WAR ON DRUGS

OLAVO HAMILTON
Lawyer, Federal Councilor of the Brazilian Bar Association (2019–2025),
Member of the Brazilian Institute of Lawyers (IAB),
Professor at the State University of Rio Grande do Norte (UERN),
Ph.D. and Postdoctoral Researcher in Law (University of Brasília – UnB).

WAR ON DRUGS

OWL
EDITORA JURÍDICA

OWL – EDITORA JURÍDICA
editora@owl.etc.br • www.owl.etc.br

Hamilton, Olavo. 1976-
War on drugs /
Natal : OWL, 2025.
175p.
ISBN: 9798282397666

1. War. 2. Drugs.

Preface by Beto Simonetti

For Afonso Hamilton.

INDEX

PREFACE

"War on Drugs" is a work that is born a classic.

Olavo Hamilton, attorney, Federal Counselor of the Brazilian Bar Association (2019-2025), and professor, outlines in these pages the reasons why the war on drugs is inadequate for protecting public health.

Hamilton revisits the origins of this policy—initially developed in the United States and replicated in various countries—and successfully presents an overview of the consequences of current anti-drug geopolitics, such as the consumption of vast financial resources, the loss of hundreds of thousands of human lives, and penal intervention leading to mass incarceration. He further emphasizes the ineffectiveness of this strategy in reducing the illicit market or mitigating consumption.

Drawing on an extensive literature review grounded in empirical research, the author concludes that the criminalization of the consumption of certain psychoactive substances often leads users to commit crimes, including drug trafficking, as a way to

finance their dependency. In his analysis, there is a direct and proportional relationship between the resources invested in the war on drugs and the global incidence of violent deaths.

At the same time, he highlights public policies that approach the issue from a perspective other than criminalization. With a humanized focus and a harm reduction framework, these policies have yielded positive public health outcomes—far superior to those resulting from the war strategy.

Olavo Hamilton stands out for his academic and professional trajectory dedicated to the strengthening of democratic institutions and offers the legal community an original and highly relevant contribution. The author's extensive *résumé* attests to the competence with which he addresses complex topics. His dedication is, in itself, a true exercise of citizenship.

I am certain that the fields of Criminal Law and Criminology gain here a new required reading. It is a great honor for me to write the foreword to this work.

Enjoy the reading,

Brasília, April 20, 2025.

José Alberto Simonetti

Lawer. President of the National Bar Association of Brazil.

INTRODUCTION

Throughout history, the use of psychoactive substances has become a recurring habit among humans, serving medicinal, religious, recreational, or simply curious purposes. Drugs have always been present in a variety of societies, helping humankind to expand or alter perception and, often, offering an escape from oppressive realities.

However, many drugs have gradually been banned, becoming illegal to consume or commercialize, primarily for ethical reasons. This process intensified at the beginning of the 20th century with the criminalization of activities linked to the supply and demand of psychotropic substances. According to the official discourse, based on state criminal legislation and theories of crime and punishment, drug prohibition is justified by the need to address public health problems associated with substance abuse.

Although the central argument for the prohibition, criminalization, and illegality of certain psychoactive substances is the protection of public health, the criteria used to select which

drugs should be banned have not always consistently followed that principle. The criminalization of the use and sale of certain psychoactives has been more influenced by the social perception of the substances—and, more importantly, by the cultural groups associated with them—than by their actual intrinsic harm potential.

The official discourse extracted from the normative command thus becomes unjustifiable. If criminal law is legitimized by the protection of a fundamental legal good, and must be invoked only as *ultima ratio* remedy, then the classification of drugs as licit or illicit should be based exclusively on their intrinsic harmfulness. Such criteria must be objective, pragmatic, and empirically based, with the specific aim of protecting public health.

However, the consequences of drug criminalization are far too severe to be accepted merely as symbolic[1]. The financial resources channeled into the subsequent war strategy, the millions of incarcerations resulting from its implementation, and the hundreds of thousands of deaths inherent to criminal activity and its repression reveal a social and human cost excessively high—

[1] Regarding the consequences of the war on drugs related to prison overcrowding, rising crime rates, and the fostering of criminal organizations, see Silva Júnior and Hamilton (2024).

utterly disproportionate to any symbolic value behind the prohibition, no matter how relevant that value may appear.

Therefore, it is essential to understand, beyond the official narrative, the process through which certain psychoactive substances became criminalized. One must investigate whether the stated aim of protecting public health was truly the driving force behind drug criminalization—or whether it served merely as a facade for political and social interests unrelated to penal policy.

Currently, any natural or synthetic substance that, when introduced into a living organism, can disrupt one or more of its functions is considered a drug (ONU 2007). Psychotropic or psychoactive substances act on the central nervous system, causing changes in behavior, mood, and cognition (WHO 1981; American Psychiatric Association 2015), and are typically classified as depressants, stimulants, or hallucinogens (Chaloult 1971).

However, understanding the illicit status of many psychotropic substances requires more than just their scientific definition or their capacity to alter human behavior. It is the *discourse* built around them that matters (Olmo 1990) and the consequences of such discourse, which, after a value judgment, gains normative classification as licit or illicit through the creation of a prohibitive norm (Boiteux 2017, 185).

Humanity shows a unique inclination toward experimenting with psychotropics and, often, persisting in their use despite inherent risks (Iversen 2016). Drugs have consistently accompanied humankind throughout time and space. Each culture has had its own: wine in Southern Europe, vodka and whiskey in the North, hemp and opium in Asia, coca and hallucinogens in South America. Whether to treat illness, connect with the divine, escape hardship, relieve social anxiety, or for sheer pleasure—drugs have always been present (Escudero Moratalla and Frígola Vallina 1996).

