Active Drug Users as Social Change Agents: Some Ethical Dimensions

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Active drug users—whom I here roughly categorize as habituated, addicted, or dependent (HAD) users who are not currently inclined to abandon their use of such drugs—may desire individually or collectively to assert themselves in the wider social world of work and social policy. Drug-dependent individuals may seek work in harm reduction centers or as custodians, accountants, or doctors. Activist drug user groups may work for legislative change in drug-related policies and social provisions for drug users, such as support groups, injecting rooms, and needle and syringe exchange programs. What ethical challenges does this pose?

1. The most fundamental one concerns normalization. Should HAD drug use be seen as a legitimate lifestyle option—as, for example, prostitution is sometimes argued to be by sex worker advocacy groups? The point might not be that drug use should be seen on a par with any other lifestyle option, such as vegetarianism, yoga, meditation, or engagement in extreme sports, but that it is not an option to be rejected outright. For some it will fit, even if for others it will be—at least personally—deleterious. How do we resolve such an ethical question, and are the ways in which our societies have generally resolved it defensible? The challenge here is that it is not easy to find any decisive reason for thinking that the HAD use of psychoactive substances is intrinsically immoral. It is arguable, of course, that dependency and the effects of certain drug use may be self-harming and that in these cases drug use is incompatible with plausible conceptions of self-dignity. But it is an argument that is not generally well-made out, for what in many communities are often claimed to be the deleterious effects of drug use are secondary effects of its criminalization. The argument must be freed from its current social trappings, especially as it can plausibly be argued that greater stigmatization and harm arise from criminalization than from the drug use itself.

In any case, given the contestedness of drug use in general, of HAD use in particular, and of the ways in which we (as societies) have chosen to differentiate drugs into different categories of licitness and illicity, dangerousness and harmlessness, there can hardly be any objection to active drug users individually or collectively challenging prevalent or prevailing social attitudes, policies, and practices concerning drug use.

2. Suppose, though, that we grant the premise that HAD drug use tends to be self-harming and ought to be discouraged, as we might those addicted to overly sugary, fatty, or salty diets. How should we respond to those who are not willing or ready to accept that they should desist and wish to seek some accommodations for people such as themselves?

Consider the situation of active drug users who operate in a social environment that seeks to discourage active drug use by criminalizing, penalizing, or regulating it. Take the case on which Einstein reflects, in which such users are employed as “peer counselors” in harm reduction work. On the plus side, it can be argued that they are likely to have better access to and greater sympathy for the needs of, say, injecting drug users than nonusers who work in such facilities. In some otherwise

1 Very roughly. I do not include those who need their eight cups of coffee a day or are in methadone programs. And we may want to distinguish between those dependent on prescription drugs and those who are dependent on traditionally illicit drugs. Any attempt to categorize the group in question must cope with the vagaries of social policy. Activist groups are generally populated by those whose interest is in social practice and policy with respect to the traditionally illicit drugs.

2 Many of these are accessible through the Prostitutes’ Education Network, available at http://www.bayswan.org/.

3 For example, violent criminal networks, overdosing or poisoning with contaminated drugs, the spread of AIDS and hepatitis C, and poverty. See, e.g., Husak (1992).

4 See, for example, the testimony of the US Surgeon General, Richard H. Carmona, before the Subcommittee on Education Reform Committee on Education and the Workforce, United States House of Representatives, “The Obesity Crisis in America,” July 16, 2003, available at http://www.surgeongeneral.gov/news/testimony/obesity07162003.htm. There have been no significant changes for the better in the years since this testimony was delivered. For a detailed analysis, see the recent Lancet series on obesity at http://www.thelancet.com/series/obesity.

5 Einstein (in press). See also Crofts and Herkt (1995), Kerr et al. (2006), and Hunt, Albert, and Montañés Sánchez (2010).

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unsympathetic communities that will be seen as an acceptable bargain—albeit for reasons that trouble me. That is, I worry that what makes it acceptable is not that it helps those for whom the programs are set up, but rather that it furthers the socioeconomic benefits of harm reduction. Ergo, employment strategies that are likely to be more effective in reducing harm are desirable.\(^8\) Nevertheless, despite the reasons for which such user involvement might be socially accepted, there is a welfare-based reason for using such people in harm reduction work. Here there is some parallel with the police use of informants. Police frequently cultivate those who are actively involved in criminality just because they have access that police are unable to get on their own. The overall task of crime control is better served by a policy that includes rather than excludes criminally active informants.

