‘Being human’ and the ‘moral sidestep’ in drug policy: explaining government inaction on opioid-related deaths in the UK

Alex Stevens
School of Social Policy, Sociology and Social Researcg
University of Kent
Chatham Maritime
ME4 4AG
a.w.stevens@kent.ac.uk

Abstract

Background: With drug-related deaths at record levels in the UK, the government faces two potential sources of pressure to implement more effective policies. One source is the individuals and families who are most likely to suffer from such deaths; i.e. working class people living in de-industrialised areas. The other source is experts who argue for different policy on the basis of research evidences.
Aim: This article aims to explain why, in the face of these two potential sources of pressure, the UK government has not implemented effective measures to reduce deaths.
Method: The article uses critical realist discourse analysis of official documents and ministerial speeches on recent British drug policy (2016-2018). It explore this discourse through the theoretical lens of Archer’s (2000) ideas on ‘being human’ and by drawing on Sayer’s (2005) work on the ‘moral significance of class’.
Results: Members of economically ‘residual’ groups (including working class people who use heroin) are excluded from articulating their interests in ‘late welfare capitalism’ in a project of depersonalising ‘class contempt’ through which politicians cast the people most likely to die as passive, ‘vulnerable’ ‘abjects’. Conservative politicians dismiss ‘evidence-based’ ideas on the reduction of drug-related death through a ‘moral sidestep’. They defend policy on the basis of its relevance to conservative moral principles, not effectiveness. This is consistent with the broader moral and political pursuit of partial state shrinkage which Conservative politicians and the social groups they represent have pursued since the 1970s.

Keywords: critical realist discourse analysis; drug-related death; evidence-based policy; class contempt; agency; abjection; UK; drug policy; political economy

Introduction

This article aims to explain why, having received clear advice on how to reduce record levels of drug-related deaths, the UK government has done so little to implement effective, life-saving measures. The UK government faces pressure to change policy from two potential sources; the individuals and families who are most likely to suffer from drug-related deaths; and experts who know the research on what measures have shown to be effective in reducing deaths and who wish to see this translated into ‘evidence-based policy’. To understand the government’s failure to recognise or respond to these pressures requires some understanding of the UK’s political economy.

Many of the people who are currently dying came of age under the Conservative government of 1979 to 1997. Its political ideology still inform current policies. Margaret Thatcher was inspired by her intellectual mentors - Friedrich Hayek and Milton Friedman, as interpreted by Keith Joseph (Harrison, 1994). Through her, Joseph bequeathed some durable beliefs to the generation of Conservative politicians who also came to political maturity under her influence. This includes the

'fact' that 'there are scroungers, unemployables and people who will not make their share of the effort' (Joseph, 1976, p. 15). For Joseph, and for many Conservative politicians since, the principles of freedom, justice and economic efficiency demand that people have to be freed from dependence on the state, which has to be shrunk. The partiality of this project of state shrinkage has since been demonstrated by the policies used in the aftermath of the 2007/8 financial crisis. Money was simultaneously handed to financial institutions and shareholders through quantitative easing, and taken away from people living in poverty by cutting social security in an intensified programme of 'welfare reform' (Grimshaw & Rubery, 2012; Sharpe & Watts, 2013; Taylor-Gooby, 2016).

The initial implementation of Thatcher's policies created mass unemployment in south Wales, the north of England and the central belt of Scotland. People who had 'nowt else' (Pearson, 1987) turned to heroin. Many of these people have continued to use heroin and other substances, including tobacco and alcohol, over many years. It is they who are now most at risk of drug-related deaths. These deaths are concentrated in people over 40, who live in these deindustrialised areas (NRS, 2017; ONS, 2017). Rates of recorded 'drug misuse' deaths are nine times higher in the most deprived decile of neighbourhoods in England than they are in the least deprived decile (117.5 compared to 13.5 per million population, ONS, 2018). In the UK, drug-related deaths primarily affect working class people.

As we will see, these people have a marginal presence in British drug policy making, while professional experts have long been central to it (Berridge, 2013). This is the second group with potential influence in changing drug policy to reduce deaths. They have succeeded in doing so in the past. A particularly influential role has been played by the Advisory Council on the Misuse of Drugs (ACMD). This was established by the Misuse of Drugs Act 1971 to provide independent advice to ministers on the reduction of drug-related harms (MacGregor, 2017). In response to its report on HIV/AIDS (ACMD, 1988), the Thatcher government supported a range of harm reduction approaches that limited the spread of HIV among people who were injecting drugs (Hope et al., 2005; MacGregor, 1998, 2017; Stimson, 1996).

The ACMD (2000) then recommended a number of measures that would reduce deaths. Some (but not all) of these were implemented, including a rapid expansion in the delivery of opioid substitution therapy (OST). Deaths subsequently fell. But they have risen dramatically since 2012 (ONS, 2017). In response, the ACMD reported to ministers on how to reduce opioid-related deaths, which still make up the largest share of deaths that are recorded as being related to drug misuse. I was the co-chair of the ACMD sub-committee that wrote this report (ACMD, 2016a)[1].

Our main recommendations were: to improve the reporting and recording of drug-related deaths; to invest in OST of optimal dosage and duration; to expand the provision of naloxone for the reversal of opioid overdose; to provide central funding of heroin-assisted treatment (HAT) for people for whom other forms of OST are not effective; to consider the establishment of medically supervised drug consumption rooms (DCRs) in areas with high concentrations of injecting drug use; to support integrated treatment for people with complex needs; and to invest more in relevant research to fill

[1] The views in this article do not represent those of the ACMD as a whole. In writing it, I have not used any information that is available to members of the ACMD but not the public.

important knowledge gaps. We also repeated earlier recommendations (ACMD, 1998, 2000) to take steps to address the socio-economic deprivation which is conducive to the development of problematic drug use.

As shown below, there has been minimal implementation of the report's recommendations, especially in England; the only country in which the UK government has direct responsibility for all aspects of drug policy (health policy is devolved to the national governments of Scotland, Wales and Northern Ireland). So the UK government faces a serious social problem which primarily affects an identifiable social group (middle-aged, working class people, living in de-industrialised areas). It has received advice from the body which is officially responsible for providing it, and which has told it that failure to follow the advice will predictably lead to avoidable deaths (ACMD, 2016a). But it has not implemented such measures. How do we explain this failure to use 'evidence-based' interventions to save the lives of UK citizens?

