

Oberlin

Digital Commons at Oberlin

Honors Papers

Student Work

2013

Drug Markets and the State: A Perspective from Political Economy

Jake M. Kosinski
Oberlin College

Follow this and additional works at: <https://digitalcommons.oberlin.edu/honors>



Part of the [Political Science Commons](#)

Repository Citation

Kosinski, Jake M., "Drug Markets and the State: A Perspective from Political Economy" (2013). *Honors Papers*. 327.

<https://digitalcommons.oberlin.edu/honors/327>

This Thesis is brought to you for free and open access by the Student Work at Digital Commons at Oberlin. It has been accepted for inclusion in Honors Papers by an authorized administrator of Digital Commons at Oberlin. For more information, please contact megan.mitchell@oberlin.edu.

Jake Kosinski

Honors Politics

Feb. 28, 2013

Drug Markets and the State: A Perspective from Political Economy

I. Introduction

The initial idea for this project was to provide a conceptual basis for studying state regulation of drugs without accepting the state's internal justifications, categories, and rhetoric. The concept occupies a middle ground between theory and comparative studies; it is meant to be inherently critical of the ways drugs are framed in current policy debate without losing an awareness of and a connection to the subtleties of real policy. Two approaches to the political economy of drugs underlie the structure of the project.

The first was to study drug regulation as a subfield of economic governance through the lens of comparative political economy. Weber's analysis of bureaucratic power, David Harvey's concept of the postmodern economy, and Hall and Soskice's work on Varieties of Capitalism provided the basic concept for the ideal types as well as the focus on material incentives, interactions with markets, and the effects of early decisions on later institutional arrangements. The second approach was to deconstruct drug policy by drawing attention to how it has been used as a tool of coercion by certain groups to gain or maintain political & economic domination. Represented here by David Lenson, Stuart Hall, Caroline Jean Acker, and Dale Pendell, this approach necessarily engages with rhetoric and culture in an attempt to expose the ideologies lying beneath benign concepts like "sobriety", "Drug-free", "normal", and "productive". The connections that historical scholarship on drug regulation has unearthed – to unabashed Eurocentrism, unreformed racism, misogyny,

homophobia, colonialism, suppression of indigenous peoples, eugenics, neo-colonialism – are ugly to look in the face.

All wars leave scars, especially civil wars, and drug wars are no different. Social healing can only begin with understanding. Understanding is difficult to achieve when those in authority distrust the public and reject rational, open debate on the grounds that it is too dangerous, too complicated, too important a decision to leave to the masses. It is time to have an open conversation about drug policy in the West, and to re-establish the bureaucracy as servants of the people, not their distant rulers. This paper does not advocate for any particular institutional arrangement, because there is no perfect regulatory solution for any market. Drugs, used in the wrong way, can cause undeniable harm, and the right policy will always depend on the larger social context. It seems appropriate, here, to reflect on the millions incarcerated worldwide for simple possession, and the simple standard that the most humane President of the second half of the 20th century would have had us follow:

“Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed”¹

This is a simple goal. It is a rational goal. It was achievable in 1977 and it is achievable today. All that stands in the way are those who have found ways to prosper by exacerbating the excesses of a perverse and dysfunctional system. Whatever drug policies are followed in the future, they should be logically coherent, intellectually honest, and socially aware.

¹ Jimmy Carter, "Drug Abuse Message to the Congress", August 2, 1977

II. Theorizing the Drug Regulation State

A. Governing the Drugs Economy

1. Why Regulation?

Over half a century ago, the Single Convention on Narcotic Drugs aimed to consolidate and standardize across national borders an agreed-upon list of illegal psychoactive drugs that would only be tolerated for “medical and scientific purposes”. This treaty, which “forms the basis of the global drug control regime as it exists today” and established the regulatory International Narcotics Control Bureau (INCB), was supposed to bring about a convergence and a consensus in the industrialized world about the best way to handle drug use and addiction². The list of illegal drugs *is* now roughly the same all across the world, but the types and intensity of enforcement continues to vary dramatically between countries, provinces, and even individual cities. These laws are interpreted and enforced by a dizzying array of organizations throughout the world: law enforcement agencies, courts, health bureaucracies, institutes of health, and many others. A long history of work in comparative politics has sought to reveal the tools and institutions that allow the state to regulate and govern the economy to some greater or lesser extent. The tools used to manage the drugs economy are fundamentally the same.

The modern state has several compelling interests in the drugs economy that predispose it to intervention in the drugs economy rather than *laissez-faire*. First, the modern state requires adequate supplies of certain drugs for medicine and warfare, and

² New York City Bar, “The International Drug Control Treaties: Just How Important Are They to US Drug Reform?”, report for Committee on Drugs & the Law (New York: NYC Bar Association, May 2012).

thus benefits from a strong domestic drugs industry with a close relationship to the state. Second, indiscriminate drug use could potentially harm economic productivity, public order, or public health, things for which the modern state takes general responsibility. Third and finally, the drugs economy is and has always been a significant part of the global economy, and state actors (whether individuals or institutions) can increase their power substantially by acquiring jurisdiction in this area. The bundle of agencies responsible for drawing the line between the drug economy and the legitimate economy and taking the necessary steps to enforce that line form a distinctive (if not always coherent) institutional arrangement that this paper will refer to as the Drug Regulation State.

2. Defining Types for the Drug Regulation State

The different forms of the drug regulation state can be captured in four types. Two of the types, Drug War and Harm Reduction, are dominant in the industrialized world for non-cultural psychoactive drugs. Decriminalization is a reform model that has gained support amongst US states and Latin American countries as criticism of Drug War hegemony has increased. Legal Market, while rarely viewed as an acceptable policy towards heroin, cocaine, or even marijuana, is the global default policy for alcohol, caffeine, and tobacco, as well as hundreds of “herbal” substances and most pharmaceuticals. The globalized consumer markets for alcohol and tobacco, as well as pharmaceuticals available only with prescription and government monopolies on substances (like alcohol in Scandinavia, or tobacco in China), can all be viewed as more or less restrictive variants of the Legal Market.

Types for the Drug Regulation State*	Drug use unofficially or officially sanctioned (non-normative drug policy)	Drug use is condemned and discouraged (normative drug policy)
Low intensity of punishment, focus on demand reduction	Decriminalization (Social compromise/gray market)	Harm reduction (Extension of the welfare state, focus on public health)
High intensity of punishment, focus on supply control or reduction	Legal Market/Government Monopoly (Ranging from consumer goods to prescription drugs)	Drug War (Reliance on law enforcement and incarceration)

***Can vary significantly (intra-state) depending on particular substance involved**

Because of the importance of historical institutions and jurisdictions, the mode of regulation, within the same country or even the same regulatory agency, can vary depending on substance. Many countries show some evidence of all the types in arrangements something like this: Harm Reduction for severe opioid and sedative addicts, some amount of Decriminalization for cannabis, Drug War for most other illicit substances, and a Legal Market or a Government Monopoly for alcohol and tobacco. The two axes, which distinguish the four types, are *normativity* and *punitive intensity*. Note that the drug regulation state has much less control over the likelihood of punishment (which is everywhere determined by the tactics, resources, and strategy of local enforcement) than

over the type and degree of punishment for those caught³. High intensity of punishment aims to curb supply; draconian penalties are intended both to deter involvement in the illicit drugs economy (through escalating punishments for higher levels of involvement) and disrupt supply directly by neutralizing supplier networks and destroying as much product as possible. Low intensity of punishment allow for more frequent, less coercive contact with user populations, which in turn allows an expansion of demand reduction efforts like education, substitution, & treatment of co-morbidities. Legal Market is strict with those who break market laws and norms, which can be easily enforced because of the market's visibility. Government Monopoly is liable to deal strictly with any nascent gray market or apprehended competitors, since their activities can threaten the legitimacy of these markets and the tax revenue they generate. In any case where intensity of punishment is high without corresponding attention to social inequalities, the impact of enforcement will fall disproportionately on the working class, the unemployed, and social or political Others. People lacking in basic resources or subject to discrimination are less able to reduce the risks of their drug use and the drug use around them, more likely to be approached and searched by law enforcement, and much less able to defend themselves against state prosecution.

Normativity is harder to define, as it involves not just policy and institutions but also rhetoric, culture, and society. A highly normative drugs policy seeks to mobilize social condemnation for drug use, reduce the public visibility of drug use, and change the habits of drug users through more or less coercive means. A less normative or non-normative

³ David Rasmussen and Bruce Benson, *The Economic Anatomy of a Drug War* (Lanham, Maryland: Rowland & Littlefield, 1994) 6

drugs policy does not commit the power of the state to changing personal habits, or systematically mark drug users as distinct from law-abiding citizens. If normativity is completely absent, then production and consumption of the drug is not differentiated from production and consumption of other economic goods. Drugs can be potent symbols of the cultural Other and the foreign, but they can also evoke fears of change within the dominant culture itself. When drug use is “constructed as so deviant as to seem utterly incompatible with conventional roles”, then the possibility that “one might encounter an addict...and fail to recognize him or her” becomes a frightening threat to personal safety and national security⁴. The construction of drug normativity, like other categories of social deviance, references and implies a social consensus or a dominant culture that may be entirely ideological. It is an especially malleable normative standard since “ “sobriety” like “freedom”, is an empty concept, a null set defined only by what surrounds it, by its various negations”⁵. During times of political uncertainty, “the depiction of a unified anticulture” can “have the effect of creating the appearance of a unified legitimate culture where there is none”⁶.

A highly normative drugs policy is therefore especially likely when politically salient identities – race, class, political affiliation, sexuality – are threatened, or in a process of change. “Drug prohibitions often represent the restatement of threatened ethnic boundaries...substances are condemned at least in part because of their association with a particular ethnic or racial group, and striking at the substance in question is a means of

⁴ Caroline Jean Acker, *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control* (Baltimore & London: Johns Hopkins University Press, 2002) 186

⁵ David Lenson, *On Drugs* (Minneapolis, MN: University of Minnesota Press, 1995) 14

⁶ Lenson, *On Drugs*, 16

stigmatizing that particular group”⁷. Strict drug norms can also be emphasized in a time when other “invisible”, deviant identities are feared and hunted. For example,

“[in] the 1950s, drug addiction and homosexuality had replaced prostitution as symbolically charged forms of deviance...addiction and homosexuality were both conditions that could be hidden...the parallel to communism at a time when Americans were being alerted to suspect co-workers in the State Department, in the labor unions, and in Hollywood studios was not merely implicit; Narcotics Commissioner Harry Anslinger argued forcefully in congressional hearings and the press that the Chinese communists were smuggling heroin into the United States in order to soften up the population in preparation for a takeover”⁸.

Normativity, unlike punishment, can wax and wane without explicit policy reform, but it is not a cultural variable independent of the drug regulation state’s influence. It encompasses the types of drug-related behavior that the drug regulation state sanctions as norms and conveys to civil society through its policies and actions, and the ways the drug regulation state enlists civil institutions, cultural identities, and rhetorical scripts in the maintenance of these norms.

The ideal types are thus *not* national models, or a categorization scheme for countries, but instead emphasize how diverse organizations, programs, and procedures become a national drugs policy, and how state practice in this area is “bound together by an idea, namely, the belief in the actual or normative validity of rules and of the authority-relationships of some human beings toward others”⁹. In order to balance this complexity, one might specify a dominant or hegemonic mode even when practice is diverse, especially when one regulatory type provides the political and cultural frame for the evaluation of

⁷ Phillip Jenkins, *Synthetic Panics: The Symbolic Politics of Designer Drugs* (New York & London: NYU University Press, 1999) 13

⁸ Acker, *Creating the American Junkie*, 185-186

⁹ Max Weber, *Sociological Writings* ed. Wolf Heydebrand (New York, NY: The Continuum Publishing Company, 1999) 272

novel substances and use patterns. No regulatory state, not even the most prototypical, would unambiguously fit a single type. Even small European states with Harm Reduction dominance participate in interdiction of major drug trafficking, and some of the most radical experiments in Decriminalization have happened in otherwise harsh Drug War states. The “conceptual purity” of these ideal types will allow an appreciation both for the international and historical diversity of “concrete cultural phenomena in their interdependence” relating to drugs policy formation while still emphasizing the major divergences in the field which have sharpened in the past few years¹⁰. The US, classified by this scheme, would look something like this:

Drug War dominance

Legal Market: alcohol, tobacco, common pharmaceuticals

Legal Market (Rx restricted): certain psychoactive pharmaceuticals

Decriminalization: marijuana (limited, varies by state)

Harm Reduction: opioids (limited, varies by state)

Drug War: dozens of Schedule I & II substances

3. Bureaucracy vs. Democracy?

The drug regulation state is a concept broad enough to incorporate all the “system[s] of laws, regulatory measures, courses of action, and funding priorities concerning (illicit) psychoactive drugs and promulgated by a governmental entity or its

¹⁰ Weber, *Sociological Writings*, 264-65

representatives”¹¹. Here it will be defined by a slight modification of the Weberian definition: if the state is the organization that claims a monopoly on the legitimate use of violence, then the drug regulation state is the organization which claims a monopoly on the determination of the legitimate use of drugs, and the means (violent or otherwise) by which to enforce this determination. Drug states in the industrialized world have through advancing strategies of bureaucratic dominance often gained a functional independence from the normal political process that would be unimaginable in other areas of policy. The US Attorney General was granted the power to emergency schedule substances in 1984 and subsequently ceded that power to the administrator of the Drug Enforcement Agency¹². Since the DEA is also a federal law enforcement agency allowed post-1984 to “seize any property allegedly used in connection with the narcotics trade”, the American federal drug state can, without consulting Congress, the President, or the court system, create laws, imprison citizens on the basis of those laws, and fund its own operations with those citizens’ confiscated property.

Comprehensive bureaucratic domination and the almost total exclusion of elected bodies from drug policy is the strongest power position a drug regulation state can hope to attain. While few other drug states have this level of power and independence, many of them attempt to exclude drug scheduling from the normal political process and emphasize the primacy of bureaucratic determination and international law over democratic will and social change. Democracy in particular, because it insists on “universal accessibility of

¹¹ Maria Moreira, Brendan Hughes, Claudia Costa Storti, and Frank Zobel, “Drug policy profiles: Portugal” in *EMCDDA Drug policy profiles* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction, June 2011) 7 (adapted from Kilpatrick, 2000)

¹² Jenkins, *Synthetic Panics*, 80-89

office” and “the prevention of...a closed “status group of officials”, “inevitably comes into contact with the general tendencies of bureaucratization”¹³. The drug regulation state, in one form or another, may be indispensable for industrial society; but the powers invested in and monopolized by the drug regulation state, insofar as it comes to function *independently of elected officials and the normal political process*, become powers held *against* the political community and in the truest sense a diminishment of democratic sovereignty.

An historical institutionalism perspective can show how the early development of the drug state bureaucracy constrained the options of policymakers later on. These constraints are particularly heavy because drug policy is a field in which technical and insider concerns have always been able to dominate public opinion and the democratic process. Apologists for the Obama administration have suggested that the President may desire reform, but that his hands are tied by the drug control treaties the United States engineered and ratified under earlier Presidents. But those “baffled” by the Obama administration’s continuation and even intensification of its predecessors’ policies should look not primarily at international relations and the binding nature of the drug treaties the US is signatory to, but at the still massive power of the drug bureaucracy to delay or kill reform legislation at the federal level and manipulate media coverage of drug policy debate¹⁴. The story of the drug war state is at times a story of ignorance and prejudice and at other times a story of genuine concern for public health, but whatever else it is, at heart it is a story of creeping bureaucratic domination and its costs. The inability or

¹³ Weber, *Sociological Writings*, 89

¹⁴ NYC Bar, “The International Drug Control Treaties”, 1

unwillingness of the Obama Administration to confront the DEA carries echoes of Weber's early warnings about public leaders and bureaucracies:

"in every case the "ruler" will always find himself in the position of "dilettante" vis-a-vis the "expert" officials trained in the operation of the administration...[and] it is the tendency of the bureaucratic administration to always exclude the public and, as far as possible, conceal its knowledge and actions from criticism"¹⁵.

On the other hand, it is too easy to mythologize the "power position of the fully developed bureaucracy", and drug policy is also a field that brings into stark relief the limits of authority and the difficulty of enforcing obedience¹⁶. By almost any measure, the period of militarized drug enforcement in America since 1982 has had few positive effects and many detrimental ones, but drug enforcement bureaucratic resources have continually grown regardless. In 2004, former Interpol chief Raymond Kendall excoriated "[p]olicies based solely on criminal sanctions:

Economic corruption increases, organised crime prospers and developing economies are hard hit by military and environmental (crop eradication) interventions that have no apparent positive effect...There is therefore an urgent need for a multi-dimensional and integrated approach...which also integrates harm reduction strategies designed to protect the health of the individual drug user as well as the well-being of society as a whole"¹⁷.

