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Rethinking Addiction and Social Recovery: From Criminalization to Education

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Abstract

This paper examines how cultural, scientific, and political understandings of addiction in the United States have shifted over time, arguing that systems of punishment have consistently overshadowed care. Using a historical-sociological approach, it draws on texts such as Carl Erik Fisher's *The Urge* (2022) and Johann Hari's *Chasing the Scream* (2015) to analyze how narratives of addiction have been socially constructed and mobilized to justify policy. By incorporating recent public health data, the paper positions addiction not only as biological dependence but also as a condition shaped by inequality, trauma, and systemic neglect. The analysis shows that early U.S. drug policy was driven more by racial and moral panic than by medical concern. The Harrison Narcotics Act of 1914, Harry Anslinger's campaign against marijuana and jazz culture, and the later War on Drugs each reframed addiction from a matter of care to one of control. These policies embedded stigma by reducing complex human suffering to labels such as "addict" or "junkie," reinforcing social hierarchies around whose pain is recognized and whose is criminalized. Despite advances in research, treatment, and harm reduction, these punitive logics persist. The opioid epidemic, for instance, reflects both corporate influence and class-based inequities in response and care. Ultimately, this paper argues that the United States has historically punished pain rather than addressed it. It calls for a shift from criminalization to education and social recovery, proposing addiction education across schools, healthcare systems, and communities as a means of reorienting public health toward collective care and a more equitable understanding of suffering.

Introduction

Addiction, whether it is known as a crisis, epidemic, or public health issue, has long been misunderstood in the United States. Decades have passed since the beginning of the so-called "War on Drugs," but even still, the ineffectiveness of this approach remains evident, as seen in the increasing recognition of its failure. Addiction rates remain high, and communities continue to suffer. According to the Centers for Disease Control and Prevention (CDC), "Excessive alcohol use is a leading preventable cause of death in the United States," and "about 178,000 people die from excessive drinking each year" (CDC, 2024). Additionally, the National Institute on Drug Abuse (NIDA) stated that "Overall, drug overdose deaths rose from 2019 to 2022 with 107,941 drug overdose deaths reported in 2022" (NIDA, 2024). These statistics make it painfully clear: current approaches are not working, and lives continue to be lost, not only to addiction but to the quiet cost of an unwillingness to confront the weight of defeat.

This "war" has misdirected its efforts, always targeting the wrong source. For too long, addiction has been framed as a war against drugs, when in reality, the true crisis lies in the response to it. Through criminalization, discrimination, and stigmatization, the deeper roots of addiction, such as pain, trauma, mental illness, and systemic inequality, have been ignored. The truth is that it is easier to wage war on drugs than to face the discomfort of collective societal responsibility. Unfortunately, this has constructed a misguided lens through which addiction is viewed, ultimately allowing something far more insidious than drugs to embed itself within society: harsh judgment, unjust policies, and blind ignorance. Together, these have fostered an increasingly toxic culture, one defined by widespread suffering. As a result, an unacknowledged reliance on substances as a coping mechanism has developed, perpetuating the very problem that is desperately seeking to be condemned.

Addiction can touch anyone, regardless of background, socioeconomic status, or education. It is not limited to specific groups or communities; rather, it is a crisis that spans across society, often rooted in the pain and trauma collectively left unaddressed. Whether that manifests in personal suffering or broader societal harm, addiction is a reflection of a culture that has normalized pain without providing the tools or support for healing. Therefore, until the cycle of stigmatization is broken and an environment that fosters understanding and compassion is created, this crisis will continue to spread, silently and systematically.

The first step is education. Meaningful action against addiction cannot begin without first establishing a clear understanding of its root causes, complexities, and widespread impacts. This entails normalizing discussions about addiction and recognizing it as an issue that requires education and prevention before it takes hold. Additionally, redefining and embracing a new understanding of how addiction affects individuals not just physically, but also psychologically and socially is urgently needed. A shift toward social recovery is necessary, one that starts now. However, to effectively combat this epidemic that has become deeply embedded within society and culture, it must be understood that addiction will never be fully eradicated. Only by acknowledging this and learning to adapt can society hope to reduce its harm rather than perpetuating its costly damage.

What is Addiction?

Addiction, whether to substances, behaviors, or even thought patterns, is deeply rooted in the human condition, emerging from fundamental drives like seeking pleasure, avoiding pain, and coping with adversity. Humans are infinitely complex in their thoughts and actions, yet their nature is profoundly simple, driven in its pursuit of survival and fulfillment. From an evolutionary perspective, our brains evolved to reinforce behaviors that enhance survival, such as eating, social bonding, and seeking shelter, by linking them to pleasure and relief (Smith & Hunt, 2021). The brain's reward system, which is primarily dependent on dopamine, is crucial in reinforcing these behaviors. However, substances and activities, such as drugs, gambling, social media, and even obsessive thought patterns, can hijack this system, leading to compulsive engagement despite negative consequences. Psychological and social factors such as trauma, stress, and environments also influence addiction, making it a complex but deeply human experience (Urschel, 2009). While not everyone develops an addiction, the vulnerability to it is an inherent aspect of human neurobiology and psychology.

Philosophically, addiction can also be viewed as a reflection of deeper human needs, such as the existential search for meaning. Many physicians, such as Carl Jung, recognized this connection; in a letter to William G. Wilson, he wrote, "You see, alcohol in Latin is *spiritus*, and you use the same word for the highest religious experience as well as for the most depraving poison. The helpful formula therefore is: *spiritus contra spiritum*" (Jung, 1961). Here, Jung points out that the Latin word *spiritus* means both "spirit" (transcendent experience of the divine) and "spirits" (alcoholic beverages). With the phrase *spiritus contra spiritum* (meaning spirit against spirit), Jung suggests that alcohol addiction often arises from a deep spiritual need, an attempt to fill an existential void. He implies that the cure for alcoholism is not just sobriety, but a genuine spiritual awakening. This idea strongly influenced the founders of Alcoholics Anonymous (AA), particularly William G. Wilson, who incorporated the concept of a "higher power" as central to recovery.

While Jung emphasizes the spiritual and existential dimensions of addiction, modern perspectives, such as those of Dr. Gabor Maté, shift the focus toward psychological mechanisms that drive addictive behaviors. Maté stated in Dr. Ryan Chatterjee's holistic health and wellness podcast*, Feel Better, Live More*, that:

> Addiction is the most human thing there is. And when you do not understand it, it looks like an aberration and an abnormality and some kind of a moral deviation. But when you understand it, it's a very human thing. So, let's just define addiction as manifested in any behaviors in which a person finds temporary pleasure or relief and therefore craves and continues with that despite negative consequences. So, the definition involves pleasure, relief, craving in the short term, harm in the long term, and inability to give it up despite the harm (Maté, 2022, 00:32).

