasizing individual choice and responsibility supports recent policy changes that profess equality and justice, yet retain past policies' discriminatory effects.

As Moore and Rose suggest, investigating how risky or problematic subjects are governed can provide insight into how prevailing modes of governmentality and political rationality function (Dawn Moore 2007; Rose 2007). In this case, I have identified one set of conditions under which the advanced liberal state will intervene – or enable experts to intervene – in its subjects' lives, indicated characteristics of “good” policy and governmental strategies according to this model, and suggested the ominous political implications of policies informed by these logics that profess justice. These findings are particularly important in light of the growing political consensus that the current system of mass incarceration and punitive drug policy needs to be reformed. The policies implemented in response to the opioid epidemic suggest what more extensive policy changes might look like, what discourses might animate them, what governmental methods they might employ, and what their effects may be for people labeled drug

addicts or criminals. I recommend that social scientists studying these reforms be acutely aware of the potentially disparate application of new laws, and if and when disparities are identified, to bring attention to the hypocrisy of equality discourse that ignores and in fact exacerbates existing inequalities.

This study also points to further areas of investigation including a more in-depth analysis of the workings and effects of the recovering/not recovering addict binary, as well as an examination of the “NAS baby” narrative and how it is used to govern poor women and families. Ethnographic work with groups using the recovery paradigm to organize and act politically and with those labeled addicts who do not identify with recovery discourse would also be compelling areas of research, particularly how recovery discourse politicizes or depoliticizes these individuals’ experiences. Finally, an analysis of recovery discourse and its role in further demonizing people labeled criminals who cannot claim an illness at the root of their deviance – particularly those who sell drugs and “prey” upon the addict’s illness – would be particularly interesting and relevant to developing policy changes.

The privileged victims of the opioid epidemic and the discourses of addiction disease and recovery have made it possible for recovery experts to proclaim there is now “hope for every addicted American” (ONDCP 2010, 35). Hope is a critical element in the political economy of ethopolitics and can be a powerful technique of government, inspiring problematic subjects to improve themselves in ways that conform to prevailing norms of subjectivity (Rose 2007). But hope can also be a revolutionary spark, inciting action and making possible new identities and ways of being beyond existing norms. My analysis suggests that the hope made possible by the discourse of recovery tends toward the former, but retains possibility for the latter.

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