Background guide

- In the words of Ruth Dreyfus, the former president of Switzerland and the minister of home affairs, “As long as drugs are considered as evil, and thereby criminalizes, they will remain in criminal hands.” She represents the new drug movement, backed by many human rights organizations and some more liberal western countries. This side of the debate argues that human rights abuses undoubtedly ensue from stringent anti-drug laws pushing the market further and further underground, such as the death penalty, extrajudicial killings, and inhuman or coerced drug treatment; such laws have also escalated public health crises like the HIV and Hepatitis C epidemics, and caused severe prison overcrowding. This movement encourages countries, policy makers, and the UN to seek alternatives to such harsh measures, such as **opioid substitution therapy, harm reduction interventions, needle and syringe exchange programs, supervised injecting facilities, and drug testing services.**
- Turning to the numbers, it is estimated that in 2003 185 million people aged 15-64 (4.7% of the world’s population) had consumed an illicit drug in the previous year, and in 2014 that number had risen 33% to 247 million (5.2% of the world’s population), despite relentless efforts to suppress the international market.
- Antonio Maria Costa represents the traditional anti-drug movement characteristic of the 20th century and many conservative countries. The former executive director of the UNODC, former Director-General of the United Nations Office in Vienna, and the former Secretary-General of the European Bank for Reconstruction and Development, he argues that the criminalization policies that have so long been in place have yielded promising results, and “it makes no sense to unravel this achievement”., He and the movement he backs believe that the drug market should by no means be validated or overseen by government authorities, and must rather be quashed by regulation and legal intervention, removing offenders from social activity and confiscating any and all illicit substances in their hands
- in 1906, 25 million people used opium (1.5% of the population), whereas today that number has fallen to only 16.5 million people (0.25% of the population). Additionally, at the turn of the 20th century the world produced 41,000 tons of opium, and by 2008 the production had been reduced five-fold; such production once spanned China, Burma, India, Persia (Iran), Turkey, and the Balkan countries, whereas today 92% of it is concentrated in Afghanistan. Coca used to be cultivated in the Andean region, Java (Indonesia), Formosa (Taiwan), and Ceylon (Sri Lana), and now is localized only in the Andes in Colombia, Peru, and Bolivia
- It begins when Egypt banned cannabis in 1884, the first country to prohibit a non-illicit drug; by 1897, the U.S. had begun prohibiting cocaine. At the turn of the 20th century, China prohibited opium through commercial treaties with the U.K., U.S., France, and Portugal, and by 1908 had committed to eliminate all domestic opium within a decade. the earliest international drug convention convened in 1912; the Hague international opium convention was adopted by China, France, Germany, Italy, Japan, the Netherlands, Persia (Iran), Portugal, Russia, Siam (Thailand), the U.K., and the British

overseas territories, including India, all of whom promised to control international trade in opium, morphine, cocaine, and heroin

- In 1990, the UN General Assembly held the first Special Session on Drug Abuse, and a second Session on the World Drug Problem in 1998; these meetings reinforced the criminal approach, and committed to secure a “drug-free world” by 2008. The UN established the International Drug Control Program in 1991, which became the UNODC in 1997. All of these organizations were geared toward the mutual aim of eradicating the threat of drugs once and for all.
- **My stance has to be that legalizing certain drugs is a no-go: ex: cocaine, heroin, opium**
- **Medication?**
- At the turn of the 21st century, Portugal decriminalized the possession of drugs for personal use, and eight years afterwards the Czech Republic revised its penal code to remove criminal penalties for the possession of drugs for personal use; in 2009, the Supreme Court of Argentina ruled that criminalizing the possession of drugs for personal use was entirely unconstitutional. Finally, in 2011, many world leaders “broke the taboo”, and demanded that the war on drugs cease immediately; they proposed five pathways for policy reform by 2014.
- Canada has promised to legalize marijuana in 2017, which will make it the first G7 country to nationally regulate an illicit drug; Mexico’s highest court has allowed the growing of cannabis for personal use; Colombia has reversed its policy of aerial spraying against coca (the raw ingredient in cocaine)
- What lies ahead is a starkly divided debate between the insurgents and the defenders; this disagreement pits several Latin American and Western European countries, such as Bolivia, Colombia, Mexico, Portugal, and the Netherlands, as well as Canada, against Middle Eastern and Asian countries like Russia, China, Singapore, Iran, and Saudi Arabia.
- The United States in particular has had a history of using its drug laws to target specific demographics as part of the long-standing race struggles that have riddled the country since its establishment two and a half centuries ago. The first anti-opium laws were implemented in the U.S. in the 1870’s and were chiefly directed at the influx of Chinese immigrants that came with the 19th century Gold Rush. The 1900’s saw the first anti-cocaine laws targeting African American men, and the first anti-marijuana laws in the 1910’s and 20’s targeted Mexican immigrants and Mexican Americans. Today, Latino and African American communities are still subject to disproportionate drug enforcement and sentencing practices
- however, president Barack Obama advocated in his eight years in office reforms to the traditional drug policy--he reduced the crack sentencing disparity, ended the ban on federal funding for syringe access programs, and supported various states’ pushes for medical marijuana legalization
    - The “assault on citizens” continues in the U.S. as 700,000 people are arrested every year for marijuana use
- **Find studies linking decrease in GDP to drug use**