An analysis of bureaucratic power in the Drug War type, in particular, needs to demonstrate how "a policy can fail completely while at the same time entrepreneurial bureaucrats expand their reputations and end up being better off"¹⁸. The desired outcomes

¹⁵ Weber, *Sociological Writings*, 96

¹⁶ *Ibid.* 96

¹⁷ Marcus Whiting and Susanne MacGregor, "The development of European drug policy and the place of harm reduction within this" in *Harm reduction: evidence, impacts and challenges* (Lisbon: EMCDDA, April 2010) 71 (from *Le Monde* 26 October 2004)

¹⁸ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 131

for a government bureaucracy (insulation from the normal political process and steady increases in funding) may not be desirable outcomes from a broader social perspective.

All drug regulation states are also highly vulnerable to corruption, determined by the degree to which that state has the power to materially affect the drug economy (by shutting down suppliers, seizing imports, economic or legal penalties for users, etc.). It is almost undisputed that the “illicit drug market is probably the most lucrative source of police corruption that has ever existed”, and that corruption in many drug states is “pandemic... the more officials hired for...suppression work, the more are bribed, or worse, become distributors themselves”¹⁹. In the language of economics,

“when...government has modified a rights structure to prevent a competitive market and has, consequently, created *incentives* for an illegal market to arise...public officials have a valuable “asset” that may be sold. They can allow certain individuals or groups to operate illegally while harassing other potential market participants...in effect they can sell monopoly rights to a private-sector underground market and then enforce that rights allocation”²⁰.

The ramping up of US drug enforcement during the 1980s was accompanied by a “fourfold increase in convictions of federal officials for corruption – from 115 in 1979 to 529 in 1988”²¹. Oversight mechanisms and institutional design may mitigate the tendency towards corruption, but even if frank corruption could be perfectly prevented, the drug regulation state would still be tempted to in general use its powers in the furtherance of established economic and political forces. It can easily become a profoundly conservative institution voraciously opposed to liberalization and reform, as these threaten to shrink its

¹⁹ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 116

²⁰ *Ibid*, 108

²¹ *Ibid*, 116

purview considerably and reduce the value of its main power resource - the power to allocate market rights in a highly lucrative and competitive sector of the modern economy.

This analysis will emphasize first the limited nature of government resources and how different bureaucracies compete amongst each other for jurisdiction and funding, and second the factors which might motivate the bureaucracy to maintain a punitive drugs policy even in the face of unintended consequences, unfriendly evidence and social protest. In a world of increasingly complex biological and chemical sciences, the ability of law enforcement bureaucrats to govern the drugs economy is increasingly threatened. Finally, this analysis needs to explain why some bureaucracies don't push for draconian drugs policies and instead remain in a limited or subservient role, and identify social, economic, and political factors which militate towards either Drug War, Harm Reduction or Decriminalization in industrialized and industrializing countries. The types must be developed so that strands of each can be seen in every country's, but they must also be analyzed as ideological narratives which in their advanced stages seek to consolidate their position in the drug regulation state and exclude the alternatives to the greatest extent possible. While punitive drug laws have existed for centuries, states did not have the capacity or willingness to implement harsh zero-tolerance policies until the 1970s and '80s. The Drug War type is a recent political creation, consciously constructed as an end to the liberalization of drug use that occurred in the 1960s and '70s. While precursors to Harm Reduction and Decriminalization can be found throughout the 19th and 20th centuries, their emergence as more comprehensive types has only occurred in recent decades as part of the search for alternatives to Drug War.

B. Distinguishing Between the Ideal Types

1. Drug War State

Drug War as an ideal type is distinguished by the dominant role of law enforcement, paramilitary, or military organizations in policy and administration. There is ample evidence in the American case that “the organized force of law enforcement bureaucrats was a major source of demand for the initial criminalization of illegal drugs”²². The first prerequisite for any drug state is a functioning national bureaucracy, and in 20th century America, “the democratization of society in its totality in the modern sense of the word [was] indeed an especially favorable...basis for instances of bureaucratization”²³. These factors, however, are not sufficient in and of themselves, or every country with a military and a bureaucracy would still be Drug War dominant. The leap from passive prohibition to aggressive drug enforcement is a substantial one, and is part of what distinguishes Drug War from Harm Reduction, which can still be highly normative.

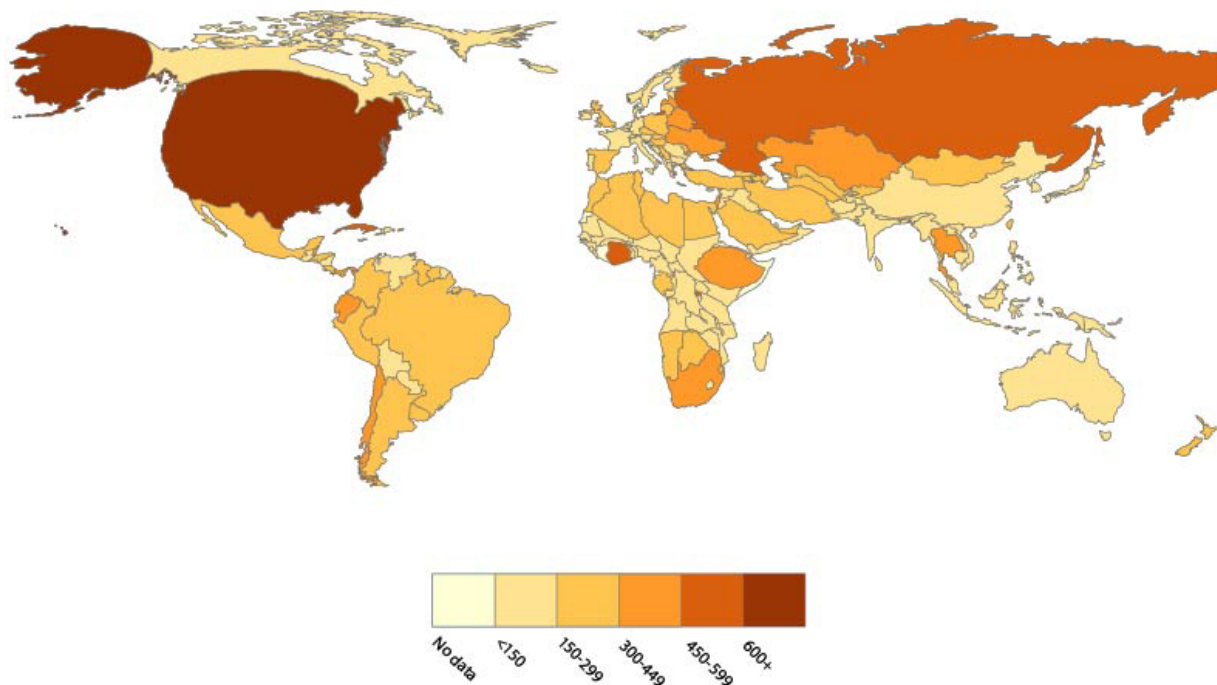
The first way to distinguish Drug War policies or Drug War dominance is through analysis of the criminal justice process, and the types and intensities of punishments administered by the state. A quick way to identify a possible Drug War dominant state is to look at measures of the enforcement mechanism it most prefers and relies on: incarceration of those involved in the illicit drugs economy. There are not many countries with prison rates higher than 250 per 100,000, and so these jump out immediately as drug-war candidates. As can be seen, even the more restrictive Western European harm

²² Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 128

²³ Weber, *Sociological Writings*, 95

reduction states (like Sweden) come nowhere close to the incarceration levels of states in the Americas and the former Soviet Union.

World Rates of Incarceration, 2011



24

Even at this macro level, the impact of the American Drug War state on an entire hemisphere comes into focus: an average of 357.5 for Caribbean countries and 175 for South American countries compared to 98 for Western Europe²⁵. Of course, general incarceration rates can be high for other reasons, so this variable cannot be studied in

²⁴ Sarah Shannon and Chris Uggen, "Visualizing Punishment" hosted on "The Society Pages, February 19 2013. Accessed April 12 2013. <http://thesocietypages.org/papers/visualizing-punishment/>

²⁵ Roy Walmsley, "World Prison Population List (9th edition)", report for International Centre for Prison Studies (London: University of Essex, 2010)

isolation, or without subtlety. But a large drug prisoner population is a sure sign of Drug War dominance, if only because it is the outcome that the other models most explicitly seek to avoid.

Another relatively quick way to compare large numbers of countries on drug policies is to look at their penalties for individual possession versus penalties for traffickers and producers, which are more universally severe. In the draconian atmosphere of the 1980s, Drug War influence was so dominant that the criminalization of personal use was added to the international treaty obligations: “the 1988 Convention requires that countries make possession for personal consumption a criminal violation”, though it does “not specify what the punishment must be”²⁶. States adopting Harm Reduction and Decriminalization policies have developed numerous ways to be in “technical compliance with the law, while [still] allowing for de facto policies more in keeping with the desired policy change within each country”²⁷. This is why the “treaty obligations” explanation of the Obama Administration’s actions in drug policy is so weak: much smaller countries like Holland and Portugal have found ways to skirt the treaties’ harsher requirements for decades, and the possibility is zero that the INCB’s enforcement mechanism (“an embargo on all prescription medicines coming into or going out of the country”) would be applied to the United States²⁸. While an about-face on drug policy would certainly be embarrassing for American diplomacy, there is no (external) material factor preventing such realignment. In the American case, the treaties are a red herring used by the bureaucracy to “conceal its knowledge and actions from criticism” and interpret its own actions as purely technocratic

²⁶ NYC Bar, “The International Drug Control Treaties”, 5

²⁷ *Ibid*, 5

²⁸ *Ibid*, 3

rather than materially self-interested²⁹. Given the flexibility that states have in assigning types and severity of punishment, the proportionality of penalties for drug use relative to other crimes indicates the degree to which the state relies on punishment to maintain normativity and deter suppliers.

The second systematic way in which they can be distinguished is the degree to which specific harm reduction initiatives are allowed, promoted, and funded by the drug regulation state. Even under Democratic presidents, the United States has lagged far behind European countries in its commitment to harm reduction programs, and sometimes these programs have been explicitly stalled or shut down by Drug War proponents. The EU explicitly calls on all Member States to provide “a number of harm reduction interventions, including: information and counseling; outreach; drug-free and substitution treatment; hepatitis B vaccination; prevention interventions for HIV, hepatitis B and C, tuberculosis and sexually transmitted diseases; the distribution of condoms; and the distribution and exchange of injecting equipment”³⁰. By contrast, even in the 2013 budget that was supposed to mark a “shift in the Obama administration’s thinking” and “a more balanced approach”, the US Office of National Drug Control Policy allocated *nothing* for drug recovery services; the Director’s only response to this discrepancy was, “I think the money sometimes lags behind the change in philosophy and the change in discussion”³¹.

But the low level of priority given to harm reduction programs and the welfare of drug users, and long delays in implementation, are hallmarks of the Drug War mentality. It

²⁹ Weber, *Sociological Writings*, 96

³⁰ Whiting and MacGregor, “The development of European drug policy”, 66

³¹ Mike Guy, “Interview with the Drug Czar”, *thefix.com*, July 2012.

<http://www.thefix.com/content/interview-drug-czar-gil-kerlikowske7459?page=all>

is clear that in the late 1980s, “habits of thought and political structures long anchored in a drug war mentality blocked rapid government response to the implications of [early H.I.V] research”³². During the height of the AIDS crisis, New York City at first refused to fund needle-exchanges and later pulled the plug on its successful pilot programs, claiming that harm reduction was “surrender in the drug war” and that “drug use was a more serious health threat than HIV”³³. In the American case, the precedent for government disapproval of harm reduction was established early on; as will be discussed in the Harm Reduction and Opioids sections of this paper, early regulatory bodies in the 1920s “equated maintenance [and physician-assisted detox] with drug pushing” and aggressively pursued doctors who attempted to treat addicts³⁴. The Drug War model relies so heavily on strong punishments to establish normativity that there is little space left for considerations of public health or user welfare.

The final way to distinguish the drug war state from other types is through an analysis of the rhetoric of the drug regulation state and the way in which it engages with the broader culture and civic society. Drugs and drug users are not merely disapproved of or targeted for interventions, but are actively demonized, stigmatized, identified, and discriminated against in multiple spheres. Importantly, they are also vigorously excluded from political debate and participation, perhaps because

“drug users in sufficient numbers could become a political force...[so] they are depicted as both “out of it” and yet violently effective in assaulting the world and its values...The media depict users as losers, but losers who are somehow always winning...They are condemned both for withdrawing from and remaining in the

³² Acker, *Creating the American Junkie*, 11

³³ Maia Szalavitz, “The Loneliness of the Addict Activist”, *thefix.com*, March 24 2013.

<http://www.thefix.com/content/activism-addicts-AIDS-needle-exchange8989?page=1>

³⁴ Acker, *Creating the American Junkie*, 34

social world. Drug users are antisocial but are continually forging reprehensible social configurations. They are lawless, but at the same time subject to the law's most intimate scrutiny."³⁵

The excommunication of drug users and advocates from participation in policy was dramatically symbolized by the Reagan Administration's "Just Say No" campaign, which

"explicitly called for an end to discourse on the subject. The absence of discussion and hence of any discrimination is necessary for the requisite demonization: during the Cold War it was not allowable to say that there could be any "good Communists", or that there were different kinds of Communists...Just as in the 1950s, when Communists were portrayed as having penetrated the very fabric of American life, now undifferentiated "drugs" were said to permeate every crevice"³⁶.

If the Drug War state is successful, the "badness" of all drug users becomes such an unquestioned consensus that considerations of user welfare become politically unspeakable and immaterial.

The Drug War type makes unusual demands upon state capacity; when these pressures become too intense, enforcement may become increasingly selective and arbitrary. If the drug regulation state loses bureaucratic legitimacy and comes to act and be viewed as simply another market or political actor, its ability to secure the popular consent necessary for any policy of law enforcement may be irreparably damaged. When this happens, Drug War dominance may be disturbed and formerly impossible alternatives may become increasingly plausible or even necessary.

2. Harm Reduction

The major innovation of the Harm Reduction type, developed in the late-80s and early-90s as an alternative to increasingly harsh Drug War policies pushed by the US and

³⁵ Lenson, *On Drugs*, 29-30

³⁶ *Ibid*, 13

the UK, was to “distinguish[h] between the drug trafficker, who is viewed as a criminal, and the drug user, who is seen more as a sick person in need of treatment”³⁷. The difference between dominance of Harm Reduction versus Decriminalization, while still substantial, is not as great a divide as between either of these and Drug War. The key difference is the degree of continued state involvement and whether a restrictive normativity towards illicit drug use is maintained. Harm Reduction seeks to broadly involve the state in “preventing and reducing drug use, dependence and drug related harms to health and society” and assuring “a high level of security for the general public”³⁸. In its purer forms it is likely to evolve when a highly developed social welfare system coexists with a restrictive attitude towards illegal drug use. In Europe, for example, there is evidence that “awareness of HIV/AIDS and its links to injecting drug use” caused a “significant shift of opinion between 1985 and the early 1990s”³⁹. While “public attitudes to drug taking...remain primarily restrictive”, the concern and priority is on “health consequences” and outcomes rather than punishing criminality and social deviance. Harm Reduction “mixes traditional law enforcement approaches with an increasing focus on public health”, but is likely to prioritize demand reduction in the long run, since supply reduction efforts are difficult to assess in an evidence-based way and can produce consequences (more violence, use of more potent drug varieties, political alienation) which are highly undesirable from Harm Reduction’s basic emphasis on public health and civic order⁴⁰.

³⁷ Whiting and MacGregor, “The development of European drug policy”, 64

³⁸ *Ibid*, 65

³⁹ *Ibid*, 71

⁴⁰ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 86, 105

Harm Reduction does not require or imply a liberal attitude towards drug use. Some Harm Reduction dominant states, perhaps hoping to maintain the deterrence value of strong normativity, reject the name itself and continue to maintain a hardline rhetoric that has little impact on practice. Scandinavia, and Sweden in particular, has been highly critical of any perceived leniency for drug users. Even the inclusion of the phrase “harm reduction” in a joint EU statement to the UN 2009 was resisted by Sweden (and possibly others), and in Stockholm in 2008 the World Forum Against Drugs declared itself opposed to “‘harm reduction’ that accept[s] drug use and do[es] not help drug users to become free...’[h]arm reduction’ is too often another word for drug legalisation or other inappropriate relaxation”⁴¹. But Sweden has dutifully implemented the recommended EU harm reduction programs, and with a 2011 prison rate of 78 per 100,000, is among the best at providing drug users with alternatives to incarceration⁴². It is perhaps not unrelated that Sweden’s government operates an alcohol monopoly, and that per-capita alcohol consumption in Scandinavia is quite high compared to the United States and the EU average. Overall, while Harm Reduction dominance is often accompanied by strong normativity and a desire to keep drug use and users out of the public sphere, the use of coercive force and incarceration is magnitudes smaller than under Drug War, and the state makes at least minimal provisions for the health and welfare of drug users seeking treatment.