Even though the effects of psychoactive substances may be partial, fleeting, and deceptive—and come at a cost—the possibility of altering one's mental state through tangible means has ensured their enduring appeal. Eating, sleeping, moving, and other fundamental actions can become unnecessary or impossible when one is psychologically overwhelmed—by grief, fear, failure, or even curiosity. In such circumstances, the supremacy of the spirit over existential conditions becomes evident. That power to affect the psyche is the core of certain substances: by momentarily enhancing serenity, energy, or perception, they help reduce anguish, apathy, or psychic routine (Escohotado 2002).

Beneath the use of psychotropics lies discontent, either fleeting or persistent, often induced by the oppressive reality that surrounds the individual. Yet, in today's social context, the use of

certain drugs is seen as a new form of sin—so much so that it has become the basis of a new category of crime (Escohotado 2002).

Within this context, the historical process of outlawing psychoactive substances—commonly referred to as the "war on drugs"—emerged as an international campaign of prohibition and military intervention led by the United States, with support from several other nations. Its declared goal: to define and reduce the illegal drug market (Cockburn and St. Clair 1998). Its primary tool: the criminalization of the use and trade of illicit psychoactive substances.

In fact, the global war on drugs is the very history of the fight against outlawed substances, waged primarily by the United States and shaped by the dominant moral sentiments of its society—though the effects have been felt worldwide. The method—a gradual criminalization of psychotropic-related activity—has since spread throughout international legal systems, creating an almost uniform legal landscape.

This initiative includes a series of U.S.-designed public policies aimed at deterring the production, distribution, and consumption of illegal drugs. The term "war on drugs" was first used in 1971 by President Richard Nixon, later popularized by the press (Dufton 2006), and eventually spread globally.

Illicit substances were redefined as national security threats, necessitating a stance rooted in domestic repression, with

criminalization as the starting point and exportation of U.S. drug policy as a goal (Woodiwiss 2005). Thus, Nixon (Nutt 2012; Rahtz 2012) solemnly declared drug abuse to be America's number one public enemy, to be combated and defeated through a new, unrestricted offensive.

We must also consider that the war on drugs may represent a form of internal control targeting specific categories of citizens and, externally, an exercise of U.S. hegemonic power over the international community[2], effectively dictating legislative and procedural standards for handling outlawed psychoactive substances.

Accordingly, the first three chapters of this book analyze the war on drugs through three phases: (1) a predominantly moral phase, in which drug prohibition is seen as a "principle"; (2) an objective phase, where criminalization is the "means" to solve problems related to psychotropics; and (3) a militarized phase, where criminalization becomes an end in itself.

The fourth chapter will explore whether the criminalization of psychoactives—the legal basis of the war on drugs—embodies what is known as *enemy criminal law*, which

[2] According to Michael Craig Ruppert (Klotter 2001, 59): "there is no war on drugs and there never will be... because the so-called war on drugs is not about drugs. It is about money. It is also about power. And it is about race."

divides offenders into two categories: the citizen, protected by full legal guarantees, and the enemy, to whom only coercion applies.

Next, the fifth chapter will examine whether the war on drugs has achieved its stated goals—or whether it has failed to reduce drug supply and demand or mitigate drug-related harm.

Since drug criminalization should be based on objective criteria of harm to others, chapter six will evaluate the actual potential harm of various psychoactive substances, including those that are legal.

Finally, chapter seven will assess the unintended consequences of drug prohibition—its social costs and potential to delegitimize drug criminalization altogether.

The war on drugs imposes a heavy social toll. It must be examined—and, if necessary, denounced. This book seeks to understand its origins, development, current state, and, most importantly, its consequences.

1. THE PRINCIPLE WAS THE WORD

Since the early campaigns for drug prohibition, public opinion in the United States has been largely shaped by media reports and official agency publications that routinely portrayed minority groups as linked to the use, transport, distribution, and sale of psychoactive substances—and thus responsible for all related harms (Cook and Hudson 1993; Hawkins 1995; Tonry 1997; Sirin 2011).

Although the term "war on drugs" was coined in 1971 by President Richard Nixon, the policies enacted under his administration—most notably through the *Comprehensive Drug Abuse Prevention and Control Act* (1970)—were in fact a development of much earlier drug prohibition efforts, dating back to 1906 with the *Pure Food and Drug Act*. This, in turn, stemmed from the historical and political movement known today as Prohibitionism.

The origins of Prohibitionism as a political system trace back to the state of Ohio, where local churches formed alliances

in a campaign to end the alcohol trade—an activity associated with gambling, prostitution, and dancing, and considered morally and physically degrading. In the second half of the 19th century, the idea gained ground throughout American civil society. For example, in 1869, the Prohibition Party was founded. Other organizations followed: the *New York Society for the Suppression of Vice* (1868), the *Woman's Christian Temperance Union* (1873), the *Anti-Saloon Leagues*(1893), and even academic groups like the *Scientific Temperance Federation* (1879), which aimed to investigate and address the issue through scholarly inquiry (Ribeiro 2013).

Dedicated publishers, journals, and newspapers emerged to advocate for alcohol prohibition, spreading the idea nationwide. To broaden its appeal, the Prohibitionist movement aligned itself with other social causes, such as the women's suffrage movement and anti-trust campaigns (Ribeiro 2013).

With these social foundations in place, the path was cleared to codify Prohibitionist ideals. The *Pure Food and Drug Act of 1906* is widely seen as the first major national milestone in state intervention in the drug trade and consumption. It established federal oversight to prevent the circulation of adulterated or harmful products, requiring labels to disclose the presence of substances like alcohol, cocaine, heroin, morphine, opium, and *cannabis* (Lima 2009).

While this law did not explicitly ban substances or propose public policies targeting specific drugs, it marked a significant regulatory shift. The U.S. government began to assert control over widely used substances under the guise of consumer protection, even though the law still allowed many of these substances to be legally sold (Rodrigues 2017).

