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DRUGS, CRIME AND PUBLIC HEALTH

THE POLITICAL ECONOMY OF DRUG POLICY

ALEX STEVENS

Drugs, Crime and Public Health

The political economy of drug policy

Alex Stevens

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Drugs, Crime and Public Health

Drugs, Crime and Public Health provides an accessible but critical discussion of recent policy on illicit drugs. Using a comparative approach – centred on the UK, but with insights and complementary data gathered from the USA and other countries – it discusses theoretical perspectives and provides new empirical evidence which challenges prevalent ways of thinking about illicit drugs. It argues that problematic drug use can only be understood in the social context in which it takes place, a context which it shares with other problems of crime and public health. The book demonstrates the social and spatial overlap of these problems, examining the focus of contemporary drug policy on crime reduction. This focus, Alex Stevens contends, has made it less, rather than more, likely that long-term solutions will be produced for drugs, crime and health inequalities. And he concludes, through examining competing visions for the future of drug policy, with an argument for social solutions to these social problems.

Alex Stevens is Professor in Criminal Justice at the University of Kent. He has worked on issues of drugs, crime and health in the voluntary sector, as an academic researcher and as an adviser to the UK government, and has published extensively on these issues.

For Jo

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Figures

Tables

Preface

I have observed the harms related to drugs and their control all my working life. I have corresponded with imprisoned British drug smugglers, and advised the families they left behind. I have visited prisons across Europe, all of them struggling to deal with influxes of drug users and of the drugs that they want to use. I have helped set up projects to support people in finding a way out of dependent drug use and into employment. I have interviewed many people whose lives have been damaged by their use of heroin and crack. Several of them have since died. Some have continued a life of petty, persistent offending. Others have turned their lives around with the help of drug treatment services, the love of their families, the support of their peers, through sheer determination or a combination of all four. I have discussed these issues in empty streets, crowded bars, fetid hostels, dilapidated bedsits, poster-strewn waiting rooms, bleak cells, noisy classrooms, windowless lecture halls, plush hotel atria and inside the warren-like corridors of number 10 Downing Street. Throughout this career, I have lived in a British society which cannot live without alcohol, where smoking tobacco still kills over 90,000 people every year, where caffeine is indispensable to office life and where cannabis and illicit stimulants are regularly used by callow teenagers and prospective cabinet ministers. I have been surrounded by drugs and drug talk. I have met some remarkable talkers. I have also heard and read a lot of nonsense. This book is my attempt to create a more adequate analysis. It discusses theoretical perspectives and presents new evidence that can be used to test them. Its aim is to change the way you think about the links between drugs, crime and public health.

At the back of this book, there is a long list of people whose work I have leaned on for both illumination and support. I have also discussed the ideas presented here with colleagues in the International Society for the Study of Drug Policy, the British and European Societies of Criminology and the Common Study Programme in Critical Criminology, with co-investigators and partners in the *QCT Europe, Early Exit* and *Connections* projects, as well as with current and former colleagues at Prisoners Abroad, Cranstoun Drug Services, the European Institute of Social Services and the School of Social

Policy, Sociology and Social Research at the University of Kent. Funding to support the research that informs this book has been provided by the European Commission, the Department of Health, the Economic and Social Research Council, the Barrow Cadbury Trust, RAPt, Phoenix Futures, the UK Drug Policy Commission, the Beckley Foundation, London Probation Service and Kent County Council. A shorter version of the analysis presented in Chapter 4 has been accepted for publication in 2011 by *Journal of Social Policy*. Additional data have been provided by the Ministries of Justice of the UK and the Netherlands, the Home Office and the UK Data Archive at the University of Essex. My thanks go to all, with apologies for any errors or misinterpretations that have entered the analysis.

My largest debt is closer to home. My partner, Jo, has been this book's greatest supporter and its most intelligent critic. She gave me the time and the inspiration to write it. It is to her that this book is dedicated, with love.

Contents

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Chapter 1

Starting points

Drugs, values and drug policy

The debate on drugs is dominated by one, endlessly recurring argument. Should drugs be legal or prohibited? Proponents in these repetitive discussions often talk as if their position, if only it could be universally accepted, holds the golden key to a future where crime, addiction and drug-related deaths are vastly reduced. The vacuous slogan of the 1998 UN General Assembly Special Session on drugs – 'a drug-free world: we can do it' – is countered by libertarian opponents of prohibition who make no less speculative claims about the benefits of allowing a free market in all psychoactive substances. As has often been noted (e.g. Currie 1993; Young 1971), these blinkered discussions close off consideration of the social issues that are at the root of many of the harms for which drugs and laws have been blamed. In this book, I will argue that these harms are deepened by inequality and that policy on drugs and crime plays a part in producing and reproducing inequality. If we were magically to achieve a drug-free world tomorrow, crime and ill-health would continue. And if a Jericho-like blast from a troop of legalizers could somehow bring the whole edifice of prohibition tumbling down, drugs would still be associated with unnecessary deaths and other harms. These harms would continue to be concentrated amongst the most vulnerable people who have been socially, economically and racially marginalized.