In answering this question, I present a critical realist explanation that follows Margaret Archer's ideas on the interplay between agency, culture and structure in the creation of social practices, as presented in her 2000 book, *Being Human*. It also uses Andrew Sayer's (2005) insights on *The Moral Significance of Class.* I apply these concepts in analysing data from political discourse on drug-related deaths. I show that part of the explanation must be that that the people who have the 'corporate agency' to decide the content of drug policy have used their power to institutionalise discourses which deny fully human status to the people who suffer most from opioid-related deaths. According to Archer (2000), corporate agency is a quality of a collectivity that has recognised its common interest and is able to act strategically towards shared goals. In this case, the corporate agent is the social collectivity whose interests are represented by the Conservative Party, including the financial services industry which provides much of its funding (Channel 4 News, 2017), and many of its most prominent members, including Prime Minister Theresa May and then Home Secretary Amber Rudd (both former bankers). These powerful actors meet demands for the use of evidence to save lives with a 'moral sidestep' towards normative positions that rest on tough enforcement of conformity and purity rather than 'liberal' compassion.

Method and data

The method I use here is critical realist discourse analysis (Flatschart, 2016; Sims-Schouten, Riley, & Willig, 2007). This starts by identifying the extra-discursive features to which discourses in the field of study may relate. It proceeds by analysing the ways in which these features are represented in the texts and utterances of participants in that field. Here, I examine the way some possible representations of the field are articulated and how some others are 'silently silenced' (Mathiesen, 2004).

The texts and speeches for analysis were chosen on the basis of their relevance to the question of how we can explain the non-implementation of effective measures to reduce opioid-related deaths. I therefore chose to include official documents and ministerial speeches that were made on the subject from the publication of the ACMD report in December 2016 until the start of this analysis (February 2018). The official documents include the government's evaluation of the 2010 drug strategy (HM Government, 2017a). This was stated to have informed the development of the new

drug strategy, which was also published in July 2017 (HM Government, 2017b). Alongside these two documents, the government published its response to the ACMD (2016a) report (Brine & Newton, 2017). On the eve of the publication of the drug strategy, the Home Secretary also published a blog on the Huffington Post website (Rudd, 2017). This is also included in the analysis.

In order to gather ministerial speeches, I used the Hansard website. Hansard is the official record of British parliamentary proceedings. I searched for speeches and answers to questions on subjects related to drug-related deaths that were given by government ministers in the House of Commons in the chosen period. This produced a dataset of 30 debates and answers to oral and written questions.

I analysed these texts using Nvivo software. First, I developed a list of provisional codes (Layder, 1998) from my reading of Archer (2000), Sayer (2005) and from my own experience in the field. I then systematically read and re-read the texts, assigning sections of text to these codes, and creating other codes when I noticed new aspects in the data (this includes the 'moral sidestep' described below). I then re-read the coded extracts of texts and organised them into the three sections presented below. My aim in doing so was to reconstruct the arguments that government officials and politicians deployed in these texts; the reasons they gave for acting as they did and the ways in which the texts blocked off or ignore other forms of action. In this way, this was a form of 'argumentative analysis' (Thompson, 1990).

Extra-discursive features of the field

My selection of extra-discursive features that are relevant to the analysis was informed by three strands of activity: long-term participant observation in and study of the British drug policy scene (Hunt & Stevens, 2004; Stevens, 2011a, 2017); my experience of the process of initiating, writing, negotiating and disseminating the ACMD (2016a) report on opioid-related deaths; and the review of the research evidence on how to explain and reduce these deaths that I led in producing this ACMD report.

These extra-discursive features include: the rise in opioid-related deaths (ONS, 2017); the distribution of these deaths by geography and neighbourhood deprivation (ONS, 2018); the government's reduction of the share of national income that is devoted to public spending (Taylor-Gooby, 2016); substantial cuts to central funding of local authorities, which have been concentrated on the most deprived areas (Hastings, Bailey, Bramley, Gannon, & Watkins, 2015); the use of fiscal policy to redistribute income from poor to rich groups in the UK (Emmerson, 2018); and the related process of welfare reform. In its reforms to the social security system, the UK government has shifted responsibility to poor people to prove that they are not 'welfare scroungers' (Wincup & Monaghan, 2016), echoing Joseph's (1976) identification of the 'unemployable' 'scrounger' as a policy target. Discursively, this stereotype has been supported by the propagation of unfounded myths, such as the widespread existence of families in which several generations have never worked and of neighbourhoods where nobody works (Macdonald, Shildrick, & Furlong, 2014).

Since their party entered government in 2010, Conservative ministers have frequently used this imaginary 'culture of worklessness' to justify retrenchment in welfare spending. The real effects of this discourse have included introduction of a punitive sanctions regime for people who do not

comply with increased conditionality in welfare benefits, abolition of two benefits that were relied on by many people with drug problems (incapacity benefit and disability living allowance), and the rolling of tax credits and benefits into one, less generous and failing system of 'Universal Credit' (NAO, 2018). Social marginalisation has been intensified as poor people – and especially those with drug problems - have been rendered increasingly responsible for solving the problem of poverty through their own efforts (Patrick, 2012; Roy & Buchanan, 2016; Wiggan, 2012).