Although it safeguarded consumers by mandating clearer labeling, it also introduced unprecedented government intrusion into the private lives of citizens. For the first time, the tradition of free commerce in psychoactive substances was subject to state regulation. The law did not criminalize drug use, but it laid the groundwork for future prohibition (Rodrigues 2017).

1.1. WAR ON OPIUM

Meanwhile, on the international stage, the 1909 Shanghai Conference brought together delegates from thirteen countries to address the issue of Indian opium, widely consumed in China. According to Rowe (2006), although the event had a performative political character, its real intent was to ban the importation and use of opium for non-medical purposes. He also notes that concerns were already raised at that time about potential side effects of prohibition on American society.

Historically, humanity has maintained a long and problematic relationship with opioids—whether natural, semi-synthetic, or synthetic. In 2022, there were an estimated 60 million opioid users worldwide (UNODC 2024). Just ten years earlier, there were 32.4 million users, including 16.5 million opiate consumers (UNODC 2015).

Opium is the dried latex extracted from the seed pod of the *Papaver somniferum*, the poppy—called the "flower of pleasure" by the Sumerians in Mesopotamia. It has been used by humans for over six thousand years, both medically and recreationally. The term "opioids" encompasses both natural derivatives of opium (known as opiates) and synthetic compounds like meperidine and methadone.

In medical contexts, few banned substances have had as many applications as those derived from opium. These include the paregoric elixir (an antidiarrheal and analgesic), morphine (a powerful painkiller, from which heroin is derived), and codeine (an analgesic and cough suppressant). However, opium use carries significant health risks, as it causes both physical and psychological dependence.

Originally cultivated in the western Mediterranean and Asia Minor, opium was prized by many ancient civilizations—Chinese, Egyptian, Greek, Roman, and others. Arab merchants, through their vast trade networks during the Middle Ages, helped

spread opium far and wide. In the 9th century, with the Arab and Persian invasions, poppy cultivation began in India. Under the Mughal Empire (1526–1707), poppy cultivation and opium trade became state monopolies. In the 18th century, the British East India Company took control and began actively promoting opium use in China to finance its purchases of tea and silk (Labrousse 2011).

In the 19th century, India (including present-day Pakistan), Persia (Iran), and Afghanistan were the main producers of opium. Most of this output was shipped to China. By 1839, the Chinese Empire recognized widespread opium addiction as a national crisis. Emperor Tao Kuang ordered strict regulation of opium imports (Rowe 2006).

To protect its opium trade, Britain declared war on China (Labrousse 2011). The First Opium War ended in 1842 with China's defeat and the cession of Hong Kong to the British (Rowe 2006; Labrousse 2011). The peace was short-lived. A second opium war (1856–1860) followed, driven by Western commercial interests—particularly the expansion of markets. China was once again defeated, and opium imports were fully legalized.

In the early 20th century, driven by nationalist ideals, China sought to end opium imports. Western powers again deployed troops, and China, lacking modern military capabilities,

was defeated for a third time. This marked the practical end of the Qing Dynasty (Rowe 2006).

Eventually, public opinion in both Europe and the United States turned against the policy of forcing opium on China. Around 1908, Britain and China negotiated to restrict the drug trade (Rowe 2006).

At the end of the 19th century, it's estimated that over one-fourth of adult Chinese men were addicted to opium (Rowe 2006), making it the largest mass intoxication event in history[3]. This crisis was only resolved after the communist revolution in 1949 (Labrousse 2011).

In the U.S., opioid use also rose throughout the 19th century—due in part to Chinese immigrants who brought with them the custom of smoking opium, and in part due to the iatrogenic (medically-induced) nature of many addictions. Constant use of opium-based medicines led to dependency (Rowe 2006).

At the time, medical professionals did not see opioid use as problematic. In fact, physicians were the largest group of American opioid users, and before criminalization, no social stigma was attached to addiction (Rowe 2006).

[3] Some studies suggest that these numbers are overestimated and that the rate of problematic users is even lower (Jay 2012).

To mitigate health issues stemming from opium use, 1909 saw the passage of the first federal U.S. regulation on psychoactive substances. President Theodore Roosevelt encouraged the Shanghai Conference to help China address its opium crisis. This initiative resulted in Public Law 221 (1909), aimed at banning opium imports for non-medical use.

In other words, the law's purpose was to prevent recreational use. The bill, proposed by Sereno Payne of New York, passed the House with minimal debate. The urgency stemmed from the need to support the Shanghai Conference's agenda (Rowe 2006).

The few objections raised were not about banning opium itself, but about potential unintended consequences. Representative Warren Keifer of Ohio feared that the law might promote domestic opium production, while Joseph Gaines of West Virginia warned it could encourage smuggling and create an illegal market. Despite these concerns, the bill passed with little resistance (Rowe 2006).

In 1911, the First International Opium Conference was held in The Hague, culminating in the 1912 Opium Convention, which regulated the production and sale of morphine, heroin, and cocaine. Soon after, the Harrison Narcotics Tax Act (1914) became the first U.S. law to restrict distribution and use of certain drugs, regulating and taxing the production, import, and sale of

opioids and cocaine—and criminalizing unauthorized commerce or prescriptions.

The Act empowered the state to decide, under the guise of scientific reasoning, which substances were dangerous and required strict control. It required medical prescriptions for products labeled as harmful, especially those containing opium or cocaine (Rodrigues 2017). Doctors could prescribe these drugs for medical treatment, but not for already-addicted individuals.