Since Harm Reduction involves a commitment to and an expansion of social welfare programs, it is dependent on political support for the welfare state. The strong welfare states of Coordinated Market Economies like Germany are more prepared to take on these

⁴¹ Whiting and MacGregor, “The development of European drug policy”, 73 (from Declaration of World Forum Against Drugs, Stockholm, Sweden, 2008)

⁴² Rob Allen, “Reducing the Use of Imprisonment: What Can We Learn from Europe?” (report for Criminal Justice Alliance, May 2012) 5

responsibilities than the more minimal welfare states of Liberal Market Economies like the United States and the United Kingdom. The two are constructed to meet different economic needs: the limited welfare states of LMEs use “means testing and low levels of benefits [to] reinforce the fluid labor markets that firms use to manage their relations with labor” and “encourage individuals to develop...general, rather than specific skills”. In CMEs, which “require a workforce equipped with high levels of industry-specific skills”, generous social and unemployment benefits “help to assure workers that they can weather an economic downturn without having to shift to a job in which their investment in specific skills does not pay off”⁴³. This in turn influences the behavior of firms and the state “in the face of more intense international competition”: while “business interests in LMEs are likely to pressure governments for deregulation” and “government is likely to be sympathetic”, in CMEs “governments should be less sympathetic to deregulation because it threatens the nation’s comparative institutional advantages...many firms draw competitive advantages from systems...that depend on the presence of supportive regulatory regimes”⁴⁴.

This bifurcated response to globalization explains why European countries were able to construct comprehensive Harm Reduction systems during the 1990s – the same decade that Bill Clinton and the House Republicans ended “welfare as we know it” in the United States. Any political program to expand the welfare state in an LME, especially during times of economic duress, is likely to attract massive business opposition. Drug policy is not completely path dependent, but there is real-world evidence that shifting to Harm Reduction policies is not as easy for LMEs as for CMEs. A functioning Harm Reduction

⁴³ Soskice, David and Peter A. Hall, “An Introduction to Varieties of Capitalism” in *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage* (London: Oxford University Press, 2001) 56

⁴⁴ *Ibid.* 57-58

model takes time to create, and involves structural reform of social services and the legal system. Unlike most of Western Europe (but similar to Spain & Greece), the UK's incarceration rate rose substantially from 2004 to 2010/2011.

Table 1: Prison Population Rates 1992 and 2010/11

Country	Prison Population rate in 1992	Prison Population rate in 2004	Prison Population rate in 2010/11
England and Wales	90	141	156
Scotland	103	134	155
Spain	105	137	154
Luxemburg	89	121	124
Portugal	97	125	119
Italy	83	96	110
France	84	91	111
Austria	90	103	104
Greece	63	79	101
Belgium	71	88	97
Ireland	61	79	95
Germany	71	98	87
Netherlands	49	123	87
Switzerland	79	81	79
Sweden	63	81	78
Norway	58	66	73
Denmark	70	70	74
Finland	70	68	59

45

It may be that LMEs, less equipped to deal with the social consequences of large-scale or long-term unemployment, tend to fall back on law enforcement approaches to increased drug and crime activity. Even the Drug Czar criticized a similar tendency in the US:

⁴⁵ Allen, "Reducing the Use of Imprisonment", 5

“people in law enforcement and criminal justice almost always have the fingers pointed at them. They're told to do something about the drug problem in a neighborhood, do something about the drug dealing downtown, do something about drug-related crime, and on and on. When you are in the business of law enforcement, you're here because you can *do* things, take charge, make decisions. And quite often mayor, councilors, elected officials turn to law enforcement as an answer to those problems.”⁴⁶

Allen identifies five reforms which separate the US and the UK from Western and Northern Europe: different and more lenient arrangements for children and adults, options to divert even relatively serious cases from prosecution, milder sentencing tariffs, better treatment options for people with drug dependency and psychiatric problems, and restrictions on remands⁴⁷. On a larger scale, in the transition to Harm Reduction dominance, “drug users have...to overcome decades of silencing and incarceration to claim their right to health care and public health protection”, which depends not just on policy reform but on real changes in bureaucratic and clinical culture⁴⁸.

3. Decriminalization

If Harm Reduction is in most cases the extension of the pre-existing institutions of public health and the welfare state, and thus path-dependent to some degree, Decriminalization is in most cases a reform measure, and a retreat from an issue of illegality that has become contested or de-legitimized. The state seeks to reduce its expenditure of organizational resources on drug regulation by removing criminal penalties for personal use and deferring more to market and cultural bodies and norms. Judicial processes may be maintained for those arrested with large quantities of drugs; often, punishment is retained for traffickers, while addicts may be required to register with the

⁴⁶ Guy, “Interview with the Drug Czar”

⁴⁷ Allen, “Reducing the Use of Imprisonment”, 8-11

⁴⁸ Acker, *Creating the American Junkie*, 11

state or attend treatment services. In Portugal, a mixed Harm Reduction and Decriminalization type, personal use is entirely decriminalized while trafficking is treated like other felonies; being caught with “more than 10 daily doses of drugs” sends an individual’s case to the Commission for the Dissuasion of Drug Abuse⁴⁹. Decriminalization seeks above all to avoid the prison populations and street violence which plague the Drug War state, and so while the state may retain options like “warnings, banning [offenders] from certain places, banning from meeting certain people, obligation of periodic visits to a defined place, removal of professional license or firearms license”, etc., only in its punishments for major international traffickers does the Decriminalization type ever approach the intensity of punishment that Drug War dominant states regularly mete out upon those convicted of simple possession⁵⁰. Punishment intensity in Harm Reduction states usually lies somewhere in between the two; punishments for small-time users and dealers may be softened considerably but possession is usually not legally decriminalized.

Decriminalization of personal use necessarily entails allowing buyers and certain sellers of the drug to operate openly and acquire legitimacy. In contrast to the Legal Market, however, sellers are either forced to remain outside the bounds of the normal consumer market and operate as a gray market (a black market that is known about and tolerated), or are allowed to become legitimate if subject to extraordinary restrictions like very high taxes, prohibitions on advertising, restrictions on legitimate customers, and limits on product and financial transactions. The cannabis coffee shops in the Netherlands are an excellent example of the second type. US reformers have pursued both avenues: the first through measures by cities and states making marijuana the lowest priority for law

⁴⁹ Moreira, Hughes, Costa Storti, and Zobel, “Drug policy profiles: Portugal”, 17

⁵⁰ *Ibid*, 17

enforcement, and the second by establishing “medical” markets where medical necessity and sanction by physician serve (in theory) to protect market participants from federal prosecution⁵¹. Decriminalization is rarely the dominant type, and so its implementation has usually been piecemeal because of the limits placed on it by higher levels of jurisdiction with a Drug War or Harm Reduction mentality. The tolerance given to sellers in practice, for example, is rarely extended to suppliers, especially of the size needed for commercial production. Because of this policy disjuncture, many Decriminalized cannabis sellers have been forced to continue to buy from the same “independent growers” who serve the illicit market⁵². Despite the recent proliferation of state medical marijuana laws in the US, the uncertain legal status of most Decriminalization experiments continues to deter many from participating:

“medical marijuana initiatives are much easier to pass than they are to implement. As long as marijuana remains in the federal government’s Schedule 1, the threat of prosecution to anyone involved with its procurement or use has deterred all but a minority of doctors, patients, and providers of medical marijuana from establishing public distribution...Most medical users [continue to] get their marijuana through the same means as recreational users: from friends who give or sell it to them, by growing it themselves, or by buying it “on the street” from professional growers”⁵³

Decriminalization policy advocates are likely to emphasize the ability of forces in society or the capitalist market to “meet needs, maintain control and manage risks” in the drugs economy without systematic state regulation and coercion⁵⁴. This coercion is viewed not just as unnecessary, but actively harmful; “because, in the end, culture is a more

⁵¹ Alison Mack and Janet Joy, *Marijuana as Medicine? The Science Behind the Controversy* (Washington D.C. :National Academy Press, 2001) 162-64

⁵² Mack and Joy, *Marijuana as Medicine*, 168

⁵³ *Ibid.* 164-65

⁵⁴ Whiting and MacGregor, “The development of European drug policy” 60

powerful tool in dealing with drinking than medicine, economics, or the law”, and the state’s pervasive interference has the disrupted natural processes of cultural adaptation to intoxicants. Specific harm intervention programs may be implemented, but drug policy is not wholly re-conceived as social welfare policy as it is under Harm Reduction, and drug treatment services are more likely to be a province of the private sector than of the state. Decriminalization can achieve some control over the drug economy by supervising a semi-legitimate gray market, or generate revenue by establishing a legal drugs market subject to taxation and heavy restrictions. Above all, it seeks to end the use of normativity as a tool of drug policy, and reconcile the gulf between drug markets and the legitimate economy.

Decriminalization is appealing to reformers in current Drug War dominant states because it can be implemented relatively quickly, it forces a rapid de-escalation of Drug War enforcement, and it signals a retreat from normativity and coercion in state regulation of the drugs market. It does not require a developed social welfare network or a sustained commitment to public health improvement. But Decriminalization can also have unintended consequences, as the historical cases of alcohol and tobacco show. By permitting drug businesses to operate semi-openly but simultaneously burdening them with heavy restrictions and legal uncertainty, Decriminalization creates powerful advocates for an eventual Legal Market. In the worst instances, the Decriminalization state or the Legal Market can become rackets for the protection of drug producers, to the detriment of public health and the state’s legitimacy.

4. Legal Market/Government Monopoly

Legal Market is fairly self-explanatory: production, distribution, and use of the drug are all legal and sanctioned, provided certain conditions are met. This does not imply that

it is an uncomplicated “default” policy, or that it has a depoliticized relationship to the drug regulation state and the drugs economy as a whole. Coffee, alcohol, and oxycodone are all sold in Legal Markets, but their availability and the requirements for producers and distributors are profoundly different. Legalization is not an all-or-nothing deal, and no substance has faced an uncomplicated path to social acceptance:

“Legalization does not necessarily imply the imposition of an unregulated market price. There could be elaborate controls on suppliers, for example, as there are in many states for alcohol, with an extreme case being one in which only physicians could supply some drugs. Less restrictive rules for sale, such as limited time of sale at specially licensed pharmacies, could be accompanied by prohibition of advertising...Movement in the direction of the legalizers’ position are likely because...many of the alleged benefits of a drug war are either false or exaggerated, and many of the unintended consequences are undesirable. Thus, legalizers could support the start of an experimentation process that involves more modest changes in drug policy...while the libertarian argument may have little chance in a national debate, it may have considerable impact in some jurisdictions, and if it is successful, it may spread through emulation”⁵⁵

Legal Market’s greatest strength is that it is a tested and true model, familiar to anyone who has bought alcohol or cigarettes, or filled a prescription. Producers can operate openly and without the stain of illegitimacy, and in return are held responsible for the authenticity and safety of their products.

Despite these advantages, the opposition to establishing Legal Markets for most drugs is exceedingly strong, and partly due to the nature of the Legal Market itself. From an economics standpoint, firms in established Legal Markets have an incentive to prevent the establishment of new Legal Markets. Statistical studies since the early 1990s have

⁵⁵ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 186-88

“confirmed previous perceptions that alcohol and marijuana are substitutes”⁵⁶. This is especially significant since evidence shows that since the ‘80s,

“public policy probably has implicitly encouraged beer consumption over marijuana...Besides the illegality of marijuana and rising penalties during the 1980s, the price of alcoholic beverages has been falling relative to the overall consumer price index, in part because the federal excise tax on beer failed to keep up with inflation”⁵⁷

At least some beer companies fear, probably correctly, that

“Legalization of marijuana would change the current equation enormously: if Moore’s (1990:124) estimates are accurate, the money price of marijuana would fall to perhaps *one-fifteenth* its illegal price. Falling search, toxicity, and safety costs, as well as elimination of legal penalties, would mean an enormous shift in incentives toward consumption of marijuana rather than beer”⁵⁸

In 2010, the California Beer & Beverage Distributors contributed money to the campaign to oppose Proposition 19, which would have “legalize[d] pot and its cultivation and distribution”⁵⁹. In a Government Monopoly of alcohol, the situation is even worse, as the bureaucracy has another strong incentive to oppose new Legal Markets. But perhaps the strongest obstacle to legalization is even simpler: “it is a drastic change in policy that is not likely to appeal to public officials concerned with job security”, and “the probable results, especially for cocaine and heroin, are likely to be perceived as undesirable by the majority of those who influence policy”⁶⁰. The idea is gaining energy in Latin America, but for all substances except marijuana, it remains a fringe proposal in the Europe and the United States.

⁵⁶ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 74

⁵⁷ *Ibid.* 188

⁵⁸ *Ibid.* 188

⁵⁹ J. Patrick Coolican, “Beer Lobby Gives \$10,000 to ‘No’ On Prop 19 Pot Legislation”, *LA Weekly*, September 21 2010.

⁶⁰ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 186

II. The political economy of drug scheduling

A. The politics of pharmacology

“As for our mercury, never forget that though it is most essential for our work and much beloved, it contains a subtle poison. Both Böhme and Paracelsus agree on this point. Paracelsus adds that it is the work of the alchemist to separate the poison from the arcanum.

The poison attacks the fixed properties (themselves moribund poisons) and dissolves them. Poison is antidote and antidote poison”⁶¹

It is hard to imagine today the enthusiasm that greeted the first pharmaceutical innovations of the modern era, especially the substances that have acquired the most severe stigma. Heroin was discovered alongside aspirin, and was at first thought to be the greater discovery. Cocaine was welcomed, as caffeine had been centuries earlier, as a tonic for the intellect and a stimulant for physical labor. Humanity’s most beneficial drugs are simultaneously its most dangerous and destructive, and it is not possible to perfectly separate those two principles. Tobacco, perhaps history’s most popular recreational drug, is an organic poison that can be used as an industrial insecticide⁶². Atropine, famous as a deadly poison and weapon of assassins, is simultaneously a WHO core drug for medical systems and an antidote to nerve gas poisoning. Even the most basic and essential products of the pharmacological revolution, the antibiotics, can with indiscriminate use bring into being more deadly versions of the diseases they are meant to treat.

If early appraisals of new drugs are often rosy and narrowly focused on their benefits, advanced industrial societies in many cases seem to have developed the opposite

⁶¹ Pendell, Dale. *Pharmako series Vol 1, Pharmako/Poeia* (Berkeley, CA: North Atlantic Books, 2010) 14

⁶² *Ibid*, 34

disorder: there is a great deal of attention to the harms that drugs cause, but without any sense of proportion or any practical discussion or plan on how to rationally assess and reduce the risks involved. Risk cannot be eliminated from the practice of medicine, nor from the pursuit of happiness through consumption, whether it is consumption of anti-depressants, cigarettes, coffee, high-fructose corn syrup or illicit methamphetamine. The loss of perspective in cultural narratives and public debate about drug use - the inability to admit that drugs have harms but also powerful benefits, that people believe they derive utility from their use of drugs, that some drugs *are* more harmful than others, that legal drugs like alcohol and tobacco cause far worse damage than illicit drugs - has immeasurably aided Drug War advocates in their attempts to stall and derail reforms patterned on Harm Reduction or Decriminalization.

The study of illicit drugs cannot be isolated, as it has traditionally been, from the study of licit drugs. No matter how precisely the state wishes to draw the line between legality and illegality, and no matter how complex a scheduling and licensing system it creates, it cannot escape from the fundamental uncertainty or arbitrariness of this distinction. It is fundamentally arbitrary because no substance has a defined, predictable effect in all instances. Because of what Lenson calls “user construction” (and Timothy Leary famously referred to as “set and setting”), the “consumerist framework [in which] all that can be said is that a given drug has certain empirically observable biochemical effects” is wrong more often than it is right⁶³. Drugs simply do not have the fixed, predictable, scientifically verifiable identities that cultural prejudice and bureaucratic administration have assigned them. It is not that chemical substances do not have distinctive properties,

⁶³ Lenson, *On Drugs*, 58-59

but that these properties can only emerge, and be studied, in the context of the interaction with infinitely more complex physical and social bodies.

