TITLE: DRUG USERS, DEMOCRACY AND VOICES FROM THE SUMMIT

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ABSTRACT
Government regulation of activism varies according to the welfare regime type and can be understood as a strategy of social risk management. The discursive location of drug policy concerns in narratives of social dislocation and reintegration resonates with “third way” social capital building strategies, and is perhaps a welcome shift from the muscular rhetoric of “Tough on Drugs”. Public policy can work to either support the building of social capital among drug users or to actively undermine it. The forms of participation in society that are envisioned for drug users under social capital strategies warrant further exploration.

The activities and relationships of the drug policy community which drives Australian drug policy development have been understudied. Considered as an open policy forum on drug related issues, the 2002 South Australian Drug Summit provides a snapshot of this community and its emergent members in action. This paper examines the discursive roles of public and expert voices in constructing “drug use” and “drug users” during this policy building process. Implications for forms of social capital building among the drug-using community and for their participation in democratic life are discussed.
Stimulating voice is an important component of democratic process, speaking powerfully of the desire to bear witness and give testament[1]. Exercising voice as place claiming is a form of social capital building with the potential to foster “subaltern counter publics” that offer broader understandings of citizenship and participation[2]. The intrinsic role of voice in localised action to rebuild social capital is noted by several authors[3-6]; providing scope for insurrectionary forms of participation[7] in democratic life for marginalised groups. Such potential is examined here through a critique of drug user location within the policy building process of the 2002 South Australian Drug Summit.

Discussion begins from the position that current discourse on drugs is nested in the view of pathology through which health, deviance and criminality are understood[8, 9]. In particular, a spectrum of drug use that incorporates illicit drug consumption and intoxication as normalised activities lacks widespread acceptance. Illicit drug users are understood as predisposed to addiction, suffering from cognitive or moral deficit[10, 11] and are problematised in terms of irrationality, abandonment of control or social deviance. Such constructions are not politically innocent[12]; occurring at an historical moment saturated by fears about identity and risk[13-15] and condensing anxieties about the self and the other.

Addiction discourse provides a mechanism for siphoning badness into classes of people who serve as containers for that “badness”[10]. Drug use is conceived of in terms of its epidemic propensities for unsanctioned pleasure, crime or ill-health. In a time beset with uncertainties, the construct of addiction helps to validate a taxonomy of control and excess; justifying strategies of discipline at the unruly margins. The capacity to distinguish self from non-self - the threat of loss of self[11, 16] - justifies strong protective and restorative interventions – the addict is subjected to those techniques of surveillance and rehabilitation reserved for the delinquent and the infirm. Under conditions of epidemic panic[17] even more specific intrusions into people’s lives and demands for their self discipline are sanctioned, with attendant implications for drug users’ participation in civic life[18].
Consideration of drug use as scientific, moral or cultural phenomena generates descriptions of place and impact that deeply affect governance. Contrasting approaches of the World Health Organisation (WHO) and the United Nations Coalition Against Drugs (UNSCAP) indicate that human rights and interdiction jockey for primacy in defining the parameters of effective drug policy. WHO’s influential global charter for Health Promotion envisions marginalised community participation in the development of healthy public policy[19]. Unquestionably drug users have drawn from the WHO framework to resist the forms of regulation proposed by both institutions[20-22]. In doing so they have sought to build capacity and policy dialogue based on understanding and mutual respect. But in the closing decades of the last century we have also seen increasing levels of censure, surveillance and intervention designed to eliminate those forms of drug consumption designated illicit as the War on Drugs has extended its concerns across the globe[23, 24].

Policy community is constituted by the interaction between government and special interest groups in the policy making process[25]. Described as the tangible web of relations that drives the Australian drug policy approach, the activities and relationships of the drug policy community underpinning national and state policy development have been under-studied[25]. A Foucauldian view argues that institutions of science, law, the church and education constitute and are constitutive of privileged capacities to frame discourse[26, 27]. The Australian drug policy community is characterised by complex, longstanding and mostly stable relationships across these domains. However observers have speculated upon the potential impact upon existing language, networks and policy frameworks of community voices that are emerging in that policy arena[25]. The deliberations of the 2002 South Australian Drug Summit offer an interesting snapshot of the drug policy community in action inasmuch as membership that is strongly reflective of hegemonic views engages with emergent voices in a declaredly democratic process[28].