1.2. THE DEVIL'S TALISMAN

Although drugs were widespread among all social classes and ethnic groups, cocaine use was commonly associated with African Americans in the southern United States, while opium and its derivatives were linked to Chinese immigrant workers. It was also common for Puritan and hygienist groups to associate such substances with violent and dangerous behavior, particularly when committed against the white majority. This set the stage for a moral and ethnic basis for prohibition.

Internationally, however, until September 1910, the drug problem was mainly seen as an opium issue. At that time, the central geopolitical conflict involved the United States and Britain over the opium trade—particularly the raw form—and was

essentially a dispute over profits and differing approaches to East Asia: colonialism versus modern capitalism (Scheerer 1993a).

The main debate was centered on international control of raw opium. The Shanghai Conference of the previous year had been a diplomatic defeat for Britain, which faced growing global criticism for insisting on a trade increasingly seen as illegitimate. To mitigate the damage from that event, Britain agreed to participate in the upcoming 1911 Hague Opium Conference, but only on the condition that the discussion not be limited to raw opium. Instead, they demanded that the scope include its derivatives and other drugs. It was in this context, in September 1910, that cocaine was introduced into the international drug control discourse for the first time—by Britain itself (Scheerer 1993a).

Germany, Britain's main economic rival in Europe, was also the world's largest producer and exporter of cocaine in the years leading up to World War I. Germany's pharmaceutical industry was more advanced than Britain's and produced large quantities of morphine, derived from opium (Scheerer 1993a).

Ahead of the Hague Conference in 1911, Britain required all participants to study the production and trade of morphine and cocaine and commit to drafting strict legislation to regulate those markets (Scheerer 1993a). With this move, Britain achieved two goals: it distributed the political burden of the drug issue among

multiple countries—especially those initially opposed to banning morphine and cocaine—and harmed the economic interests of Germany. In other words, the stigma associated with the opium trade, which had exclusively tarnished Britain after the Shanghai Conference, was now shifted to rival nations and their products (Scheerer 1993a, 176).

Despite Dutch efforts at the 1911 Hague Conference to promote a more rational regulatory policy over a prohibitionist stance, Germany's uncoordinated diplomacy angered many delegations and damaged the country's image (Scheerer 1993a, 180). Britain, in turn, met both its goals: weakening a key economic competitor and sharing the stigma of drug commerce. More importantly, the conference set the foundation for the international war on drugs, expanding its scope beyond just opium.

Thus, the groundwork was laid for the international prohibition of cocaine, established through the 1911 Hague Conference, the 1912 Opium Convention, and, in the U.S., the 1914 Harrison Narcotics Tax Act.

However, cocaine had long existed in human history. The coca leaf (*Erythroxylum coca*) was considered sacred by the Incas (Iversen 2016) and continues to be chewed in many parts of South America. Its cultivation is still nearly monopolized by three Andean countries: Bolivia, Peru, and Colombia. For over five thousand years, coca has been deeply integrated into the identity

of Andean highland communities, used for medicinal, cultural, and ritual purposes (Labrousse 2011).

Spanish colonizers initially condemned the coca leaf as the "devil's talisman," but eventually encouraged its production after realizing it boosted labor performance among farmers and miners in what are now Peru and Bolivia. In Colombia, where Indigenous peoples make up less than 3 percent of the population, coca cultivation remained limited to personal consumption until the 1970s (Labrousse 2011).

Cocaine was first isolated from coca leaves in 1860 by the German chemist Albert Niemann. He named the substance and described the extraction process in his doctoral thesis at the University of Göttingen, titled *Über eine neue organische Base in den Cocablättern* (Niemann 1860), earning him his PhD.

Two years later, the German company Merck, based in Darmstadt and a pioneer in morphine production, began producing small amounts of cocaine for researchers (Courtwright 2002). Merck also marketed cocaine pills, claiming they enhanced vocal resonance for singers (Iversen 2016).

Soon, cocaine began to spread. In 1863, Corsican pharmacist Angelo Mariani created and patented an alcoholic coca leaf infusion that enhanced the plant's effects. His product, Vin Mariani, gained international popularity through advertising

campaigns that touted its rejuvenating and health-boosting properties.

Even Pope Leo XIII endorsed the drink, becoming one of the public figures featured in its promotions. Inspired by Vin Mariani's success, Coca-Cola was created in 1885, originally containing alcohol, coca extract[4], and caffeine. Today, only the caffeine remains.

By the late 1800s, German and Dutch pharmaceutical companies were importing large quantities of coca leaves from Peru and Bolivia to meet growing demand (Labrousse 2011). But it was only around 1890 that some of the negative effects of cocaine began to be investigated (Rowe 2006), with its addictive potential quickly becoming clear (Iversen 2016).

Cocaine abuse became an urban issue: from pickpockets in Montreal to prostitutes in Paris's Montmartre, from West End actresses in London to Berlin university students who would give up everything to sustain their addiction (Courtwright 2002). In addition to its addictive nature, cocaine is now known to cause severe paranoid reactions, indistinguishable from functional psychotic disorders, which may take weeks to subside after discontinuation (Rowe 2006).

[4] In a proportion twenty times lower than that usually consumed by an average user in a single dose of cocaine (Escohotado 2002).

Nonetheless, by the late 19th century, cocaine had become widely popular and attracted attention from many researchers, including Sigmund Freud (1884). Based on third-party observations and personal use, Freud expressed optimism about cocaine's potential for treating nervous fatigue, indigestion, cachexia, morphine addiction, alcoholism, chronic asthma, and impotence. He reviewed the scientific literature extensively and was enthusiastic about the drug's possibilities.

In the early 20th century, the Netherlands promoted coca cultivation in its colony of Java, which would soon become the world's largest producer. Around the same time, Japan began cultivating coca in Taiwan. These Asian crops allowed German, Dutch, and Japanese pharmaceutical industries to meet the first global wave of cocaine demand between the 1910s and 1940s (Labrousse 2011).