Just as any drug war is really a war against certain people, drugs' effects are inseparable from the contexts in which they are used. "[E]ven the commonest pharmaceuticals do not work autonomously" because of differences in individual biochemistry and the power of the placebo effect. Even the ability of aspirin or Tylenol to relieve pain is dependent on user construction and an "ongoing relationship" of expectation between the user's consciousness and the administration of the drug⁶⁴. Alcohol, the most ubiquitous recreational substance in the world, is an extremely protean drug capable of causing a wide range of behavioral changes. Its modern, Western associations with social disinhibition, anxiolysis, promiscuity, and even violence are cultural constructions, not pharmacological actions: "Persons learn about drunkenness what their societies import to them, and comporting themselves in consonance with these understandings, they become living confirmations of their society's teachings"⁶⁵. Anthropological studies of isolated cultures confirm that different social constructions of the drug can lead to vastly different behavior; among the Camba of Bolivia, for example, where heavy, regular consumption of high-proof alcohol leads to "no social pathology – none. No arguments, no disputes, no sexual aggression, no verbal aggression. There was pleasant conversation or silence... Where norms and standards are clear and consistent, the drinker can become more rule-bound than his sober counterpart"⁶⁶.

⁶⁴ Lenson, *On Drugs*, 60

⁶⁵ Malcolm Gladwell, "Drinking Games" (*New Yorker*, February 15 2010) 72

⁶⁶ Gladwell, "Drinking Games", 73-74

There is little hope that neuroscientific techniques like receptor binding assays will comfortably resolve these ambiguities in the near future. A massive gap lies between confirming that, as suspected, a behavioral stimulant like cocaine or amphetamine has dopaminergic activity *in vivo*, and predicting the behavioral effects of an unknown molecule through empirical tests in the absence of live experiments or user feedback:

What is enormously difficult to comprehend is the contrast between the action of a drug on a simple neuron, which causes it either to fire or not to fire, and the wide diversity of central nervous system effects, including subtle changes in mood and behavior which that same drug will induce...At the molecular level, an explanation of the action of a drug is often possible; at the cellular level, an explanation is sometimes possible; but at the behavioral level, our ignorance is abysmal. There is no reason to assume, for example, that a drug that inhibits the firing of a particular neuron will therefore produce a depressive state in an animal: there may be dozens of unknown intermediary reactions involving transmitters and modulators between the demonstration of the action of a drug on a neuronal system and the ultimate effect on behavior⁶⁷.

Today's science is still unable to predict the effects of drugs in the absence of sociological studies, but the imprimatur of science and health authorities has been used to justify the criminalization of drugs since the beginning of the drug regulation state - even when scientists and public health officials have been systematically excluded from the drug policy-making process. Drug policy is always social and always political, and any attempt to reduce it to scientific or technocratic determination must be understood as a project of bureaucratic domination.

Modern pharmacological law rivals any corporate tax code in its loopholes for insiders and its self-contradictions. Worse, its tautologies have overflowed into social thought and even language:

⁶⁷ Daniel Perrine *The Chemistry of Mind-Altering Drugs* (Washington D.C. : American Chemical Society, 1996) 21 (from Cooper et Al. *The Biochemical Basis of Neuropharmacology*, 6th ed.)

Even the ordinary usage of the term “drug” is utterly ambiguous. While the War on Drugs rages on, you can still drive past a mall and see a seven-foot neon sign reading DRUGS on the facade of a chain pharmacy. We assume that this is possible because there is a clear distinction between drugs taken for medical purposes and those taken for recreation, but this boundary too is far from rigid..

The unavoidable fact of the matter is that a substance becomes a drug in the pejorative sense when and only when a law interdicts it - only when somebody decrees that it is a drug, that it is another antithesis to sobriety. It becomes an official medicament when its availability is restricted by prescription. Other substances with psychoactive powers, such as sugar and many herbal remedies, are for some reason unregulated, or classified as vitamins, minerals, or foods. This dubious taxonomy was not accomplished in a single instant. It was the product of many discrete legislative actions over a long period of time. As one substance after another was interdicted or restricted, the operant definition of sobriety also changed. And for each of these changes, it is not difficult to find an ulterior motive”⁶⁸

THC, a Schedule 1 drug with “no recognized medical value”, has been synthesized and patented as “drobabinol” - available by prescription to cancer patients for nausea, at hundreds of times the cost of extracted THC. Heroin, similarly Schedule 1 with “no recognized medical value”, is prescribed in the UK and other advanced European medical systems - and in fact, as a prodrug whose “effects...are almost entirely due to morphine”, is basically equivalent to drugs which are regularly used and prescribed in hospitals across the country⁶⁹. Perspectives from political economy are uniquely suited to untangling the economic and political motives responsible for creating the norms and institutions of the modern drug economy. Political economy’s focus on institutions and material actors can help separate the “signal” of structural change in policy from the “noise” of cultural tropes and assumptions, and it has long sought to clarify the process by which economic changes or opportunities are translated into political imperatives and cultural narratives.

⁶⁸ Lenson, *On Drugs*, 4

⁶⁹ Perrine, *The Chemistry of Mind-Altering Drugs*, 66

Illicit drugs and drug users are banned and persecuted not because of their effects on public health (which can be reduced better by other methods) or the threat they represent to the nation-state (which has always been dubious), but because particular coalitions aligned at particular times: status groups threatened by economic and demographic change, politicians who stand to gain political power by exacerbating class and ethnic tensions, bureaucracies looking to expand their resources and jurisdiction, and domestic producer groups threatened by the appearance of a new product or distribution scheme. In the United States and other countries dominated by these coalitions, the otherwise convergent trend towards Harm Reduction in the industrialized countries has been heavily contested or halted.

B. Fordism and the creation of drug regulation states

The development of drug regulation states in the first half of the 20th century took place within much larger political-economic shifts that entailed drastically expanded responsibilities for the state in the maintenance of an industrial economy and society. The modernizing states of Europe and the USA, mindful of the new potential for both productivity and rebellion in the working class, sought to control behavior to an extent that had previously been thought either tyrannical or impractical.

“The socialization of the worker to conditions of capitalist production entails the social control of physical and mental powers on a very broad basis...[an] intricate affair [that] entails, in the first instance, some mix of repression, habituation, co-optation and cooperation, all of which have to be organized not only within the workplace but throughout society at large”⁷⁰.

⁷⁰ David Harvey, *The Condition of Postmodernity: An Enquiry into Cultural Change* (Oxford: Blackwell Publishers Inc, 1999) 123

Drug policy, in the beginning, was explicitly economic policy, designed to change entrenched spending habits in order to make consumerism work. This was not a shadow agenda but was foremost in the minds of key figures in the economy: “supported by industrialists such as Henry Ford and Pierre du Pont...[p]rogressive reformers sought to bring science, law, and moral authority to bear on social problems, including those associated with drug use”⁷¹. Owners like Ford, whose name would become symbolic for this entire period and model of capitalist production,

“meant to provide workers with sufficient income and leisure time to consume the mass-produced products the corporations were about to turn out...but this presumed that workers knew how to spend their money properly...the ‘new man’ of mass production had [to have] the right kind of moral probity, family life, and capacity for prudent (i.e. non-alcoholic) and ‘rational’ consumption to live up to corporate needs and expectations”⁷².

For many early reformers, drugs were a threat to industrialization itself, a self-destructive atavism that suggested a return to the savage and pre-industrial, with all their foreign and racial connotations.

In the United States, this reform process was already underway in the early 19th century, and reformers looking for the causes of crime, poverty, and unrest in the new industrial cities quickly latched on to the highly visible alcoholic debauchery of the time:

“For Europeans and the British, drinking was a way of life essential in societies where most water source was polluted. They brought this way of life with them to the colonies...[and] alcohol was a staple of colonial life. Wine, and opium for that matter, were also among the mainstays of colonial physicians and lay medical practice”⁷³.

⁷¹ Tracy, Sarah and Caroline Jean Acker, introduction to *Altering American Consciousness* ed. Sarah Tracy and Caroline Jean Acker (Amherst & Boston: UMass Press, 2004) 7

⁷² David Harvey, *The Condition of Postmodernity*, 126

⁷³ Tracy and Acker, *Altering American Consciousness*, 3

But a combined movement of middle-class reformers, Protestant churches, and employers sought to change what these social groups saw as the bad habits of the American working class. Other factors were technological innovation and changing demographics:

“the efficiency and profitability of turning corn into whiskey, heavy frontier drinking, the spread of urban saloons, and the arrival of beer-drinking Germans and whiskey-swilling Irish...The American Society for the Promotion of Temperance (ASPT), founded by evangelical clergymen in 1826, also gained support from farmers, industrialists, and homemakers...Alcohol was seen as imperiling capitalist enterprise, domestic tranquility, and national virtue. In the 1850s, eleven states passed prohibitory legislation, although most were soon repealed”⁷⁴.

Though alcohol would eventually be cleared of these slanders - that it was anti-capitalist, made men prone to violence, encouraged sexual deviancy, and made the nation vulnerable to foreign attack- these same barely altered tropes have formed the backbone of almost every drug prohibition campaign since.

Drug prohibition became a key part in the new urbanism and a cornerstone in the modernization of American cities. Drug manufacturers and doctors were not in a good political position to contest these moves - in the new climate of morality and civic high-mindedness, they were criticized for profiting from suffering by turning a blind eye to addiction in their patients or customers. “For the manufacturers and purveyors of medicines - physicians, pharmacists, and pharmaceutical manufacturers - widespread drug use contributed to a crisis of professional legitimacy”⁷⁵. Campaigns moved simultaneously against prostitution, gambling, alcohol, heroin, cocaine, and new forms of dancing. By 1910 major American cities had closed their brothels and ended their unofficial tolerance of gangs and vice districts. The move towards modernity was defined by the new ability of the

⁷⁴ Tracy and Acker, *Ibid.* 4

⁷⁵ Tracy and Acker, *Ibid.* 7

city (backed up by the state) to regulate the urban vice market, and the substitution of criminal sanctions for social condemnation. The unintentional result was uneven cultural change, a "new pattern...in which some norms were liberalized while other behaviors were more harshly condemned"⁷⁶. Alcohol, tobacco, serial or casual heterosexuality, and gambling were eventually liberalized and cleansed of their association with vice and the underworld, but other behaviors became highly illegal and associated with extreme deviancy, especially prostitution, opiate and cocaine use, and alternative sexualities.

During WWI, the interwar years, and WWII, the links between the American state and the pharmaceutical industry, as well as between normativity and regulation, only increased. The state during wartime depends on its domestic drugs industry to supply medicines for the wounded, performance enhancers for specialists like airplane pilots, and poisons & antitoxins for offensive or defensive chemical warfare. The onset of WWI quickly made the Western Allies realize their deficiencies in chemical design and production; "American dependence on German pharmaceuticals was starkly apparent" and "nearly all the important drug discoveries of the preceding sixty years had been made in Germany"⁷⁷. Concerned about Germany's early dominance in chemistry and drug production, the American state worked hand-in-hand with burgeoning domestic industry to create German-style funding, research, and production networks in the US. American dominance was cemented in this sector through government weapons research and adaptation of German industrial methods: while "few American pharmaceutical firms before World War I extended their scientific efforts beyond...quality-control tasks", the "U.S. Army Chemical Warfare Service provided an American precedent for tightly organized cooperative

⁷⁶ Acker, *Creating the American Junkie*, 3

⁷⁷ *Ibid*, 68, 64

research to identify useful compounds and produce them in large quantities” and together with a new generation of research-oriented firms, “sought to transplant the German research tradition to American soil”⁷⁸. The World Wars, and the new links they forged between national defense, the medical profession, and the pharmaceutical industry, were a crucial period in the construction of the drug regulation state. Industry leaders and the American Medical Association, eager to escape the taint of their “long historical association with unscrupulous manufacturers of nostrums”, welcomed the legitimacy brought by increasing federal interest and regulation⁷⁹.

After WWII, the US worked to spread both its economic and drug policy institutions throughout its new global sphere of influence. “The international spread of Fordism occurred...within a particular frame of international political-economic regulation and a geopolitical configuration in which the United States dominated through a very distinctive system of military alliances and power relations”⁸⁰. The synthesized products of the new pharmaceutical revolution were celebrated and distributed worldwide, while plant-based and extracted drugs associated with traditional medicine, foreigners, and racial minorities were suppressed like never before. By the 1950s, the links between the state, Fordism, and social normativity seemed ironclad:

“The decisions of corporations became hegemonic in defining the paths of mass consumption growth, presuming, of course, that the other two partners in the grand coalition [labor and the state] did whatever was necessary to keep effective demand at levels sufficient to absorb the steady growth of capitalist output”⁸¹.

⁷⁸ Acker, *Creating the American Junkie*, 70-71

⁷⁹ *Ibid*, 70

⁸⁰ Harvey, *The Condition of Postmodernity*, 137

⁸¹ *Ibid*, 134

But the nascent civil rights movement and the Vietnam War soon revealed serious cracks in the new American hegemony and the supposed cultural consensus of the 1950s. New patterns of drug use became indelibly associated, amongst both the authorities and young drug users, with a particular political experience and a new, critical attitude towards authority. By the end of the Fordist period, the drug normativity that had helped reinforce consumerism and suppress dissent against the dominant economic order had deteriorated. The true importance of this normativity for Fordism's growth dynamics is difficult to assess, but in the eyes of the new moral conservatism of the '70s and '80s, drug use and other deviancies were the root source of both economic stagnation and cultural fragmentation. The reappearance of social normativity that occurred in the 1980s was not a spontaneous cultural shift. The resurgent conservative movement in the late '70s and '80s engineered it, and understood it as the social cornerstone for the drastic changes they sought to make to Western economies.

C. Post-Fordism: revolt and restoration

The Post-Fordist economic shift produced two very divergent trends in the political economy of psychoactive drugs. The first trend was one of liberalization and the diffusion of technology: increasing availability, access to, and use of a wider variety of drugs than ever before, vastly improved techniques for drug research and production, and the acceptance of many psychoactive pharmaceuticals as part of normal, domestic American life. Prominent members of both the dominant culture and the later counterculture envisioned a future of "better living through chemistry" where new drugs would solve not only hosts of medical complaints and illnesses, but even deep personal, social, and political problems. But the second trend, which would prove dominant in the end, was one of

increasing risk, fear, and control. The Thalidomide scandal ended the honeymoon period between the American government and the pharmaceutical industry. The adoption of marijuana and the psychedelics by the anti-war counterculture led states to associate alternative drug use with new forms of resistance and radicalism. Many Western states, led by the US, increasingly saw uncontrolled drug use as a threat to public order and authority, and launched intentionally harsh and repressive campaigns in order to restore a normative authority that new leaders believed had been lost during the 1960s.

Several incidents early in the 1960s led to government mistrust of the pharmaceutical industry and new institutional attitudes towards drug regulation, emphasizing caution and restriction over innovation. Thalidomide, a sedative that caused nerve damage and severe birth defects in Europe, was never approved in the US because of a single stubborn regulator named Frances Kelsey. The Merrell Corporation had been aggressively pushing for access to the American market and tried to get her fired when she questioned studies the company submitted to the FDA in 1962⁸². When the damage became world news later that year, the American medical establishment's prior concern that "new medicines were reaching European patients earlier than Americans" understandably faded into the background⁸³.

"Reports of the magnitude of the tragedy in Europe soon aligned support behind an increase in the FDA's regulatory authority over drug testing...[and] the agency tilted heavily toward precaution during the 1970s and early 1980s"⁸⁴.

⁸² Arthur Daemrich, *Pharmacopolitics: Drug Regulation in the United States and Germany* (Chapel Hill & London: UNC Press, 2004) 26-27

⁸³ Daemrich, *Pharmacopolitics*, 29

⁸⁴ *Ibid*, 27-30

Scrutiny of pharmaceutical companies only increased after Sandoz's investigational compound LSD-25 became the unofficial sacrament of the California counterculture and the most popular psychedelic drug in history⁸⁵. The end result was that during the same time that technological innovation was unleashing an explosion of new compounds, the regulatory climate was one of suspicion and extreme caution. Drug makers' fears of government and media attention increasingly led them to shy away from advocating for or investigating controversial substances like psychedelics (Sandoz abandoned LSD production in 1965 and changed its company name to Novartis)⁸⁶. Regulators' total rejection of many promising substances during this period, and the conservatism it fostered in the pharmaceutical industry, helped lay the groundwork for the Drug War offensives of the late 1960s and 1980s.