- **How am I going to show that illegal drugs don't lead to racism?**
- African American constitute roughly 13-20% of the total drug offenders in the U.S., and thus should theoretically occupy an equal proportion of jail cells; however, African Americans constitute 43% of persons convicted of drug felonies in state courts, 53.5% of persons admitted to state prison with new convictions for drug offenses (compared to 33.3% for white people), and in 2007, African Americans accounted for 33.2% of people entering federal prison fro drug persons. 256.2 per 100,000 African American adults are sent to state prison for drug prison, compared with just 25.3 white adults.
- Philippines: president Rodrigo Duterte. He won the election on a campaign platform promising to rid the country entirely of all drugs and corruption, and has, in his time in office, already been responsible for the killings of over 400 dealers by police
- the 1961 Single Convention, the 1971 Expanded Convention, as well as the 1988 Convention against Drug Trafficking. These conventions "explicitly and expressly hold governments accountable" for their domestic and international drug control policies and responses. They also create two international oversight bodies--a policy making body, the Commission on Narcotic Drugs (CND), and a body responsible for ensuring compliance and adjudicating interpretations, the International Narcotics Control Board (INCB)
- **REQUIREMENTS:**
- Solutions should provide, in addition to a firm stance on the legality of drug use and supply, effective alternatives to regulation and measures to promote the health and wellbeing of citizens suffering from addiction. Rehabilitation services, healthy needle use initiatives, and, should your policy call for it, effective law enforcement procedures could all be beneficial to debate
- Will more citizens benefit from more stringent anti-drug laws, or comprehensive drug reform? Will legalizing and regulating the drug market validate its activity and increase drug use, or take it out of criminal hands and make it safer?
- Is it within the power of the United Nations to sway the domestic drug policies of its member states should a resolution come to a consensus for the new wave of drug policy reform?
- To what extent can the government be engaged in the drug market? Should regulation and legalization be confined only to certain illicit substances, or all of them? By what criteria should a substance be dubbed legal or illegal?
- What effect have drug laws had in the past on drug use? To what extent are the human rights of citizens breached when they are incarcerated for drug use? How best can we improve the conditions of those penalized for substance abuse, should the market continue to be criminalized?
- **Care for addicts**
- **Black market**
- **Human rights and incarceration**
- **Law enforcement and drugs**

The Economist explains: The difference between legalisation and decriminalisation
http://www.economist.com/blogs/economist-explains/2014/06/economist-explains-10

- Uruguay has legalised the drug too. Other places have taken a different approach, decriminalising but not legalising. On February 25th Jamaica passed a law decriminalising possession of small amounts of ganja. Several other countries, mostly in Europe and Latin America, have done the same thing; Portugal has decriminalised the possession of all drugs
- Decriminalisation does not mean that people can use drugs with impunity. Instead it means that possessing small amounts no longer lands the perpetrator with a criminal record or a jail sentence. Under Jamaica's new law, people caught with up to two ounces (57 grams) of cannabis can be fined, but not arrested or taken to court. Drug users in Portugal can be forced to attend classes aimed at getting them back on the straight and narrow. People found with cannabis in Italy may have their driving licences confiscated. By contrast, legalisation, of the sort enacted in Uruguay and a handful of US states, means that consumers face no penalty at all (unless, for instance, they smoke in public places). More importantly, it means that the supply side of the business—cultivation, transportation and retailing—is also legal. In Jamaica, selling cannabis will remain a crime; in Alaska it will soon be a legitimate, taxable occupation.

List of Schedule 1 Drugs (US) https://www.drugs.com/article/csa-schedule-1.html
Schedule I drugs are those that have the following characteristic according to the United States Drug Enforcement Agency:

- The drug or other substance has a high potential for abuse.
- The drug or other substance has no currently accepted medical treatment use in the U.S.
- There is a lack of accepted safety for use of the drug or substance under medical supervision.
    - Heroin (diacetylmorphine)
    - LSD (Lysergic acid diethylamide)
    - Marijuana (cannabis, THC)
    - Mescaline (Peyote)
    - MDMA (3,4-methylenedioxymethamphetamine or "ecstasy")
    - GHB (gamma-hydroxybutyric acid)
        - GHB or Gamma Hydroxybutyrate ($C_4H_8O_3$) is a central nervous system (CNS) depressant that is commonly referred to as a "club drug" or "date rape" drug. GHB is abused by teens and young adults at bars, parties, clubs and "raves" (all night dance parties), and is often placed in alcoholic beverages. Euphoria, increased sex drive, and tranquility are reported positive effects of GHB abuse.1,2 Negative effects may include sweating, loss of consciousness (reported by 69 percent of users), nausea, hallucinations, amnesia, and coma, among other adverse effects.
        - Xyrem (sodium oxybate), a brand name prescription drug was approved by the Food and Drug Administration (FDA) in 2002 for the treatment of narcolepsy, a sleep disorder that causes excessive sleepiness and recurring daytime sleep attacks. It is the sodium salt of gamma hydroxybutyrate. Xyrem is a highly regulated drug in the U.S. It is a

Schedule III controlled substance, and requires patient enrollment in a restricted access program.
        - GHB is also a naturally-occurring metabolite of the inhibitory neurotransmitter gamma-aminobutyric acid (GABA) found in the brain. The naturally-occurring metabolite GHB is present in much lower concentrations in the brain than those levels found when the drug is abused. As a result of fermentation, natural GHB may also be found in small but insignificant quantities in some beers and wines.
    - Ecstasy (MDMA or 3,4-Methylenedioxymethamphetamine)
        - Ecstasy (MDMA ,3,4 methylenedioxymethamphetamine) is a synthetic, psychoactive drug chemically similar to the stimulant methamphetamine and the hallucinogen mescaline. Street names for MDMA include Ecstasy, Adam, XTC, hug drug, beans, and love drug. Ecstasy is an illegal drug that acts as both a stimulant and psychedelic, producing an energizing effect, as well as distortions in time and perception and enhanced enjoyment from tactile experiences.
        - Ecstasy exerts its primary effects in the brain on neurons that use the chemical serotonin to communicate with other neurons. The serotonin system plays an important role in regulating mood, aggression, sexual activity, sleep, and sensitivity to pain.
        - Research in animals indicates that Ecstasy is neurotoxic; whether or not this is also true in humans is currently an area of intense investigation. Ecstasy can also be dangerous to health and, on rare occasions, lethal.
    - Psilocybin (Magic Mushroom)
        - Psilocybin (4-phosphoryloxy-N,N-dimethyltryptamine) and psilocin are both indole chemical compounds obtained from certain types of dried or fresh hallucinogenic mushrooms found in Mexico, Central America and the United States. These compounds have similar structure to lysergic acid diethylamide (LSD), and are abused for their hallucinogenic and euphoric effects. Hallucinogenic effects are probably due to effects on central nervous system serotonin (5-HT) receptors.
        - There are over 180 species of mushrooms that contain the chemicals psilocybin or psilocin. Like the peyote, hallucinogenic mushrooms have been used in native rites for centuries. Both psilocybin and psilocin can also be produced synthetically in the lab. There have been reports that psilocybin bought on the streets can actually be other species of mushrooms laced with LSD.
        - Psilocybin effects are similar to those of other hallucinogens, such as mescaline from peyote or LSD. The psychological reaction to psilocybin use include visual and auditory hallucinations and an inability to discern fantasy from reality. Panic reactions and psychosis also may occur, particularly if large doses of psilocybin are ingested.