The Harrison Narcotics Tax Act of 1914 in the U.S. marked the start of a state-backed system of control over drug use, particularly targeting opium, coca leaves, and their derivatives. This regulatory framework rested on a puritanical and moral foundation, combining medicine, law, and treasury authority (Lima 2009).

Although the act was framed as a commercial and tax measure, its true purpose was to curb drug consumption and

movement. At its core was an ethical argument: drugs were not merely substances—they were moral threats.

Following the U.S. lead on opium and cocaine criminalization, Brazil enacted Decree 4.294 (1921), imposing penalties on those who sold cocaine, opium, morphine, and their derivatives. It also created special facilities for the internment of individuals addicted to alcohol and "poisonous substances," and introduced criminal and administrative procedures for drug offenses.

Selling, offering for sale, or administering "poisonous substances" without legal authorization or proper sanitary controls resulted in fines. However, if the substance had a "narcotic quality," such as opium or cocaine, the act became a crime punishable by one to four years in prison (Brazil 1921, Art. 1). Thus, it wasn't the substance's harmfulness that justified criminalization—but rather its psychoactive nature.

1.3. FROM ABSTINENCE TO INTOXICATION

Returning to the internal context of the United States, the next step was the criminalization of alcohol—long integrated into human culture. Alcoholic beverages, the oldest of all recreational drugs (Iversen 2016), are present throughout recorded history.

The earliest known reference to alcohol consumption dates back 7,000 to 7,400 years, with a ceramic jar containing wine residue found in 1968 in Iran (McGovern et al. 1996).

Alcohol is deeply embedded in the social fabric of many cultures and is closely related to the prevailing societal model. A society's level of alcohol consumption is directly correlated with its level of anxiety. The primary function of alcohol across cultures has always been to relieve anxiety (Horton 1943).

Nevertheless, not long after the campaign against cocaine and opium, the Eighteenth Amendment to the U.S. Constitution (US Constitution, amend. 18, 1919) established the prohibition of alcoholic beverages in the United States. It declared the production, transport, and sale of alcohol illegal. Rejected only by the states of Connecticut and Rhode Island, the amendment was ratified by the remaining states on January 16, 1919, and came into effect on January 17, 1920.

Shortly after, the United States passed the National Prohibition Act of 1919, also known as the Volstead Act. This law not only reinforced the prohibition but also criminalized the sale, manufacture, and transport of alcoholic beverages throughout the country.

Thus began the era of the Great Prohibition—a model that, according to its advocates, would eliminate vice and restore moral rectitude and dignity to American citizens. The law marked the

triumph of puritanical social segments and the rise of state-sponsored therapeutic governance, characterized by control over individual and collective behavior. As a direct consequence of what became known as the Prohibition Era, organized crime flourished in the United States. The legal framework meant to shield the nation from the ills of vice also fueled the growth of criminal networks. The resulting illegality created the conditions for American mafias to grow and prosper (Rodrigues 2017).

With alcohol driven underground, a highly profitable black market emerged. Mafia groups, already present in certain cities, seized the opportunity to dominate the illegal alcohol trade, controlling everything from production to distribution through secret bars known as speakeasies. Al Capone, one of the most notorious mafia leaders in Chicago, built an empire based on the smuggling and illegal sale of alcohol, amassing considerable wealth and power.

Prohibition also weakened law enforcement capacity. Police officers and authorities were often bribed to allow the illegal trade to continue. Organized crime thus expanded and diversified, branching out into other illicit activities like prostitution and gambling. In the end, Prohibition had the opposite effect of its stated intent, empowering criminal organizations and increasing gang-related violence.

Even Albert Einstein (2007), who lived through this historical context and received the Nobel Prize in Physics in 1921, spoke out against the dangers of laws that cannot be enforced. In his view, such laws undermine public respect for the legal system and contribute to rising crime. Regarding the Eighteenth Amendment and the National Prohibition Act of 1919, Einstein stated:

> The prestige of government has undoubtedly been lowered considerably by the Prohibition law. For nothing is more destructive of respect for the government and the law of the land than passing laws which cannot be enforced. It is an open secret that the dangerous increase of crime in this country is closely connected with this. (Einstein 2007, 40–41)[5]

After thirteen years in force, Prohibition was repealed on December 5, 1933, with the ratification of the Twenty-First Amendment to the U.S. Constitution (US Constitution, amend. 21, 1933), which annulled the Eighteenth Amendment. While the repeal did not immediately dismantle organized crime, it acknowledged that alcohol prohibition had failed in its objectives.

The fact that alcohol was deeply rooted in the cultures of all peoples was key to its resilience against both prohibition and

[5] Albert Einstein's thinking does not differ from that of Beccaria (2001, 675), according to whom "you will see abuses grow as empires increase. Now, since national spirit weakens in the same proportion, the tendency to commit crimes will grow because of the advantage each person discovers in the abuse itself; and the need to aggravate penalties will necessarily follow the same progression."

stricter regulation. Campaigns against alcohol and other psychoactive substances in the late 19th and early 20th centuries were remarkably similar. The same moral arguments used against narcotics were applied to alcohol. Over time, however, alcoholic beverages resisted the legal constraints that ultimately banned other so-called illicit drugs.

David T. Courtwright (2002, 3309) explains this phenomenon—what he calls the "privileged status of alcohol"—by pointing to the economic interests of Western nations, which dominated global economic and diplomatic affairs. For instance, early 20th-century France relied on the alcohol industry (producers, retailers, transporters, cork manufacturers, etc.) for the livelihood of about five million people, roughly 13 percent of its population. In Russia, alcohol taxes accounted for the entire national defense budget (Courtwright 2002).