Putnam’s concept of social capital envisages social relations of trust, mutuality, reciprocity and social agency and those resources potentially accessible through participation in social networks[29-31]. This understanding of social capital is evident in the South Australian government’s concern to re-invigorate community, economic
and social fabric through strategies of social inclusion. But social inclusion can be a strategy of normative integration that seeks less to build a bridge of understanding across communities of difference as to draw society’s residual membership into the throng[33] with potential for disempowering effects upon drug users[34-36]. The auspicing of the South Australian Drug Summit by the Government’s Social Inclusion Unit signalled potential for shift away from emphasis on health and law and order concerns towards dislocation and disadvantage as the paradigmatic issues to be addressed by effective drug policy. The Drug Summit was held over 5 days in June 2002. Representatives from Aboriginal and Culturally and Linguistically Diverse Communities, non government organisations young people, drug users and their families, politicians and representatives from key government departments with a stake in drug policy issues were invited to attend[32]. The Summit aimed to establish better understanding of drug issues, consider community views, canvass innovative strategies in a bipartisan forum and build consensus on future directions for drug policy in South Australia. A key priority was the “identification of strategies to re-integrate people excluded from society as a result of drug use”[28].

If government regulation of activism can be understood as a strategy of social risk management[6], personal narrative can be viewed as an incitement to discourse that may serve interests other than those of marginalised groups. Cultural capital is developed through giving voice to identity politics, because however constrained, the latter produces real empowerment[37]. In this sense, experiential voices offer countervocabularies to mainstream discourse. But stories of lived experience also risk exposure to voyeuristic desire to experience spectacle and taboo[38] and openness to forms of observation and regulation that consolidate rather than subvert existing discourses and power arrangements.

Sanctioned use of power is at stake in the legitimation of either institutionalised or experiential knowledge claims[39]. It is therefore important to distinguish between those Drug Summit voices that reflect institutional knowledges and those that might be considered more in terms of democratic outbreak of voice as described by Carson[1]. Canvassed across state politics, biomedicine, criminology, the judiciary, the church and education, institutional speakers in the SA event are consistent with the traditional constituents of the wider Australian drug policy community. Plenary,
questions and comment on proceedings are considered as expressions of public voice. Quotes are delineated as “Speaker”, “Public” or “Chair”. “Speaker” refers to any person providing a formal address to the Summit. “Public” refers to plenary comment or delegate questions and “Chair” indicates the comments of the sessional chair. Experiential knowledge is given discursive space within the speakers’ program and dominates the public plenary process, so attention is paid to what is spoken from the position of lived experience through both mechanisms.

Illicit drug use is often referred to under the more generic banner of *drug use* in the Hansard record of the Drug Summit. From here on in, where the latter term appears in either the edited Hansard transcripts or in my commentary, it refers to illicit drug use only. Some typographical errors appear in the transcripts - where this occurs, correct spelling appears in brackets alongside any error, along with clarifying terms as needed. Names have been altered to protect anonymity.

**DRUG USER CONSTRUCTION IN THE SUMMIT**

Badging this exercise as a “Summit” implied a panoramic command of the policy vista. However the view investigated here was always partial, swayed by authorities of voice and practice that have far-reaching implications for participation of the drug using community in democratic life. The dominant construction of drug users is of *others* in relation to self and society imagined as pristine and boundaried. Drug use occurring *within* borders is leakage to be contained before the entire body politic is deluged by crime, social breakdown and abuse that exist, ever threatening, at the margins.

Adversarial paternalism towards drug use is positioned as commonsense. Drugs are pernicious, pervasive - deeply threatening to the most precious institutions of civilised life. The highest priority is to save children, our greatest resource, from the nightmare consequences of drug use.

[Day 1, Chair (Hon Member 3): 132-133; 144-147]
Drug use and misuse knows no boundaries, no politics, no religion and no discrimination. The threat is universal....Like other parents, I fear what might happen if my kids ever got mixed up with drugs or even took some pills in a nightclub with catastrophic consequences. It is every parent's nightmare.

Reflexive communication is canvassed as critical to the Summit process, but endgame has only one acceptable outcome – victory in the fight against drugs – a battle in which community is positioned as infantry.