At the same time that these revelations were calling into question the social benefits of the alliance between medicine, the state, and the pharmaceutical industry, cultural changes and technological innovation were profoundly changing drug use patterns in the United States. Previous illicit drug user populations had mostly existed on the margins of American society, either as members of racial minorities, the urban working class, or both; having little hope of voice or acceptance in the larger culture, they had to accept their stigmatization, though many "developed self-justifying ideologies"⁸⁷. But during the 1960s, "an explosion of drug use by middle-class youth" meant that drug users – especially of marijuana and psychedelics - were increasingly white, educated, middle-class, and

⁸⁵ Perrine, *The Chemistry of Mind-Altering Drugs*, 266-67

⁸⁶ *Ibid*, 257

⁸⁷ Acker, *Creating the American Junkie*, 185

politically motivated⁸⁸. These new drug users had the economic and social privilege to publicly demand changes in drug policy, and to contest the stigmatization that the state imposed upon them with the labels of “user” and “addict”. In this way, “the counter-cultural critiques and practices of the 1960s...paralleled movements of the excluded minorities and the critique of depersonalized bureaucratic rationality”⁸⁹. The biggest changes that came about were the creation of treatment networks and a reduction in the stigma surrounding drug use and addiction:

“As drug use spilled out of isolated and marginalized groups into more mainstream sectors of American society, addiction was redefined in less stigmatizing terms. A broadening menu of available psychoactives...contributed to the development of a generic concept of dependence that could embrace not only a wide variety of drugs, but also compulsive behaviors such as gambling. The introduction of methadone maintenance treatment in 1964 signaled...the beginning of an expansion of treatment methods and access to treatment...A grassroots movement of free clinics, most famously the Haight Ashbury Free Clinic in San Francisco, began in the late 1960s to meet the medical needs of young people who had cut themselves adrift from families and mainstream institutions; in this clinical setting, a new set of encounters between clinicians and drug users produced a new definition of addiction”⁹⁰

Many of the interventions developed informally by the counterculture during this time were resurrected during the AIDS crisis and continue to underpin Harm Reduction policies today. But the federal commitment to improving treatment proved short-lived, and any hopes of adopting Harm Reduction policies nationwide were dashed by the rise of the new moral conservatism.

Neoliberal conservatives rose to power by focusing political and media attention on the least appealing, most threatening elements of the new liberality. Tolerance for drugs in

⁸⁸ *Ibid*, 9

⁸⁹ Harvey *The Condition of Postmodernity* 139

⁹⁰ Acker, *Creating the American Junkie*, 9

America peaked under the Jimmy Carter's administration, and he personally advocated national decriminalization of up to an ounce of marijuana⁹¹. But this was to change quickly as "the height of the decriminalization movement in 1977-78 coincided with a growing conservative reaction against what was seen as the decadent legacy of the radical 1960s – in matters of sexuality and personal behavior as much as in drug abuse"⁹². The New Right breathed new life into stereotypes of the drug user as a freakish, often violent Other by focusing on unfamiliar synthetic drugs and formerly unspeakable sexual deviancies:

"during 1977, morality campaigners won significant victories by focusing on aspects of the new permissiveness to mobilize mass constituencies. A movement against child pornography was the first strategy in several decades that succeeded in reversing public tolerance of sexually explicit materials. Closely related to the child pornography issue was an official campaign to suppress pedophilia and child molestation, a theme used indirectly to stigmatize homosexuals and gay rights laws. A new politics of morality became apparent...[t]his conservative mood provided the context for the official severity towards methamphetamine and the even harsher attitude towards PCP. Though public tolerance towards drug abuse did not suddenly in the late 1970s, the emphasis on synthetics did succeed in creating a plausible anti-drug rhetoric with wide social appeal. Like child pornography, PCP and methamphetamine seemed literally indefensible..."⁹³.

The new morality campaigners also resurrected old class and racial anxieties about drug use, which had new political salience in an era where scenes of mass unemployment and urban unrest, exacerbated by monetarist policies, came to dominate white America's perception of the urban environment:

"In the late 1970s, by far the most intense publicity concerning the damage done by illicit drugs focused on PCP...This drug raised the issue of how one's humanity could apparently be destroyed by drugs, leaving a savage and primitive monster, and racial rhetoric implied that such atavistic reversion was especially likely for African

⁹¹ Carter, "Drug Abuse Message to Congress"

⁹² Jenkins, *Synthetic Panics*, 56

⁹³ *Ibid*, 56-57

Americans...Throughout, the paramount danger was that savage “jungle” habits would be transmitted to the young white middle class”⁹⁴

This rhetoric, and the policy it influenced, was about much more than just resurrecting old prejudices and turning back the clock on social equality. The new monetarist governments intended to profoundly reshape the economy, and the new morality provided the necessary basis of authority for divisive economic policies. In Britain, for example, the Thatcher government’s “social market doctrine [sought] to dispose of unemployment as a matter for political concern or government intervention, by putting the blame for unemployment on the failure of individuals...to adapt themselves to the requirements of the market”⁹⁵. The New Right associated social normativity and capitalist productivity, asserting that the decline of morality and respect for authority was the direct cause of economic decline and the growth in political radicalism and dissent. In return for diminished liberties, they promised “a renaissance of liberty and the liberal society, the creation of a new national consensus by which the chains of collectivism [would] be thrown off, the trends of the past thirty years reversed, and...national and economic fortunes revived”⁹⁶. These governments constructed the Drug War type to enlist law enforcement in the suppression of working class opposition and the consequences of massive unemployment resulting from monetarist policy. A newly harsh, fearful public morality and hugely expanded discretion for law enforcement would help prevent the development of

⁹⁴ Jenkins, *Synthetic Panics*, 57

⁹⁵ Andrew Gamble, “The Free Economy and the Strong State: The Rise of the Social Market Economy”, *Socialist Register* Vol .16 (1979) 17

⁹⁶ Gamble, “The Free Economy and the Strong State”, 3

widespread social protest by liberal professionals or “the main obstacle to the realization of the social market economy – the organized working class”⁹⁷.

D. Relationship with industry and medicine

The first drug regulation states arose alongside domestic pharmaceutical industries and medical establishments, and the importance of these relationships is undoubtedly fundamental to the drug state’s functioning but too complex for easy generalizations regarding each type. There are powerful incentives for industry, the state, and medicine to cooperate in governing the drugs economy, but has at times sought power at the expense of the others. The era of aggressive drug prohibition in the United States began with such a power grab. In 1919, the Treasury Department began criminally prosecuting physicians who practiced opioid harm reduction (maintenance and substitution) and clinics that had arisen in the wake of the 1914 Harrison Act, which limited the use of opioids to the medical professions⁹⁸. While some American physicians had sought government help in limiting their responsibility for opiate addiction, they had not intended to cede control of prescription practices to the federal bureaucracy. But hamstrung by the “deeply problematic nature of opiates for physicians” (who were often blamed for opioid addiction in their patients), “physicians and pharmacists...reacted with fear”⁹⁹. Many addicts “initially sought help from physicians” when the Harrison Act interrupted their formerly legal supplies of drugs, which “could have meant proper medical treatment for thousands of addicts who had not sought help before”¹⁰⁰. The aggressive intervention of the Treasury

⁹⁷ Gamble, “The Free Economy and the Strong State”, 20

⁹⁸ Acker, *Creating the American Junkie*, 32

⁹⁹ *Ibid*, 36, 51

¹⁰⁰ Acker, *Creating the American Junkie*, 51

Department's narcotics division established bureaucratic dominance over the medical profession in one stroke, and the development of Harm Reduction in the United States was dealt an early blow "with the sanction of the American Medical Association (AMA), [which] came to favor strict enforcement of the Harrison Act"¹⁰¹. Early experiences with prohibition gave powerful advantages to bureaucrats in their relationship with the medical profession, and in countries with a long history of aggressive prohibition the dominance of the bureaucracy (and Drug War by extension) over the Harm Reduction priorities of the medical establishment is almost assured.

It is a mistake, sadly common in popular opinion and culture, to assert an uncomplicated relationship between "Big Pharma" and the state, and thus to suggest that all drugs policy is essentially an industry conspiracy against the public¹⁰². The first important point is that the pharmaceutical industry is not a monolith with a unified voice or set of interests, which vary widely based on firm size, nationality, and market strategy. Second, pharmaceutical firms *have* at times fiercely contested the increasing heavy regulation of their products and distribution networks by the DEA, though this has been on a case-by-case rather than a systematic basis. The Drug Abuse Control Act of 1965, which made many common pharmaceuticals prescription-only, was "bitterly opposed by the pharmaceutical industry"¹⁰³ Many pharmaceutical firms would plausibly benefit from looser regulation, especially those with research interests in the cannabinoid and psychedelic fields. The interests of the pharmaceutical industry vis-a-vis the state are not pre-determined or solely geared towards naked economic gain, but evolve through years

¹⁰¹ *Ibid*, 36

¹⁰² Martha Rosenberg, "6 ways Big Pharma manipulates consumers" (*Salon.com*, April 28, 2013)

¹⁰³ Jenkins, *Synthetic Panics*, 38

and decades of institutional and cultural routine. Firms operating in the drugs economy today, depending on the types of products and services they wish to offer, occupy one of three groups in regards to the drug regulation state. Only one of the types is an unambiguous supporter of Drug War policies in almost every instance. The vulnerabilities of the other positions, and especially the degrees of dependence on maintaining a working relationship with the bureaucracy, help explain why industry has not sought to substantially contest the strictures of the drug regulation state and has in most cases been a willing participant in drug prohibition.

1. New Entrants and Reformers

The first group is composed of firms whose desired market strategy is blocked by the actions of the drug regulation state, and so have an interest in some degree liberalization and reform. One example would be GW Pharmaceuticals, whose “oral marijuana spray, [Sativex](#), is a patented standardized dose of natural cannabis extracts”, but continues to face massive regulatory hurdles because of the blanket prohibition on cannabinoids¹⁰⁴. As will be detailed later in the cannabinoid and psychedelic sections, the heavy restrictions on research into these compounds were probably designed to prevent these economic interests from ever materializing. They also had a decades-long dampening influence on research which only started to fade in the mid-90s, and which stained all those working in the field with social illegitimacy:

“human research with hallucinogens has, until now, vanished from the scene...A source of embarrassment and shame, hallucinogen research became a non-issue, virtually disappearing from the professional literature and educational curriculums. By the early 1970s, psychiatric researchers and academicians had perceived that to

¹⁰⁴ Paul Armentano, “Why I’m Not Convinced Big Pharma is Behind Pot Prohibition” (*Huffington Post*, July 9, 2008)

continue to advocate for human research with hallucinogens, or to even be identified with past interest in their therapeutic potential, might seriously jeopardize their future careers...For those who would maintain their enthusiasm for the potentials of these singular substances, a path of professional marginalization would follow. For those who would take a stand against their perfidious threat, accolades and professional advancement would be forthcoming”¹⁰⁵

The substantial obstacles to any human research with these drugs and the social stigma surrounding their use in any context led major pharmaceutical firms to stay far away from any compound that showed even a hint of psychedelic activity.

Aside from their suppression by the drug regulation state, however, psychedelic drugs seem poorly designed to become the blockbuster commercial products that large pharmaceutical firms focus and depend on. Many of the most culturally popular psychedelics are plants or fungi with long histories of human use; they cannot be patented, and if legalized, could be grown by consumers rather than purchased. There is little to no evidence that the “classical” psychedelics have addictive qualities, or that synthetic variations produce substantially improved efficacy; and unlike all the best-selling pharmaceuticals, they work best with infrequent use rather than daily dosing:

“Relatively few studies used LSD as a “psychopharmacotherapeutic” agent in humans, *i.e.* daily dosing regimes...the psychedelic approach, favored by North American researchers, involved administration of a single, or at most a small number of, high dose (300 to 1500 mcg) LSD session(s) after a relatively short course of psychotherapy”¹⁰⁶

Worldwide, this group continues to be weak, and is mainly the province of small firms, non-profits like the MAPS (Multi-Disciplinary Association for Psychedelic Studies),

¹⁰⁵ Charles S. Grob MD, “Psychiatric Research with Hallucinogens: What Have We Learned?” (*Yearbook for Ethnomedicine and the Study of Consciousness*, 1994).

¹⁰⁶ Rick J. Strassman MD, “Hallucinogenic Drugs in Psychiatric Research and Treatment: Perspectives and Prospects” (*The Journal of Nervous and Mental Disease*, Vol. 183 No. 3, 1995)

university researchers, and of course, gray and black market chemists. Psychedelic research has enjoyed a renaissance, especially in the past decade; “the bitter and acrimonious debate that raged through the 1960s and 1970s and into the 1980s has subsided” in the FDA if not the DEA or the ONDCP, as “scientific and health policy makers have determined that these drugs, although possessing an inherent abuse potential, do have a safety profile of acceptable magnitude when compared to drugs currently the subject of formal research investigation as well as others actively dispensed in clinical practice”¹⁰⁷. Nevertheless, the bureaucratic obstacles to any of these drugs reaching even a restricted medical market are immense. Virtually all drugs approved by the FDA today are “fast-tracked” (a process which still takes years) through a process adopted under industry pressure in the early 1990s, but universities and nonprofits do not have the millions of dollars upfront required to access this inside track:

“The FDA was notoriously slow about approving new drugs until the industry agreed in 1992 to pay large (six-figure) user fees to expedite the process. By 1997, the FDA had received over \$320 million in fee income, mainly from the largest drug companies”¹⁰⁸.

2. The Neutral Sector

The second group is undoubtedly the largest and contains most of the largest pharmaceutical corporations that are mostly neutral in regards to the drug regulation state. They produce or sell products that are either largely uncontroversial and unregulated or controversial products that are nonetheless recognized as socially necessary. Unlike the

¹⁰⁷ Grob, “Psychiatric Research with Hallucinogens”

¹⁰⁸ Jenkins, *Synthetic Panics*, 92

small-scale non-profits and researchers in group 1, most of the firms in group 2 are for-profit corporations with products in the mainstream consumer or medical markets.

Because of this, group 2 has greater financial and political resources than group 1, and a much greater ability to defend its product markets from state intervention. In 2012, when the DEA spearheaded an effort to place controls on hydrocodone similar to those in place for more powerful opioids, a strong drug industry reaction motivated Congress to reject the measures¹⁰⁹. These companies might, at times, prefer a looser regulatory regime, and their relationship with the drug regulation state is sometimes adversarial. Nonetheless, they do not support publicly support reform or liberalization in the drug policy arena, either because they perceive the opportunity costs to be excessively high or because they view the drug regulation state's restrictions as a worthwhile trade-off for the benefits it can deliver.

The opportunity cost is the enmity of a government bureaucracy that has extraordinary power to allocate market rights and in the course of doing so can easily decide the future of a product and sometimes an entire firm. Firms at every single stage of the production chain for Scheduled substances depend on a working relationship with the DEA:

Enacted in 1970, the CSA establishes a statutory framework through which the federal government regulates the lawful production, possession, and distribution of controlled substances. Further, the act requires persons who handle controlled substances or listed chemicals (such as drug manufacturers, wholesale distributors, doctors, hospitals, pharmacies, and scientific researchers) to register with the Drug

¹⁰⁹ Guy, "Interview with the Drug Czar"

Enforcement Administration (DEA) in DOJ, which administers and enforces the CSA¹¹⁰.

An effort to change drug laws, always seen as a threat by the DEA, could invoke enhanced scrutiny in retaliation. The DEA showed, when it moved to quash the (flagrantly abusive) Florida painkillers market in the late 2000s, that it is willing and able stop the dispensing of Scheduled substances from pharmacies over a wide jurisdiction and tussle with national pharmacy chains¹¹¹. Any company seeking to change drug laws to sell a new product is more likely to be portrayed by the media as a callous and greedy pusher than a libertarian champion of individual freedom. Finally, the trend for decades has been towards greater restriction, and few firms are daring enough to put their own resources into fighting a seemingly inexorable global political project.

The largest firms also receive indirect benefits from a harsh regulatory environment, and they may be loath to give up these structural advantages. Quite simply, drug prohibition drives monopolization, on both the legal and illegal sides of the drug business, because political access becomes just as (if not more) important than product quality or market acumen. Drug testing and approval now requires a very large amount of money and a working relationship with the FDA, a huge barrier of entry for any new firm contemplating entering the market. The massively complicated drug approval process leaves almost no bureaucratic resources for monitoring pharmaceutical use in society: “In contrast to the streamlined approval process, the observation of adverse drug reactions is

¹¹⁰ Garvey, Todd. “Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay Between State and Federal Laws” (Report for the Congressional Research Service, November 2012) 2

¹¹¹ Doyle, Michael. “Feds battle Walgreens in painkiller distribution case” (*Miami Herald*, March 9, 2013) 1

relegated to a far less efficient and proactive system: once a pharmaceutical is approved, the work of exposing harmful effects is chiefly a matter for private activist groups and attorneys”¹¹².

