

INPUD RESPONSE: Open Letter to Russell Brand



The International Network of People who Use Drugs' (INPUD) response to Russell Brand's documentary, *Russell Brand: End the War on Drugs*

Dear Mr Brand,

The International Network of People who Use Drugs ([INPUD](#)) is a global peer-based organisation that seeks to promote the health and defend the human rights of people who use drugs. We, the INPUD Secretariat, feel compelled to respond to substantial parts of your recent documentary, entitled [End the War on Drugs](#).¹ Our friends at Students for Sensible Drug Policy UK (SSDP) [have already written to you](#)² regarding this programme, and we can only echo and add to their concern that “your personal views may have already caused great damage, given your public status and following”.

Though the programme made some helpful points with which we (and many public figures other than yourself) would agree, namely in highlighting some of the failures and harms of the so-called war on drugs, unfortunately many of your arguments were frequently contradictory, poorly informed, myopic, moralising, generalising, and discriminatory. In short, much of the discussion served to feed directly into the harm which people who use drugs experience as a result of criminalisation, misinformation, and stigma.

You use the term ‘addict(s)’ and ‘addiction’ throughout the programme; would it have been so difficult to refer more neutrally to ‘people who use drugs’, ‘drug users’, or ‘people with drug dependencies’, to focus on describing people, and not reducing them to a pathologised identity? The World Health Organisation have called since the 1960s for ‘addiction’ terminology not to be used.³ You state that “drug addiction is not a crime; drug addiction is an illness”. To state this as if it is irrefutable ignores a wealth of academic, scientific, and medical work. The ‘addiction-as-disease’ model is highly contested, since it is based on an arbitrary and changeable set of ‘symptoms’ that principally revolve around the labelling of people who use drugs as sick and dangerous, disempowered, and unable to exercise agency, choice, and self-determination. To

¹ BBC, *Russell Brand: End the Drugs War*, available at <http://www.bbc.co.uk/programmes/b04v2zrg>

² SSDP UK, 2014, *An Open Letter To Russell Brand*, available at <http://ssdp.org.uk/an-open-letter-to-russell-brand/>

³ World Health Organization (WHO), n.d., *Lexicon of alcohol and drug terms published by the World Health Organization*, available at http://www.who.int/substance_abuse/terminology/who_lexicon/en/

⁴ INPUD and Youth Rise, 2014, *The Harms of Drug Use: Criminalisation, Misinformation, and Stigma* (London: INPUD and Youth Rise), available at http://www.inpud.net/The_Harms_of_Drug_Use_JayLevy2014_INPUD_YouthRISE.pdf

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assert that drug dependency is unequivocally a disease or illness is simplistic to say the least. Indeed, as stressed in the aforementioned letter from SSDP, “[d]rug dependency occurs as a result of myriad physical, psychological, genetic, socio-economic, structural and environmental factors, and is not solely a medical problem... It is important to understand the value and limitations of each conceptualization because ‘addiction’ is still a highly controversial and politicised phenomenon”. As is well-stated by Dr Helen Keane:

“The more effort is put into finding answers, the more questions keep proliferating. What kind of thing is addiction? Is it a disease or a syndrome or a psychological process? Is it a metaphorical disease or a real one (and what exactly is the difference)? If it is a disease what are its symptoms? How do its physical, psychological and social factors interact and what is their relative importance?” (Keane, 2002: 10)⁵

Drug dependency, what you refer to as ‘addiction’, is not clear cut. To suggest that it is, is wilfully misleading and feeds into stereotypes and assumptions about people who use drugs that are generalising, denigrating, and belittling.

This leads us on to the topic of stigmatising people who use drugs: you aptly emphasise that “there is a stigma around addiction that prevents progress.” We entirely agree. Yet regarding your choice of terminology, you regularly fall back on stigmatising and pejorative words and phrases during your programme. The word ‘clean’ was used throughout the programme to refer to people who are not currently using drugs. This word perhaps appears to be innocuous to you, and even affirmative in cases where a person desires to cease their drug use, as you have done; however, the use of ‘clean’ suggests that to be a person who use drugs is to be the converse, is to be ‘dirty’. It therefore feeds into widely-held stigmatising assumptions and stereotypes of people who use drugs. Similarly, focussing almost exclusively on people who use drugs who come to the attention of healthcare providers and the authorities – as you have done in your programme – hardly paints a representative picture of people who use drugs: your selective sampling is comparable to suggesting that people who visit A&E for alcohol related problems are indicative of people who drink alcohol generally. As is noted in SSDP’s letter, “while matching the stereotype most viewers were expecting... [the individuals in the programme do] not represent the vast majority of people who use drugs, heroin or otherwise. As a result your programme has acted to perpetuate this stereotype.”

You lament the stigma that can be associated with drug dependency and drug use, and paradoxically describe people who use drugs as (we quote) “sick, fucked people.” Mr Brand, this is

⁵ Keane, H., 2002, *What’s Wrong with Addiction?* (Melbourne: Melbourne University Press)

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hardly leading by example: the terminology that you use feeds into, and is informed by, the grotesque stigma you implausibly claim to abhor. You may wish to identify as being or having been 'sick' (and, indeed, 'fucked'), but to superimpose this vulgar pathologisation onto others and to represent them in this way is presumptive and offensive. Using emotive terms like 'hopeless scenario' to describe people's situation is also hugely disempowering and fatalistic.