[Day 1, Chair (Hon Member 3): 212-225]
I want everyone here-police, judges, health and welfare experts, parents, carers and (here is the key) young people themselves-to help us in the fight against drugs. The public, too, must have their say, because it is their state and their children-these are our children.....to win the fight against drugs we must dig deeper into the very core of our communities, drawing strength from each other as we organise against the dealer and the pusher.

Concurrent epidemics of drug use, drug-related crime and violence are described by expert speakers.

[Day 2, Speaker (Sidney): 558-560]
We need to keep our eye on that ball (heroin use).. and this great explosion in the use of amphetamine-type substances.

[Day 3, Speaker (Jeff): 443-453]
...If your house gets broken into it will be broken into by a child or by somebody who is trying to get your DVD to take down to Cash Converters to sell it to get another cap of heroin. It did not matter what we did. We used to put them on bonds; we used to put them on suspended sentences. Eventually, we’d lock them up and, lo and behold, a few months later they would be back having broken into someone else’s house.

[Day 1, Speaker (Dr. Hammond): 1039-1043]
Violent behaviour is an increasing consequence of methylamphetamine use.... (that) needs to be thought about in terms of the health, welfare and social agencies that are
likely to be in contact with these people, as well as our law enforcement agencies that may have to deal with people who go into unprovoked rage without appearing to have been provoked.

Institutional voice struggles with concepts of drug use that are not inherently dysfunctional. No description is posited in the definitional space without reference to some form of warning about inherent weaknesses or danger – in our psyche, or in the drugs themselves.

[Day 2: Speaker (Professor Janz): 1502-1504]
People who develop problematic drug use have vulnerabilities in a range of areas and it may well be things about life possibilities, employment opportunities, economic disadvantage and social disadvantage.

Addiction as predator roams unchecked, threatening the fabric of civilisation. Rationality, productivity, responsibility and self-discipline – the prized virtues of neo-liberal citizenry - are at risk [40].

[Day 3, Speaker (Arch): 1998-2001]
Problems never travel alone: they hunt in packs. Loss of control often includes violence, crime, various health risks, creation of danger for self and others.... Financial costs of use and addiction mean financial problems, unemployment, housing problems.

Users are viewed with contempt for failing to 'face the real world' without the use of drugs[41]. By contrast to be drug free is to be authentically “grown up”, responsible and resilient.

[Day 4, Speaker (Reverend Peters): 530-535]
The age at which you start heavy drug use is the age at which you stop growing emotionally.10 years on, people who may have done a detox and they're going okay but they're still often a 17 year old emotionally because they started to use drugs to deal with the sort of knocks and criticisms and disappointments that you and I-everyone-faces each day.
“Social Inclusion” signals a fresh policy response to drug issues in South Australia. Yet that initiative’s most influential speaker locates drug use in a sub-culture of malfeasance to be literally “tackled” by new policy directions that are yet innovative and inclusive.

[Day 1, Speaker (Father Edwards): 428-431; 510-512]
I was manipulated, lied to and completely conned. Despite many years’ experience as a counsellor, I was ill-equipped to deal with the culture of deceit. In the struggle of these two people with their addiction, I witnessed fractured relationships, failed study, unstable employment and unsuccessful attempts at treatment programs…We want to ensure that this summit will be seen in the years ahead as a turning point in tackling our drug culture, of offering lifelines of support to people in this culture and ways of helping young people handle the culture without being victims of it.

Drug use as causative and expressive of a sub-culture of trickery signifies spiritual lack, loss of meaning and a failure of modern values.

[Day 4, Speaker (Reverend Peters): 621-623; 641-642]
one of the sad things about the loss of spiritual connection is also the loss of the rite of passage, where we tell stories that are big-transcendent stories about meaning, significance and belonging, rather than winner/loser stories or wealth to happiness stories…we need some alternative rites of passage-those that aren't simply negative and self-obsessive-to fill the vacuum.

[Day 3, Speaker (Jeff): 473-477]
We are dealing with people who…have habits of dishonesty which go back decades, and they have drug-taking habits, which sometimes go back decades. So they are pretty tough customers.

A community perceiving itself to be threatened tends to define ‘self’ within boundaries and ‘other’ as outside of those boundaries, proceeding to police and regulate
movement across those borders[42]. Crime and disease panic find resonance with desires to eradicate drug use from community spaces.