Even better for established firms, the prohibitions of the drug regulation state have fallen most heavily on the most potentially innovative drugs, the psychedelics and the cannabinoids. Prohibition thus protects firms working with established drug families (opioids, stimulants, sedatives, and antidepressants) from being blindsided by new products from a body of compounds that the large pharmaceutical firms have largely neglected and understand poorly. This has today created a dichotomous system for substance classification based on origin. Substances synthesized by large pharmaceutical corporations, if considered liable to abuse, are placed in Schedule II or more likely III or IV. Substances derived from plant sources, or synthesized by independent researchers or chemists, are placed in Schedule I, regardless of their merits. Scientists wishing to engage in even the most benign experiments with a massive range of substances can only do so under the auspices of the government and top corporations supervised by the DEA¹¹³. The indirect effect of prohibition has been to confine legitimate medical research to massive corporations and a few universities, and to neglect or bury contributions from other sources no matter what their potential value. In conclusion, though there is no conspiracy by large pharmaceutical firms to support prohibition, and at times their interests run counter to those of the drug regulation state, they are nonetheless an important bulwark of support for the status-quo. Their conservative attitude towards reform can be explained by

¹¹² Jenkins, *Synthetic Panics*, 92

¹¹³ Todd Garvey, “Medical Marijuana”, 2

their dependence on the bureaucracy for market rights and the benefits they passively derive from the anticompetitive effects of prohibition.

3. Prohibition Profiteers

The third category will be crucial for this analysis and could be expanded to include many industries and firms beyond pharmaceutical production, especially drug testing & treatment and private corrections. These firms occupy product or service niches that are either sustained entirely or heavily subsidized by drug prohibition. Since their market strategies would be either useless or less effective in an open market, they have a strong motivation for increasing or at least maintaining existing restrictions surrounding drugs, and are alongside law enforcement bureaucrats the strongest supporters of harsh drug restrictions and drug war states.

These firms are the fiercest defenders of Drug War policies. In many cases they attempt to use the media or connections with the bureaucracy to make drug policy harsher in order to increase their opportunities for business. The strongest reaction against the recent legalization of marijuana by state initiative in Washington and Colorado came from the DEA and its former chiefs, eight of whom signed a letter to the Attorney General this March demanding a crackdown. Two of these former chiefs own the massive drug testing company Bensinger, Dupont & Associates, which conducts drug testing, mainly for marijuana, for “10 million employees around the US. Their clients have included the biggest players in industry and government: Kraft Foods, American Airlines, Johnson & Johnson, the Federal Aviation Administration and even the Justice Department itself”¹¹⁴. An especially strong alliance has formed in the US between prison guard unions and private

¹¹⁴ Kevin Gray, “The Drug Warriors Cashing In on Pot Prohibition” (*Thefix.com* March 21, 2013) 2

prison corporations; Corrections Corporation of America and GEO Group spent millions on political contributions during the 2000s (mostly in Florida, Georgia, and California), and combined, spend close to \$2 million dollars a year lobbying Congress to maintain high federal prison populations¹¹⁵. These efforts are supported by public sector law enforcement and prison guard unions, probably because “law enforcement agencies around the country could lose as much as \$11 billion in taxpayer money if marijuana prohibition is repealed, according to Harvard economics professor Jeff Myron. Weed arrests account for half of all drugs arrests in the US”¹¹⁶.

In the US, due to continual state underinvestment in drug treatment services, a large for-profit drug treatment sector has become another bulwark of Drug War policies. When President Nixon declared the first War on Drugs, he also promised federal support for treatment programs, and “publicly funded methadone maintenance clinics and therapeutic communities were established in cities around the country”¹¹⁷. But Ronald Reagan eviscerated funding for these programs while escalating enforcement, forcing those drug addicts who could pay into the private sector. The result was a profoundly unequal “two-tier system of response to drug dependence: treatment for the middle and upper classes and incarceration for most others, including the poor, the uninsured, ethnic minorities, and immigrants” and thus a “profusion of private sector drug treatments that offered detoxification, counseling, and other treatment services...[which] coexisted with continuing

¹¹⁵ Amanda Petteruti and Paul Ashton. “Gaming the System: How the Political Strategies of Private Prison Companies Promote Ineffective Incarceration Policies”, report by the Justice Policy Institute, June 2011.

¹¹⁶ Kevin Gray, “The Drug Warriors Cashing In on Pot Prohibition”, 2

¹¹⁷ Acker, *Creating the American Junkie*, 218

and pervasive stigmatization of drug users both as citizens and as patients"¹¹⁸. This group of firms will continue to forcefully advocate for Drug War policies no matter what the consequences are for the rest of society, and so will their employees, unless they can be persuaded that equally secure jobs would be available in a more humane system.

III. The practice of prohibition – drug scheduling in action

The reactions of mainstream American institutions in the late 19th & early 20th century to the new drugs that were becoming available established a model and rhetoric for later regulation and prohibition. From very early on, the reaction of the dominant American media and society figures towards drugs tended towards moral panic. Moral panic is "an incident of widespread social fear that appears seemingly out of nowhere and that grows in the space of a few months or years, then fades to nothing...Issues ignite public concern when they successfully focus generalized public anxiety over matters such as race, gender, ethnicity, or generational tensions"¹¹⁹. It can be suspected or diagnosed:

“when the official reaction to a person, groups of persons or series of events is out of all proportion to the actual threat offered...when the media representations universally stress 'sudden and dramatic' increases (in numbers involved or events) and 'novelty', above and beyond that which a sober, realistic appraisal, could sustain, then...it is appropriate to speak of the beginnings of moral panic"¹²⁰.

The first extracted alkaloids appeared commercially in the late 19th century, and more fully synthetic pharmaceuticals began appearing during the interwar period. Many of these drugs became associated with a particular foreign country, immigrant group, or racial

¹¹⁸ Acker, *Ibid.* 219, 9

¹¹⁹ Jenkins, *Synthetic Panics*, 4-5

¹²⁰ Stuart Hall et al, "Policing the Crisis: Mugging, the State, and Law and Order". *Crime and Social Justice* No. 12 (1979)

group. Drugs do not occur in the absence of users, but their inert forms are hooks on which to hang emotions and desires arising from stressful demographic and economic change. Drug policy is inherently close to the question of who is "in" and who is "out", of where the boundaries are or should be between nation, state, and individual. In a country with a highly normative, highly punitive drug state, the consequences for winners and losers both are enormous, and drug policy is likely to be heavily influenced by xenophobia and culture.

All drug classification systems are arbitrary, but fortunately, drug regulation states have for most of history been preoccupied with a few categories of substances. The following section divides the most heavily regulated and contested drugs into 'families' with similar uses and patterns of regulation. Each of these families, from a regulatory viewpoint, is potentially risky or harmful for a different reason. The types of risks presented, along with early observations of use patterns and user groups, provided the basis for state interest in the drugs economy and the construction of drug regulation states. The first step in a truly integrated drugs policy is a lucid examination of the risks and benefits of the drugs used in the modern world. Drug policy is not a smoothly continuous process; it has usually been formulated in bursts of activity followed by long periods of relative inaction. The initial encounters between regulatory institutions and each particular drug family were thus still influential in policy decades later, even when new social or scientific studies had overturned previous conclusions and assumptions. The institutional pattern is not, of course, set permanently, and there is evidence in the American case that certain drugs, especially heroin and methamphetamine, have had cyclical patterns of use over the course of decades.

A. Drug families I: Opioid narcotics

The opioids were the family of drugs most influential in bringing about the creation of a wide-ranging drug control authority. The story of the drug regulation state could in many ways be said to have begun with the extraction of morphine, “first isolated in pure form from opium latex in the first decade of the 19th century”¹²¹. Its simultaneous discovery by Derosne, Séguin, and Sertürner suggests that its isolation was only a matter of technological advancement, since the pain-relieving properties of opium had been known as far back as 4000 B.C.¹²² If any drug family cried out most obviously for some degree of restriction, it was the opioids, because they are both notoriously physically addictive and indispensable for the practice of medicine. Indeed, the commercialization of opium in the 19th and morphine in the 20th century was the strongest impetus behind the establishment of a licensed medical profession with privileged access to restricted medicines under the aegis of the state. In 1900, the pharmaceutical industry, the medical market, and the market for physicians were all disorganized and almost totally free from state control. By the end of WWI, however, this project had been almost completely accomplished. The rapid development of the drug regulation state can only be explained by the rapid growth in importance of the pharmaceutical and medical sectors during a time of nationalist competition and eventually industrial war.

Opioids, alongside alcohol and prostitution, were the highest priority for would-be reformers, but the stigma that legal regulation generated only interfered with sincere attempts to deal with increasing addiction. There is no doubt that the growth of opioid addiction was real, and that America society was unprepared to deal with the quick rise in

¹²¹ Perrine, *The Chemistry of Mind-Altering Drugs*, 49

¹²² *Ibid*, 45-49

drug use. But the foreign origins of opioids, and the deep fears the junkie lifestyle evoked in business leaders during an era of industrialization, led to a “lush mythology” which exaggerated the problem and stigmatized users far than was ever warranted or helpful.

The hypodermic syringe was invented in 1850s, heroin “introduced as a cough remedy in 1898”¹²³. In the years leading up to the Harrison Act’s enactment,

“the sale of opiates outside of medical channels increased, especially in northeastern American cities. Recreational use of opiates shifted from the smoking of opium centered in urban Chinatowns to nonmedical consumption of morphine, swallowed or injected subcutaneously...By 1910 heroin sniffing had attached to a shifting urban entertainment scene that included dance halls, poolrooms, and vaudeville theater...To many upper-middle-class Anglo-American Protestants, the traditional elites in American cities, this pattern of drug use reflected an alarming increase in vice, a problem that added to their anxieties about the profound social transformations resulting from industrialization, urbanization, and new patterns of immigration. Their concerns resulted in an array of Progressive Era reform movements”¹²⁴.

Unfortunately, the opiophobia unleashed by these progressives not only outlasted them, it allowed the burgeoning federal bureaucracy to sabotage the first attempts by doctors and social workers to manage the problem without the involvement of law enforcement. The intense normativity of the era’s social scientists and clinicians compounded the problem:

“the interaction between the first cohort of modern recreational opiate users and researchers in psychiatry and pharmacology produced a construction of the tough urban addict...closely linked to the creation of a federal treatment and enforcement structure grounded in a supply-side policy approach to dealing with unauthorized use of opiates and cocaine”¹²⁵

¹²³ Tracy and Acker, *Altering American Consciousness*, 5d

¹²⁴ Acker, *Creating the American Junkie*, 2-3

¹²⁵ Acker, *Creating the American Junkie*, 9

The American federal government first attempted to create a treatment hospital for opioid addicts in the 1930s, but it was sabotaged by its heavy use of coercion: “most of the inmates were federal prisoners serving sentences for violation of drug law...[and] within a few years of its opening”, “a combined hospital-prison became simply a prison”¹²⁶. The Federal government *has* allowed an increasingly broad range of Harm Reduction interventions by states, cities, and private groups, but the pittance allotted to these programs compared to enforcement, and the continued stigmatization and incarceration of addicts on a large scale, means that the US’s commitment to Harm Reduction remains mostly rhetorical.

It seems that the trend in the industrialized countries today, and even in the United States, is towards highly normative Harm Reduction policies for opioids. The latest annual report by the ONDCP is full of mentions to Harm Reduction programs and priorities:

“The Administration’s approach to drug policy...emphasizes the importance of recognizing that drug addiction is a chronic disease of the brain and that drug policies should be balanced, compassionate, and humane. To effectively address the disease, prevention, treatment, and recovery support services should be integrated into health care systems...It supports the use of modern approaches to the drug problem, to include the expansion of medication-assisted therapies for drug treatment and criminal justice reforms such as alternatives to incarceration that break the cycle of drug use, crime, incarceration, and re-arrest”¹²⁷.

Even the most conservative of policymakers should be able to appreciate that the battle cry of a “Drug-free America” makes no sense in the case of opioids.¹²⁸ They are used to relieve the unbearable pain of those in surgery, soldiers wounded in battle, terminal cancer patients, the very old on their deathbeds. Without them medicine would be, if not totally

¹²⁶ *Ibid*, 181

¹²⁷ “National Drug Control Strategy 2013”, Office of National Drug Control Policy, White House.

¹²⁸ Lenson, *On Drugs*, 14

impossible to practice, then at least exceptionally cruel. Most people in the industrialized world will, at some point in their life, be given these drugs by a doctor, and benefit from their still unequaled analgesic properties. The visibility of the opioids and the impossibility of disputing their usefulness have made Harm Reduction the obvious choice, even for governments that continue Drug War policies in general. Unfortunately, the rationality that has taken hold in health policy and clinics has not spread to law enforcement and popular culture. Users of illicit opioids are still heavily stigmatized (and are consequently secretive), and in many countries are still more likely to be blamed and incarcerated for their drug habit than referred to treatment or screened for co-morbid physical and mental health conditions.

In the US, this continuing stigma is evident in the mystique that continues to surround one particular semi-synthetic opioid, even as more powerful synthetics are regularly used in medical practice. One of the questions that began this Section II - why heroin is legal in Europe, but illegal in the United States - has not been answered. One possible explanation is that it has a higher abuse liability than morphine and other opiates, but no study has shown this to be consistently true¹²⁹. Another argument relates to a kind of institutional memory - "doctors are appalled at the thought of employing a substance about which there is so lush a mythology of superstitious dread and cultural revulsion"¹³⁰. But Switzerland and Britain, where the medical profession has fought *for* the use of heroin, have just as long a history as the US with opioids and addict populations. The differences in national usage of particular opioids, however, points towards industry influence on which

¹²⁹ Pendell, *Pharmako* Vol. 1 *Pharmako/poeia*, 122

¹³⁰ Perrine, *The Chemistry of Mind-Altering Drugs*, 66

opioids are preferred for medical practice. The US, more than any other country, has shifted towards synthetic and semi-synthetic opioids, especially oxycodone and oxymorphone.

There is no pharmacological reason to prefer oxycodone to morphine. But today the United States manufactures 83% and consumes 80% of the oxycodone produced globally¹³¹. Oxycodone was one of the synthetics produced by Germany when the country was isolated from opium supplies during wartime. Its patent long-expired, Purdue Pharma repackaged it in 1995 in time-release form (a “contin”). Purdue’s advertising strategy aimed to explicitly confront and capitalize on the opiophobia instilled in the American medical profession by Drug War policies. It “knew it needed to overcome doctors' fears about addiction, so it treated the time-release formula as a magic bullet. It claimed the drug would give pain patients steadier 12-hour coverage, avoid withdrawal, and frustrate addicts seeking a euphoric rush”¹³². Sales rapidly increased “from \$45 million in 1996 to \$1.5 billion in 2002 to nearly \$3 billion by 2009”¹³³. Unlike morphine, it can be derived from thebaine - a non-narcotic poppy alkaloid that can only be derived in industrial quantities from genetically engineered poppy strains grown in Spain and Australia. Those two countries accounted for 96% of all thebaine exports in 2010, but industry in the US processes it into a usable form and produces 60% of the world’s industrial thebaine¹³⁴.

Oxycodone is, of course, no less euphoric or addictive than any other strong μ -opioid agonist, a fact that doctors, patients, and addicts across America quickly began to realize.

¹³¹ International Narcotics Control Board, “Narcotic Drugs: Estimated World Requirements for 2012 and Statistics for 2010” (INCB Technical Publications: accessed March 20 2013) 87

¹³² Katherine Eban, “Oxycontin: Purdue Pharma’s Painful Medicine” (*Fortune*, November 9 2011)

¹³³ *Ibid.*

¹³⁴ INCB “Narcotic Drugs: Estimated World Requirements” 84

But this happy coincidence of domestic manufacturing, reliable supply from allied countries, and allegedly non-addictive analgesia went a long way towards accounting for the success of oxycodone and the lack of state interest in supervising its use until widespread abuse and addiction (especially in Florida) were too blatant to ignore. Purdue Pharma was able to avoid federal prosecution by funding campaigns to warn and educate about prescription abuse and paying the government a \$600 million fine. The company started “RX Patrol, a website that circulates police reports on drug crimes” and even “offers rewards for citizens who bring perpetrators to justice”, a strategy to reinforce oxycodone’s legitimacy by blaming its problems on criminals with a desire to get high rather than a deliberately misleading marketing strategy and loose supervision of prescriptions¹³⁵.

The switch to oxycodone had benefits for the state and industry - more of the processing is done domestically for thebaine than for morphine, it cannot be diverted for heroin production, and it can be obtained from Western democracies rather than developing countries in Asia and Africa. The benefits for Purdue Pharma were impressive - their product not only captured significant market share, but also drove massive growth in the painkiller market as whole. In 2010 they captured \$3.1 B of the \$11 B painkiller revenues in the United States 2010¹³⁶. Unclear, and apparently immaterial, are the interests of patients, who were encouraged to pay significantly more for a drug falsely portrayed as non-addictive and not liable to overdose or tolerance. Furthermore, due in large part to strategies like those used by Purdue, opioid use in the US has skyrocketed in the past two decades, with uncertain consequences in the long run. Three times as many Americans died

¹³⁵ Eban, “Oxycontin: Purdue Pharma’s Painful Medicine”

¹³⁶ *Ibid.*

from opioid overdoses in 2008 than in 1999, and the US alone now consumes more than half of the world's opioid production each year¹³⁷.