These latest developments relate to another extra-discursive feature that shapes policy agendas and responses in the UK. Its society and politics have long been structured by social class (Parkin, 1972; Thompson, 1963). Class may no longer be as easy to discern as it once was; it is now comprises of 'multiple differentiations' (Sayer, 2005, p. 15). But it continues to influence aspirations, expectations, tastes, life expectancy and prospects, incomes, wealth, consumption patterns, voting intentions, and affective relationships (Dorling, 2014; Savage, 2000; Savage et al., 2013; Skeggs, 2004; Skeggs & Loveday, 2012). Members of different social classes also tend to hold different attitudes towards the suffering of materially poor people. Social surveys and qualitative interviews suggest that people in the higher income groups are more likely to see poverty as an individual failing and to resist policies which redistribute resources to the poor (Edmiston, 2017; Kantola & Kuusela, 2018; Lamont, 1992; Svallsfors, 2006). Psychological experiments tell us that '[i]ndividuals of lower social class display increased attention to others and greater sensitivity to others' welfare compared to individuals of higher social class, who exhibit more self-oriented patterns of social cognition' (Piff & Robinson, 2017, p. 6). People tend to be more inclined to show compassion to people whom they consider to be socially similar (Sayer, 2005). Sayer argues that such evaluations are made on the basis of moral judgements along lines of class. The failure by one social class to recognise and act on the needs of another is a form of 'class contempt', or 'the tendency not to see or hear others as people' (Sayer, 2005, p. 163) on the basis of their class position.

Data and discourse analysis

The non-performative absorption of recommendations

In their response to the ACMD (2016a) report, the relevant junior ministers from the Home Office and the Department of Health and Social Care declared that they 'accepted the majority of the recommendations in the report… with the exception of drug consumption rooms' (Brine & Newton, 2017). In the usual meaning of the words, to accept a recommendation implies that you agree with it and will implement it. However, analysis of this ministerial response and subsequent speeches and actions shows that ministers do not agree with the recommendations and do not intend to implement them.

The response to the recommendations welcomed the ACMD's advice, but treated it selectively. It referred to actions that the government was already taking (of which ACMD members were already aware), instead of accepting the need for new action. The letter which the chair of the ACMD had sent to Amber Rudd with the report emphasised '[t]he most important recommendation in this report is that government ensures that investment in OST of optimal dosage and duration is, at least, maintained'. The ministerial response (and other texts in the dataset) says nothing about dosage or

duration of OST, other than to refer to national clinical guidelines. As the ACMD and others have suggested, these guidelines have not been sufficient to achieve optimal dosage and duration of OST in practice (ACMD, 2014, 2015; Hickman et al., 2018; Recovery Orientated Drug Treatment Expert Group, 2012), which is why new governmental action was recommended.

The ACMD (2016a) report and the government's own evaluation of the 2010 drug strategy (HM Government, 2017a) show reductions in spending on treatment, including OST. Accepting the ACMD recommendations in this area would involve acknowledging that more spending is necessary, relative to ongoing reductions. Instead, the ministerial response claimed that spending was being maintained through the retention of the 'ring-fenced grant' until 2018/19; a dissimulation of the fact that substantial cuts to both the central public health grant and to funding for local authorities have created a serious threat to treatment coverage and quality (ACMD Recovery Committee, 2017).

The ministerial response also included acceptance of recommendations on HAT and naloxone. The ACMD (2016a) specifically recommended 'central funding' of HAT, due to the failure of local funding to sustain the three clinics that had been providing the service until 2015. The ministerial response belied its pretended agreement with the ACMD by arguing that such services should be funded locally. No new central funding for HAT has been provided.

On naloxone, the ministerial response and the 2017 drug strategy refer to a range of existing efforts (but no new funding) to encourage local agencies to provide naloxone. As an analysis by the charity Release has shown, these initiatives have so far failed to provide anything more than patchy and inadequate provision of naloxone in England (Release, 2017). Most worryingly, some local authorities with relatively high levels of drug-related deaths (e.g. Wigan and Hartlepool) reported to Release that they had no plans to make take-home naloxone available.

Another example of the lack of agreement and implementation of these 'accepted' recommendations is the approach taken to research funding. The ACMD (2016a) reported important gaps in knowledge. Its response to an earlier draft of the drug strategy had also highlighted substantial evidence gaps, particularly in the areas of demand and supply reduction (ACMD, 2016b).This was backed up by the government's drug strategy evaluation, which noted a lack of evidence on several aspects of UK drug policy (HM Government, 2017a). The ACMD (2016a) report suggested seven specific areas of necessary research, six of which go beyond the evaluation of health interventions to reduce deaths. The ministerial response and other texts (including the 2017 drug strategy) did not acknowledge these evidence gaps and did not create new research projects or investment. In the government debate that introduced the new drug strategy, the minister rather said 'we have a good evidence base upon which to build for the future' (Newton, 2017).

The ministerial response to the ACMD referred to existing funding of research through the National Institute of Health Research (NIHR), the collation of law-enforcement data by the National Crime Agency (NCA), and the UK's participation in the European Research Area Network on Illicit Drugs (ERANID). NIHR is not a specific funder of drug-related research. It has not been able to meet the need for research in this field since it was created in 2006, probably due to the very large range of other topics that it covers. In the most recent publicly available data on spending on health research (UK Clinical Research Collaboration, 2015), less than one percent of approximately £2 billion in

reported funding was devoted to issues of drug 'addiction' or opiate use. All of the funded projects on these topics focus on prevention or treatment of drug use. This is far from meeting the range of evidence gaps identified by the ACMD and the drug strategy evaluation. For example, it does nothing to inform us on the effectiveness of investment in supply reduction and law enforcement.

These gaps cannot be met through data gathered by the NCA. The NCA is not a research organisation. It publishes very little of the data it collects. The government does participate in the ERANID research initiative. But the ministerial response failed to mention that the UK opted out of the ERANID (2016) call for research on 'the impact of drug policy on society', so limiting the ability of British researchers to produce evidence on drug demand and supply reduction.

The government's stated acceptance of the ACMD recommendations are an example of 'non-performative language'. It is a set of statements that 'do not bring about the effects that they name' (Ahmed, 2006). In Mathiesen's (2004) terms, this non-performative acceptance of recommendations serves to 'silently silence' objections to the *status quo* by 'absorption'; appearing to agree with a challenge while taking little action to resolve it. When challenged in Parliament, the minister claimed 'it is simply not true that we have not taken on board all the recommendations' of the ACMD (Newton, 2017). But by not actually implementing these recommendations, ministers sustain conditions that are harmful for other people. In the section below, I examine the ways in which political actors represented themselves and these other people in their discourse.