The debate on drugs largely ignores issues of equality, and especially the role of drug policy in reproducing inequality. It diverts our attention away from the social mechanisms that produce social harms. It deepens the gap between rich and poor, powerful and powerless that so hinders our ability to reduce harms and increase freedoms. Part of the problem is the lack of a coherent, justifiable system of values to underpin drug policy. Drug policy emerges from competing ways of thinking about these values. Selective attachments to abstinence conflict with utilitarian arguments for the reduction of the economic burdens of drug use. Enlightenment or religious notions of the need for sober self-regulation come up against the apparently universal human desire for intoxication (Klein 2008). Conservative ideas on individual responsibility and sobriety conflict with liberal discourse on personal fulfilment and freedom of choice (O'Malley 2002). One potential response to these

conflicts is to step back and view all of them dispassionately, decrying both the moralism of one position (prohibition) and the attempt at disciplinary control of another (harm reduction). Politicians, drug users and their families do not have that option. They are faced with the urgent need to choose, to act. This chapter will seek to provide a rationally justified basis for these decisions. It will then describe the themes that run through the development of modern drug policy, in order to prepare the way for the arguments of this book.

Drug, harms and rights

Not all the acts that are criminalized are inherently harmful. Homosexuality was once considered a crime. Now it is recognized, by the law at least, as an area of individual freedom. Not all harmful acts are criminalized. Examples include the endangerment of human life and health through unsafe working practices, as well as the destruction of wealth by risky banking decisions. We need a better basis than the criminal law for analysing social harms (Hillyard *et al.* 2005). A previous discussion of the moral basis of drug use and associated harms has argued that criminal laws against drug use are unjustified (Husak 1992). However, it (apparently deliberately) did not provide a justifiable principle on which to base discussion of these rights and harms. This book uses the work of the moral philosopher, Alan Gewirth (1978) to provide a rational basis for defining human needs, and therefore for defining social harm. His argument is a contemporary development of Kant's categorical imperative: 'Act in such a way that you treat humanity, whether in your own person or in the person of any other, always at the same time as an end and never merely as a means to an end' (Kant 1981 [1785]: 36).

Gewirth writes in technical language. At the risk of offending philosophers, I will attempt to lay out the steps of his argument here in relatively simple terms. It rests on the law of non-contradiction. This is one of Aristotle's laws of thought. It states that a proposition and its contradiction cannot both be true. Although many attempts have been made to disprove this law, they have all ended in confusion. This is because the law applies even to attempts to contradict it. Arguments against the law are terminally vulnerable to the question: is your proposition that 'a proposition and its contradiction can both be true' itself true or false? To accept this literally nonsensical proposition would be to allow an infinite proliferation of contradictory meanings. No statement could reliably signify any content, as its opposite could be equally valid. This basic problem means that relativist attempts to rule out any possibility of moral judgement, which rely on contradicting the law of non-contradiction, are fatally flawed. This does not mean that such judgments are simple, or need no basis apart from religion, intuition or individual preference. Rather, it commits us to open discussion of right and wrong on the basis of logical rules to which we are rationally committed, whether we like it or not.

The first principle of Gewirth's argument is that any person who seeks to act must value the necessary conditions of action. Such an agent needs freedom and well-being. As Gewirth (1982: 47) puts it, '[s]ince agents act for purposes they regard as worth pursuing . . . they must, insofar as they are rational, also regard the necessary conditions of such pursuit as necessary goods'. He argues that every agent must accept, on pain of self-contradiction, that she has rights to the necessary conditions of action. The next step is to note that because a person accords these rights to herself (or himself) on the grounds of being an agent, then she (or he) must also, again on pain of self-contradiction, accord these rights to other persons who have the capacity to act towards purposes. Gewirth calls this the 'principle of generic consistency', or PGC. Echoing Kant's categorical imperative, the PGC 'requires of every agent that he accords to his recipients the same rights to freedom and well-being that he necessarily claims for himself' (Ibid: 53). The PGC is a rule of mutual respect. This rule cannot automatically resolve debates about what constitutes harmfulness (these questions are always more difficult in practical examples than in the abstract principles, as will be seen in later chapters), but it provides a useful basis on which to ground definitions of rights, duties and harms.