This definition by Maté not only broadens the understanding of addiction beyond substance use but also highlights its universal nature, which suggests that addiction can manifest in various forms of behavior driven by a desire for temporary relief, despite the long-term harm it causes. Understandings like this have explored addiction in a new light, as not just a medical issue but also a psychological one, rooted in loneliness, trauma, or

the inability to find fulfillment in modern life. However, although addiction can include behaviors like gambling, overeating, shopping, sex, and excessive social media use, the term is most commonly associated today with substance use disorders.

This strong association between addiction and substance use has also influenced language, often leading to labels like “addict” or “alcoholic,” which can carry a stigma and impact a person’s recovery journey. Such labels can reduce an individual’s identity to their condition, overshadowing their full humanity and their ability to differentiate themselves from their addiction (Smith & Hunt, 2021). However, within recovery communities and 12-step programs like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), some individuals may self-identify as “alcoholics” or “addicts.” This language is deeply ingrained in these programs’ philosophies, emphasizing personal accountability, shared experiences, and the acknowledgment of addiction as a lifelong disease. Many people in recovery find empowerment in using these terms, as it helps them connect with others facing similar struggles and reinforce their commitment to sobriety. Ultimately, the most respectful approach is to allow individuals to define their own experiences and identities, using the language that best reflects their journey while remaining mindful of the broader impact of stigmatizing terminology. But in this case, it’s generally more appropriate and humanistic to refer to a person struggling with substance use as someone with a substance use disorder (SUD).

DSM-5: Substance Use Disorder Criteria

Understanding when a substance use disorder or an addiction is developing is crucial not only on a personal level but also on a societal scale, as it allows for earlier intervention, which can prevent the escalation of addiction and reduce its widespread social consequences. Early recognition helps individuals seek treatment before the disorder causes severe health, legal, or economic issues, leading to lower healthcare costs, reduced crime rates, and less strain on social services (SAMHSA, 2008). Additionally, widespread awareness and education about the signs of developing addiction can help shift societal attitudes away from stigmatization and towards a more compassionate, proactive approach to public health and prevention. Therefore, by understanding the importance of early recognition and intervention, the role of standardized diagnostic criteria in identifying substance use disorders can be utilized more effectively.

According to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association [APA] 2013), a SUD is characterized by patterns of symptoms that arise from continued substance use despite its harmful effects. Based on decades of research, the DSM-5 outlines eleven criteria that fall into four categories: impaired control, physical dependence, social problems, and risky use. These criteria include using more of a substance than intended, having unsuccessful attempts to cut down, intense cravings, tolerance, withdrawal symptoms, and spending excessive time obtaining or using the substance. Additionally, substance use that leads to neglecting responsibilities, relationship issues, abandoning social activities, use in dangerous situations, and continuing use despite physical or mental health problems are also included in the criteria. Like other illnesses, substance misuse worsens over time, and

clinicians use these criteria to assess severity. One symptom indicates a person is at risk, two to three suggest a mild disorder, four to five indicate a moderate disorder, and six or more signify a severe substance use disorder, which is classified as an addiction (APA, 2013).

The DSM-5 introduced significant revisions to how substance use disorders are defined and diagnosed. Unlike the DSM-4, published in 1994, which separated “abuse” and “dependence” into distinct categories, the DSM-5 moved toward a spectrum model of addiction. It also added “craving” as a diagnostic criterion to better reflect the brain’s role in compulsive substance use and removed “legal problems” due to its cultural and socioeconomic bias. Additionally, the DSM-5 formally recognized conditions such as Cannabis Use Disorder and Gambling Disorder, acknowledging both withdrawal symptoms and the legitimacy of behavioral addictions.

These changes reflect advances in neuroscience and clinical research, but they also emerge within a broader social context. Since the 1990s, the demographic profile of individuals diagnosed with substance use disorders in the United States has shifted, with increasing visibility of white, suburban populations affected by addiction, particularly during the opioid crisis. Some scholars argue that this shift has influenced a move away from more punitive, morally coded language toward a more medicalized and less stigmatizing framework. By replacing terms like “dependence” with “substance use disorder,” the DSM-5 aims to provide a more precise and flexible diagnostic tool while reducing confusion and stigma in both clinical and public discourse (APA, 2013). However, although the DSM-5 offers a structured framework for diagnosing substance use disorders, it should not be viewed in isolation. To truly understand addiction, it is important to adopt a holistic approach that goes beyond just the diagnostic criteria. This means examining the biological, psychological, and social factors that contribute to substance use. This is where the biopsychosocial model of addiction becomes vital.

The Biopsychosocial Model of Addiction

One of the major advancements in the field of addiction research and understanding was the introduction of the biopsychosocial model (Engel, 1977). Engel’s model challenged the prevailing biomedical model, which focused on medicine only concerning biological factors. He argued that a comprehensive understanding of health and illness requires considering the exchange of biological, psychological, and social factors. This model is heavily applied to understanding addiction, and it also shifts the focus from the disease itself to the individual’s experience and the various factors that perpetuate their illness. While the DSM-5 doesn’t explicitly use the term “biopsychosocial model,” it recognizes the importance of biological, psychological, and social factors in understanding mental disorders and requires clinicians to consider these factors in their assessments and diagnoses (APA, 2013). Therefore, this model is an essential component needed to advance addiction treatment and prevention.

Addiction is a complex condition shaped by biological, psychological, and social factors. Sociologically, many people are first introduced to substances through peer environments or family dynamics where drug use is normalized to cope or socialize.

However, while not everyone exposed to drugs develops an addiction, these social influences play a major role in shaping behavior. Broader societal factors like poverty, trauma, lack of opportunity, and limited access to healthcare further compound vulnerability, especially in marginalized communities (Gerra et al., 2020). This often leads to social inequality, which exacerbates these challenges and creates stigma, making it harder for individuals to access help or treatment (NIDA, 2022).

In addition to social influences, addiction is reinforced by psychological patterns that perpetuate the cycle. When individuals experience emotional or physical pain, substances often become a way to self-soothe, offering temporary comfort that reinforces use. (Urschel, 2009). Psychological factors, such as cognitive distortions, further contribute to continued substance use. For instance, someone may rationalize their use after a stressful day, thinking, “I deserve this,” or believe they have control over their substance use, even when their behavior suggests otherwise. These cognitive distortions, along with environmental cues that trigger cravings, create a cycle that is difficult to break (Urschel, 2009). Over time, these psychological patterns continue to strengthen, further entrenching the cycle of addiction, which in turn impacts physical biology.