'Being human': agency in drug policy

The critical realist approach sees discourses as sets of statement that construct objects, which are deployed by social actors who have reasons for constructing such objects in that way. Their uses of these discourses goes on to influence the cultural context in which future discourses are created and deployed, as part of the 'morphogenetic' development of social action (Archer, 2000). We can trace various forms of agency in the textual data gathered for this analysis. We can see, for example, a form of 'corporate agency' (Archer, 2000) at play in the presentation of the government as the co-ordinator of a range of 'partners' in the attempt to reduce drug use.

This form of agency is clearly stated in ministerial communications in the dataset, especially in the blog written by the Home Secretary to introduce the drug strategy (Rudd, 2017). She constructs herself as a powerful and benevolent agent: 'My job as Home Secretary is to keep families and communities across our country safe'. She states how she will lead other organisations in achieving this task through a 'Drug Strategy Board that I will personally chair to ensure everyone is accountable'. And she clearly states the ultimate aim of the collaborative effort that she will lead: 'We owe it to future generations to work together for a society free of drugs.' In other words, a society in which there are no people who use drugs.

The 2017 drug strategy and ministerial speech are also full of references to how the government will lead a collaborative, multi-partner approach that will, through the enacted agency of the government, reduce drug use and protect communities and 'the vulnerable'. In deploying this discourse, government ministers construct themselves as the central players in the dramatic struggle between 'families and communities' and the enemy which threatens them; 'drugs'.

Remarkably absent from this constructed drama are the people whom it most directly concerns; i.e. people who use drugs. Drug use is never presented as an active choice, taken by responsible adults. People who use drugs are constructed not as agents in their own right, but as objects of the government's actions in protecting them.

The trope which ministers repeatedly use is to describe the objects of their policies as 'vulnerable'. The concept of vulnerability appears over 20 times in the drug strategy document and is central to it (Wincup & Brown, 2018). Indeed, the job title of the junior minister responsible for drugs policy does not include the word drugs. She is the 'Parliamentary Under Secretary of State for Crime, Safeguarding and Vulnerability'. Describing people merely as 'vulnerable' denies their agency. It justifies the taking of decisions by others on their behalf. As Brown (2017) has noted, the status of being vulnerable is conferred on groups who are seen as passive victims of circumstance. But this only leads to governmental responsibility to act if they conform with attempts to protect them. Social exclusion has intensified for people who do not comply (Grover, 2010; Young, 1999).

Ministers' description of the objects of drug policy as a generic adjective ('the vulnerable') avoids having to give these people a name, or describe their most pertinent social characteristics.[2] Age is mentioned in the dataset, usually either in the context of protecting young people, or as an explanation for increasing deaths among an 'older cohort' of people who use heroin. Other social characteristics, such as race, gender and class are hardly mentioned. Gender, for example, is only mentioned in relation to the 'vulnerability' of female sex workers (Wincup & Brown, 2018).

The social distribution of drug-related death was highlighted in the ACMD (2016a) report, but not in the 2017 drug strategy. In this way, the people who suffer most from drug-related deaths have been rendered invisible by governmental discourse. They are simultaneously hidden amongst the other groups considered vulnerable, and stigmatised as passive, unemployable scroungers (Wincup & Monaghan, 2016). This is entirely consistent with Archer's (2000) suggestion that groups who lack structural power will find it difficult to articulate their concerns and get them culturally recognised.

This lack of articulation has two forms. One is the lack of voice. The other is the lack of collective mobilisation. People without corporate agency find it difficult to create a platform from which to communicate their shared problems. As Sayer (2005, p. 158) puts it, '[t]he poorest are … not only materially deprived but linguistically disappropriated and hence disempowered'. People without voice also find it difficult to link their interests with those of other groups in order to create shared goals and strategic action. They therefore cannot attain the status of corporate agency. They are left with their status as a 'primary agent'. This is a term that Archer uses to describe collectivities which have not recognised a common interest and developed a set of common goals which they can strive for collectively.

[2] A minister only mentioned one person who died by name (Newton, 2017). This was an exceptional case of a 15 year old girl called Martha whose death was related to MDMA. She was remembered during a debate on drug policy by two Labour MPs (Jeff Smith and Louise Haigh) and a Liberal Democrat (Layla Moran). Her mother (Anne-Marie Cockburn) was in the public gallery of the House of Commons for the debate. In general, people who use drugs were depersonalised in the discourse.

In the data analysed for this article, ministers accord to themselves the qualities of fully human and moral agents. They present themselves as acting to safeguard society from an external evil which threatens it. In doing so, they deny to people who suffer most from drug problems the status of being human agents in their own right.

The 'moral sidestep' in the avoidance of 'evidence-based policy'

While the people most affected by drug-related deaths do not have corporate agency in policy discussions, members of the public health 'policy constellation' (Stevens & Zampini, 2018) do have some articulated agency. These health professionals, academics and non-governmental organisations work alongside each other in arguing for policy change, as exemplified in reports from the ACMD, as well as the UK Drug Policy Commission (UKDPC, 2012), the Royal Society of Arts (RSA Commission on Illegal Drugs Communities and Public Policy, 2007), the British Medical Association (BMA Board of Science, 2013) and both the Royal Society and the Faculty of Public Health (Royal Society of Public Health, 2016), followed by the Royal College of Physicians (2018). They are institutionally committed to arguing for 'evidence-based' policy change (Lancaster, 2016; Smith, 2007). But their (and my) deployment of research evidence in policy debates on drug-related deaths has not had the intended effect of changing policy.

In the data analysis, I observed that when politicians argue for policy change on the basis of evidence, they were most powerfully met with moral claims, rather than evidential refutation. I describe this as a 'moral sidestep'. This occurs when a political actor avoids making changes on the basis of evidence by citing the important of moral concerns. In the data collected for this article, it is most clearly visible in the response given by Theresa May to a Parliamentary question on 20th December 2017. The Scottish Nationalist MP, Ronnie Cowan, referred to the rise in deaths and to evidence from 'eight European countries, plus Australia and Canada' on the effectiveness of 'supervised drug consumption rooms'. He then asked, 'in the interests of public health, will the Prime Minister introduce DCRs in the United Kingdom?' Her reply was highly informative:

> I have a different opinion to some Members of this House. Some are very liberal in their approach to the way that drugs should be treated. I am very clear that we should recognise the damage that drugs do to people's lives. Our aim should be to ensure that people come off drugs, do not go on drugs in the first place and keep clear of drugs. That is what we should focus on (May, 2017a).