        - Hallucinogens that interfere with the action of the brain chemical serotonin may alter:
            - Mood
            - sensory perception
            - Sleep
            - Hunger
            - body temperature
            - sexual behavior
            - muscle control
        - Physical effects of psychedelic mushrooms may include a feeling of nausea, vomiting, muscle weakness, confusion, and a lack of coordination. Combined use with other substances, such as alcohol and marijuana can heighten, or worsen all of these effects
        - Other effects of hallucinogenic drugs can include:
            - intensified feelings and sensory experiences
            - changes in sense of time (for example, time passing by slowly)
            - increased blood pressure, breathing rate, or body temperature
            - loss of appetite
            - dry mouth
            - sleep problems
            - mixed senses (such as "seeing" sounds or "hearing" colors)
            - spiritual experiences
            - feelings of relaxation or detachment from self/environment
            - uncoordinated movements
            - lowered inhibition
            - excessive sweating
            - Panic
            - paranoia - extreme and unreasonable distrust of others
            - psychosis - disordered thinking detached from reality
    - Methaqualone (Quaalude)
        - Quaaludes (methaqualone) are a synthetic, barbiturate-like, central nervous system depressant. Methaqualone is an anxiolytic and a sedative-hypnotic drug. Quaaludes were introduced as a safe barbiturate substitute, but they later showed that the possibility of addiction and withdrawal symptoms were similar to those of barbiturates.
    - Khat (Cathinone)
        - Khat leaves are chewed for stimulant and euphoriant effects and are used to treat obesity and prevent hunger in areas with meager food supplies. Some users experience dysphoria and sedation. Khat is prohibited in the US, France, Switzerland, and Sweden
        - Constipation is commonly associated with khat use. Other adverse effects include tachycardia, palpitations, increased blood pressure, anorexia, stomatitis, esophagitis, and gastritis. Anaphrodisia is reported frequently

by men using khat. Khat may cause oral and gastric cancer, cerebral hemorrhage, MI, duodenal ulcers, hypertension, testicular degeneration, low birth-weight infants, and a variety of other severe effects including addiction and the attendant ills.

- Because of its social acceptability and euphoriant effects, khat chewing often plays a dominant role in celebrations, meetings, marriages, and other gatherings. Khat use even has been prevalent in the Somali military. It has been issued to soldiers in their daily rations with the intention of inhibiting their need for food and sleep, as well as increasing their aggression. 2
- The amount of khat chewed per user is 100 to 200 g of leaves and stems over 3 to 4 hours. The tender leaves and stems, which lose their potency 1 day after harvest, are chewed and the juice is swallowed. 2 Khat has a sweet taste and an astringent action. 3 Large amounts of liquids are consumed while chewing because of the dryness induced by the plant.

- Bath Salts (3,4-methylenedioxypyrovalerone or MDPV)
  - Psychoactive bath salts (PABS) are a designer drug of abuse that has led to reports of dangerous intoxication from emergency departments across the US. "Bath salts" are not a hygiene product, as the name might imply. "Bath salts" are central nervous system stimulants that inhibit the norepinephrine-dopamine reuptake system and can lead to serious, and even fatal adverse reactions
  - MDVP is structurally related to methylenedioxymethamphetamine (MDMA) and cathinone derivatives. MDMA is a schedule I hallucinogenic substance and cathinone derivatives (cathinone, methcathinone) are listed as schedule I stimulants. Animals studies have demonstrated elevated levels of extracellular dopamine 60 minutes after administration of MDVP.
  - "Bath salt" users usually snort the drug intranasally, but it can also been injected, smoked, orally ingested or used rectally. Effects may occur with doses as low as 3 to 5 milligrams, but average doses range from 5 to 20 milligrams. There is a great risk for overdose because retail packages may contain up to 500 milligrams. If ingested orally, absorption is rapid with a peak "rush" at 1.5 hours, the effect lasting 3 to 4 hours, then a hard "crash". The total "bath salts" experience may last upwards of 8 hours
  - "Bath salts" have been reported to have a powerful addictive potential, as well as the ability to induce tolerance (more of the drug is required over time to get an equivalent "high"). Reports note intense cravings similar to what methamphetamine users experience.2 As "bath salts" may be cut with other unknown and potentially addictive substances, the true magnitude of toxicity and addiction may be even higher. As of September 2011, routine drug screens do not detect "bath salt" psychoactive ingredients.

Legal/illegal drugs - determining factor
http://boards.straightdope.com/sdmb/archive/index.php/t-53684.html

- Factors determinative of control or removal [of drugs] from schedules
    - (1) Its actual or relative potential for abuse.
    - (2) Scientific evidence of its pharmacological effect, if known.
    - (3) The state of current scientific knowledge regarding the drug or other substance.
    - (4) Its history and current pattern of abuse.
    - (5) The scope, duration, and significance of abuse.
    - (6) What, if any, risk there is to the public health.
    - (7) Its psychic or physiological dependence liability.
    - (8) Whether the substance is an immediate precursor of a substance already controlled under this subchapter.
- Add all of the factors below and score:
    - a) Circumstances of discovery - discovered by lab of existing [+10] and successful [+2] pharmaceutical company as part of funded research seeking exactly that sort of drug [+4]? Or by unemployed genius doctor in the privacy of his own lab [-4]? Or by noncredentialed organic-chem geeks in search of new thrills and drug-sales profits [-15]?
    - (b) Historical use - In existence and in use before the era of FDA approval [+10] and favored for use by doctors [+5] or the general public [0]? Or ethnically [-5] and/or politically [-10] marginalized misfits who mainly use it to get high [-10]? Or no historical use so far [-5]?
    - c) Primary and side effects - Is well-suited for institutional control of misbehavior [+10] or else addresses an existing and previously identified illness or condition [+3] with no major ill side effects [+3] and doesn't infringe on the market of any patented pharmaceutical owned by a major competing pharmaceutical chain [+4]? Addresses human conditions that have been politicized in some fashion [-50 to +50 depending on the politics]? Has recreational drug potential [-10]
- I think that the Controlled Substance Analogue ammedment to the CSA is also worth mentioning.
    - In essence, it states that if you create a new drug and its effects are similar to an already-illegal drug, that drug is illegal by definition. This act was designed to curb so-called "designer drug" manufacture. Of course the sticky part would be trying to figure out exactly what they mean by "similar."
- **Combat the positive image built up by media and pop culture of drugs**
- **Women and drugs**
- **Education**
- **Smuggling - black markets**
- **Border task force??**
- **Partial legalization**
- **Corruption**
- **Law enforcement**