[Day 4, Public (Mary): 1186-1190]

Children who see these (needle and syringe disposal) containers ask their mums, 'What's this for?' and they say, 'It's for drug users to put their needles in, dear'. What is this saying to our children? It's saying that interjecting (injecting) drugs is a normal part of our society, it's just a given. What we are doing is normalising what is a very dangerous practice. Injecting pure water, just the act of injecting, is dangerous.

Institutional voice is publicly echoed in fears about normalising drug use, of letting it across the line in the sand. At stake? The safety and well-being of our children.

[Day 3, Public (Pastor Street); 2844-2847]

A group of elders drew a line in the sand and said, 'That's enough. We're going to make sure our children live.' We've got a group of elders in this room, and we need to start drawing some lines in the sand and start to see that our children live.

Ex-drug user and affected family testimonies dominate the spaces given to experiential voice. Three of the four drug users participating in the speakers program identify as addicts in recovery. Reified as addict, the drug user is damaging to self, to loved ones and if not damaging to society, then an active drain on its resources. Loss of selfhood, dysfunction and fall from grace are confirmed in narratives that hold the possibility of restored community goodwill through redemptive acts.

[Day 2, Speaker (William): 2858-2859; 2861-2864]

The coach promised us a bottle of beer every time we won a game... By the end of the season we retired from the football and we went into drugs and other things, and that was the next step. After becoming an alcoholic, I ended up on the wrong side of the road and, out of the past 24 years, I spent 14 of those in prison. I spent 12 of those on heroin..
To gaze upon the spectacle of the other re-affirms safe distance from forms of contamination that might threaten an anxious self[11]. Confessional tone exposes the addict’s story to prurient gaze, to confirmation of deficit and victimhood that has been identified as a serious barrier to effective activism in marginal communities[7]. Plenary testimonials affirm the patheticised narratives of addiction.

[Day 3: Public (Adele): 2658-2667]

*My daughter and her husband have been intravenous drug users for many years and they have been on the methadone program for 10 years. They both have hepatitis C...My son-in-law is dying of cancer. He has melanoma and brain tumours, and he has about two months to live, at the most. He ignored all the signals and never sought medical attention until it was too late. My daughter does not have a future.*

Narratives of redemption are perfectly suited to social capital envisaged as normative integration – being welcomed back into the community fold is about cessation of drug dependence, productive life, and service to others. Through reinscription as an identity of purpose and utility the *reformed addict* receives another chance.

[Day 2, Speaker (Bridget): 2481-2486]

*(I didn’t) think, with the level of anxiety and depression that I used to experience, that I’d actually be able to function in the world. Even walking into a supermarket was hard. I guess I’m extremely grateful to the Woolshed because I’d rediscovered some dreams I’d had since I was a child. I am currently halfway through my degree at university and undertaking something that I’d always wanted to do but wasn’t able to do because of where I was at.*

[Day 4, Public (Julie): 852-854]

*I would like to say that I was a using addict for over 20 years of my life. I have been clean for nearly six years now. I have an undergraduate degree and I am about to do my postgraduate degree next year.*

Summit affirmation of addicts *in recovery* happens from the podium. Similar tributes towards speakers with alternative views of drug use are not forthcoming.
Q26: I work with the Aboriginal Sobriety Group. I have been sober for 30 years and that is total abstinence, so am I a failure?

A26 (Chair) No, you are a great success. What a good note on which to rock off to morning tea.

Inability to engage in unsettling the boundaries of cultural containment[37] is unsurprising, noting that the risk attached to user exposure is flagged very early.

I think it is very brave of them to come forward and face this conference. I am not sure, if I was a drug user, that I would be as brave as they were, and I congratulate them for coming forward and giving us an insight.

Polyphonic voice represents drugs as part of human practice and culture, with the potential for controlled and beneficial use. Rationales that do not operate from a model of social or personal deficit refute negative portraits of drugs and users. In representing drug use as integrated part of human existence rather than setting it outside as an external force these voices offer a more complex positioning than that of threat, with very different sets of policy questions attached. They create resistant space in relentlessly pathologised terrain.