In this reply, May draws a clear 'moral boundary' (Lamont, 1992; Sayer, 2005) between herself and 'some Members of this House'. She described them as 'very liberal', thereby connoting herself as the opposite of liberally indulgent; conservative and tough. She does not attempt to challenge Cowan's claims on the effectiveness of DCRs. Instead she repeats her government's position on the need to rid society of drugs. The government's drug strategy evaluation shows that the government does not have the evidence to tell it how this aim could be achieved. It is a moral aspiration, not an evidenced position.

Here, May was repeating the moral sidestep she had already practised on the 22nd November 2017. When challenged by Crispin Blunt (a Conservative MP) on the 'legalisation and regulation of

cannabis markets' in the USA and Canada and 'decriminalisation in Portugal and elsewhere', she said:

> When I was Home Secretary, work was undertaken by the Home Office on the experience in a number of countries and the different ways they approached the issue of drugs, but I am afraid that I have a different opinion from my honourable Friend on drugs… It is right that we continue to fight the war against drugs (May, 2017b).

Note again the absence of discussion or refutation of evidence. May mentions research by the Home Office on the experience 'in a number of other countries', but she does not use its findings. Rather, she almost disowns it by stating that it 'was undertaken' in the passive voice. The report in question showed there is little cross-national relationship between the severity of penal sanctions for drug offences and levels of drug use and related harms (Home Office, 2014). Then ministerial colleagues, Norman Baker and Nick Clegg (both Liberal Democrats) have since reported that May ordered changes to the report, removing recommendations to consider following the Portuguese example (Asthana, 2016; BBC, 2014). In her Parliamentary response to Mr Blunt, she refers not to the evidence contained in the report, but to a moral crusade; 'the war against drugs'.

This sidestep away from refuting claims on the basis of evidence is visible in several ministerial statements in the data collected for this article. It is interesting in what it reveals about how ministers deal with pressure that emanates from the public health policy constellation. It is also interesting to note the moral content to which this sidestep is taken, as drug policy is often decided on moral rather than evidential grounds (Zampini, 2018). The sidestep does not move to a morality of care or compassion, but rather to abstinent purity and conformity. These are quintessentially conservative 'moral foundations' (Graham, Haidt, & Nosek, 2009) which enable their proponents to perform 'totemic toughness' (Stevens, 2011b); the willingness to show hostility to a supposedly threatening minority in order to pretend to protect a wholesome majority.

Discussion

This is an 'intensive' study that is primarily concerned with 'what makes things happen' in a specific case (Sayer, 2000, p. 20). Here, the focus is on UK drug policy on opioid-related death between 2016 and 2018. More 'extensive' research could include comparisons with other periods and topics in UK drug policy, or the response to drug-related deaths in other countries. The USA, Canada and France would be particularly interesting and contrasting cases, given their different trajectories in policy and death rates.

Some hints on the differences between this and other periods in UK drug policy are given by the greater willingness of previous governments to invest in life-saving services for people who use drugs (MacGregor, 2017). Indeed, a previous Conservative minister gave the following response when challenged to implement ACMD advice on reducing a health problem that was seen as a threat to the whole of society, rather than just to people who use heroin: 'when a legitimate basis for expenditure is found our task is to find the resources to meet it. I see the AIDS budget as one which will inevitably increase as the scale of the problem increases' (Mellor, 1989).

Nowhere in recent debates has a minister promised that as the scale of drug-related deaths increases, so should the budget for reducing them. To do so would contradict the fundamental political economic project of the currently dominant corporate agent; shrinking public expenditure in ways that protect the wealthy and so produce a 'divisive welfare state' (Taylor-Gooby, 2016). This is a form of social provision which differs markedly from the liberal welfare state that was created during the post-war, post-Beveridge report consensus by both Conservative and Labour parties, which Joseph (1976) so vehemently decried.

Instead of acting as an expression of solidarity, the welfare system (and drug policy) now operate as a motor of division, channelling resentment towards working class people who are considered unwilling rather than unable to work. Such resentment can lead to support for punitive and stigmatising arrangements for the delivery of welfare as well as harsh penal sanctions in the criminal justice system (Grover, 2010; Young, 1999). It can also, as shown in this article, lead to a failure to provide effective services to save the lives of denigrated social groups, such as working class people who use heroin. In Butler's (2016) terms, these lives are not considered 'grievable'. Governmental discourse operates as 'an intrinsically political knowledge-making processes that frame some lives as not visibly or perceptibly real and therefore not "lose-able"' (Fraser, Farrugia, & Dwyer, 2018, p. 30). So effective measures to prevent these lives being lost and grieved are not taken.

In public attitudes, however, there is ambivalence towards people who have problems with drugs. They are seen as deserving of both care and sanction (Matheson et al., 2014; Singleton, 2010). Some political actors have exploited this ambivalence to deepen the increasing fissiparousness that Archer observes in economically 'residual' groups who are excluded from power in 'late welfare capitalism'. 'Their social exclusion plus their diversity condemns them as a collectivity to the passivity of primary [rather than corporate] agency' (Archer, 2000, p. 284). Resentment and vindictiveness against some sections of the working class has been used to win support (or at least acquiescence) for welfare reform and cuts to incomes and services (Grover, 2010), including to drug treatment budgets.

Archer's concepts valuably indicate that this is not just a tactic of one political party; it is a strategy adopted by a social group who share interests and are structurally empowered to institutionalise their 'self-oriented patterns of social cognition' (Piff & Robinson, 2017). This is visible in recent Conservative Party policy (Grimshaw & Rubery, 2012), but it was also present in the discourse of the 'New Labour' government (1997 – 2010). This government also changed welfare policy to emphasise individual responsibility and the morally authoritarian 'othering' of undeserving claimants (Connor, 2007). Civil servants, special advisers and Labour ministers created the 'high harm causing users' (PMSU, 2003) of crack and heroin as an object to be blamed for large portions of crime and targeted for control (MacGregor, 2017; Stevens, 2011a). This shows that corporate agency goes beyond the boundaries of political parties. A structurally advantaged social group can dominate the cultural, intellectual landscape (Archer, 2000). And this can feed into the policies of all parties for decades (Beland, 2005).