- **Drug tests**
- **Social problems leading to drug use**
- **Research on drug treatment**
- **Criteria for legalizing/making a drug illegal**
- **Research discussion groups w/ former users**
- **Overdose protection**

https://www.brookings.edu/wp-content/uploads/2016/07/Galeotti-Russia-final.pdf

- With 6 percent of the population using drugs, Russia is suffering from serious and problematic drug consumption and a growing public health crisis.
- The Kremlin regards the drug challenge as a nationalist, securitized, and moral problem. Drug addiction is considered a moral deficiency rather than a medical issue, which reinforces the Russian government's predilection for a punitive approach.
- Extensive availability of heroin from Afghanistan is particularly problematic. Russia is both a transshipment and a destination country for Afghanistan's opiates.
- Framed as a security threat, the influx of Afghan heroin is viewed at best as a Western failure and at worst as a malign attempt to damage Russia. Domestically, the Russian government adopts a law enforcement model toward traffickers and users alike, rather than harm reduction, drug prevention, and treatment models.
- Even so, efforts to address drug trafficking and consumption in Russia have been undermined or warped by the lack of resourcing, political will, and turf wars among Russian security agencies. Russia's growing economic problems also necessitate liquidity on the part of many financial institutions, encouraging them to turn a blind eye to dirty money.
- The intertwined economic, political, and social crises of Russia's "wild '90s"—after the collapse of the USSR at the end of 1992—combined with the new freedoms of cross-border trade and travel led to an explosion in drug use and trafficking. There was a more than ninefold increase in the number of addicts in the first 18 years of post-Soviet Russia.1 Coinciding with Russia's aging and unhealthy population and compounding its demographic crisis, this also led to a massive increase in associated problems such as the spread of hepatitis, drug-resistant tuberculosis (TB), HIV, and AIDS—the rate of new HIV infection doubled every six to twelve months between 1995 and 2001.2 As the country began to stabilize at the end of the decade, so, too, did its drug problem. However, since then, the problem has again started to become increasingly serious: by the beginning of 2014, an estimated 1.3 million Russians had HIV, for example, largely contracted through contaminated needles

Principles of Harm Reduction http://harmreduction.org/about-us/principles-of-harm-reduction/

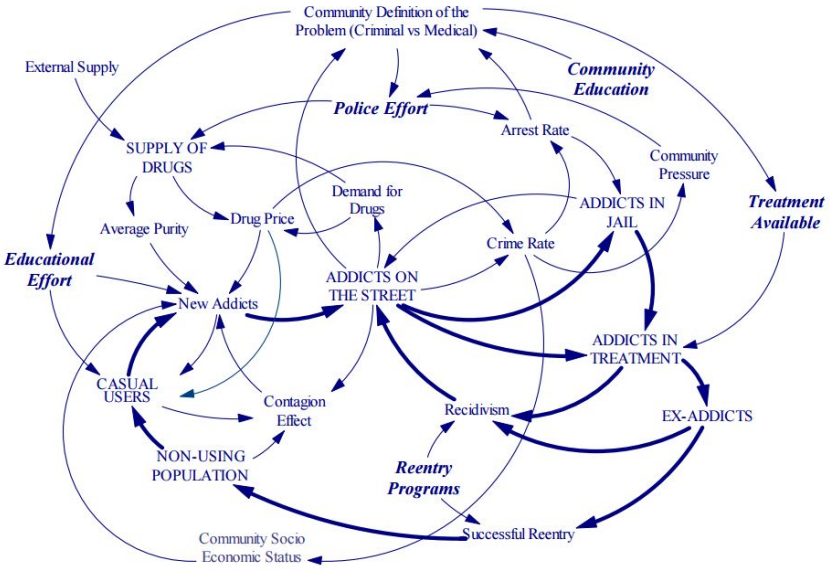
- Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm Reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs.
- Harm reduction incorporates a spectrum of strategies from safer use, to managed use to abstinence to meet drug users "where they're at," addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies

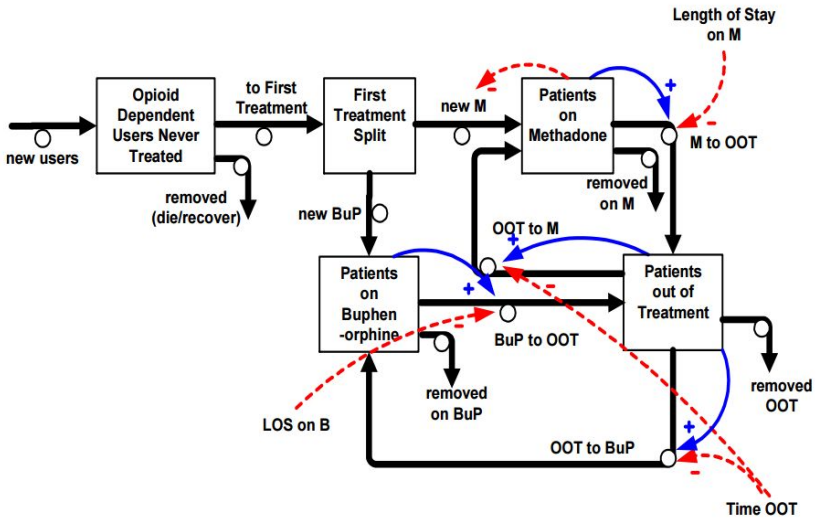
designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

- Harm reduction:
    - Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
    - Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.