B. Drug families II: Psychedelics and cannabinoids

The Drug War type built on earlier systems of drug prohibition, but went far beyond them in its scope and ambitions. The Drug War state first appeared in the United States in the late 1960s, and it was prompted more by psychedelic and cannabinoid use than by any of the other new recreational drugs. "Two "drug wars" have been waged since World War II...The first escalation of drug enforcement occurred between 1965 and 1970, when the drug arrest rate rose from 34 to 228, a 114 percent annual rate of increase"¹³⁸. Why did these drugs, those that most specifically alter consciousness, attract such fearful reactions from conservatives and authority figures? The answer, in America, is that a resistance against the state's power in one area, the power to make war, became associated with drug deviance. The timing of the first War on Drugs was impeccable: "it's declaration by President Richard Nixon in 1973 came just as American forces were returning from Vietnam, and just as the countercultural revolution was disintegrating at home...Domestic political opposition to the war rippled out into broader cultural insurgency, and the counterculture was born...¹³⁹"

Perhaps because the counterculture, a product of the Vietnam War, was explicitly a "revolution of consciousness", a "reaction back into the old individualist idealism of the American nineteenth century" which "rejected not only the memories, art, ethics, and politics of the previous generation, but its very consciousness, whatever it was that made

¹³⁷ Eban, *Ibid.*

¹³⁸ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 6

¹³⁹ Lenson, *On Drugs*, 10

hatred of the Other worth the price of extinction”¹⁴⁰. The criticisms that the counterculture made of postwar consumer society were frightening to those who had grown up in earlier times and still valued social stability and authority, and figures like Leary and Alpert specifically attributed these criticisms to the insights they received from psychedelics:

“along with the social upheaval surrounding opposition to an increasingly unpopular war in South-East Asia, hallucinogens assumed a central role in a movement that began to question many of the basic values and precepts of mainstream Euro-American culture. The populace, fueled by sensational media accounts, grew to identify hallucinogens as a prime suspect in inciting the accelerating state of cultural havoc. And along with the drugs themselves, adherents of the experimental and treatment models became increasingly identified as part of the problem. Such circumstances were in no way improved by the rash pronouncements from the radical wing of what had rapidly become identified as an hallucinogen-inspired political movement”¹⁴¹

On top of this, the counterculture was intensely critical of America society during a time of national crisis, as the country contemplated its first military defeat in generations:

“the war was going badly, [and] a scapegoat was needed. The counterculture and allied political dissent from the war effort were conflated under the rubric of drugs...The declaration of the War on Drugs in 1973 represented a relocation of the enemy from a country half a world way to our own cities and towns. It was – and to some extent still is – a war of revenge against U.S. citizens held responsible for the defeat in Vietnam”¹⁴².

Conservatives and the federal government learned to associate psychedelic drugs with political protest, and this fear persists today: “Widespread use of drugs might spawn a class of Others for whom perception itself is variable and capable of operating in more than one mode. It might even (as for an instant in the 1960s) lead to mass apostasy”.¹⁴³

¹⁴⁰ *Ibid.* 10

¹⁴¹ Grob, “Psychiatric Research with Hallucinogens”

¹⁴² Lenson, *On Drugs*, 9-11

¹⁴³ *Ibid.*, 29

But the disproportionate repression directed towards these drugs may have even deeper roots. Compared to alcohol as well as other illicit drugs of abuse, the traditional psychedelics and marijuana are much less liable to cause overdoses, cancer, addiction, and violence. Under a pure Harm Reduction type, they become de-prioritized, simply because they do not pose the same social risks as the opioids and stimulants. What they *might* pose a risk to, unlike the opioids and the stimulants (which are in some sense the perfect capitalist products, “a kind of parody of the routine engines of desire”) is the consumerist materialism that has encouraged under flexible accumulation¹⁴⁴. Perhaps the federal government’s inability to admit this fear is the reason that the official reasons against marijuana medicalization and legalization have changed little over the decades and today seem outdated in an age where psychoactive pharmaceuticals are ubiquitous:

“the rhetoric of the industrial age still prevails, wherein a worker using cannabis is said to be unproductive, a student incapable of learning, a driver more prone to accidents...but...the real heterodoxy lies in the fact that cannabis’s oneiric or aesthetically disinterested consciousness can momentarily detach the user from the consumerist matrix on which both the postmodern economy and its social order depend”¹⁴⁵

Cannabis and the psychedelics were also perfect symbols for the counterculture because they could be grown by individuals or small groups rather than mass-produced and distributed through commercial or medical systems. These drugs may not be inherently anti-capitalist, but it did not seem (at least initially) that could become just another commodity. Lenson, however, suggests that this side-effect was in fact purposeful and intended, describing it as “Consumerism policing itself, rather than Consumerism

¹⁴⁴ Lenson, *On Drugs*, 116

¹⁴⁵ *Ibid*, 108

policing the world to protect it from anti-capitalist “others” like Communists or neutrals”¹⁴⁶:

“In the 1960s pot smoking became a symbol of the counterculture’s anticapitalist bias; the drug was *supposed* to be free...curtailing cultivation only drives users back into the black market. One wonders if this was its aim. In this way users are at least compelled to reenter a consumerist arena of some kind, even if an illegal one. The skyrocketing cost of marijuana during this period suggests that its economic nature has been redefined: from “free herb” to a luxury consumer item. This metamorphosis aligns marijuana more closely with other drugs that cannot be so readily produced privately for personal consumption, and facilitates the notion that “drugs” are in some sense all the same”¹⁴⁷

Pushing users back into the familiar degradations of the black market, despite its consequences for these users and society, may have seemed less frightening than allowing them to freely develop a system of unregulated, de-commodified production by small communities and individuals.

Again, it is impossible to ascertain how vital the drugs really were to the politics and consciousness of the era. The best evidence that they *were* significant is the importance attached to them by both proponents and detractors, and the disproportionality of the crackdown when it came. What is certain is that the early use of marijuana and LSD in the West “intersect[ed] with several powerful social forces in American culture: the leaden proprieties of the conformist ‘50s, Leary’s “parochial social insanities”, were being cast aside...[and] the presumptive authorities of church and state were being revealed as the corrupt proponents of an immoral war; and the ugly gangrene of American racism was

¹⁴⁶ *Ibid.* 109

¹⁴⁷ *Ibid.* 109

being exposed by the civil rights movement”¹⁴⁸. These drugs would not be easily forgiven, indelibly associated in the eyes of authorities with political radicalism.

Nixon fell, but the Drug War state did not; “After Nixon’s resignation in 1974, the intent to prosecute the War on Drugs was emblemized by President Gerald Ford’s appointment of Nelson Rockefeller as vice president, since Rockefeller, as governor of New York, had implemented the most draconian drug laws in the nation’s history”¹⁴⁹.

Incarceration rates continued to rise, but more slowly than before, at least until Reagan came into office. Marijuana use, though it remained illegal, was never eradicated from segments of the popular culture, and even by the end of the ‘70s it was losing its ability to shock the public into moral panic. The damage done to psychedelics was more lasting and more severe: “The hallucinogens, along with the proponents of their continued exploration, were cast out, becoming pariahs in a land and a time that increasingly viewed them as threats to public safety and social order”¹⁵⁰. As discussed in Section II, they have once again become subjects of intense scientific interest and research, conducted by a more cautious and rigorous generation. “[T]empered with an appreciation that the controversial nature of these drugs caused a suspension of nearly a generation’s worth of research”, they have learned to emphasize “ongoing studies...taking a painstaking, systematic approach, and...avoiding claims that cannot be substantiated by data”¹⁵¹. The downside of this low-profile approach is that these researchers are very hesitant to engage in public advocacy and activism for drug law reform.

¹⁴⁸ Perrine, *The Chemistry of Mind-Altering Drugs*, 266

¹⁴⁹ *Ibid*, 9-11

¹⁵⁰ Grob, “Psychiatric Research with Hallucinogens”

¹⁵¹ Strassman, “Hallucinogenic Drugs in Psychiatric Research and Treatment”

C. Drug families III: Stimulants

By the last few years of the 1970s, it seemed like the huge demographic shifts in American drug consumption habits would spell an end to decades of restrictive drug policy on marijuana. President Carter and several federal agencies publicly called for the decriminalization of personal amounts of marijuana. By the “height of the decriminalization movement in 1977-78”, “eleven states and several cities” had done so, “seventeen more significantly reduced their penalties” and overall, “strict enforcement of drug laws seemed benighted and futile”¹⁵². “It seemed for a time that pot, at any rate, was destined for some form of legalization. The turning of the tide against it is often attributed to the advent of cheap mass-marketed stimulants”¹⁵³. Crack and methamphetamine provided opportunities to portray stimulant use as a problem caused by and affecting, respectively, urban blacks and rural working-class whites, rather than a national problem of abuse tacitly encouraged by states and business interests in the postwar economy.

Synthetic stimulants, outside of medical use, are more associated with work and the working class than any other class of drugs. Unlike other drugs associated with the underclasses, however, stimulants have proved popular with employers as well; witness the presence of coffee makers in almost every American corporate office. Pendell describes amphetamine as:

“The worker’s friend, but the boss’s friend as well. You’re putting out extra, ramping overtime, robbing your body to finish the shift. The boss meets his quota and pockets the surplus. Colonial bosses in South America paid their workers with coca”¹⁵⁴

¹⁵² Jenkins, *Synthetic Panics*, 56

¹⁵³ Lenson, *On Drugs*, 116

¹⁵⁴ Pendell, *Pharmako* Vol. 2 *Pharmako/Dynamis* 153

This is probably because in low, measured doses, stimulants (including the most popular drug in the world, caffeine) don't seem like drugs; they are

“perceived as nearly transparent to both cognition and intellect. The user is able to function well in almost all physical and mental activities – better, indeed, because she or he is oblivious to hunger and fatigue...Often people *feel like working*...motivation to work seems to be conflated with or empowered by a sublimated mechanism of desire. It is because of the basic compatibility of stimulants at this level with work and ordinary social life that these drugs were at first thought to be relatively transparent”¹⁵⁵

The initial enthusiasm for amphetamine, the prototypical modern stimulant, should therefore not be surprising. Caffeine is, in almost every way, an inferior substance:

“caffeine generally has no effect on reaction time while amphetamine improves reaction time; caffeine impairs hand steadiness while amphetamine improves hand steadiness; amphetamine improves coordination performance more than does caffeine. In all areas, amphetamine at the proper dosage had fewer side effects than caffeine. *Neither caffeine nor amphetamine improved intellectual performance*”¹⁵⁶

Ironically, caffeine's unpleasant side effects and higher general toxicity make impossible the massive binges, dose escalations, and resulting psychotic escapades that amphetamine addicts engage in. When corporate white America was confronted by the true nature of its favorite productivity aid, it reacted with an understandable horror.

Stimulants, at first embraced by the state during wartime and the postwar boom, eventually became more stigmatized (in illicit forms of use) than any other class of substance. Many of the initial users were soldiers, as “during World War II, large quantities of amphetamine (hundreds of millions of doses) were issued to soldiers, sailors, and

¹⁵⁵ Lenson, *On Drugs*, 118

¹⁵⁶ Pendell, *Pharmako* Vol. 2 *Pharmako/Dynamis* 149-150

aviators on both sides of the conflict”¹⁵⁷. Speed (the popular name for amphetamine) was used for productivity, not just by beatnik writers like Jack Kerouac, but mathematicians like Paul Erdos, as well as millions of workers at all levels of the economy:

“The 1950s were the speed decade. In 1954 two percent of the adult population of the United States used amphetamine habitually, and a much larger percentage used amphetamine occasionally. The numbers were even higher in Japan. Speed, we might say, fueled the post-war recovery...As late as 1971, stimulants, mainly amphetamines, were reported to account for twenty percent of medical prescriptions”¹⁵⁸

But as use accelerated and developed, the side effects of heavy amphetamine use became increasingly impossible to ignore: “Rampant paranoia. Bad-mouthing. Violence and general unsocial acting out. Complete loss of perspective. Burn out, or full schizophrenic psychosis. Trouble”¹⁵⁹.

The problem is that the mental “transparency” of stimulants, and their compatibility with normal social function, is only a cultural construction, and one that quickly breaks down at very high doses or with more intense routes of administration like smoking or intravenous injection. Instead of functioning optimally, “the mind seems to be running too fast, so that narrative and logical connectors begin to disintegrate”¹⁶⁰. In binges or extreme doses, stimulants can “invert[] the hierarchies of motivation by which people conduct their daily lives”, revealing the “voracity of human desire at its uttermost” and bringing on a state which “clinical literature variously describes...as schizophrenic, psychotic, or autistic ...to the clinical observer, [the] behavior closely resemble[s] the compulsions of

¹⁵⁷ Pendell, *Pharmako* Vol. 2, 150

¹⁵⁸ Pendell, *Pharmako* Vol. 2, 150-51

¹⁵⁹ Pendell, *Ibid.*, 153

¹⁶⁰ Lenson, *On Drugs*, 117

psychotics”¹⁶¹. To an unprepared observer, a speed freak-out can be profoundly disturbing; despite myths in popular culture, stimulants are much more likely to cause psychotic episodes than the psychedelics, and high doses combined with sleep deprivation can provoke in otherwise-normal individuals a state that is almost indistinguishable from paranoid schizophrenia.

Speed users found little sympathy in the psychedelic counterculture of the 1960s and 70s. The highly visible consequences of stimulant abuse, plus amphetamine’s association with corporations and the military, led the otherwise drug-friendly counterculture to participate in the stigmatization of speed users. Flagrant abuse of any drug can produce anti-social consequences, but speed was also “associated with working-class youth whose behavior and aspirations often clashed with the more middle-class hippies”¹⁶². Countercultural icons like Allen Ginsberg denounced amphetamines and their users:

“Speed is anti-social, paranoid-making, it’s a drag, bad for your body, bad for your mind, generally speaking, in the long run uncreative and it’s a plague in the whole dope industry. All the gentle nice dope fiends are getting screwed up by the real horror monster Frankenstein speed freaks who are going around stealing and bad mouthing everybody”¹⁶³

In mainstream society, stereotypes of the crackhead and the tweaker replaced the by-then worn stereotype of the stoned hippie, who had begun to seem more comical than threatening.

The shift from a liberal atmosphere to an all-out drug war occurred with astonishing speed. Tragically, the more tolerant policies of the late ‘60s and ‘70s may have contributed

¹⁶¹ Lenson, *On Drugs*, 132, 122

¹⁶² Jenkins, *Synthetic Panics*, 45

¹⁶³ *Ibid*, 43-44

to their own demise - by being successful. At the start of the 1984-89 escalation, “illegal drug use among high school seniors and persons in households already had been declining for half a decade”¹⁶⁴. Stimulants had already lost a great deal of social legitimacy in the wider culture: after being stigmatized in an intense campaign organized by Senator Dodd of Connecticut, their casual availability was curtailed and “seriously addicted pill heads” were subjected to an intense campaign of dehumanization and association with “extreme instances of random violence and crime sprees”¹⁶⁵. Overall, a trend of “[d]eclining white and middle-class usage permitted the drug problem to be framed as a distinctively urban and minority phenomenon”¹⁶⁶. Stimulant abuse was redefined with crack as an urban black problem, and again with methamphetamine as a problem of the rural working class. This entailed some suppression of historical memory, since methamphetamine, the “deadly new drug” of the ’70s, ’80s, ’90s, and 2000s has been a popular drug in regional American markets since the early 1950s and ’60s¹⁶⁷. Scrutiny of government use of stimulants during wartime, and of the marketing and prescribing practices for medical amphetamines, melted away in the face of a new, seemingly unending moral panic.

The rising profits of the private sector treatment industry and the new drug testing industry showed the healthcare sector that prohibition did not necessarily mean reduced profits. This new productive dynamic between the private drug treatment industry and the drug war state led to a tacit industrial endorsement of draconian drug war policies. Finally, law enforcement organizations in the US had a powerful new incentive to prosecute particular kinds of drug offenders. In the 1980s the DEA, bolstered by the synthetic and

¹⁶⁴ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 172

¹⁶⁵ Jenkins, *Synthetic Panics*, 37

¹⁶⁶ *Ibid*, 97

¹⁶⁷ *Ibid*, 38

stimulant panics, “complained to Congress that it was short on PE/PI (Purchase Evidence and Pay for Information) money”. In response, Congress made major amendments to asset forfeiture laws in 1984¹⁶⁸. The Comprehensive Crime Act of 1984 “required the Justice Department to share the proceeds with state and local agencies participating in the investigations”, a “bureaucratic innovation which allowed for an expanded interbureaucratic network of cooperation”¹⁶⁹. Now, if local or state police could attract federal interest, they stood to share in the substantial gains from asset seizures, which by 1991 had become worth \$700 million annually.