My dreamings for the orientation of drugs in my world would be that people are healed emotionally, mentally, spiritually and physically with them; people have enriching experiences with them; people's legal standing, sense of self-worth and dreams for the future are not sacrificed through drug use or through attitudes to drug users; people are not put in danger, deprived or merchandised through drug use.

Human beings have this pervasive capacity to be intoxicated. There are lots of different forms of intoxication. There are religious ecstasies, whilst someone can be intoxicated with money, and someone else can be intoxicated with all the agonies and
ecstasies of sport…drugs are sort of a modern technology for inducing these intoxicated states.

Interchangeable use of terms capturing degree of drug consumption inevitably collapses the spectrum into description of drug use that has become problematic for individuals. Voices that contradict or seek to clarify these understandings are heard less frequently than those that amplify existing panic. For example the commonsense linkage between drug use and crime is rarely questioned. But here readings of complexity within a proscribed marketplace surface in the talk of both the eminent criminologist and the drug user organisation representative. Both provide advice that contrasts sharply with the packaging of causality and effect by other institutional perspectives.

[Day 3, Speaker (Dr Green): 260-263]
So, it is not as if people start taking drugs, become dependent and then start doing burglaries and robberies to feed the habit. The data show that they were doing the criminal act, the illicit activities, before their first drug use and certainly before they became dependent.

[Day1, Public (Audrey): 1881-1883]
I believe that (the nature of the drug problem). is actually directly related to making distinctions between 'licit' and 'illicit' drugs. These distinctions put people in situations where they are committing crimes every time they use their drug of choice.

If, in the welter of discussion about drug users few offer a resistant view, much less is revealed from declared identities as current drug users.

Where user voice is heard, representation is of legitimate citizenry excluded from its rightful place in the drug debate that is unfolding.

[Day 1 Public (Sean): 1729-1732]
I represent HEMP SA\(^1\) and, as well as that, some of the estimated 476 000 South Australians who at some time during their life have tried cannabis. That is about half the population of the City of Adelaide.

[Day 2, Public (Nomad): 1552-1553]
you can go out and buy yourself 20 doses of alcohol, take it home, do whatever you do and you will incur no penalty. You can go out and buy two-fifths of a tablespoon of white powder drugs and be locked up for five to eight years of hard labour.

[Day 2, Speaker (Jackie): 2818-2823]
Users are mothers, fathers, sisters, brothers, grandfathers and grandmothers. We hold down jobs, we look after children, we are trainees and we are professionals. We are active participants in society. We are not all dependent on drugs and we are not all addicts. We are not all drop kicks who lie and are thieves. Some of us do have problems with drugs and issues that surround drug use, but a lot of us don't…

Drug users are object rather than subject of deliberations, interpellated from perspectives of parents, service providers, and policy makers. The drug user as family, health, law and order problem to be managed is repeatedly affirmed as the target for correction on every level. Responses to consumption, drug-related crime or risks of both require escalation of technologies across the prevention and treatment spectrum and even greater intervention into the lives of drug users.

[Day 3, Speaker (Dr Hammond): 340-344]
...those who present for treatment often present (too) late...Police often come into contact with people much earlier in their drug using career and it represents a real opportunity to prevent that history of ongoing use.

[Day 2, Speaker (June): 2559-2562]
But we need more. We need far more rehabilitation services and we need far more agreement on the level of treatment....recovery has very many levels to it until you can expect a person to reach abstinence.

\(^1\) Help End Marijuana Prohibition
Explanations of socially inclusive practice are of interest. The descriptions provided to the Summit can be read as strategies of normative integration and border patrol.

[Day 4, Speaker (Tim): 82-84]

*Different forms of social capital have been identified; for example, the tight bonds of family kinship and close peer groups compared to bridges to members of other groups, especially those with significant resources or influence.*

The *Granny* is the tightest of those bonds envisaged in the government’s rendering of social capital. Emblematic of the ties that bind, she is the front line in managing drug-related harm.

[Day 3: Speaker (Rhonda): 2204-2207 & 2247-2248]

*Becoming the main caregiver for your grandchildren is no easy task especially if you’re an oldie and in poor health, but you know that your priority is to keep the children together. When I turned 60 years old, I expected to put my feet up and enjoy my old age. Instead of getting a time of rest, you have to look after little ones. I wanted a Jason Recliner didn’t I?… Like I say, help the oldies. Keep us from dying; there’s only a few of us left.*

Throughout the Summit process drug users are unconceptualised as a civic entity (whilst possessed of a discrete sub-culture) There is no recognition of community, capacity or positive identity.