The same held true across Western nations and many colonial governments in Africa and Asia. Opium, on the other hand, gradually declined in economic significance, particularly within the British Empire. As opium trade from India and China diminished in the late 19th and early 20th centuries, Britain became less resistant to regulating or banning it.

Today, the global alcoholic beverage market is valued at approximately 2.31 trillion U.S. dollars, with projected growth to 2.52 trillion by 2024 (Fortune Business Insights 2024). The

market is expanding due to rising demand for premium beverages, a growing preference for super-premium spirits, and the increasing popularity of online alcohol sales. For comparison, in 2015, global sales of wine, beer, and spirits totaled about one trillion U.S. dollars (Iversen 2016).

But it's not just about economics. Alcohol and tobacco have long been part of the lifestyle of society's most influential groups—those who wield real power over which substances are deemed harmful or acceptable. The same goes for opinion leaders, including artists, academics, and journalists (Courtwright 2002).

Social acceptance of alcohol is closely tied to cultural, economic, and political power structures, rather than its legal status. In many societies, alcohol plays a traditional role in social rituals, celebrations, and religious ceremonies. In Western cultures like France and Germany, for example, wine and beer are integral to national identity.

1.4. MARY JANE

A Returning to the 1930s, U.S. foreign policy regarding drug control assumed a somewhat contradictory and even ironic character. While domestically the United States was recognizing the failure of Prohibition with respect to alcohol, on the

international stage it was intensifying efforts to combat drugs—especially those originating in economically peripheral countries or associated with the industrial development of European states with which the U.S. maintained commercial rivalry. The criminalization of psychoactive substances expanded.

International initiatives to control certain substances reflected the new global distribution of power, increasingly dominated by the United States. This distribution became particularly evident in relation to psychotropic commodities: those deemed legal and inherent to the culture of hegemonic states (such as alcohol and tobacco), and those criminalized and linked to the traditions of less influential nations in global affairs (Lima 2009).

In this historical context, in 1935, President Franklin D. Roosevelt publicly supported the adoption of the Uniform State Narcotic Drug Act (1934) by all states of the federation. The goal was to standardize, at the national level, the prohibition and criminalization of psychoactive drugs (those not tied to American cultural heritage). The ethical argument for this policy, deeply marked by ethnic undertones, shaped its rhetoric.

Alongside its increasing domestic prohibitions, the United States—already a central actor in international drug control since the early 20th century (Woodiwiss 2005)—advanced a global

prohibitionist agenda, exporting its legislative model to other nations.

U.S. leadership was confirmed at the 1931 Geneva Conference, where it secured commitments from most participating states (with few European exceptions) to take domestic action against addiction and drug-related behavior.

From the mid-1930s onward, *cannabis* became the new target—another ancient drug. Hemp is native to the steppes of Turkestan, corresponding today to parts of Central Asia and northwestern China, where it still grows wild, particularly between Kazakhstan and Kyrgyzstan, covering about 150,000 hectares. *Cannabis* was used in ancient Egyptian and Assyrian cultures (Labrousse 2011), and for over six thousand years, it served various functions. It was valued as a multipurpose crop used not only to produce medicine but also cooking oil, edible seeds, fodder, and hemp fibers for ropes, fishing nets, and textiles—especially for the poor in China, as silk was reserved for the wealthy (Courtwright 2002).

In Asia, *cannabis* was incorporated into Hindu and, later, Buddhist rituals, accompanying the latter throughout its expansion. In the first and second centuries, the Romans used hemp on a large scale to make ropes for their ships. From the seventh century onward, the spread of Islam played a key role in disseminating *cannabis*, a substance that had become deeply

embedded in Islamic culture. Muslim merchants introduced it throughout the Middle East and, by the early eleventh century, brought it to sub-Saharan Africa and Morocco (Labrousse 2011).

However, the Islamic relationship with *cannabis* was ambivalent. It was sometimes linked to ritual practices viewed as heretical, which nearly led to its prohibition. At other times, it was tolerated and widely used. This tension stemmed in part from its association with *sufi gari*[6], whose practices were often met with suspicion by orthodox authorities.

Despite sporadic suppression efforts, by the mid-16th century *cannabis* production was well-established, especially in the Nile Delta. Soon after, Arab merchants successfully introduced *cannabis* to the East African coast, from where it spread to central and southern Africa. Unlike tobacco, *cannabis* use flourished among *Khoikhoi*, *San*, and other South African peoples well before European contact (Courtwright 2002).

In Western Europe, the Catholic Church condemned *cannabis* in the 15th century, marginalizing it in contrast to substances like wine and beer, which were accepted by both society and religion (Labrousse 2011). Yet this marginalization did not hinder the plant's expansion or its diverse applications.

[6] Practitioners of Sufism, a mystical and contemplative branch of Islam that promotes a direct, intimate, and permanent relationship with God through chants, music, and dance—practices considered illegal under the sharia law in several Muslim countries.

Cannabis was widely known across the Old World by the time Columbus departed from Palos de la Frontera on August 3, 1492. The ropes of his three ships were made of hemp (Courtwright 2002).

Later, in the 18th century, Napoleon's expedition to Egypt helped popularize *cannabis* among physicians and writers (Labrousse 2011). Spain cultivated *cannabis* in its colonies from the 16th to the 19th centuries (Courtwright 2002). In England, scholars and enthusiasts imported it from India. The British introduced *cannabis* cultivation to Jamaica to extract hemp fibers. By the mid-19th century, enslaved people on the island used the plant for ritual and recreational purposes (Labrousse 2011).

In Brazil, *cannabis* arrived with Angolan slaves who began cultivating it around 1549 among sugarcane plantations, with the landowners' consent. The Angolans called it "maconha." Over time, Indigenous communities began using *cannabis* for various purposes—medicinal, recreational, invigorating, and textile. The Brazilian Northeast became the region most closely tied to *maconha* culture (Courtwright 2002).