In both cases, however, risks and problems are involved. In the case of informants, although their use in most police departments is well and productively established, coercion may be involved and demands may be made that require informants to undertake unacceptable risks. And of course, they continue to engage in illicit conduct, a pact with the devil that may come to undermine the integrity of police work.\(^7\) In the case of HAD users, the problem is more likely to be one of impaired performance. We can grant that in some cases, drug use may stabilize performance, but in many cases, drug use and impaired performance are related, and organizations employing those who are HAD users may well need to consider liability issues in the event that something goes wrong. That said, we might wonder whether it is fair, let alone respectful, to view people’s capacity for work solely through the prism of their drug use (rather than through the effects of that use on their performance). There is, though, the further concern (as with informants) that the legitimacy of harm reduction as an interim measure in the hoped-for rehabilitation of drug users will be undermined by the role of those for whom HAD drug use is not a step toward treatment or rehabilitation.\(^8\)

It is not easy to generalize here. Many substances are addictive and they have no single set of psychic or other effects. As Einstein points out, there are many famous people—successful people—who have been HUD users. For some, no doubt, their use affected only themselves, diminishing its moral impact; for others, however, there was a connection between their drug use and their success in interpersonal contexts. Clearly, some account has to be taken of drugs’ effects (generally and individually) and side effects and not just their use. And in such an accounting, there is the need to be aware that although the “side effects” most generally cited are negative, they can also be positive for both the user and others.

3. Even if the moral status of drug use—and drug dependency—is contested territory, a complication arises as a result of societal stigmatization and its all too often consequences of dehumanization and criminalization. It might be argued—as indeed many have—that we have a moral obligation to observe properly constituted laws, even if we would be better off without them. That might seem to have implications for knowingly employing those who are in violation of them. But even if there is some secondary obligation of this kind—and not all would argue that there is\(^9\)—we still need to consider whether its merits outweigh the serious effects of criminalization.\(^10\) True, criminalization is not the only possible form of regulation, and other forms of regulation of the kinds we associate with tobacco, alcohol, and prescription drugs might have stronger moral claims.\(^11\)

Whatever we may wish to argue about the social standing of HUD drug use, the simple fact is that drug users do not ipso facto disqualify themselves from human consideration. What they may advance on their behalf, whether or not as a society we choose to accept it, has as much—if not more—claim to be taken into consideration in determining social policy as the deliberations of nondrug users, especially as it relates to policies regarding drug use, drug user treatment, and so forth, but also concerning issues such as accommodations within the workplace.\(^12\) “If not more”—because those who are HUD drug users are often better placed to appreciate the possibilities in their situations and the failures in others’ comprehension.\(^13\) We generally think that women should have an important input in decisions concerning their social possibilities and that minority groups should have an important say in policies that encompass them. HUD drug users are in that respect no different. Just as persuasively, and perhaps socially closer, we should give serious consideration to what prisoners say with respect to the conditions of their confinement. We are not bound by their observations and recommendations, but we should be bound to take them into account. Anything less is dehumanizing.\(^14\)

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\(^8\)See Kleinig (2006).
\(^9\)See, e.g., the classic discussion of Smith (1973).
\(^10\)I think here of the vigorous and somewhat distasteful American debate about the employment of illegal immigrants. Whatever one may posit as an ideal world, the tendency is for people to be sacrificed to politics or ideology.
\(^11\)Not that any form of regulation will be without its drawbacks. The claim is a comparative one.
\(^12\)The problems are formidable enough for those with a history of drug use and who are seeking to change their situation. See Klee, McLean, and Yavorsky (2002). The Americans with Disabilities Act (ADA) offers only limited respite. See, e.g., Weber, Moore, and Bruyere (2001). For those who remain active drug users, the problems are even more formidable.
\(^13\)For some movements in this direction, see Osborn and Small (2006), Tops (2006), and van Dam (2008).
\(^14\)Although the involvement of HUD drug users in developing social policy is often construed in terms of their empowerment, the idea of empowerment is itself problematic. I prefer to construe their involvement as a recognition of their human dignity. See Fielding (1996).
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Drug Use Research: Drug Users as Subjects or Agents of Change

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Researchers seek consistency, reliability, and control; whereas the stereotype of drug users is that of inconsistent, unreliable, and out of control. On the basis of drug use treatment and medical models, research programs that involve drug users are often designed to control and dictate the behaviors of drug users. This system leads to interactions that perpetuate stereotypes and narrowly prescribed social roles. Moreover, such programs often focus on and

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