The focusing of blame on 'welfare scroungers' and 'high harm causing users' contributed to the casting of people who use drugs as abject; 'being vile or unworthy; refuse, scum, dregs… humiliation, degradation; dispiritedness, despondency' (Oxford English Dictionary, cited in Tyler, 2013, p. 20). As Tyler argues, 'one of the major consequences of the fabrication of national abjects such as 'the

welfare scrounger' in public culture is the curtailment of the representational agency of these individuals' (Tyler, 2013, p. 26).

The discursive construction of people who use drugs as denigrated objects of fear and control during the New Labour era fed forward (morphogenetically) into Conservative ministers' non-performative ignoring of the social characteristics, agency and suffering of these people. These discursive practices have real consequences. The extra-discursive effects of class contempt against people who use heroin include the continuation of the project of partial state shrinkage, as well as the failure to implement evidence to reduce their deaths.

Conclusion

In the data analysed here, Conservative ministers displayed a high degree of corporate agency. They have acted and spoken consistently in support of the aim (which they share with their financial backers) to shrink state spending in ways that maintain the incomes and power of the rich. Archer's concept of corporate agency as involving coordinated action towards shared goals fits these actions well. Her concept of 'residual primary agency' also helps us to understand why people who are potential agents in this debate have not been able to enact such agency, due to their difficulties in achieving either aspect of articulation. Working class people who use heroin do not have a platform from which to give voice to their concerns, and they have not created coordinated action in defence of their own interests.

Members of the public health policy constellation have more presence in the debate. But their calls to change policy have been avoided through ministers taking a 'moral sidestep' away from the evidence towards normative claims. Some researchers may be reluctance to act as campaigners as well as experts (Smith & Stewart, 2017). They may have a justifiable reluctance to take on the task of arbitrating on moral positions, as well as on the research evidence (Humphreys & Piot, 2012). But we should recognise that our recommendations are inherently value-laden (Zampini, 2018). Recommendations to reduce drug-related deaths typically prioritise compassion and the right to life over the desire for a 'society free of drugs'.

In future, we might see more political mobilisation both by people who use drugs and by members of the public health policy constellation. This could possibly turn public ambivalence towards 'the vulnerable' into support for policies based on compassion and research evidence, rather than the moral positions of purity and conformity. In the meanwhile, the corporate agent which is currently in control of UK drug policy evidently fails to recognise the full humanity of the people most likely to die. So it refuses to compromise its moral and material preferences in order to implement measures that would predictably save these lives.

Acknowledgement

I would like to acknowledge the contribution to this article of Universities UK, the representative body of university employers. Through its incompetent handling of the pensions dispute of 2017/18, it forced members of the University and College Union to take strike action. This article benefitted

greatly from discussing some of its ideas with colleagues on the picket lines. The article is dedicated to these inspiring colleagues, in solidarity.

References

ACMD. (1988). *AIDS and Drug Misuse*. London: Department of Health and Social Security.

ACMD. (1998). *Drug Misuse and the Environment*. London: The Stationery Office.

ACMD. (2000). *Reducing Drug Related Deaths*. London: The Stationery Office.

ACMD. (2014). *Time limiting opioid substitution therapy*. London: Home Office.

ACMD. (2015). *How can opioid substitution therapy (and drug treatment and recovery systems) be optimised to maximise recovery outcomes for service users?* London: Home Office.

ACMD. (2016a). *Reducing opioid-related deaths in the UK*. London: Home Office.

ACMD. (2016b). *ACMD Response to Drug Strategy*. London: Home Office.

ACMD Recovery Committee. (2017). *Commissioning impact on drug treatment: the extent to which commissioning structures, the financial environment and wider changes to health and social welfare impact on drug misuse treatment and recovery*. London: Home Office.

Ahmed, S. (2005). The Non-Performativity of Anti-Racism. *Borderlands E-Journal*, *5*(3). Retrieved from http://www.borderlands.net.au/vol5no3_2006/ahmed_nonperform.htm

Archer, M. S. (2000). *Being Human: The Problem of Agency*. Cambridge: Cambridge University Press.

Asthana, A. (2016). Nick Clegg accuses Theresa May of tampering with drug report. *The Guardian*. Retrieved from https://www.theguardian.com/politics/2016/apr/17/nick-clegg-accuses-theresa-may-drug-report-conservatives

BBC. (2014). Ex-minister Norman Baker publishes drug plans “blocked” by Theresa May. Retrieved March 17, 2017, from http://www.bbc.co.uk/news/uk-politics-30611157

Beland, D. (2005). Ideas and Social Policy: An Institutionalist Perspective. *Social Policy and Administration*, *39*(1), 1–18.

Berridge, V. (2013). *Demons: Our changing attitudes to alcohol, tobacco, and drugs*. Oxford: Oxford University Press.

BMA Board of Science. (2013). *Drugs of Dependence: The Role of Medical Professionals*. London: British Medical Association.

Brine, S., & Newton, S. (2017). *Government Response to Four Reports from the Advisory Council on the Misuse of Drugs*. London: Home Office.

Brown, K. (2017). Global ‘vulnerabilities’: New configurations of competition in the era of conditionality? In D. Horsfall & J. Hudson (Eds.), *Social policy in an era of competition: From global to local perspectives*. Bristol: Policy Press.

Butler, J. (2016). *Frames of war: When is life grievable?* New York: Verso.

Channel 4 News. (2017). Elections for sale: who funds Britain’s political parties? Retrieved April 22, 2018, from https://www.channel4.com/news/factcheck/elections-for-sale-who-funds-britains-political-parties

Connor, S. (2007). We’re onto you. *Critical Social Policy*, *27*(2), 231–252.

Dorling, D. (2014). Thinking about Class. *Sociology*, *48*(3), 452–462.

