Recovery Needs its Stonewall

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Burn it down. Let radical love light the fire and lead the way.
—Christa Thomas-Sowers

Most of my friends are people in recovery, people who use drugs, outreach workers, sex workers, harm reductionists, indigenous midwives, formerly incarcerated community health advocates, radical doctors, homeless activists and overdose survivors. I'm a former crackhead and alcoholic, among other things.

Since receiving the invitation to participate in this symposium, I have been canvassing my friends in person and online about what to "carry forward" in our response to the overdose crisis. There were, of course, differences and nuances in responses. But almost everyone ultimately mirrored Christa's observation: Nothing. Not one thing.

You should hear in this answer rage, trauma and a depthless sense of betrayal. But it is the rage of frontline workers who have confronted this epidemic for years, understand the policy dimensions better than virtually anyone and have built our overdose prevention infrastructure—to the extent that it exists. Behind this response lie decades of accumulated thinking, heartbroken reflection and community knowledge.

I want to attempt a form of critical theory that David Graeber suggests in his *Fragments of an Anarchist Anthropology*. I want to distil some elements of the unspoken analysis that underlies our rage and offer it back to my community as a reflection of our living, growing movement.

DROP: NORMALIZATION

The precipitating causes of the overdose crisis reflect discrete state policies: the volatility of the black market created by prohibition; fear of seeking treatment produced by criminalization and the resultant stigma; the evisceration of community and social services produced by decades of neoliberal policy; the social and health impact of mass incarceration, racist policing and drug convictions on housing, employment and healthcare. Many of these same policies block the evidence-based, internationally recognized interventions that could mitigate deaths, including Overdose Prevention Sites, safe supply of opioids, street-level drug screening/surveillance and the full incorporation of harm reduction into our programs and systems of care.

The result is an artificial context where the government—acting chaotically at multiple levels and through often conflicting agencies—produces the conditions of the crisis while barring the use of our strongest public health tools. Activists, policymakers and local state agencies are forced to extemporize novel interventions within this involuted matrix. There must be some technical planning or political theory term for this type of double bind. Living through it as your friends die is unbearable.

Those of us on the frontlines bear the psychic toll of swallowing this hypocrisy, choking our rage so that we can engage with a state whose resources we need in order to keep our people alive. Our interventions and programs are second-choice gambits quickly rigged to cope with these constraints; even when they make a modest impact, we arrive at work every day knowing that they are ersatz holding operations for the suite of interventions that we actually need but are legally denied.

My colleagues and collaborators understand the sacrifice and dedication of people working at every level of the crisis—from street outreach to departments of health. But none of us believe that any aspect of this macabre pantomime is necessary. We are dying from a callous alloy of racism, cynical indifference, Puritanism, lack of imagination and—most fundamentally—dishonesty. Any community less crippled by shame, fear and criminalization would have started the fires a long time ago.

At a basic level, the structure of this legal impasse distorts the contours of the crisis, obscuring what we are actually dealing with. Significant research identifies stigma as a major impediment—if not the single greatest obstacle—for people seeking help for problematic substance use. At every intersection (institutional, cultural, individual) stigma is interwoven with, works through and is reproduced by racism, neoliberal class and housing structures, for-profit medicine and the criminalization of substance use.

There is no way to model or design interventions to address stigma as it actually functions in this society without addressing the still accelerating "War on Drugs" and these other issues. Indeed, public officials and politicians often euphemistically talk about "stigma" to avoid directly acknowledging and addressing the public health consequences of prohibition. It is not that we should refuse to tackle discrete issues until we have the capacity to transform these systems (we urgently need to make whatever gains we can), but that the state-manufactured deadlock makes it impossible to clearly delineate their attributes and effects. Our social science is hamstrung by ad hoc pseudo-concepts and working fictions. We are wandering between mirages.

MODIFY: "MEDICAL MISTRUST"

A searing irony of the COVID-19 pandemic is the scale of devastation within Black communities combined with the level of suspicion among many African Americans regarding vaccinations. In recent years, public health experts have discussed this phenomenon as "medical mistrust." The pandemic made even more visible the intensity of suspicion regarding health institutions and the medical profession among communities rendered vulnerable and marginalized by structural violence, including people who use drugs.

Jessica Jaiswal is among the scholars of health and race to have described the shortcomings of "medical mistrust" as a concept—one that too often locates root causes in past events rather than in current structures and that lends itself to pathologizing communities by locating mistrust within their "culture." The insufficiency of the term is reflected in the fact that it is sometimes employed to capture both the entirely rational suspicion of biomedicine created by centuries of racial trauma and the middle-class culture of vaccine hesitancy in some of America's wealthiest suburbs.

The agency here begs relocation—from besieged communities to the healthcare system and professional castes (especially doctors and healthcare administrators) who have alienated themselves from the people these systems claim to serve. To invoke the work of Camille Robcis (and through her a radical transition of community-based, institutional medicine), we need a politics of medical "disalienation."

To ask how to build trust in healthcare among communities that are continually abused and betrayed by the current system is obscene. Instead, we must honestly discuss the conditions of dis-alienating healthcare from these communities. There are some obvious—but at the moment completely daunting—first steps: affordable quality healthcare accessible to everyone; diversifying the medical professions and transforming medical education; greater representation of local communities among employees of the medical institutions that serve them; increased patient and community power in institutional review and governance; and radically rethinking the relationship between the space of the clinic and its surrounding neighborhoods.