The biological aspect of addiction is fundamental to understanding its development and persistence. Dopamine, often called the “feel-good” neurotransmitter, plays a central role in addiction. Substances like drugs or alcohol artificially elevate dopamine levels, creating intense feelings of euphoria. Over time, the brain adapts to this overstimulation by reducing its own natural dopamine production, resulting in tolerance (Urschel, 2009). As a result, individuals require more of the substance to achieve the same effect. When the substance is unavailable or the individual attempts to stop, withdrawal symptoms sink in, ranging from irritability and fatigue to severe depression and anxiety, which reinforce the cycle. Additionally, chronic substance use impairs the prefrontal cortex, the region of the brain responsible for decision-making and impulse control, which makes it increasingly difficult to resist the urge to use substances, even in the face of negative consequences (Urschel, 2009). This neurological impairment helps explain why addiction persists despite the individual’s desire to quit.

The biopsychosocial model recognizes that no single factor causes addiction. Instead, it emphasizes the interdependence of biological, psychological, and social influences, each playing an equal role in both the development of addiction and the path to recovery. This can be understood through a simple yet profound equation: ⅓ biological (what is put into the body) + ⅓ psychological (how one thinks and reframes) + ⅓ social (how one behaves and connects within a sober network) = sober living. Therefore, true recovery, then, must address not only the individual but also their broader environment by reducing stigma, expanding access to care, and tackling the social conditions that perpetuate addiction.

A Deeply Conflicted System

The story of addiction stretches back through the ages, weaving a complex and nuanced narrative that reveals its long and often unclear history. In *The Urge: Our History of Addiction,* Carl Erik Fisher writes:

> From the hallucinogenic drugs in Mayan and Aztec ceremonies to the mysterious drink soma that appears in the ancient Indian *Rig Veda*, various cultures have used intoxicants to communicate with the spiritual world– are these uses "therapeutic," in terms of spiritual healing, or recreational? The ancient Greeks understood alcohol intoxication as a beneficent form of possession, not a physical process: they thought that drinking changed thoughts and feelings because the drinker literally became one with the god Dionysus (Fisher, 2022, pp. 100-101).

Fisher's passage raises the question of whether such historical uses of substances should be classified as therapeutic or recreational, showing how cultural interpretations of substance use have evolved. It reveals that substance use was historically viewed in various ways, sometimes as a means of connecting with the divine, sometimes as a tool for healing, and sometimes as a socially accepted practice, rather than being seen as a crime or personal failing. This historical perspective challenges the modern understanding of addiction as purely a biological or psychological disorder, suggesting that attitudes toward substance use have shifted over time and are influenced by cultural, spiritual, and societal factors. So, if substance use was once seen as a means of divine connection, healing, or social ritual, how did the United States arrive at a point where drug use is so often met with punishment rather than understanding?

From Prescription to Prohibition: Medicine, Morality, and the Making of Illicit Substances

The path from normalized substance use to criminalization in the United States didn't happen overnight; it evolved alongside shifting social anxieties, profit motives, and systems of control. While alcohol Prohibition is often remembered as America's first large-scale drug ban, the roots of substance criminalization in the United States run even deeper, stemming from racialized fears in the late 1800s and early 1900s. Drug use was not always framed in moral or criminal terms. In fact, at the time, substances like morphine, opium, cannabis, and cocaine were widely available in everyday products, sold in pharmacies, syrups, tonics, and even baby medicine. Much of this widespread use stemmed from war: Civil War soldiers, for example, returned home addicted to morphine after its medical use on the battlefield, a condition known at the time as "soldiers' disease" (Fisher, 2022). The pain-relieving qualities of these substances were seen as practical, even necessary, and their use was largely medicalized or socially accepted rather than stigmatized.

However, as substances became associated with particular marginalized groups, the narrative began to shift. Long before alcohol was targeted, laws restricting opium use started on the West Coast, primarily aimed at Chinese immigrant communities whose use of opium-smoking pipes sparked moral panic among white Americans. This fear was not

solely about the drug itself, but about who was using it and with whom. White anxieties fixated on the idea that Chinese men, through opium dens, were luring white women into spaces of perceived moral and sexual danger, a narrative steeped in racism and xenophobia (Fisher, 2022). These early drug laws were less about public health and far more about preserving racial and social hierarchies, using the idea of the "dangerous drug user" to justify exclusion and control. Similar patterns emerged with cocaine in the South, where racist myths about Black cocaine users fueled calls for restriction. These fears culminated in the Harrison Narcotics Act of 1914, one of the earliest federal drug laws, which transformed substances like opium and cocaine from everyday medicines into symbols of criminality (Fisher, 2022).

Later, Fisher expands on how this policy shaped the stigmatization and public attitudes surrounding individuals with substance use disorders, framing drugs themselves, rather than broader social conditions, as the ultimate threat:

> By the end of the Progressive Era's drive toward prohibition, the dominant stereotype of drug users was profoundly negative, and society was left with no compassion for people with addiction. They were "demons," "villains," "scourges," and "plagues" —everything at once, subhuman, contagious, and possessed, yet all by choice. Just as recent reports have described people with addiction scavenging failed construction sites for drug money, by the 1920s, urban addicts were known to pick through city dumps looking for scrap metal, which they sold to illicit dealers to fund their drug use. They were known as "junkmen" —later, "junkies" —and like any nickname that sticks, the label worked on many levels, evoking not just how these people survived but also the way respectable America viewed them: as human trash (Fisher, 2022, p. 145).

This passage highlights how stigma does not exist in isolation; rather, it is carefully constructed through language and reinforced by social conditions. The label "junkie," for example, wasn't just a casual insult; it was a deliberate reduction of a person's entire existence to their addiction, their poverty, and their perceived worthlessness. Importantly, this dehumanization made punitive policies easier to implement and justify. If addicted people were cast as dangerous villains or human trash, then locking them away, or abandoning them entirely, became not just acceptable, but necessary in the eyes of the dominant society.

This narrative also erased any context around addiction: poverty, trauma, mental illness, racism, and systemic inequality were pushed aside in favor of a much simpler story, that addicts were to blame for their own suffering. Unfortunately, this way of thinking continues to haunt drug policy today. Terms like "junkie," "crackhead," or "addict" still carry the weight of this history, collapsing a complex human experience into a caricature of failure and moral decay. And when people internalize these labels, when they see themselves the way society sees them, it can trap them even deeper into cycles of shame, isolation, and substance use (Becker, 1963). However, it wasn't until Prohibition that this logic of criminalizing substances extended beyond marginalized groups. Targeting alcohol, a substance used across all classes and races, exposed the impossibility of policing human desire when that desire belongs to everyone, not just the marginalized.