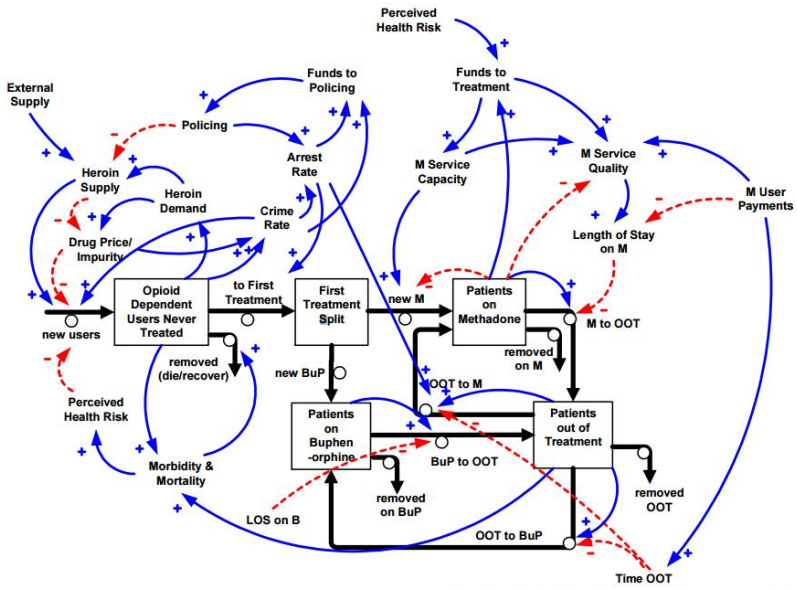
Surfacing the hidden demand for opioid dependent treatments for drug policy makers
https://www.systemdynamics.org/conferences/2008/proceed/papers/MCDON421.pdf

- Illicit drug policy has been the subject of important SD studies addressing the interaction between policing and medical treatment and estimating the prevalence of national cocaine use. Here we modeled the impacts of policy changes associated with wider use of newer opioid pharmacotherapies besides methadone. These newer drugs allow less supervision of dosing and changes in the mix of prescribing and dispensing arrangements. Key aspects of the model were estimation of potential demand for the enhanced range of therapies and the cost and treatment impacts of changes in cycling on and off treatments due to pricing and service configurations.
- The Persistent Poppy by Levin, Roberts and Hirsch in 1975. This book outlined the delicate balance between criminal and medical activities and the potential intolerable consequences of extreme policies of "full prohibition" and "full legalization" mediated through feedback effects via the price of heroin. The policy interventions described in this book include educational effort, police effort, community education, re-entry programs, available methadone treatments and counseling





-
- Within the methadone treatment sector there are a number of sub-sectors. To enter treatment patients must be prescribed methadone by a medical practitioner, registered to prescribe methadone. The model differentiates between three types of prescribing medical practitioners, on the basis of who pays for the prescribing and the cost of that prescribing; those employed by public treatment clinics, those working in private practices (including those prescribing out of private clinics) and those employed to work in the prison system. The Commonwealth government pays for prescribing in private practices while the state government covers the cost of prescribing in prisons and public clinics. The cost of prescribing in prisons and public clinics differs. Patients flow between the three prescriber types, as well as flowing in and out of treatment. There is also a dispensing sub-sector differentiating again between methadone dispensing locations on the basis of who pays for dispensing and the cost of that dispensing. Dispensing is undertaken under the control of a pharmacist. Prison patients are all prescribed and dispensed in prison pharmacies. While the majority of patients prescribed in a public clinic will be dispensed their methadone in that clinic some are dispensed methadone by community pharmacists in the pharmacy. The pharmacy might be more convenient; perhaps closer to home than the public clinic. All of the patients whose prescriber is a medical practitioner in private practice are dispensed in a community pharmacy. The State government pays for dispensing undertaken in public clinics and in prisons while the patient pays for dispensing in community pharmacies. Hence there is a patient flow from the prescribing sector to the dispensing sector and information flows from both those sectors to the costs sector



- http://www.psychedelic-library.org/drugsandrights1.htm
  - Interesting passage: “Perhaps efforts to combat segregation continue to prove difficult precisely because the root causes of racism have not been addressed. But I will not press this response here. Suppose it is true that the state should fight segregation without addressing the root causes of racism. Why might this be so? Segregation is a public manifestation of racism, and it may be possible to alter the structure of racist institutions without undermining racism itself. If the state sought to criminalize all manifestations of racism, law enforcement alone could not have much effect without addressing root causes. However, not all expressions of racism are subject to criminal penalties. In our private lives, we Americans remain free to act according to whatever racist beliefs we happen to hold. No laws prevent private displays of racism. One need not invite a member of a particular race to his private parties, but he is obliged to serve him in his public restaurants. Racism itself is not the target of desegregation efforts.
  - But the war on drugs is different. LAD criminalizes both private and public acts. The state does not recognize a personal sphere in which individuals remain free to behave according to their preferences; it enacts a general prohibition of recreational drug use. For this reason, law enforcement in this area has a much more ambitious task than is assigned to those who fight against public segregation. It is less likely that the war on drugs can succeed without attending to the root causes of drug use.
  - A second issue is typically neglected in understanding and evaluating the war on drugs: Why has war been declared on illegal drugs? The simplistic answer is that drugs pose a threat to American society comparable to that of an invading enemy. Self-protection requires the mobilization of resources equivalent to those employed in time of war. For reasons that will become clear, I do not believe that this answer can begin to explain the extraordinary efforts of the state in combating drugs. Few wars—and certainly not the war on drugs—can be understood as a purely rational response to a grave social crisis.