The PGC sets up a hierarchy of rights that can be useful in deciding which harms are most important. Rights are of greater priority when they are more needful for the creation or maintenance of the freedom and well-being that are necessary for purposive action. On this basis, Gewirth distinguishes three, hierarchical levels of rights: basic; nonsubtractive; and additive. Basic rights refer to an agent's right to the preconditions of agency. These include life, physical integrity and health. Harms to nonsubtractive rights are those harms which reduce, but do not destroy, the agent's capacity for action. Examples include losses by theft, deception, exploitation and defamation. We have additive rights to those conditions and actions which increase our ability to act towards our own purposes.

The PGC therefore also provides a basis for the discussion of whether there is a human right to use drugs. The answer is fairly easy in the case of drugs that are used to save life, or reduce pain. These support basic goods. It is necessary to be alive and to be free from severe pains in order to be able to pursue your purposes. But is there a right to use drugs non-medically?[1] It would be possible to construct an argument that there is no such right. It could consist of two claims. The first is that drug use is inherently harmful to the ability to guide one's conduct rationally. As there exists a right to be protected from harm to our rational capabilities (a basic right), it is also right that institutions exist that protect us from drug use by forbidding it. There is therefore no right to drug use.

There are serious problems with this argument. The first is that drug use is not always harmful to the capacity for rational action. Even if a minority of users becomes dependent on drugs, and others may suffer other forms of

cognitive impairment, it seems that the vast majority of people who have ever used illicit drugs have done so without causing damage to their capacity to act towards intended purposes. Indeed, drug use is one of those intended purposes for people who find it pleasurable. Drug use is not always harmful to rationality. As the first claim fails, so the second claim (that institutions based on this claim are justified in forbidding drug use) also fails. So the answer to the question of whether there is a right to drug use appears to be yes. But it is a rather small yes. People may rationally choose to experience the effects of psychoactive substances, even if they have no objective need for them. The ability to do so falls within the category of additive goods. It increases people's capacity to fulfil their own purposes. However, in some circumstances, drug use may cause harms to the rights of others. Again, the hierarchy of rights applies. Drug use, as an additive right, cannot be rationally justified where it leads directly to harm to the basic or nonsubtractive rights of other people. This is why the 'yes' given to the question on the right to use drugs is so small. If my right to use drugs conflicts with your rights to retain your property, or to your own health, then that right to drug use is superseded.

Some proponents of abstinence might argue that, in practice, this rules out the right to drug use. They could argue that drug use inevitably leads to theft (or to higher taxation to pay for treatment and imprisonment of drug users) or other harms to others. But these are matters that can be tested empirically, rather than being left at the level of assumption. And empirically it can be shown that, in very many cases, use of psychoactive substances does not lead to stealing, treatment or harms to others. Even drugs that are considered more dangerous, such as cocaine and heroin, have many users who do not cause or suffer these types of harm (Cohen & Sas 1994; Eisenbach-Stangl *et al.* 2009; Shewan & Dalgarno 2006; Warburton *et al.* 2005a; Zinberg 1984). For these users, drug use expresses their additive rights and does not harm any basic or nonsubtractive rights.

Some forms of drug use, of course, do cause such harms. One example is smoking tobacco in enclosed spaces alongside other people. This has been shown empirically to cause harms, including fatal cancers (Taylor *et al.* 2007). In this case, the expression of an additive right conflicts with the basic right to life of the recipients of this action. The action is therefore wrong, and institutions are justified in taking steps to reduce it (within limits, in line with the hierarchy of rights). There is no right to use drugs in ways that directly inflicts harms to others. Examples of such harms include administering drugs to others against their will, or without fully informing them of the dangers involved.[2]

The right to use drugs is usually backed with a citation of the utilitarian thinker, John Stuart Mill (1974 [1859]). His argument that we should be allowed to do what we want with our own bodies has been attacked on the grounds that he provides no basis for agreement of that principle with others

who do not share it (although others have defended him from this accusation [Riley 2006]). Gewirth's approach sidesteps this debate by establishing the argument for the limited right to use drugs on a rationally necessary position – the idea that we must all value the conditions which enable us to act towards purposes.