Edmiston, D. (2017). The poor “sociological imagination” of the rich: Explaining attitudinal divergence towards welfare, inequality, and redistribution. *Social Policy & Administration*. https://doi.org/10.1111/spol.12366

Emmerson, C. (2018). *Spring Statement 2018: more difficult choices ahead*. London: Institute for Fiscal Studies.

ERANID. (2016). *Society and responses to drug use: Call for Proposals*. Portugal: European Research Area Network on Illicit Drugs.

Flatschart, E. (2016). Critical Realist Critical Discourse Analysis: A Necessary Alternative to Post-

marxist Discourse Theory. *Journal of Critical Realism*, *15*(1), 21–52.
Fraser, S., Farrugia, A., & Dwyer, R. (2018). Grievable lives? Death by opioid overdose in Australian newspaper coverage. *The International Journal on Drug Policy*, *59*, 28–35.
Graham, J., Haidt, J., & Nosek, B. A. (2009). Liberals and conservatives rely on different sets of moral foundations. *Journal of Personality and Social Psychology*, *96*(5), 1029–1046.
Grimshaw, D., & Rubery, J. (2012). The end of the UK's liberal collectivist social model? The implications of the coalition government's policy during the austerity crisis. *Cambridge Journal of Economics*, *36*(1), 105–126.
Grover, C. (2010). Social Security Policy and Vindictiveness. *Sociological Research Online*, *15*(2), http://www.socresonline.org.uk/15/2/8.html.
Harrison, B. (1994). Mrs Thatcher and the Intellectuals. *Twentieth Century British History*, *5*(2), 206–245.
Hastings, A., Bailey, N., Bramley, G., Gannon, M., & Watkins, D. (2015). *The Cost of the Cuts: The Impact on Local Government and Poorer Comunities*. York: Joseph Rowntree Foundation.
Hickman, M., Steer, C., Tilling, K., Lim, A. G., Marsden, J., Millar, T., … Macleod, J. (2018). The impact of buprenorphine and methadone on mortality: a primary care cohort study in the United Kingdom. *Addiction*, *113*(8), 1461–1476.
HM Government. (2017a). *An Evaluation of the Government's Drug Strategy 2010*. London: HM Government.
HM Government. (2017b). *2017 Drug Strategy*. London: Home Office.
Home Office. (2014). *Drugs : International Comparators*. London: Home Office.
Hope, V. D., Judd, A., Hickman, M., Sutton, A., Stimson, G. V, Parry, J. V, & Gill, O. N. (2005). HIV prevalence among injecting drug users in England and Wales 1990 to 2003: Evidence for increased transmission in recent years. *Aids*, *19*(11), 1207–1214.
Humphreys, K., & Piot, P. (2012). Scientific evidence alone is not sufficient basis for health policy. *Bmj*, *344*(February), e1316–e1316. https://doi.org/10.1136/bmj.e1316
Hunt, N., & Stevens, A. (2004). Whose harm? Harm and the shift from health to coercion in UK drug policy. *Social Policy & Society*, *3*(4), 333–342.
Joseph, K. (1976). *Stranded on the Middle Ground? Reflections on Circumstances and Policies*. London: Centre for Policy Studies.
Kantola, A., & Kuusela, H. (2018). Wealth Elite Moralities: Wealthy Entrepreneurs' Moral Boundaries: *Sociology*, *early online*. https://doi.org/10.1177/0038038518768175
Lamont, M. (1992). *Money, Morals, and Manners: The Culture of the French and the American Upper-Middle Class. University of Chicago Press*. Chicago.
Lancaster, K. (2016). Performing the Evidence-Based Drug Policy Paradigm. *Contemporary Drug Problems*, *23*(2), 142–153.
Layder, D. (1998). *Sociological Practice: Linking Theory and Social Research*. London: Sage.
Macdonald, R., Shildrick, T., & Furlong, A. (2014). 'Benefits Street' and the Myth of Workless Communities. *Sociological Research Online*, *19*(3), 1–6. https://doi.org/10.5153/sro.3438
MacGregor, S. (1998). Pragmatism or Principle? Continuity and Change in the British Approach to Treatment and Control. In R. Coomber (Ed.), *The Control of Drugs and Drug Users* (pp. 131–154). London: CRC Press.
MacGregor, S. (2017). *The Politics of Drugs: Perceptions, Power and Policies.* Basingstoke: Palgrave Macmillan UK.
Matheson, C., Jaffray, M., Ryan, M., Bond, C. M., Fraser, K., Kirk, M., & Liddell, D. (2014). Public opinion of drug treatment policy: Exploring the public's attitudes, knowledge, experience and willingness to pay for drug treatment strategies. *International Journal of Drug Policy*, *25*(3), 407–415.
Mathiesen, T. (2004). *Silently Silenced: Essays on the Creation of Acquiescence in Modern Society*. Winchester: Waterside Press.
May, T. (2017a). Engagements, 20th December 2017. *Hansard*, *633*.