- No one doubts that the drug problem calls for state action, but why has a militaristic response been thought appropriate? The metaphors used to describe a phenomenon constrain what will appear to be an acceptable solution to it. If we really are at war against drugs, the alternative of decriminalization can be characterized only as a shameful retreat. William von Rabb, commissioner of the U.S. Customs Service, protests that legalization would be "an unconscionable surrender in a war [in which] there can be no substitute for total victory."[23] But what is "total victory," and why is it necessary? A policy that does not work can always be changed, but a war that is not won can only be lost. With hindsight, it appears that Americans may have been hasty in rallying to the call for a war on drugs. Perhaps we should not be talking about a drug *war* at all, but rather about a drug *policy.* A rational policy might well include massive efforts by our criminal justice system, but other components of a sensible policy—treatment, education, and the option of simply leaving people alone—are not easily expressed within a war mentality.
- What needs to be explained is why some problems are singled out for attention, whereas others are relatively ignored.[24] The abuse of legal drugs such as alcohol and tobacco is not the only hazard likely to be overlooked by the war on illegal drugs. Another such problem is lead. Federal authorities estimate that one out of every six children under the age of six suffers from irreversible lead poisoning.[25] Children with elevated lead levels have impaired auditory and language functioning, decreased attention spans, liver and kidney damage, altered electroencephalogram readings, and a median IQ deficit of six points compared to their low-lead classmates.[26] Despite these alarming data, no one has called for a declaration of war on lead. Why not? There is no need to suppose that the state is conspiring to deliberately manufacture a crisis in order to support an Orwellian expansion of Big Brother. An alternative account explains why the public has been so receptive to a militaristic response to drug use.
- The public fears that America is a nation in decline. Crime, poverty, poor education, corporate mismanagement, and an unproductive and unmotivated work force are cited as evidence of this deterioration. Who, or what, should be blamed? The political climate limits the range of acceptable answers. Conservatives will not allow liberals to blame institutional structures for our problems. The difficulty cannot be that government has failed to create the right social programs to help people. Nor will liberals allow conservatives to blame individuals for our problems. The difficulty cannot be that people are lazy, stupid, or egocentric. What alternative explanations remain?
- Illegal drugs provide the ideal scapegoat. Drugs are alleged to be so powerful that persons cannot be blamed very much for succumbing to them, as they could be blamed for not studying or working. And drugs are so plentiful and easy to conceal that government cannot be blamed very much for failing to eliminate them. Even better, most drugs are smuggled from abroad, so Americans can attribute our decline to the influence of foreigners. In blaming drugs, politicians need not fear that they will antagonize a powerful lobby that will challenge their allegations and mobilize voters against them. Almost no organized bodies defend the interests of drug users. Illegal drugs represent a "no-lose" issue, the safest of all political crusades.”

- How is "drug" defined by those who make the effort to define it at all? The answer depends on the discipline where an answer is sought. Perhaps the most frequently cited medical definition is "any substance other than food which by its chemical nature affects the structure or function of the living organism."[29] Undoubtedly this definition is too broad. Nonetheless, I tentatively propose to adopt it until a better alternative becomes available.
- Notice that this definition refers only to the pharmacological effect of a substance and not to its legal status. For two reasons, "drugs" must not be defined as synonymous with "illegal drugs." First, it would be absurd to suppose that a non-drug could become a drug, or that a drug could become a non-drug, simply by a stroke of the pen. A legislature can change the legal classification of a substance, but not the nature of that substance; it has no more power to decide that a substance is a drug than to decide that a substance is a food. Second, a philosophical study designed to evaluate the moral rights of drug users can hardly afford to rely uncritically on the existing legal status of substances, since the legitimacy of these determinations is part of what is under investigation. To suppose that "drugs" means "illegal drugs" begs important questions and concedes much of what I will challenge. In what follows, I will use the word "drug" to refer to both legal and illegal substances that satisfy the medical definition I cited.
- Legal definitions of "drugs" are somewhat more complicated than the earlier medical definition. The federal Controlled Substances Act incorporates the following definition of "drugs" from the Food, Drug, and Cosmetic Act:
- "Drugs" means (a) substances recognized in the official United States Pharmacopeia, official Homeopathic Pharmacopeia of the United States, or official National Formulary, or any subsequent to any of them; and (b) substances intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (c) substances (other than food) intended to affect the structure or any function of the body of man or other animals; and (d) substances intended for use as a component of any article specified in subsections (a), (b) and (c) of this section; but does not include devices or their components, parts or accessories
- As I will argue in Chapter 3, possessory offenses are anticipatory; they provide a means to prevent the consummate harms associated with drug use before they occur. If drugs were not used, no one would worry about their possession.
- Although there is some variation among states about the particular schedule where a given drug is placed, the federal act categorizes drugs roughly as follows: Schedule I includes heroin, LSD, and marijuana; Schedule II, cocaine and amphetamine-type stimulants; Schedule III, nonamphetamine-type stimulants and barbiturates; Schedule IV, barbiturate and nonbarbiturate depressants; and Schedule V, compounds with low amounts of narcotics, stimulants, and depressants. Three states (Arkansas, Tennessee, and North Carolina) have created a special "Schedule VI" solely for marijuana
- Several criteria in the act must be interpreted before such a recreational drug can be described. Criterion (B) in Schedules I-V is especially difficult to understand. Applications of the Controlled Substances Act require a determination of whether a "drug or other substance" has a "currently accepted medical use." Drugs without a currently accepted

medical use are placed in Schedule I; otherwise, they are placed in subsequent schedules. How does one decide whether a given drug has an accepted medical use?