[Day 4, Speaker (Tim): 82-89]

*Lack of social capital, therefore, severely restricts an individual's capacity to join or to be reconnected to a community. Few networks, low trust and little shared value limits opportunities for participation and attachment to a community. In the language of drug programs, high social capital is a protector factor, while low social capital is a risk factor.*
There is no place for current users in the drug-free spaces of high social capital communities. Individualised within technologies of surveillance and correction, users are to be managed on every street.

[Day 2, Public (Eve): 1662-1665]

two or three people in every street in every suburb in every city and in every smallest country town who will know at least basic first aid techniques to help their family, friends and neighbours to address their drug related distress at the earliest appearance of a drug problem, particularly in melodramatic behaviour, that is, in extreme role plays—extreme heroes, extreme villains, extreme comedians and people generally who exhibit an extreme state.

Social inclusion becomes the mutant child of Narcotics Anonymous, Neighbourhood Watch and “Tidy Town”.

[Day 4 Speaker (Tim): 159-160 & 164-166]

recently, a hard rubbish collection was organised by local residents... It doesn't sound much, but it's a great beginning. As the community becomes more confident, then maybe one day they will tackle bigger issues and maybe one day they may even decide to tackle the local drug scene.

In “doing” social inclusion participation is understood very differently from drug user and anti-drug perspectives.

[Day 2, Public (Brian): 1745-1750]

adopt the Nike approach, and that is 'just do it'. People in the community should just get out there and do it...The Reverend Ted Noffs back in Wayside Chapel in the late 1970s in Kings Cross, was confronted with drug addicts and all those issues outside his chapel. He was there baptising kids and so he decided to do something about it.

This description of drug users’ engagement in what might otherwise be considered as a high capital building venture describes 15 years of partnership between government, biomedicine and injecting drug users in running needle and syringe programs. Starkly observable here is how users are conceptualised as legitimately and inextricably
linked to the venture’s success; reflecting that mutuality, reciprocity and agency so essential to community.

[Day 4, Public (Nomad): 1201-1233]

….Countries that don’t have adequate clean needle programs have AIDS… decimating their marginalised communities…. The reason we don’t have that here is the courage of our leaders in the late 1980s and 1990s to implement harm minimisation programs, including needle exchange. If we were to forget to maintain our vigilance against it, it would not just be hepatitis C that we would have to worry about; AIDS is still there and it could still destroy this country and the lives of millions and millions of people. I caution you not to go down the path of lowering the fence and letting this stuff in….we need more resources, more needle exchange, not less.

In this (rare) positioning in the summit process the enemy of the people is a virus not a drug or a drug user, and resources must be linked to defeat it. While philosophically problematic from the “border anxiety” perspective, with potential to exclude people living with HIV and HCV for being on the side of the viral[27], there’s greater scope for participation of drug users in community building processes than indicated by other narratives.

DISCUSSION

Institutional social “inclusion” posits a re-integrative model that repels illicit drug use as pathological practice from healthy and strong communities and mandates a series of corrective practices to compel drug users to behave in a more orderly fashion. Individual drug users are identified as targets for health, social and juridical intervention in the dominant discourse of the Summit. Even polyphonic voice, when positioned from the institution, tends towards tropes of dependence and weakness and a need for assistance that justifies continued intervention. Reckoning of users as citizens exercising their intrinsic right to use drugs is rare, and never occurs from the position of expert speaker. Resistant voices argue for rethinking of drug use as part of human culture, for better understanding of equity issues. If resistant statements are
under-represented through the Summit process, then voices of those speaking in directly oppositional terms to the prevailing discourses are completely marginalised.

Existing concerns that public policy can work to actively undermine the building of social capital among drug users are supported here - normative integration as a form of social capital building is ultimately disempowering for the user community. As such I argue for caution against uncritical embracement of Putnam’s theory of social capital as a socially just and inclusive approach to drug use. Deployed in that form, at this juncture in the Australian drug policy building process, his theories may have limited utility in achieving more democratic forms of participation by drug users in civic life.

References


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