These preliminary steps towards disalienation, however, will remain ineffective until the scale of harm is recognized and the medical professions approach communities—including people who use drugs and people in recovery—and ask how they can begin to repair the damage they have both participated in and enabled through their passivity within the current system.

KEEP: THE "RECOVERY REVOLUTION"

In the words of veteran recovery activist William White, we are in the midst of a two-decade-old "recovery revolution" that has transformed how we understand both addiction and the work of healing individuals and communities from substance-related trauma. The modern recovery movement—beginning with Alcoholics Anonymous but with antecedents that stretch back to indigenous anti-alcohol and anti-colonial movements of the 18th century—is the largest example of decentralized, direct democracy in human history. It is also one of our longest-running experiments in restorative justice.

That said, the 1970s witnessed its institutionalization and partial co-option by a for-profit treatment industry that marketed an increasingly dogmatic conception of abstinence and 12-step fellowships as the only viable modality of recovery. Two decades of research, institution building and imagination have resulted in initial steps being taken towards dismantling this paradigm. The new recovery advocacy movement, reflected in films like *The Anonymous People* and Ryan Hampton's book *American Fix*, has popularized the idea of "multiple paths of recovery," including moderation and alternatives to 12-step programs.

Harm-reduction activism, drawing on the pioneering labor of European drug users unions and ACT UP's underground needle exchange programs, has radicalized this framework by questioning forms of race and class normatively present in mainstream depictions of recovery. Slowly and unevenly, these ideas are beginning to circulate more broadly within recovery culture, provoking debate and the beginnings of searching for self-evaluation. The 2020 #blacklivesmatter rebellion lent greater momentum to those—mainly Black, indigenous and people of color in recovery—who have started the difficult, overdue and under-recognized work of questioning forms of white privilege and racism that exist within many recovery spaces.

At the same time, the recovery universe is meteoric, exploding. We are witnessing the proliferation of thousands upon thousands of podcasts, blogs, Youtube channels, recovery gyms, recovery running clubs, recovery yoga, new mutual-aid philosophies and frameworks (Christian, Buddhist, secular, Yogic, Native American, Islamic…), retreats, community centers, researchers…. Already underway even before the pandemic, the migration of mutual aid meetings online during the shutdown exposed a new generation to recovery culture beyond 12-step fellowships. And these novel ideas are slowly flowing back into the rooms of AA and Narcotics Anonymous. Our community is accomplishing the near impossible.

Since the 1950s (as Robert Putnam describes in Bowling Alone in America), America has watched the collapse of its face-to-face civic life: the decline of unions, civic organizations, political clubs, parent-teachers associations, veterans organizations, youth groups and so on. During these same decades, recovery meetings have spread to every town and—in some cities—every neighborhood. Wherever we are (on an airplane or in prison), we can reach out to each other and be assured of solidarity and love.

In a time when our society is ferociously polarized, we have created a culture based on the principle that no one is expendable, no one should be thrown away—although as my friend Sarah Edwards recently reminded me, we regularly fail to live up to this commitment. Even so, no matter who you are, no matter what your past, we will welcome you and hold you close if you are willing to examine your life, to live honestly in relation to your past and to work—always imperfectly—towards reparation. We embrace those many outcasts few others in this society want: people who have taken lives, who have abandoned families, who have abused partners, who have stolen from friends as well as people who have suffered the violence of these acts—and the many people who are in both categories at once.

As Mariame Kaba reminds us, this duality is often not the exception but the norm in poor, Black and brown communities. It may be a searching road—and those who walk it experience it as half-steps, service and humility, not some brand of redemption—but there is always a path to a different life. We hold this hope for everyone, often long before they can believe it for themselves. "No matter how far wrong you've gone," sings Gil Scott-Heron, one of our great sages, "you can always turn around." We are leading a rebellion against what the philosopher Achille Mbembe describes as "necropolitics," the politics of abandoning a discarded segment of humanity to die.

There is nothing else quite like this un-captured, un-privatized mass movement of mutual aid of the despised for the despised. As M.E. O'Brien suggests in her beautiful essay Junkie Communism: "Our revolutionary politics must embrace the many broken and miserable places inside ourselves. It is from these places of pain that our fiercest revolutionary potential emerges." This potential has not gone unnoticed.

In a seemingly well-meaning effort to respond to the overdose crisis and the crisis of medical alienation, federal agencies like the Substance Abuse and Mental Health Services Administration (SAMHSA) are investing significant resources in recovery support, recovery community centers and peer recovery specialists. Along with this infusion comes the professionalization and bureaucratization of our spaces, our labor, our work of loving. We have yet to understand what this transformation entails for the practice of peer support, a mode of activism with roots in ACT UP and the psychiatric survivors movement of the 1970s (and ancestors that include Native American sobriety circles and temperance clubs created by freedmen after Emancipation). Brooke Feldman warns about co-option. Even less benign is the expansion of corporate recovery tools, technologies and platforms. These are the instruments of extraction and enclosure. We are starting to witness a recovery counter-revolution.

The recovery community does not need Microsoft-funded software platforms and federal grants. We need to cultivate our rage. We need a beautiful, compassionate, open-hearted revolt. As they let us die and demand our ongoing silence and complicity (and even gratitude), we need to take a page from some drag queens and queers of color who on one sweltering June night took the fight out into the street and said fuck this bullshit. We need our Stonewall.