The DEA was allowed to pay informants directly from the assets seized in cases, and responded with a deliberate strategy of mass arrest and conviction. Rather than going directly after traffickers or large suppliers, “a large number of arrests and convictions of drug buyers and street-level sellers [was] made relatively easily” to try to “induce cooperation” by bargaining “the release of assets seized...[or] a money payment” against the threat of a harsh prison sentence: “[t]he higher minimum sentences passed by state legislatures and the Congress gave prosecutors a more significant threat that could be used to induce accused drug criminals to bargain”¹⁷⁰. Together the private treatment sector, the courts, police agencies, and the federal drugs bureaucracy became developed a powerful vicious cycle of incarceration and asset seizure which, if diminished from its peak, continues to this day. The numbers climbed year after year, only leveling off in the ‘90s:

“Drug arrests per 100,000 population reached its peak level of 528 in 1989, a twenty-fold increase from its 1960 level of twenty-six...the drug arrest rate grew slowly between 1970 and 1984, about 2.6% per year. Renewed escalation of drug

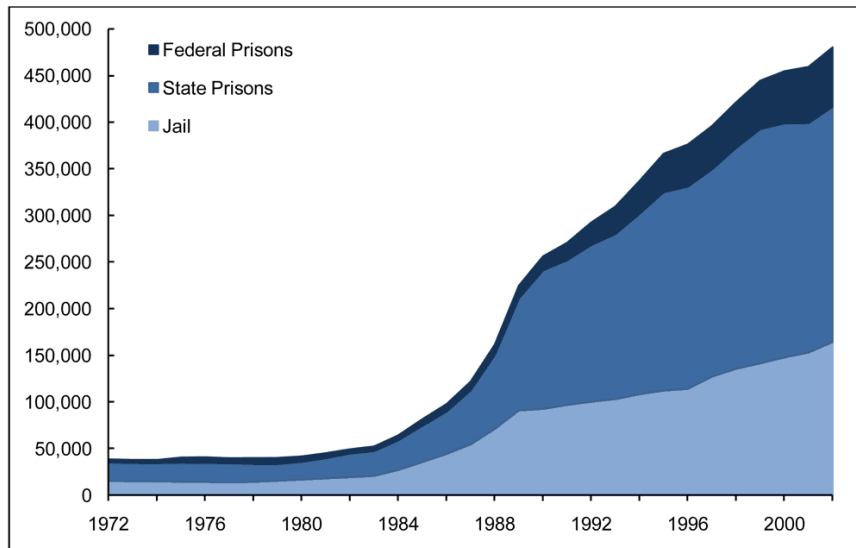
¹⁶⁸ Rasmussen and Benson, *The Economic Anatomy of a Drug War*, 165

¹⁶⁹ *Ibid*, 132

¹⁷⁰ *Ibid*, 164-65

enforcement during the 1984-1989 [the war on cocaine] period saw arrests per 100,000 population rise from 312 to 538, an average annual increase of 14.5%...Together the 1965-1970 and 1984-89 periods account for over 80 percent of the increase in the drug arrest rate from 1960 to 1990"¹⁷¹.

Figure 1: Estimated number of adults incarcerated for drug law violations in the United States, 1972 - 2002.



Source: Data were extracted from Beck (1997), Beck & Glaze (2002), Cahalan (1986), Harrison & Karberg (2003), and Pastore & Maguire (2003) as described in Caulkins et al. (2006).

IV/Conclusion: Twilight of the Drug War state?

It is tempting to imagine how drugs policy might look if cultural biases and historical institutionalism could be cast aside. The closest case to that scenario has been the development of drug policy in Portugal since 1974, and it offers promise for the future of drug policy reform. Ironically, the country's isolation during a right-wing dictatorship largely insulated it from both 20th century drugs and drug laws. The development of a liberal harm-reduction focused drug policy in Portugal benefitted from the country's late exposure to addiction and widespread drug use. While the country adopted the recommendations of the International Opium Convention of 1912, the country did not

¹⁷¹ *Ibid*, 6-7

begin to systematically regulate the “production, traffic and use of narcotics” until 1970, when the country was still under a dictatorship. Unsurprisingly, that law provided for punitive sanctions in the form of incarceration: two to eight years for trafficking, six months to two years for “consumption causing danger”¹⁷².

In drug policy terms, Portugal was fortunate in that its 1974 democratic revolution occurred during a period of drug experimentation by the middle class and young similar to the second demographic shift experienced in 1960s and ‘70s America. This new experimentation was “associated with the idea of new-found freedoms” and the government created a Youth Studies Centre and Drug Criminal Investigation Centre to develop a rational and coordinated program of supply reduction and intervention¹⁷³. The idea of drug decriminalisation developed within the Youth Studies Centre, and was introduced in 1976 in a text “suggest[ed] that the ‘concept of drug use as a criminal act’ should be revised and replaced...to bring it under an administrative offence framework”. Even after ratification of the 1971 UN Convention on Psychotropic Substances and its “increased...repressive focus on drug trafficking” the “law recognised the drug user as a patient in need of medical care, stating that the priority was to treat and not to punish”¹⁷⁴.

Portuguese society avoided the traumatic turn-of-the-century drug panics that were so influential in developing the concept of drug use as a criminal rather than as a health problem. The closed society of Portugal’s dictatorship may have incidentally helped by limiting in-migration; drug use was never associated with foreigners or ethnic minorities, nor was it especially associated with political radicalism. The lack of political salience in the

¹⁷² Moreira, Hughes, Costa Storti, and Zobel, “Drug policy Profiles - Portugal” 9

¹⁷³ *Ibid.* 10

¹⁷⁴ *Ibid.* 11

drug issue in Portugal allowed government bodies to develop policy without distorting influence from the media, industry, or moral entrepreneurs. In the aftermath of a dictatorship there was no desire to sustain or recreate the kind of repressive apparatus necessary to implement a prohibition drug policy. The liberal atmosphere resulting from a successful democratic transition may best explain why Portugal's government was willing to work with the tide of demographic change and wider drug experimentation rather than embracing the zero-tolerance conservative attitude that became dominant in Western drug policy in the 1970s and '80s.

The Drug War type is facing the strongest challenges today that it has since its inception. In Europe, increasing public knowledge about drugs and a diminished appetite for incarceration is leading most countries in the directions of Harm Reduction or Decriminalization for the most common illicit drugs. Copenhagen has announced that it will create legal cannabis markets, unilaterally if necessary, and other liberal European cities have expressed interest in similar policies¹⁷⁵. Two United States have passed referendums requiring their state governments to do the same, and federal drug enforcement is seeing budget cuts for the first time in decades due to the "sequester"¹⁷⁶. Continuation of Drug War policies for cannabis at the national level are indeed threatened; while the federal government may be able to shut down a large number of dispensaries, "principles of federalism prevent the federal government from mandating that the states support or participate in enforcing the federal law"¹⁷⁷. But the explosion of ideas for Decriminalization and Legal Markets in Latin America may be the biggest threat of all. Uruguay's plans to

¹⁷⁵ Peter Stanners, "Life after cannabis prohibition: The city announces its ambitions" (*The Copenhagen Post*, March 15, 2013)

¹⁷⁶ "The Federal Drug Budget Under Sequestration" (policy brief by Carnevale Associates, Dec 2011)

¹⁷⁷ Garvey, "Medical Marijuana", 6

legalize marijuana, Bolivia's to decriminalize or legalize coca, and continent-wide tolerance for the native psychedelic ayahuasca strike at the cultural divisions between "drugs", "alcohol", and "medicines" that are the basis of almost every drug regulation state¹⁷⁸.

For proponents of reform, it is an exciting time to be alive. It would be naïve, however, to expect that liberalization will continue without obstacles, or that the backlash has not already started to materialize. Large numbers of workers and powerful financial interests are dependent on the maintenance of a harshly punitive drugs policy. Reform involves creating new jobs in health and public safety to replace those that must be lost in law enforcement and the prison industry. Above all, this paper should caution that not all proponents of reform want the same things, or carry the same assumptions about drug use. The gaps between Legal Markets, Decriminalization, and Harm Reduction are very real, and their advocates have very different ideas about the level of drug use that is acceptable or desirable in society. Countries, based on their economies and the histories of their state institutions, have different capabilities and limitations. Change will not be easy, and it will take time; but the reform movement today is stronger than ever before, and stronger for its diversity of opinions. Drug policy is once again becoming a contentious, complicated, raucous, diverse and politicized debate – as it should be.

¹⁷⁸ McCarton Ackerman, "Uruguay Lays Out Plan for State Pot Business" (*thefix.com*, July 30 2012)

Bibliography

Acker, Caroline Jean. *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control*. Baltimore & London: Johns Hopkins University Press, 2002.

Ackerman, McCarton. "Uruguay Lays Out Plan for State Pot Business" (*thefix.com*, July 30 2012)

<http://www.thefix.com/content/uruguay-government-marijuana90443>

Allen, Rob. "Reducing the Use of Imprisonment: What Can We Learn from Europe?" Report for Criminal Justice Alliance, May 2012.

http://www.prisonpolicy.org/scans/CJA_ReducingImprisonment_Europe.pdf

Armentano, Paul. "Why I'm Not Convinced Big Pharma is Behind Pot Prohibition". *Huffington Post*, July 9, 2008.

http://www.huffingtonpost.com/paul-armentano/why-im-not-convinced-big_b_111523.html

Carter, Jimmy. "Drug Abuse Message to the Congress.," August 2, 1977. Online by Gerhard Peters and John T. Woolley, *The American Presidency Project*.

<http://www.presidency.ucsb.edu/ws/?pid=7908>

Coolican, J. Patrick. "Beer Lobby gives \$10,000 to 'No' On Prop 19 Pot Legislation". *LA Weekly*, September 21, 2010.

http://blogs.laweekly.com/informer/2010/09/beer_lobby_gives_10000_to_no_o.ph

p

Daemmrch, Arthur. *Pharmacopolitics: Drug Regulation in the United States and Germany*. Chapel Hill & London: University of NC Press, 2004.

Doyle, Michael. "Feds battle Walgreens in painkiller distribution case". *Miami Herald*, March 9, 2013.

<http://www.miamiherald.com/2013/03/19/3295204/feds-battle-walgreens-in-painkiller.html>

Eban, Katherine. "Oxycontin: Purdue Pharma's Painful Medicine". *Fortune*, November 9, 2011.

<http://features.blogs.fortune.cnn.com/2011/11/09/oxycontin-purdue-pharma/>

Gamble, Andrew. "The Free Economy and the Strong State: The Rise of the Social Market Economy". *Socialist Register* Vol. 16 (1979): accessed April 18, 2013.

<http://socialistregister.com/index.php/srv/article/view/5431#UXnFs4KKP> 9u

Garvey, Todd. "Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay Between State and Federal Laws". Report for the Congressional Research Service, November 2012.

<http://www.fas.org/sgp/crs/misc/R42398.pdf>

Gladwell, Malcolm. "Drinking Games". *New Yorker*, February 15, 2010.

http://www.newyorker.com/reporting/2010/02/15/100215fa_fact_gladwell

Grob, Charles S. "Psychiatric Research with Hallucinogens: What Have We Learned?".

Yearbook for Ethnomedicine and the Study of Consciousness (1994): accessed April 20, 2013

<http://www.druglibrary.org/schaffer/lsd/grob.htm>

- Gray, Kevin. "The Drug Warriors Cashing In on Pot Prohibition". *Thefix.com*, March 21, 2013.
<http://www.thefix.com/content/marijuana-legalization-drug-prohibition-lobbying-revolving-door8111>
- Guy, Mike. "Interview with the Drug Czar". *Thefix.com*, July 2012.
<http://www.thefix.com/content/interview-drug-czar-gil-kerlikowske7459?page=all>
- Hall, Stuart et al. "Policing the Crisis: Mugging, the State, and Law and Order". *Crime and Social Justice* No. 12 (1979): accessed April 18, 2013.
<http://www.jstor.org/stable/29766074>
- Harvey, David. *The Condition of Postmodernity: An Enquiry into the Origins of Cultural Change*. Oxford: Blackwell Publishers Inc, 1990.
- International Narcotics Control Board, "Narcotic Drugs: Estimated World Requirements for 2012 and Statistics for 2010". INCB Technical Publications: accessed March 20, 2013.
http://www.incb.org/documents/Narcotic-Drugs/Technical-Publications/2011/Part_FOUR_Complete_English-NAR-Report-2011.pdf
- Jenkins, Philip. *Synthetic Panics: The Symbolic Politics of Designer Drugs*. New York & London: New York University Press, 1999.
- Lenson, David. *On Drugs*. Minneapolis, MN: University of Minnesota Press, 1995.
- Mack, Alison and Janey Joy, *Marijuana as Medicine? The Science Behind the Controversy*. Washington D.C. : National Academy Press, 2001.
- Maria Moreira, Brendan Hughes, Claudia Costa Storti, and Frank Zobel, "Drug policy

Profiles - Portugal” in *EMCDDA Drug policy profiles* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction, June 2011)

<http://www.emcdda.europa.eu/publications/drug-policy-profiles/portugal>

“National Drug Control Strategy 2013”, Office of National Drug Control Policy, White House.

http://www.justicepolicy.org/uploads/justicepolicy/documents/gaming_the_system.pdf

New York City Bar. “The International Drug Control Treaties: Just How Important Are They to US Drug Reform?” report for Committee on Drugs & the Law (New York: NYC Bar Association, May 2012).

http://www2.nycbar.org/pdf/report/uploads/5_20072283-InternationalDrugControlTreaties.pdf

Pendell, Dale. *Pharmako* series Vol 1,2,3. *Pharmako/Poeia, Pharmako/Dynamis, Pharmako/Gnosis*, Berkeley, CA: North Atlantic Books, 2010.

Perrine, Daniel. *The Chemistry of Mind-Altering Drugs*. Washington D.C. : American Chemical Society, 1996.

Petteruti, Amanda and Paul Ashton. “Gaming the System: How the Political Strategies of Private Prison Companies Promote Ineffective Incarceration Policies”, report by the Justice Policy Institute, June 2011.

http://www.justicepolicy.org/uploads/justicepolicy/documents/gaming_the_system.pdf

Rasmussen, David and Bruce Benson. *The Economic Anatomy of a Drug War: Criminal Justice in the Commons*. Lanham, MD: Rowman & Littlefield Publishers Inc, 1994.

Rosenberg, Martha. "6 ways Big Pharma manipulates consumers", *Salon.com*, April 28, 2013.

http://www.salon.com/2013/04/28/six_ways_big_pharma_wants_to_profit_from_our_health_concerns_partner/

Shannon, Sarah and Chris Uggen. "Visualizing Punishment" hosted on "The Society Pages", February 19 2013. Accessed April 12 2013.

<http://thesocietypages.org/papers/visualizing-punishment/>

Soskice, David and Peter A. Hall, "An Introduction to Varieties of Capitalism" in *Varieties of Capitalism: The Institutional Foundations of Comparative Advantage* (London: Oxford University Press, 2001).

Stanners, Peter. "Life after cannabis prohibition: The city announces its ambitions" (*The Copenhagen Post*, March 15, 2013)

<http://cphpost.dk/national/life-after-cannabis-prohibition-city-announces-its-ambitions>

Strassman, Rick J. "Hallucinogenic Drugs in Psychiatric Research and Treatment: Perspectives and Prospects". *The Journal of Nervous and Mental Disease*, Vol. 183 No. 3 (1995): accessed April 18 2013.

<http://www.psychedellic-library.org/rjspap.htm>

Szalavitz, Maia. "The Loneliness of the Addict Activist". *Thefix.com*, March 24 2013.

<http://www.thefix.com/content/activism-addicts-AIDS-needle-exchange8989?page=1>

"The Federal Drug Budget Under Sequestration" (policy brief by Carnevale Associates, Dec 2011)

http://www.carnevaleassociates.com/the_federal_drug_budget_under_sequestration_12-4-11.pdf

Tracy, Sarah and Caroline Jean Acker, introduction to *Altering American Consciousness*, ed. Sarah Tracy and Caroline Jean Acker (Amherst & Boston: University of Massachusetts, 2004).

Walmsley, Roy. "World Prison Population List (9th edition)", report for the International Centre for Prison Studies (London: University of Essex, September 2010)
<http://www.idcr.org.uk/wp-content/uploads/2010/09/WPPL-9-22.pdf>

Weber, Max. *Sociological Writings*, ed. Wolf Heydebrand. New York, NY: The Continuum Publishing Company, 1999.

Whiting, Marcus and Susanne MacGregor. "The development of European drug policy and the place of harm reduction within this", in *Harm reduction: evidence, impacts and challenges* (Lisbon: European Monitoring Centre for Drugs and Drug Addiction, April 2010).

<http://www.emcdda.europa.eu/publications/monographs/harm-reduction>