- According to one possible answer, a drug has an accepted medical use only when the FDA approves an application to market it. But this answer cannot be correct. The FDA might reject an application to market a drug for seven distinct reasons, including the failure of the application to contain relevant patent information.[45] The absence of medical use cannot be inferred simply from the lack of FDA marketing approval.
- A second possible answer is that a drug has an accepted medical use when sufficient numbers of the medical community believe that it has such a use.[46] But this interpretation opens a Pandora's box. If medical practitioners agree that the best treatment for drug addicts includes administration of an addictive drug under medical supervision, then no addictive drug will satisfy this criterion for placement on Schedule I. According to this interpretation, any addictive drug could have a medical use. But this result cannot be what the drafters of the act had in mind by an "accepted medical use."[47] They clearly had no intent to duplicate the so-called British System and to allow medical practitioners to prescribe Schedule I narcotics to addicts.
- A closely related problem is to determine how a drug can acquire an "accepted medical use" once it has been placed on Schedule I. According to some commentators:
- The true test of [the statutory scheme] will be in loosening restraints when justified. A scheme that is directed only to wards tighter and tighter controls will, in time, lose its most important attributes, flexibility, and the capacity to adjust to changing social circumstances.[48]
- But flexibility is hard to achieve under the act. A drug that is illegal for doctors to prescribe cannot possibly have a medical use that is accepted. Nearly half of the cancer specialists responding to a questionnaire answered that they would prescribe marijuana if it were removed from Schedule I.[49] But it is not clear that this poll shows that marijuana *has* an accepted medical use. Thus the debate about how a drug gains or loses an "accepted medical use" remains unresolved. Deciding whether a drug has or lacks a medical use has turned out to be a quagmire
- The legislative history of the Controlled Substances Act reveals the following four guidelines to identify the extent of a drug's potential for abuse:
    - (1) There is evidence that individuals are taking the drug... in amounts sufficient to create a hazard to their health or to the safety of other individuals or of the community; or
    - (2) There is significant diversion of the drug... from legitimate drug channels; or
    - (3) Individuals are taking the drug... on their own initiative rather than on the basis of medical advice from a practitioner licensed by law to administer such drugs in the course of his professional practice; or
    - (4) The drug or drugs... are new drugs so related in their action to a drug or drugs already listed for having a potential for abuse to make it likely that the drug will have the same potentiality for abuse
- No one pretends that drugs are good or bad per se. Trying to decide whether drugs are good or bad is like trying to decide whether fires are good or bad: It depends on the

purpose(s) for which they are used. As the examination of the Controlled Substances Act demonstrates, war has not really been declared on *drugs.* **War has been declared on persons who make a certain *use* of drugs. I will describe this use as *recreational.* By "recreational use," I mean consumption that is intended to promote the pleasure, happiness, or euphoria of the user.**

- **The use of a drug is medical if it is intended to treat a disease, illness, injury, or other interference with normal functioning. But this criterion is less easy to apply. Difficulties in determining whether a given incidence of drug use is medical result from uncertainty about whether the condition for which a drug is taken qualifies as a disease, illness, injury, or other interference with normal functioning**

ECONOMIC AND SOCIAL CONSEQUENCES OF DRUG ABUSE AND ILLICIT TRAFFICKING
https://www.unodc.org/pdf/technical_series_1998-01-01_1.pdf

- The bulk of income generated from drug sales remains in the consumer countries, i.e. most profits are made, and re-invested, in the industrialized countries. More than 90 per cent of the value added (gross profit) of cocaine and heroin is generated at the distribution stage of the illicit drug industry. Taking 1991 figures, for instance, one gram of 100 per cent pure cocaine retailed for $4.30 in Colombia;29 its final retail price in the United States was between $59 and $297.30 The gross profit margin, or value added, was thus between 93 and 98.5 per cent of the retail value
- The small share of less than 10 per cent, in most cases less than 5 per cent, of income generated in the illicit drug industry which goes to producer countries is, however, large enough to have a significant impact on some of those economies. Paradoxically, the much larger drug income generated in the industrialized countries is of almost negligible economic importance to them. Estimates of the "benefits" of the operations of the illicit drug industry to the economy of Bolivia, for instance, suggest that they probably amounted to a gross value added of $0.7 billion, equivalent to 15 per cent of GDP (1989)32 according to Government sources, with other estimates for the late 1980s showing even higher values.33 Of this, roughly $280 million were retained by factors of production in Bolivia. The actual contribution of the industry to the economy, therefore, according to United States sources, was an estimated 6 per cent of GDP.
- Many of the apparently beneficial economic effects resulting from the production and trafficking of illicit drugs are not quite as advantageous to the countries concerned as might prima facie appear. A number of producer countries have started to suffer from what is generally known as "Dutch disease",38 leading to stagnation or even contraction of other, non-drug-related sectors, which makes their economies even more dependent upon a single illicit commodity. Especially in those areas and countries where no vertically integrated illicit drug industry has been built or is only starting to emerge (such as in Bolivia or Peru), drug traffickers present themselves only at irregular intervals to buy the farmers' illicit drug crops, thus frequently creating boom and bust cycles in the local economies
- A study for Australia estimated the costs of drug abuse (including both licit and illicit substances) to be equivalent to 4.8 per cent of GDP (1992), with costs related to illicit drug abuse amounting to $1.2 billion, i.e. 0.4 per cent of GDP or $70 per capita.42 The

overall costs of substance abuse (licit and illicit) rose by less than 13 per cent between 1988 and 1992 in real terms; the increase in costs related to illicit drug consumption amounted to 25 per cent, and was thus almost twice as large

- Based on estimates of some 130,000 to 150,000 hard-core abusers, the average annual costs to society per addict were thus approximately £13,000, or approximately $23,100
- Drug abuse occurs most frequently among young people in the 15-35 age group, with a particular concentration in the 18-25 age group. It thus includes those who have entered or who are just about to enter the workforce. Given the high unemployment rates in many countries, entry into the workforce is often a major problem. Consumption of illicit drugs limits chances of entering or remaining in the workforce, while frustration caused by failure to find adequate employment favours drug consumption, thus creating a vicious circle. There is often a strong correlation between unemployment and drug-taking habits, both in developed and developing countries.
    - The 1992 British Crime Survey, for instance, revealed that life-time prevalence of drug abuse among the unemployed was 60 per cent higher than among the employed.
- While drug abuse affects labour markets by reducing productivity, it also generates some employment, particularly in the drug-producing countries, although this is less than generally believed. Employment generated by opium production affects less than 1 per cent of the labour force in Pakistan.61 It is only in the two major opium-producing countries, Afghanistan and Myanmar, that the percentage might be expected to be higher. Information available on coca suggests that the percentage is small in Colombia (0.4 per cent of the economically active population), rather high in Peru and particularly high in Bolivia. In Peru, between 2.4 and 4.5 per cent of the economically active population are involved in activities related to the coca industry
- Prices of illicit drugs, in contrast to those of other commodities, primarily reflect the perceived level of risk involved in manufacture and trafficking. Prices and profits in the illicit drug industry are not proportional to factor costs, but seem to be related proportionately to the risks and the degree of monopoly at each stage of production and marketing.71 Heroin and cocaine prices throughout the 1980s and early 1990s showed a surprisingly strong correlation and behaved in tandem, which suggests that perceived risks (probably due to the degree of success or failure of law enforcement) were, indeed, the major factor determining the prices
- One frequently cited study, dating back to the early 1970s in the United States, suggested that marijuana might be strongly price-elastic, with elasticity ranging between -1.0 and -1.5.76 Another study in the United States estimated elasticities for heroin to be in the range of -0.21 to -0.38.77 This suggests that demand becomes progressively less elastic, or more inelastic, as the addictive nature of the substance increases. These results are, however, in part contrast to more recent work. A study in the mid 1980s argued that, given that average expenditures on marijuana represented a small proportion of disposable income, demand for marijuana was close to inelastic at existing price levels (price elasticity of 0 to 0.5).78 Only a massive increase in prices could be expected to have a significant impact upon demand levels. It was assumed, by contrast,