From Jamaica, *cannabis* made its way to Mexico, where it was called "marihuana" by rural workers. From there, it crossed the border into the United States in the early 20th century, brought by Mexican immigrants and Caribbean sailors (Labrousse 2011).

The habit of smoking *cannabis* spread across the U.S. with the arrival of over a million Mexican workers during the first three decades of the 20th century. Tens of thousands moved throughout the Midwest, working in construction, railroads, factories, and mills, even reaching Chicago (Courtwright 2002).

At the same time, *cannabis* spread north and east from New Orleans, brought by sailors from the Caribbean and South America beginning in 1910. Americans were already familiar with smoking via tobacco, which helped normalize *cannabis* consumption. The country also had an abundant domestic supply (Courtwright 2002).

In Tennessee, inmates subjected to forced labor smoked dried *cannabis* flowers growing by the roadside. In San Quentin prison, inmates cultivated their own *cannabis* within prison grounds (Courtwright 2002).

In this context, the Marihuana Tax Act of 1937 was passed. Personal and medical use of hemp remained legal, but the law imposed a symbolic tax—starting at one dollar—on any commercial or medical *cannabis*-related activity, while establishing a fine of $2,000 and/or five years in prison for any violation of its complex and invasive regulations.

Whenever a doctor, dentist, or veterinarian prescribed *cannabis*, they were required to submit detailed reports to the Treasury Department, including the patient's identity, diagnosis,

reasons for the prescription, and other case-specific information. Any omission or error could result in penalties. Compliance with the law was practically impossible for users, professionals, or businesses.

Some authors argue that the true goal of the law was to destroy the hemp industry (French and Manzanárez 2004), protecting the cellulose[7] and synthetic textile sectors (Gerber 2004). Hemp fiber was an excellent raw material for both paper and textiles. With new extraction methods, it had become a viable and cheaper alternative. For example, paper made from hemp cost about half as much as that made from wood pulp (Rowe 2006).

Clearly, many interests were at play in the push to outlaw *cannabis*. Thomas C. Rowe (2006) emphasizes the roles of three key figures in the history of the Marihuana Tax Act: Hamilton Wright, William Randolph Hearst[8], and especially Harry J. Anslinger. All pursued personal agendas, discarding any evidence that conflicted with their interests.

In 1930, the Bureau of Narcotics was created within the U.S. Treasury Department, and Harry J. Anslinger—the nephew of Treasury Secretary Andrew Mellon—was appointed as its director (Robinson and Scherlen 2007; Fahey and Miller 2013).

[7] Hemp was first used for paper production around the year 100 BC.

[8] A controversial and influential personality, immortalized in the film Citizen Kane (Welles 1941), written, produced, directed, and starred by Orson Welles, released in 1941, considered by the American Film Institute (2007) as "the greatest film of all time."

Mellon was also the owner of Mellon Bank, a key financier of DuPont, the largest wood and paper manufacturer in the U.S.

These individuals had close ties to William Randolph Hearst, a newspaper magnate with major holdings in wood and paper. Hearst used his newspapers to campaign aggressively against *cannabis*, benefiting both the paper-cellulose industry and the rise of synthetic textiles like polyester, in which he also had investments. DuPont had just developed nylon, which hemp-based fabrics threatened (Robinson and Scherlen 2007; Straight 2005).

Still, such lobbying required a social base. In 1930s America, *cannabis* was associated with specific ethnic groups, particularly Mexican laborers. In the wake of the Great Depression, white Americans in southern states pressured lawmakers to reduce Mexican immigration, viewing these workers as competitors for scarce jobs. This led to mass repatriations (Rowe 2006).

Against this backdrop, Hearst's media empire promoted an aggressive campaign linking *cannabis* use with violence and social decay, again relying on a moral and ethnic narrative[9].

[9] It is important to recall that "the criminal justice system always acts selectively and selects according to stereotypes fabricated by mass media. These stereotypes allow for the classification of criminals who match the image that fits the constructed narrative, leaving out other types of offenders (white-collar, golden, traffic-related crimes, etc.)" (Zaffaroni 1991, 130).

Hearst owned the *San Francisco Examiner* (1887), *The New York Morning Journal* (1895), *The Evening Journal* (1896), *The Chicago Examiner* (1902), and *The Boston American*(1904), as well as magazines like *Cosmopolitan* and *Harper's Bazaar*. At its peak, his empire reached 30 million readers and was worth $220 million (Rowe 2006).

Although Hearst's precise motives remain unclear—some speculate he sought to protect his paper interests (Herer 2010)—his *anti-cannabis* campaign was decisive in securing the passage of the Marihuana Tax Act and the suppression of the hemp industry[10].

Later, the Narcotics Control Act of 1956 further tightened *cannabis* laws, supporting the blanket criminalization of *cannabis* and its active compound—a trend soon mirrored in the legislation of many sovereign states.

After its unrestricted criminalization, *cannabis* became part of the hippie culture, which originated from the beat movement popular among intellectuals during the 1950s (Iversen 2016). The media visibility of the hippies piqued the interest of many young people, especially in reaction to the Vietnam War, suburban materialism, and racial segregation. *Cannabis* thus

[10] "The power to control the flow of information is the power to control how human beings think. The ability to determine, direct, and select information can become a source of power comparable to that held by those with great natural, technological, and economic resources" (Machado 2005, 3).

became a symbol of rebellion, widely used by both college and high school students.

Its acceptance grew so rapidly that by 1979, about 55 million Americans had experimented with some form of *cannabis*. Two-thirds of those aged 18 to 25 had used marihuana. Ironically, a drug criminalized and stigmatized by the United States had now become a global phenomenon (Courtwright 2002). According to 2022 data, there are 228 million *cannabis* users worldwide (UNODC 2024).