Alcohol, once casually consumed and even used medicinally, was rebranded during the temperance movement as a moral threat, an inherently evil substance capable of

enslaving its users. This view gave rise to the concept of "pharmacological determinism," the belief that drugs have uniquely corrupting powers, independent of context or choice (Fisher, 2022). Religious figures like Lyman Beecher helped popularize this rhetoric, calling for total abstinence and framing alcohol as a tool of Satan rather than a social substance. This marked a dramatic shift from earlier Christian teachings that only condemned excess use.

Prohibition, which began in 1920 with the ratification of the 18th Amendment and the enactment of the Volstead Act, was a large-scale attempt to outlaw the sale and production of alcohol, and it failed spectacularly. Ultimately, fueling organized crime, underground markets, and widespread public defiance, the criminalization of alcohol showed that trying to suppress a universal human desire through punishment was destined to fail. Although Prohibition was repealed in 1933 and alcohol gradually normalized back into society, rather than learning from Prohibition's failure, policymakers simply shifted the same flawed approach onto other substances, deepening cycles of criminalization and harm and entrenching a punitive framework that still shapes drug policy and enforcement today (Fisher, 2022).

The Politics of Punishment: The Anslinger Legacy and the War on Drugs

In the aftermath of Prohibition's failure, rather than reassessing the logic of criminalization, U.S. policymakers doubled down, redirecting their moral crusade from alcohol to other substances, particularly those associated with marginalized communities. Enter Harry Anslinger, the first commissioner of the Federal Bureau of Narcotics, who became the architect of America's punitive drug regime. While alcohol quietly returned to mainstream respectability, Anslinger helped cement the idea that other substances, especially marijuana, heroin, and cocaine, were not just dangerous but inherently criminal (Hari, 2015).

Rather than focusing on harm reduction or treatment, Anslinger relied on fear-based propaganda and racist narratives to build public support for sweeping crackdowns. Marijuana was his primary target: not because it posed a greater threat than alcohol or tobacco, but because of its association with Black jazz musicians, Mexican immigrants, and other so-called "undesirables." Through sensationalist headlines and fabricated testimonies, he linked cannabis to madness, violence, and moral collapse. His campaigns gave rise to the "Reefer Madness" era and helped pass the Marihuana (sic) Tax Act of 1937, effectively criminalizing the plant nationwide (Hari, 2015).

Anslinger's persecution of jazz legend Billie Holiday stands as one of the most haunting examples of how drug enforcement became a tool of racial and political suppression. Holiday's rendition of "Strange Fruit," an emotional protest against the lynching of Black Americans, caught the attention of Anslinger, who viewed both the song and its performer as threats to the racial status quo. He warned her to stop singing it, and when she refused, he launched a personal crusade to destroy her. Rather than offering support for her known heroin addiction, Anslinger sent agents to stalk and harass her. He planted drugs on her to

incriminate her, orchestrating her arrest to discredit her growing popularity and silence her activism. Even as she lay dying in a hospital bed, Anslinger ensured she was handcuffed and denied proper medical care, making her one of the earliest and most tragic casualties of America's war on drugs (Hari, 2015).

Anslinger's reach didn't stop at U.S. borders. He lobbied the United Nations to adopt global drug treaties modeled after American prohibitionist policies and used U.S. trade leverage to force other countries into compliance. Nations that resisted were threatened with economic sanctions or exclusion from international markets. Under his leadership, the U.S. didn't just export policy; it exported ideology, insisting that prohibition was the only legitimate way to manage drug use, even as the domestic consequences of this approach grew increasingly severe (Hari, 2015).

This punitive framework hardened further in the mid-20th century, cementing during the Nixon administration's declaration of the War on Drugs in the 1970s. Though framed as a public safety effort, internal memos revealed its true purpose: to target marginalized groups. Nixon's aides admitted to their plan of associating heroin with Black communities and marijuana with antiwar activists to discredit both, without using overtly racist language, a tactic of coded criminalization. This logic extended into military policy with Operation Golden Flow, a program requiring returning Vietnam soldiers to pass drug tests before reentering the United States. Soldiers who failed these tests were not permitted to board flights home until they completed detoxification and passed another drug test, illustrating how addiction was treated through containment, surveillance, and forced compliance rather than sustained medical care (Fisher, 2022).

The War on Drugs escalated under Reagan in the 1980s through policies such as mandatory minimum sentencing laws, which required fixed prison terms for certain drug offenses, and "three strikes" laws, which imposed life sentences after repeated felony convictions. At the same time, intense media coverage surrounding crack cocaine fueled public panic and reinforced racialized stereotypes about drug use. These laws disproportionately targeted poor communities of color, despite similar rates of drug use across racial and class lines. Crack users were portrayed as dangerous criminals, while powder cocaine offenses, which were more commonly associated with wealthier white individuals, were punished far more leniently.

This double standard became especially visible in 1989, when George H. W. Bush held up a bag of crack cocaine during a televised address, claiming it had been purchased "just across the street" from the White House. In reality, the Drug Enforcement Administration had orchestrated the event by sending a young Black teenager from another part of the city to complete the transaction at that specific location for the cameras (Hari, 2015). The moment functioned as political theater, designed to provoke fear and justify expanding the drug war, often at the expense of marginalized communities.

All the while, legal substances like tobacco and alcohol remained normalized or celebrated. Alcohol continued to be marketed as a symbol of leisure and success, despite its strong links to addiction and violence. Meanwhile, cigarette companies resisted regulation for decades, even as the health risks became undeniable. (Fisher, 2022). The result was a system where criminalization replaced care, and incarceration stood in for treatment. Drugs like cannabis, heroin, crack, and methamphetamine were presented not

as public health issues, but as moral failings to be punished. Prisons filled up, not with violent offenders, but with individuals struggling with addiction, most of them poor, most of them from communities that had long been marginalized or neglected (Hari, 2015). Anslinger may have died in 1975, but his legacy remains deeply embedded in U.S. drug policy. His worldview, that addiction is a moral weakness and punishment is the proper cure, continues to echo in the enforcement, legislation, and stigmatization of drug use today. What began as propaganda has become practice, and generations have paid the price.

Addiction Today: Old War, New Wounds

Across the country today, addiction rates are steadily rising, fueled by a complex mix of trauma, economic instability, mental health challenges, and the widespread availability of both legal and illicit substances. In 2021 alone, over 46 million Americans aged 12 and older were estimated to have a substance use disorder, yet fewer than 7% received treatment (NIDA, 2023). While recent data shows a slight decline in overdose deaths, many public health experts attribute this decrease to expanded access to naloxone or “Narcan,” a medication that can reverse opioid overdoses. Additionally, the increased availability of medication-assisted treatment, greater public awareness of fentanyl contamination, and broader harm reduction efforts overall have contributed to the declining rates of overdose (CDC, 2025). However, the overall crisis remains staggering in scope and severity. Structural inequalities, limited access to care, and a severe shortage of mental health professionals further exacerbate the situation, particularly in communities of color, where overdose deaths have sharply increased (NIDA, 2024). The persistence and growth of addiction today make it increasingly clear that the issue is not about moral failing, but about a fractured system that continues to respond too little, too late.