You argue in favour of 'pragmatism', and being 'practical' in terms of what works, what is demonstrated to work. But there is not a one-size-fits-all model; different things work for different people. Drug consumption rooms work: the majority of the annual 183,000 drug-related deaths globally are from overdose⁶, and there has not been a single death from overdose in a drug consumption room. They save lives. In addition, you deplore the conditions in which people who use drugs are forced to inject in public spaces, having nowhere hygienic and safe to use their drugs; drug consumption rooms provide just that safe and hygienic environment. Yet you deride the consumption room you visit as a 'well-run crackhouse'. Your arguments are confusingly inconsistent.

Similarly, though you argue for 'pragmatism', you bewail people being 'parked' on methadone, despite the fact that methadone provision and opiate substitution treatment generally are demonstrated to decrease HIV and hepatitis C incidence and can help people to cease using heroin should they so desire. There is already staunch opposition to harm reduction, so that only 10% of people worldwide who require harm reduction have access to these imperative services.⁷ People who inject drugs only receive an average of two needles and syringes per month. Only around 8% receive opiate substitution programmes. Your spouting poorly-informed opposition to these interventions may well serve to worsen an already delicate situation.

Instead of such harm reduction interventions, abstinence and 'recovery' from drug dependency are presented by you as the only legitimate goal of interventions and services for people who use drugs. Is this pragmatic and practical when, as well you know, these are not the only services available for people who use drugs, and are not well-suited to all? Asserting that the goal must be to get people off drugs is short-sighted, dictatorial, and simplistic, superimposing one (your) model onto everybody. In short, it undermines agency and self-determination of people who use drugs to choose when and if they want to use or not use drugs, and how they wish to achieve this. What could be more disempowering than telling somebody that they don't know what their own best interests are?

⁶ UNODC, 2014, *World Drug Report* (Vienna: UNODC)

⁷ Mathers B. M. et al., 2010, HIV prevention, treatment, and care services for people who inject drugs: a systematic review of global, regional, and national coverage. *The Lancet*: DOI:10.1016/S0140-6736(10)60232-2

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This is aside from the fact that people who – to use your preferred term – relapse having been in abstinence-based treatments such as NA (of which you are a staunch supporter) often have not had access to harm reduction information, education, and support through these services. They can therefore use quantities of drugs which they are familiar with using, despite a decrease in tolerance due to abstinence; this thus increases the risk of overdose (especially in the case of opiate use). In addition, as SSDP note, abstinence-based treatment ‘dramatises any small lapse’, creating a sense of abject failure amongst those who have not conformed to the expectation that they cease drug use entirely and permanently. So, not only do you undermine the agency and self-determination of people who use drugs to choose which services suit them, but the services that you advocate actually exacerbate social exclusion and marginalisation for some. Yet again, you feed into that which you lament, advocating *against* nuanced pragmatism.

In conclusion Mr Brand, perhaps you should make your mind up: do you want people to be able to use their drugs in a context that prioritises health and wellbeing, without being socially excluded, or do you want people to use their drugs in dangerous spaces where they have to rush their drug use, increasing the risk of unsafe injecting, needle sharing, infections, harassment, and violence? Do not deride the former if you wish to avoid the latter. Do you wish to emphasise pragmatism and practicality and provide nuanced and variable services that cater to people on their own terms, respecting their agency and self-determination, or do you wish to superimpose your personally preferred abstinence-based treatment on everybody? If you wish for pragmatism, you should perhaps drop the demand for a one-size-fits-all dictatorial and judgemental approach, and adopt a more nuanced perspective. Similarly, you should decide whether you wish to challenge and undermine stigma and discrimination, or whether you wish to contribute to drug-userphobic rhetoric that generalises people who use drugs as pathological, dysfunctional, and marginalised, as ‘sick, fucked people’, as you so offensively put it. If you wish to challenge stigmatisation, we strongly suggest you cease to so enthusiastically contribute to it.

Whilst you may think you are advocating and agitating for progressive change, you actively undermine the validity of harm reduction programmes; if you had your way, though people would not be treated as criminals, they would be treated as sick, deviant, and unable to make decisions about their own wellbeing. They would be forced into the abstinence-based treatment you so fervently favour, for lack of any alternative. There must be space for preferences in addition to yours, Mr Brand. Your worldview leaves little space for harm reduction, nor does it allow for consideration of the vast majority of people who use drugs whose drug use brings with it no problems, who are in no need of any form of intervention, or are in need of intervention that does not sit well with you.

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We do not desire to denigrate or undermine your own experiences of drug use, or of abstinence-based treatment. We do stress, however, that it is at best enormously presumptive to assume that your own experiences and desires are indicative of everybody's. We, a facet of the international drug user rights movement, have consistently affirmed the phrase 'nothing about us without us', and have demanded to be respected as experts on our own lives. We need drug policy reform, but with the inclusion of those for whom such reform applies: the drug using community.

We do not presume to speak for you; do not presume to speak for us. And do not presume to posture as an advocate for drug policy that reduces harm, stigma, and social exclusion when you contribute to these very things.

Sincerely,

INPUD Secretariat
London, UK