that demand for cocaine, though less elastic in the short term, would become moderately elastic in the long term. Such a result would be in line with the Becker and Murphy model of "rational addiction" (1988), which predicts that demand for illicit drugs, while inelastic in the short term, can be expected to become more elastic in the long term.

- Calculated (participation) price elasticities for annual abuse, i.e. the change in the number of annual abusers as a result of price changes, amounted to -0.90 for heroin, -0.55 for cocaine, and -0.06 for marijuana. For the more dependent group of "monthly" abusers (i.e. those who have consumed drugs at least once in the preceding month), price elasticities, as theory suggested, were found to be smaller, though still significant. (Participation) price elasticities for "monthly" abuse were -0.80 for heroin, -0.36 for cocaine and -0.04 for marijuana. The study, using a sophisticated regression model, was based on some 50,000 single observations
- In many countries, the lowest income groups show a higherthan-average consumption of drugs. Among the middle classes, illicit drug consumption tends to be below average. Though rising again among the higher-income groups, it still remains below that of the lower-income groups. The sociological explanation for this phenomenon is usually the general argument about the frustrations of poverty and the boredom of affluence
- The effects of the illicit drug industry on both the balance of trade and the balance of payments of a producer country, if viewed in static terms, tend to be positive. Drug exports generate much-needed foreign exchange
- The country study carried out by UNRISD and the United Nations University on Mexico, for example, shows that illicit drug abuse correlates more strongly with the disintegration of the family than with poverty
- **Although families have a powerful influence on shaping the attitudes, values and behavioural patterns of children and thus preventing substance abuse, peer groups often prove to have an even stronger influence.122 The negative influence of peers appears to increase when parents abdicate their traditional supervisory roles. Family factors thought to lead to, or intensify, drug abuse include prolonged or traumatic parental absence, harsh discipline, failure to communicate on an emotional level and parental use of drugs.**
- Though the mortality risk from consumption of illicit drugs is a matter of concern, it should be noted that the existing drug control mechanisms (prevention, education and law enforcement), although unable to prevent substance-abuse-related mortality (SARM), do seem to have prevented the actual number of SARM cases from reaching the levels currently being experienced with the abuse of licit psychoactive substances.
- School children who use drugs often suffer from impairment of short-term memory and other intellectual faculties, impaired tracking ability in sensory and perceptual functions, preoccupation with acquiring drugs, adverse emotional and social development and thus generally impaired classroom performance. Reduced cognitive efficiency leads to poor academic performance and a resulting decrease in self-esteem. This contributes to instability in an individual’s sense of identity which, in turn, is likely to contribute to further drug consumption, thus creating a vicious circle.

- Environmental damage related to illicit drugs is caused in producing countries by clearing of forests, growing of crops as monocultures, processing of harvested plants into drugs and the use of environmentally dangerous chemicals without the necessary precautions being taken. Although environmental damage due to illicit drug production has, to some extent, been documented, there appears to have been little effort, to date, to compare illicit drug-related damage to that resulting from licit agriculture and industry
- The type of environmental damage found in any one country will depend on the specific role that country plays in the operations of the illicit drug industry. In the Andean countries, for example, coca farmers cut down forests on steep hillsides which are prone to erosion, instead of expanding cultivation of the rich alluvial soil on the valley floors.129 It is feared that coca cultivation may have resulted in the deforestation of 700,000 hectares in the Amazon region in Peru
- **Environment**
- Consequently, their practices are far more wasteful, depleting the soil and not giving it a chance to recover between crops. In an effort to raise productivity, illicit cultivators frequently use herbicides and insecticides in larger amounts than would normally be considered acceptable. The intense use of pesticides by coca cultivators in the Chapare area has already seriously contaminated the groundwater
- improper disposal of toxic wastes created during the processing of plant material into a form of consumable drug. In Boliva, some 30,000 tonnes of toxic chemicals used in the processing of illicit drugs are flushed down the waterways each year without any proper waste water treatment being carried out. These chemicals, which range from moderately toxic to extremely destructive in environmental terms, include lime, sodium carbonate, sulphuric acid, kerosene, acetone and hydrochloric acid. Moreover, some 200,000 tonnes of discarded coca leaves are left to leach into the soil every year.134 In Peru, the extensive use of chemicals to process drugs and the practice of disposing of them by the quickest means possible has been responsible for killing whole species of fish and aquatic plants in the Huallaga river.
- Drugs increase the likelihood of many kinds of criminal activity. Drug-related crime occurs primarily in the form of trafficking-related activity, including violent conflicts among trafficking groups competing for increased market share. It also results from the need of drug consumers to finance their addiction through theft and prostitution.
- The usual pattern is, however, quite different. United States drug-related law enforcement expenditure (police, courts, prosecution, corrections) by the Federal Government was $13.3 billion in 1995,151 with an additional $8.5 billion (1991) spent by state governments, i.e. a total figure equivalent to approximately 0.3 per cent of GDP. That figure was higher than the individual GDP of 150 of the 207 world economies in 1995. Even higher, in proportional terms, have been the funds invested by the Colombian Government to fight drug-trafficking. Colombia spent $0.9 billion or 1.1 per cent of its GDP in 1995 and $1.3 billion, equivalent to 1.6 per cent of GDP in 1996 for this purpose
-