It is important to mention that many individuals struggling with substance use today also face co-occurring mental health disorders or are entangled in the criminal legal system, factors that can delay, disrupt, or altogether block access to early intervention and preventive care (Urschel, 2009). In 2021 alone, over 1.5 million individuals with substance use disorders were incarcerated, making up roughly 65% of the U.S. prison population (Smith & Hunt, 2021). Unfortunately, these jails and prisons are rarely equipped to provide sustained, evidence-based treatment. Access to medication-assisted treatment, behavioral therapy, or even basic mental health care remains limited. In many cases, individuals are left to endure painful and dangerous withdrawal symptoms without medical support, reinforcing the pain that often underlies their substance use in the first place. Even upon release, the support structures needed for long-term recovery are frequently missing. Individuals reenter society with few resources, facing barriers to employment, housing, and continued medical care (NIH, 2024). These conditions create a perfect storm for relapse, particularly in the first weeks after release, which has consistently been shown to be one of the most dangerous periods for overdose and death (NIH, 2012).

Luckily, efforts such as the increased availability of naloxone and the expansion of harm reduction strategies have shown real promise. By recognizing that addiction can

never be fully eradicated, harm reduction offers a pragmatic response, meeting people where they are rather than relying on abstinence alone. Yet even as a modern, science-backed understanding of addiction emerges, the systems surrounding it, especially the criminal justice system, remain anchored in outdated, punitive approaches. Ultimately, the persistent high death toll underscores the urgent need for a more comprehensive strategy: one that expands access to treatment, addresses social determinants of health, and implements evidence-based policies to both prevent addiction and support recovery.

The Manufactured Opioid Crisis

The modern crisis, especially the opioid epidemic, didn’t emerge from the shadows of illicit drug use; it was manufactured in plain sight. In the late 1990s, Purdue Pharma released OxyContin, a high-dose opioid painkiller marketed as a “safe” solution for chronic pain (Fisher, 2022). Backed by aggressive pharmaceutical sales tactics and misleading claims that the drug had a low risk of addiction, prescriptions for OxyContin skyrocketed. Importantly, Purdue targeted doctors in rural and working-class areas already facing high injury and illness rates, making them more susceptible and ultimately turning these communities into profit centers.

Internal company documents later revealed that Purdue had long been aware of OxyContin’s addictive potential and widespread misuse. Despite evidence that patients were becoming dependent and that the drug’s supposedly “abuse-resistant” time-release formula could easily be bypassed, the company continued aggressively marketing the medication while downplaying its risks. In 2007, Purdue Pharma and several of its executives pleaded guilty to federal charges for misleading doctors and the public about OxyContin’s dangers (Van Zee, 2009). However, as prescriptions multiplied, so did addiction rates, and by the time the medical system began to recognize the damage, millions had already been exposed. Many who became dependent on prescription opioids eventually turned to cheaper and more accessible alternatives like heroin and fentanyl. The result was an explosion in overdose deaths that continues to shape the current addiction crisis (Fisher, 2022).

Fentanyl, a synthetic opioid 50-100 times more potent than morphine, has made the crisis even deadlier. Unlike earlier waves of the epidemic, which often involved prescription pills, today’s overdose deaths are more likely to involve illicitly manufactured fentanyl, often mixed into other street drugs without users’ knowledge. The result: rapid, unpredictable deaths at unprecedented rates. Between 2011 and 2021 alone, 649,599 adults aged 18 to 64 died from drug overdoses in the U.S., with an average age of just 41.7 years. More than two-thirds of those deaths were men. While the crisis has disproportionately impacted white individuals (74.8%), overdose deaths among Black and Indigenous populations have risen at alarming rates in recent years. The ripple effects of this are devastating: over 321,000 children lost a parent to overdose during that same period. In just ten years, the rate of children affected by parental overdose more than doubled, from 27 to 63 per 100,000, creating a legacy of intergenerational trauma that will be felt for decades (NIDA, 2024). Ultimately, what began as a crisis fueled by corporate greed has evolved into a relentless public health emergency, leaving a trail of broken

communities, lost generations, and a future that demands urgent, compassionate intervention.

Alcohol: The Normalized Crisis

All the while, alcohol misuse continues to thrive in plain sight, legally, culturally embedded, and widely accepted. In the United States, alcohol use disorder (AUD) has become one of the most common forms of addiction, affecting over 29.5 million people aged 12 and older as of 2021 (SAMHSA, 2022). Despite its legality, alcohol contributes to more preventable deaths annually than most illicit drugs, playing a major role in liver disease, accidents, violence, and mental health deterioration. Additionally, hospitalizations and treatment admissions for alcohol-related conditions have surged, yet the societal perception of alcohol remains largely benign, even celebratory (SAMHSA, 2022). From casual drinking culture to stress-induced consumption, alcohol has become a normalized coping mechanism for millions. This widespread reliance on alcohol, paired with a lack of awareness and early intervention, points to a deeper societal issue, one where a silent epidemic continues to grow, even as the warning signs become harder to ignore.

All of this becomes evident when discussing and researching addiction, as there often lies a separation between alcoholism and other substance use disorders. Alcohol is legal, socially accepted, and embedded in cultural rituals, yet it is responsible for a staggering portion of global drug-related deaths. Despite this, major reports like the *World Drug Report* often exclude alcohol from broader discussions about drugs, treating it as something apart from the spectrum of substance use (United Nations publication, 2022). This artificial separation fuels cultural double standards in which individuals who struggle with alcoholism are more likely to be viewed through a lens of disease or hardship. However, at the same time, individuals who use heroin or methamphetamine are often vilified and cast aside.

Alcohol's continued acceptance is no accident; unlike other stigmatized substances, it has been culturally rehabilitated precisely because it is no longer seen as the drug of marginalized groups, but as a normalized part of mainstream, privileged society. The continued prevalence of alcoholism, even under full legality, illustrates a critical truth: criminalization is not a prerequisite for addiction, nor is it an effective deterrent. If anything, it shows that addiction can thrive in the absence of criminal penalties when systemic support, education, and treatment resources are lacking.

The Failure of Federal Consistency

When looking at drug laws themselves, it becomes evident that the legal status of various substances often reflects fear, history, and politics rather than public health or logic. The Controlled Substances Act (CSA) classifies five schedules of drugs based on a substance's accepted medical use, potential for abuse or addiction, and harmfulness. It is through these criteria that these substances are federally regulated for manufacturing,

distribution, importation, exportation, and use (NIH, 2024). It should not be a shock that the CSA is riddled with inconsistencies, often classifying substances based on political and cultural perceptions rather than scientific evidence, resulting in a legal framework that criminalizes some drugs with proven medical benefits while excluding others with well-documented harms.