Drugs, harms and public health: terms for analysis

The limits of this Gewirthian argument are set by the levels of harm that can be directly attributed to drug consumption. It is very difficult, however, to disentangle the harmful effects of drug use from the deleterious consequences of drug control. There is a lot of investment in testing the direct, pharmacological and criminal harms of illicit substances. There are many academic journals stuffed with papers on these subjects. Investment in testing the effects of drug policy is relatively small, especially if we want to look at other areas of policy than the treatment of dependent users (Babor *et al.* 2010). This book will play a part in redressing that balance. It invites readers to go elsewhere[3] if they want to find out more about the detailed histories, pharmacologies and physical effects of particular illicit substances. But please stick with this book if you are interested in the interaction between drug users and policies on drug control, crime, health and welfare. The word 'drugs' will be used a shorthand for those psychoactive substances that are currently prohibited by UN conventions.[4,5] The term drug users will usually refer to people who consume these substances, although many other people, including poor farmers, criminal traffickers and powerful politicians also use drugs for their own purposes. Some use will be made of terms like dependence and addiction. Despite the inclusion of drug dependence in the diagnostic classifications used by doctors and statisticians worldwide, the existence of an identifiable disease of drug addiction, with distinctive causes and symptoms, is still controversial.[6] Drug policy will be discussed as an area of state action where laws, institutional capacities, funding programmes and governmental discourse meet in a 'hybrid of social control and social welfare policies' (Benoit 2003: 288). Health will be used in the sense of 'complete physical, mental and social well-being' (WHO 1946). With these definitions of health and harm, improving public health becomes a question of minimizing threats to well-being in the form of physical, mental and social harms.

There is potential for conflict between some interpretations of public health and the primacy of human rights on which Gewirth – and this book – insists. As Griffith Edwards (2004) and many others have noted, public health campaigners are sometimes tempted to place collective health over the rights of the individual. There are at least three critical perspectives on the promotion of public health. The first is libertarian opposition to any interference in the freedom of individuals to decide what is best for themselves (M. Friedman 1992; Szasz 1975). The second position comes from the

tradition of political economy. It is that health agencies, in practice, tend to focus on individual responsibility to change unhealthy activities. Health interventions tend to ignore the wider structural issues, including poverty, inequality and environmental degradation, which influence rates of smoking and other risky behaviours (Marmot & Wilkinson 1999). There is a tendency within this tradition to blame the state for harming drug users in seeking to further its own power (e.g. S. Friedman 1998). A third position builds on the work of Michel Foucault (1998) on 'biopower'. It sees public health as a discipline of control which creates categories and knowledge and so produces the power which regulates individuals and actions (Lupton 1995).

I agree with other writers on the extreme dangers of the libertarian approach to drug use. Allowing a completely free market in all potentially harmful substances would be very likely to increase the mortal and morbid harms of drug use (Inciardi 2008; Transform 2009a). I also avoid the Foucauldian position. It has substantial problems at its own foundations, including its moral relativism and its crypto-normativism[7] (Habermas 1987). It has been criticized for misrepresenting the field of public health (e.g. by Dean 1997). It tends to see all public health initiatives as exercises in disguised coercion. This ignores the fact that many people owe whatever freedom they have (by virtue of being alive) to the existence of public health measures. These programmes can protect people's health by giving them informed choices over their actions. This may represent 'governance through freedom' (O'Malley 2002). To me, and according to the PGC (Gewirth 1996), this is preferable both to governance by force and to no governance at all. So this book will take a political economic approach. It will analyze drug use and control in the context of the social, economic and political arrangements which surround and inform them. It will try to avoid the temptation to pin the blame for all harms on an imaginarily unitary state.

The book focuses on drug policy in the UK (more specifically, England) and other countries with similar levels of economic development, who share a similar position in the chain of drug consumption. Readers from the USA, Australasia and mainland Europe will be able to apply the analyzes it presents to their own national contexts. The book does not discuss the more global harms of drug production and policy. The extreme harms that are associated with US drug policy in Colombia are covered elsewhere (Haugaard *et al.* 2008; Ramírez Cuellar 2005; Stokes 2004), as are the wider issues of drug regulation in Latin America (Latin American Commission on Drugs and Democracy 2009). The Transnational Institute has also provided useful discussions of the problems related to drug production and control in Afghanistan (Jelsma & Kramer 2009) and Burma/Myanmar (Kramer 2009). Across the world, the current systems for drug regulation have contributed to other harms. These include the denial of effective analgesic medication to 80 per cent of the world's population, including millions of people who die in agony

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