May, T. (2017b). Engagements, 22nd November 2017. *Hansard*, *631*.
Mellor, D. (1989). Debate on AIDS. *Hansard*, *144*.
NAO. (2018). *Rolling Out Universal Credit*. London: National Audit Office.
Newton, S. (2017). Drug Policy Debate, 18th July 2017. *Hansard*, *627*.
NRS. (2017). *Drug-related deaths in Scotland in 2016*. Edinburgh: National Records of Scotland.
ONS. (2017). *Deaths related to drug poisoning in England and Wales: 2016 registrations*. London: Office for National Statistics.
ONS. (2018). More than half of heroin/morphine misuse death hotspots in England and Wales are seaside locations. Retrieved April 7, 2018, from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/halfofheroinmorphinemisusedeathhotspotsinenglandandwalesareseasidelocations/2018-04-04
Parkin, F. (1972). *Class Inequality and Political Order*. St Albans: Paladin.
Patrick, R. (2012). Work as the primary 'duty' of the responsible citizen: a critique of this work-centric approach. *People Place and Policy Online*, *6*(1), 5–15.
Piff, P. K., & Robinson, A. R. (2017). Social class and prosocial behavior: current evidence, caveats, and questions. *Current Opinion in Psychology*, *18*, 6–10.
PMSU. (2003). *SU Drugs Report. Phase 2 report: Diagnosis and recommendations* (Vol. 2005). London: Prime Minister's Strategy Unit.
Recovery Orientated Drug Treatment Expert Group. (2012). *Medications in Recovery: Re-orienting Drug Dependence Treatment*. London: National Treatment Agency for Substance Misuse.
Release. (2017). Take Home Naloxone in England. Retrieved February 5, 2018, from https://www.release.org.uk/naloxone
Roy, A., & Buchanan, J. (2016). The Paradoxes of Recovery Policy: Exploring the Impact of Austerity and Responsibilisation for the Citizenship Claims of People with Drug Problems. *Social Policy & Administration*, *50*(3), 398–413.
Royal College of Physicians. (2018). RCP supports Royal Society for Public Health report on drug policy. Retrieved June 7, 2018, from https://www.rcplondon.ac.uk/news/rcp-supports-royal-society-public-health-report-drug-policy
Royal Society of Public Health. (2016). *Taking a New Line on Drugs*. London: Royal Society of Public Health.
RSA Commission on Illegal Drugs Communities and Public Policy. (2007). *Drugs - facing facts*. London: Royal Society for the encouragement of Arts, Manufactures and Commerce.
Rudd, A. (2017). Our Drugs Strategy Will Tackle a Corrosive, Creeping Threat Destroying Countless Lives. Retrieved February 7, 2018, from http://www.huffingtonpost.co.uk/amber-rudd/drug-strategy_b_17474964.html
Savage, M. (2000). *Class Analysis and Social Transformation*. Buckingham: Open University Press.
Savage, M., Devine, F., Cunningham, N., Taylor, M., Li, Y., Hjellbrekke, J., … Miles, A. (2013). A New Model of Social Class: Findings from the BBC's Great British Class Survey Experiment. *Sociology*. https://doi.org/10.1177/0038038513481128
Sayer, A. (2000). *Realism and Social Science*. London: Sage.
Sayer, A. (2005). *The Moral Significance of Class*. Cambridge: Cambridge University Press.
Sharpe, T., & Watts, M. (2013). Unconventional Monetary Policy in the UK: A Modern Money Critique. *Economic Issues*, *18*(2), 41–64.
Sims-Schouten, W., Riley, S. C. E., & Willig, C. (2007). Critical Realism in Discourse Analysis: A Presentation of a Systematic Method of Analysis Using Women's Talk of Motherhood, Childcare and Female Employment as an Example. *Theory & Psychology*, *17*(1), 101–124.
Singleton, N. (2010). *Attitudes to Drug Dependence*. London: UK Drug Policy Commission.
Skeggs, B. (2004). *Class, self, culture*. *Class, Self, Culture*. London: Routledge.
Skeggs, B., & Loveday, V. (2012). Struggles for value: Value practices, injustice, judgment, affect and the idea of class. *British Journal of Sociology*, *63*(3), 472–490.
Smith, K. E. (2007). Health inequalities in Scotland and England: the contrasting journey of ideas

from research into policy. *Social Science and Medicine*, *64*(7), 1438–1449.
Smith, K. E., & Stewart, E. A. (2017). Academic advocacy in public health: Disciplinary 'duty' or political 'propaganda'? *Social Science and Medicine*, *189*, 35–43.
Stevens, A. (2011a). *Drugs, Crime and Public Health: The Political Economy of Drug Policy*. Abingdon: Routledge.
Stevens, A. (2011b). Telling Policy Stories: An Ethnographic Study of the Use of Evidence in Policy-making in the UK. *Journal of Social Policy*, *40*(2), 237–256.
Stevens, A. (2017). Principles, pragmatism and prohibition: explaining continuity and change in British drug policy. In A. Liebling, S. Maruna, & L. McAra (Eds.), *Oxford Handbook of Criminology, 6th Edition* (pp. 825–845). Oxford: Oxford University Press.
Stevens, A., & Zampini, G. F. (2018). Drug policy constellations: a Habermasian approach for understanding English drug policy. *International Journal of Drug Policy*, *57*(61–71).
Stimson, G. V. (1996). Has the United Kingdom averted an epidemic of HIV-1 infection among drug injectors? *Addiction*, *91*(8), 10851088.
Svallsfors, S. (2006). *The Moral Economy of Class: Class Attitudes in Comparative Perspective*. Stanford, California: Stanford University Press.
Taylor-Gooby, P. (2016). The Divisive Welfare State. *Social Policy and Administration*, *50*(6), 712–733.
Thompson, E. P. (1963). *The Making of the English Working Class*. London: Penguin.
Thompson, J. B. (1990). *Ideology and Modern Culture: Critical Social Theory in the Era of Mass Communication*. Cambridge: Polity Press.
Tyler, I. (2013). *Revolting Subjects: Social Abjection and Resistance in Neoliberal Britain*. London: Zed Books.
UK Clinical Research Collaboration. (2015). *UK Health Research Analysis 2014*. London: UK Clinical Research Collaboration.
UKDPC. (2012). *How to make drug policy better: key findings from UKDPC research into drug policy governance*. London: UK Drug Policy Commission.
Wiggan, J. (2012). Telling stories of 21st century welfare: The UK Coalition government and the neo-liberal discourse of worklessness and dependency. *Critical Social Policy*, *32*(3), 383–405.
Wincup, E., & Brown, K. (2018). Vulnerability and UK drug policy: a useful lens for thinking about the link between drug use and inequality? Paper presented at *12th Annual Conference of the International Society for the Study of Drug Policy*. Vancouver.
Wincup, E., & Monaghan, M. (2016). Scrounger narratives and dependent drug users: welfare, workfare and warfare. *Journal of Poverty and Social Justice*, 24(3), 261-275.
Young, J. (1999). *The Exclusive Society*. London: Sage.
Zampini, G. F. (2018). Evidence and morality in harm-reduction debates: can we use value-neutral arguments to achieve value-driven goals? *Palgrave Communications,* 4(1), 1–10.