For instance, salvia, the most potent naturally occurring hallucinogen on the planet, is legal in many U.S. states and remains unclassified under the CSA, despite its ability to induce extremely intense, disorienting, and often frightening psychedelic experiences (DEA, 2024). In stark contrast, psilocybin, the active compound found in "magic mushrooms," is classified as a Schedule I substance, meaning it is considered to have a high potential for abuse and no accepted medical use, even though mounting scientific evidence shows its effectiveness in treating depression, PTSD, and even addiction (NIH, 2024). Adding to this legal inconsistency is the recent rise of commercial Amanita muscaria mushroom products, often sold online or in smoke shops. These products contain muscimol, a psychoactive compound that induces a high like that of psilocybin. Yet muscimol is also not scheduled under the CSA, making it legal at the federal level (FDA, 2024).

Cannabis: Legal Loopholes and Public Health Gaps

These paradoxes in drug policy are also especially clear when looking at how cannabis is systematically understood and regulated. Despite being classified as a Schedule I drug at the federal level, alongside substances like heroin and LSD, cannabis has been legalized for recreational use in over 20 U.S. states and for medical use in even more (NIH, 2024). This means an individual can legally buy a product in one state and be arrested for possessing the same product in a neighboring state. The 2018 Farm Bill further blurred the lines by legalizing hemp production and sale nationwide. Hemp is classified essentially as cannabis that contains no more than 0.3% delta-9 tetrahydrocannabinol (Delta-9 THC) on a dry weight basis. Delta-9 THC is the psychoactive compound found within cannabis that gets users high (FDA, 2019). Ultimately, this new classification of hemp created a booming market of dispensaries selling cannabis-adjacent products that are technically legal under federal law, even as cannabis itself remains federally prohibited.

However, to complicate matters even more, in many states like North Carolina, where cannabis remains illegal for recreational use, dispensaries can also legally sell cannabis concentrates, which can contain up to 80% tetrahydrocannabinolic acid (THCA) because of a legal loophole. The key distinction is that this legal definition of hemp only limits products containing less than 0.3% delta-9 THC and does not account for THCA, the non-psychoactive precursor to delta-9 THC. While THCA doesn't produce a high in its raw form, it converts into delta-9 THC when heated through smoking, vaping, or dabbing, ultimately creating the same effects. So, if a concentrate has less than 30% active delta-9 THC, but 80% THCA, it is still technically "hemp" under the law. This allows products with high THCA concentrations, like wax or rosin, to be sold legally in NC despite having effects identical to illegal cannabis (FDA, 2019). The result is a legal landscape full of

contradictions: cannabis is simultaneously criminal, medicinal, recreational, and commercial, depending entirely on where one is standing.

These complex policies and new products entering the market are still relatively recent and evolving, leaving many states scrambling to adapt their regulations in real time. North Carolina has begun the process toward tightening age restrictions on hemp-derived products, cutting off access for those under 21. Although this policy is intended to protect youth, it can unintentionally harm those already struggling by limiting access without offering resources for support or treatment. This can leave young individuals struggling with cannabis use disorder without a legal supply, potentially pushing them toward unregulated markets where the risk of encountering contaminated substances or transitioning to more dangerous drugs is significantly higher.

Not to mention, the availability of higher-potency products and increased frequency of consumption are both factors that contribute to a surge in cannabis-related harm. This includes not only a rise in cannabis use disorders, but also potential mental health impacts such as anxiety, depression, and, in some cases, psychosis, particularly among young or vulnerable individuals (Urschel, 2009). These mental health consequences contribute significantly to the strain on public health systems, as more individuals require psychiatric evaluation, crisis intervention, and long-term care, not because of legalization itself, but because of the lack of infrastructure to support those most vulnerable during the transition. Compounding this issue is the widespread lack of education and public awareness around cannabis use disorders, including the warning signs of problematic use. Many individuals are unaware of what constitutes heavy or unhealthy cannabis consumption, and currently, there are too few resources that exist to guide them before addiction takes hold.

It is important to understand that while cannabis rarely causes direct drug-related fatality, it accounts for a substantial share of global drug treatment admissions and is now the most frequently cited primary substance in many national health systems (United Nations publication, 2022). In the United States, emergency room visits related to cannabis have already increased in states where legalization has occurred, often due to overconsumption of edibles or high-THC concentrates. However, the strain is not isolated to legalized states; with the rapid growth of the national hemp industry and the widespread availability of cannabis-adjacent products like THCA, public health systems across the country are facing similar challenges, regardless of local laws (CDC, 2023). As access continues to outpace education and regulation, the gap between use and understanding grows wider, putting more individuals at risk and leaving public health infrastructure struggling to keep up.

Misconceptions, Double Standards, and Cultural Contradictions

These contradictions in drug policy and public perception are not accidental; they reflect systems of control rooted in fear, racism, and political convenience. From the selective enforcement of laws to the arbitrary categorization of substances, these

frameworks focus more on regulating behavior than protecting public health. Misinformation reinforces this imbalance by vilifying some substances while downplaying others, maintaining a focus on punishment rather than prevention. All these misconceptions do more than misinform; they actively hinder progress. When society relies on stigmatizing stereotypes or incomplete narratives, it misses critical opportunities for effective prevention, treatment, and policy reform.

Addiction does not exist in a vacuum; it is deeply entangled with the need for connection, the pursuit of relief, and the realities of systemic inequality. Yet, public discourse rarely reflects this complexity. Instead, it sustains contradictions, blaming individuals while ignoring broader social failures. Peer pressure is frequently framed as the central antagonist in discussions about addiction, especially among adolescents. However, this narrative oversimplifies a much more complex reality. The desire to belong, to feel included, doesn't end after high school; it simply evolves. In American culture, drug use is deeply embedded in social rituals, serving as a symbolic marker of connection and celebration. From college tailgates and 21st birthday bar crawls to weddings, music festivals, and holiday gatherings, substances often act as social glue. Participation in these rituals can signal inclusion, making peer pressure less about coercion and more about conformity, a desire to fit in, be seen, and feel "normal."

Substance use, then, is often less about rebellion and more about resonance with the surrounding culture. While many individuals do turn to substances to cope with trauma, anxiety, or emotional pain, that is not the only story. Some are driven by curiosity, self-exploration, or the simple pursuit of pleasure. Others may use substances to connect to experience joy, relief, or a sense of belonging. Therefore, altering one's state of consciousness is a fundamentally human impulse, observed across cultures and history, and it should not be pathologized by default. When society stigmatizes this pursuit, it fails to ask why people seek escape in the first place, and instead places blame on the individual, reinforcing stereotypes and sustaining the illusion that addiction is simply a personal moral failure.

Pain, Perception, and Power

For too long, the deeper question at the root of this crisis has been left unaddressed: Why the pain? So much time, resources, and energy are spent focusing on the visible symptoms of addiction, substance use, dependency, and relapse, without addressing the deeper, often invisible, causes. As Dr. Gabor Maté argues in *The Myth of Normal*, addiction is not merely about the substance itself but rather the underlying distress that drives people to seek relief. He emphasizes that it is impossible to understand addiction without asking what relief the individual finds or hopes to find in the drug or addictive behavior (Maté, 2022). Maté's intentional use of the word "relief" underscores that addiction is not the pursuit of pleasure, but rather an attempt to escape pain, a coping mechanism, and, at its core, a response to suffering. However, unfortunately, there is a noticeable lack of public information outlining the pleasurable or functional effects of substances, and without acknowledging this dimension, discussions around addiction remain incomplete.

This limitation reflects a broader problem within modern medicine itself. In *The Birth of the Clinic*, Michel Foucault describes the concept of the "medical gaze," a system in which patients become reduced to symptoms, diagnoses, and pathological behaviors rather than understood as whole people shaped by social and emotional realities (1973). Within addiction treatment, this gaze can strip individuals of agency and humanity, encouraging institutions to focus on managing behaviors and categorizing disorders rather than understanding suffering. Substance use then becomes something to discipline and contain, rather than a response to trauma, alienation, or despair. In this sense, the medical system can unintentionally mirror the punitive logic of the criminal justice system, prioritizing control over care.

This perspective aligns with Maté's broader critique in *The Myth of Normal*, where he argues that modern culture is becoming increasingly toxic, marked by chronic stress, disconnection, and emotional suppression. In such a context, it is not surprising that many individuals turn to substances as a means of coping, as they can provide a sense of control, relief, or temporary escape from overwhelming environments (Maté, 2022). This helps explain why a culture that demands constant productivity, perfection, and emotional suppression often pushes people toward whatever offers relief or ease, even if only temporary.

Maté further emphasizes in *In the Realm of Hungry Ghosts* his guiding mantra when treating addiction: "The issue is not why the addiction, but why the pain" (2010, p. 19). This question shifts the focus from judgment to inquiry, from condemnation to compassion. Therefore, healing from addiction at the individual level requires the ability to face emotional pain with honesty and resilience, rather than resorting to avoidance. Likewise, society as a whole must also confront the deeper wounds, structural, cultural, and psychological, that fuel the addiction crisis, embracing discomfort as an essential part of collective recovery.

Unfortunately, it is easier for some to turn a blind eye to the pain than to confront it. Ghada Waly, the current executive director of the United Nations Office on Drugs and Crime, states in the *World Drug Report 2022*:

> Drugs can kill. Addiction can be an unending, agonizing struggle for the person using drugs; suffering is needlessly compounded when people cannot access evidence-based care or are subjected to discrimination. The consequences of drug use can have ripple effects that hurt families, potentially across generations, as well as friends and colleagues. Using drugs can endanger health and mental health, and is especially harmful in early adolescence. Illicit drug markets are linked with violence and other forms of crime. Drugs can fuel and prolong conflict, and the destabilizing effects, as well as the social and economic costs, hinder sustainable development. The whole of the international community shares the same goals of protecting the health and welfare of people everywhere. But too often in the debate on drug policy approaches, we forget this basic and shared understanding, which is rooted in the fact that drug use for non-medical purposes is harmful (United Nations publication, 2022, p. 4).

Framing this as the universal starting point, that drug use itself is the problem, oversimplifies a deeply complex issue. It vilifies the drug rather than examining the conditions that lead people to use it. The reality is that drug use has existed across all

cultures and eras of human history, and it will continue to exist regardless of how harshly it is criminalized or stigmatized. Addiction is not simply born from exposure to a substance; it is rooted in trauma, pain, poverty, isolation, and systemic inequality. Efforts to wage war on drugs ignore this reality, focusing instead on eradicating the substance entirely rather than addressing the human suffering underneath it. Ultimately, this approach shifts the blame onto drugs themselves, obscuring the larger social forces at play that have shaped drug policy for generations.

But why? Why has this gone on for so long? This could be because powerful institutions profit from this misunderstanding of addiction. Private prisons, for example, benefit financially from the mass incarceration of nonviolent drug offenders, while parts of the rehabilitation industry often prioritize revenue over recovery. Beyond money, there is also power to be gained in controlling public perceptions. By manipulating the image of people who struggle with addiction, portraying them as dangerous, irresponsible, or morally corrupt, governments and media outlets maintain social hierarchies, allowing for the justification of punitive policies (Hari, 2015). This narrative deflects attention away from systemic failures, like poverty, generational trauma, and lack of access to mental health care, and instead places blame on the individual.

The Role of Educational Deficits

Despite scientific advances and shifting attitudes, the United States remains caught in a contradiction: speaking of addiction as a disease yet continuing to treat it as a crime. Such unjust portrayals highlight the urgent need for a cultural shift toward a more nuanced and compassionate understanding of addiction, one that begins in childhood. Initiating education early equips children with the knowledge and coping skills necessary to navigate challenges and make informed decisions, potentially preventing the onset of substance use disorders. To achieve this, first, acknowledge that the current and sole educational approach targeted towards addiction for America's youth is not only misguided but also severely lacking in substance, believe it or not.

For decades, Drug Abuse Resistance Education (D.A.R.E.) was the primary drug education program for young children, relying on simplistic, fear-based messaging that proved ineffective in reducing drug use (DPA, 2023). In 2009, it adopted the “Keepin’ it REAL” curriculum, shifting toward life skills and decision-making. However, this new approach still fails to address the root causes of addiction. While the program has evolved over the years, its legacy of fear-based messaging continues to leave young individuals without a true understanding of how factors like trauma, stress, and social conditions contribute to substance use. As a result, these individuals unfortunately become more susceptible to addiction and substance use disorders in the future (Nordrum, 2014).

This gaping hole in education regarding substance use and addiction extends into medical training as well. A study conducted in 2022 by Ramadurai et al. highlights the lack of trauma-informed care (TIC) in medical education, despite the well-established connection between trauma and substance use disorders. Ultimately, many healthcare providers remain unequipped to recognize or respond to trauma, leading to ineffective and

even harmful treatment approaches (Ramadurai et al., 2022). TIC, which is a relatively new approach, recognizes the deep impact of trauma on substance use disorders. It emphasizes trust, safety, and sensitivity to triggers, allowing individuals to seek help without fear of judgment or retribution. It also goes beyond treating surface symptoms by addressing the emotional wounds that often drive addiction. The lack of TIC integration in current medical practices means that many treatment approaches focus solely on the symptoms, offering only temporary relief rather than fostering long-term healing, ironically, the definition of addiction itself.

Unfortunately, this limitation is not simply a gap in training but reflects deeper structural features of the biomedical model. As Byron Good argues in “How Biomedicine Constructs Its Objects,” medical education actively socializes students to see the patient primarily as a biological body to be diagnosed and managed. Through this process, students are trained to prioritize symptoms, lab values, and diagnostic categories while pushing aside the patient’s lived experience, narrative, and social context (Good, 1994). This framework shows how the biomedical model can unintentionally narrow the clinician’s attention, putting pathology above meaning and intervention above understanding. As a result, substance use is often treated as a discrete clinical problem to be managed pharmacologically or behaviorally, and often without the integration of trauma-informed care. This can lead to treatment approaches that are technically effective in the short term but fail to address the underlying conditions that produce suffering, reinforcing a cycle of relapse and repeated intervention.

Ultimately, the persistent lack of education about addiction, especially its connections to trauma and mental health, has resulted in a society that chooses ignorance over understanding. Schools, workplaces, and healthcare systems continue to reinforce outdated narratives, perpetuating stigma instead of fostering informed discussions. Treating addiction requires a holistic approach, one that goes beyond the common belief that drugs are the source of the problem. It requires confronting the underlying pain, systemic inequalities, and social conditions that drive individuals toward substance use, and recognizing addiction not as a personal failure but as a symptom of broader societal neglect.

Moving Towards Social Recovery

The national response to addiction remains largely reactive. Public perception continues to fixate on a narrow and extreme image of addiction, one characterized by homelessness, violence, and personal failure. This limited portrayal obscures the reality that addiction crosses all social and economic boundaries when, in fact, many individuals living with substance use disorders are employed, raising families, and maintaining the appearance of stability, until the facade can no longer hold.

Additionally, interventions frequently occur far too late, only after overdose, arrest, or crisis. This represents not just systemic inefficiency but also a moral failure in itself. Therefore, to change the way addiction is perceived and treated, a cultural shift is necessary, one that normalizes conversations about substance use, prioritizes effective

and compassionate care, and recognizes it as a societal issue rather than a personal failing.

It should be known that addiction is a complex, cyclical condition that's driven by intertwined biological, psychological, and social factors. Many individuals struggling with addiction often face insecurity in foundational areas such as safety, connection, and belonging. As a result, effective treatment must also address mental health needs, processing trauma, building emotional resilience, and reconstructing a sense of stability, elements often missing in current approaches. This is why initiating education early equips children with the knowledge and coping skills necessary to navigate challenges and make informed decisions, potentially preventing the onset of substance use disorders. Ultimately, when emotional regulation skills are not taught, when mental health care is inaccessible, and when social inclusion is conditional, substances may become a stand-in for what is otherwise missing.

Therefore, by shifting the lens away from individual blame and toward the broader systems and cultural forces at play, a more compassionate and accurate understanding of substance use can emerge, recognizing the universal human need for connection, exploration, and relief. The approach must also shift to one rooted in education, empathy, and systemic change to combat stigma, and therefore confront the punitive legacy seen today, particularly the policies that have disproportionately harmed marginalized communities. Only by replacing ignorance with education can a future be created where those struggling with addiction receive the support, not the shame, they deserve.

This also means expanding access to diverse, evidence-based recovery pathways. Recovery models such as 12-step programs, medication-assisted treatment (MAT), and trauma-informed therapy represent vital components of a comprehensive approach to addiction, yet they are often underfunded, misunderstood, or inconsistently implemented.

Twelve-step fellowships like Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) provide structure, peer support, and spiritual guidance, though their abstinence-based frameworks may not be suitable for all individuals. On the other end, MAT, which combines evidence-based medications such as methadone, buprenorphine, or naltrexone with behavioral therapy, has been shown to significantly reduce relapse and overdose rates, particularly in individuals with opioid use disorders (Urschel, 2009).

Trauma-informed care further expands the scope of recovery by addressing the emotional and psychological roots of addiction, emphasizing safety, trust, and individualized support (Ramadurai et al., 2022). Despite their promise, these models are often inaccessible due to stigma, unequal distribution of resources, and systemic underinvestment. Therefore, turning away from criminalization and investing in the integration of these treatments into public health systems is essential. Without such support, the full potential of these recovery models remains unrealized, and the broader goal of social recovery continues to be out of reach.

At the heart of this transformation is harm reduction: a practice that emphasizes meeting individuals where they are without judgment and providing the tools, knowledge, and support necessary to reduce harm before a crisis emerges. This includes public education on what constitutes heavy or risky substance use, how to recognize early

warning signs, needle-exchange programs, naltrexone distribution services, and ensuring resources are accessible before individuals reach critical points (Hari, 2015).

These harm reduction strategies should be integrated across all levels of society, including schools, workplaces, healthcare settings, and community institutions. It is essential that the public, not just those at high risk, are informed about the signs of problematic substance use, and that individual recovery is normalized and destigmatized. Having said that, going through recovery from an addiction should never be viewed as a personal shortcoming but as a process that reflects self-awareness, accountability, and resilience, principles that can benefit all individuals regardless of substance use status.

Other nations offer valuable blueprints for what's possible. Countries such as Portugal and Switzerland have implemented decriminalization alongside robust public health initiatives that prioritize harm reduction, early intervention, and social reintegration over punishment (Hari, 2015). Their models demonstrate that health-centered approaches not only reduce addiction rates but also ease the societal burdens that punitive policies intensify. While decriminalization alone is not a cure, it is a critical step toward reducing stigma and redirecting resources from incarceration to care. Removing criminal penalties also increases the likelihood that individuals will seek treatment without fear of legal consequences. It ultimately opens the door for deeper investments in education, mental health, and long-term support.

Ending the War: Education, Empathy, and Change

The statistics, the deaths, and the broken families all reveal what decades of moral panic have concealed: addiction is not a failure of character; it is a public health emergency. And yet still today, the structures built to address it continue to reflect outdated, punitive ideologies more than they embody the science or humanity of the present. From the opioid crisis fueled by corporate negligence at Purdue Pharma to the racially targeted criminalization seen during the War on Drugs, the warnings have been numerous and largely disregarded. Addiction is not a crime, not a moral lapse, and certainly not a singular narrative. Until institutions and policies are restructured to reflect that complexity, this reckless cycle of harm will persist, leaving countless lives and communities at risk. In the end, education is not only the way out of this crisis, it is the only way forward, and it will guide society toward compassion, understanding, and lasting change, if allowed.

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