More recently, several U.S. states have started to legalize *cannabis*, granting it a new legal status. This legalization process has unfolded gradually, driven by social and political change, gaining momentum in the late 20th century and accelerating in the 21st.

A major turning point came in 1996, when California became the first state to legalize medical *cannabis* with the approval of Proposition 215. This opened the way for other states—such as Alaska, Oregon, and Washington—to adopt similar legislation. This first wave of medical *cannabis* laws was based primarily on the recognition of therapeutic benefits, despite federal prohibition.

The movement for recreational *cannabis* legalization began to gain real traction in 2012, when voters in Colorado and Washington approved referendums that legalized adult use and

possession of *cannabis* for those over 21. These measures were a milestone: for the first time, U.S. states established legal, regulated markets for recreational *cannabis*. Others soon followed: Alaska and Oregon in 2014; California in 2016, with Proposition 64, which consolidated the trend in one of the largest U.S. markets.

In the following years, the movement continued to grow. In 2018, Vermont became the first state to legalize recreational use via legislation rather than popular vote. In 2020, states like New Jersey, Montana, and Arizona joined through referendums; and in 2021, New York and New Mexico also passed laws regulating recreational use.

Despite state-level legalization, *cannabis* remains illegal under federal law, classified as a Schedule I drug, which creates ongoing conflict between state and federal regulations. This legal contradiction affects enforcement, banking services, and commercial oversight, as *cannabis* possession and distribution remain federal crimes. It also impacts U.S. foreign policy, which still maintains a prohibitionist stance internationally.

Cannabis legalization has not only transformed social and economic dynamics in many states, but it has also stimulated debates about social justice. Many states have sought to address past injustices, particularly the disproportionate imprisonment of minorities for *cannabis*-related offenses, by expunging criminal

records and encouraging minority participation in the new *cannabis* industry.

Thus, although *cannabis* remains a complex legal issue at the federal level, state-level legalization has advanced rapidly, reflecting cultural shifts and giving rise to a multibillion-dollar legal market. The evolution of this scenario will continue to shape the future of U.S. drug policy, with possible federal implications if the government eventually revises its prohibitionist approach.

1.5. CONSOLIDATION OF SIN

Returning to the 1960s and still under the influence of the United States, the Single Convention on Narcotic Drugs was signed in New York on March 30, 1961. It was called "single" because it consolidated and updated, in the context of the Cold War, all previous international treaties on drug control. These included the 1912 International Opium Convention and the 1953 Protocol (Lima 2009).

In essence, the Single Convention established a broad international drug control system, requiring states to incorporate into their domestic laws the strategies and measures it set forth. It reinforced efforts to suppress the cultivation, production, circulation, and trade of drugs within each country. It also set

deadlines for the gradual elimination of certain substances: 15 years for opium and 25 years for cocaine and *cannabis*—goals that, unsurprisingly, were never achieved (Boiteux et al. 2009).

The 1961 Convention became the most comprehensive international treaty on psychoactive substances. Comprising 51 articles, it listed the substances considered psychotropics and classified them according to their properties. It established control and inspection mechanisms, defined special restrictions for the most dangerous substances, regulated the inclusion of new substances, and gave the United Nations authority to oversee international drug policy. It also prescribed internal enforcement measures against trafficking and recommended that all intentional acts involving the production, sale, or possession of illicit substances be appropriately punished (Lima 2009).

The prohibitionist-punitive model adopted in the first phase of drug criminalization was grounded in two fundamental principles: one moral-religious, the other hygienist. The moral-religious principle was based on the view that drug use is immoral or sinful, often promoted by religious groups that viewed abstinence as the only acceptable response to what they considered deviant behavior. This perspective heavily influenced the early rhetoric against psychoactive substances.

The hygienist principle, on the other hand, was rooted in ideals of public health. It aimed to promote the notion of a drug-

free world, assuming that the eradication of drug use would lead to a healthier and more orderly society. In the early 20th century, this idea was reinforced by eugenics movements and efforts to "purify" society of elements deemed degenerative or undesirable.

These two principles became interwoven to justify punitive and repressive policies that criminalized not just drug trafficking but also consumption. Together, they laid the foundation for the modern war on drugs—a system focused on repression and control rather than public health or harm reduction. The result was mass incarceration and the marginalization of drug users, without actually solving the problem of abusive drug use.

2. THE MEANS JUSTIFY THE END

A Returning to the internal policy of the United States and its global imposition of drug control strategies, it is clear that although the American philosophy on drugs was refined during the early 1960s, there was no substantial break with the essence of earlier policies. These had always been rooted in the moral certainty of the dominant values that had shaped U.S. society at the turn of the 20th century (Woodiwiss 2005).

Richard Nixon upheld the old belief that a drug-free nation was an achievable goal. In his view, domestic efforts had to be paired with a strong international front, and he turned the fight against drugs into a top government priority, mobilizing all federal agencies and departments to contribute (Woodiwiss 2005).

Thus, the so-called war on drugs officially began with the Comprehensive Drug Abuse Prevention and Control Act of 1970, which not only regulated and classified drugs—allegedly based on their potential for abuse and dependence—but also consolidated the entire legal framework regarding the

identification and prohibition of illegal substances. The Act assigned to the Drug Enforcement Administration (DEA), under the U.S. Department of Justice, the authority to determine which drugs would be prohibited for use and sale.

Richard Nixon fully framed the drug debate in ethical and moral terms, portraying the war on drugs as a moral struggle against evil. His goal was a world free of psychoactive substances. This war was to be waged on two fronts: reducing supply and reducing demand, both enforced through criminal law (Nutt 2012). In this framework, criminalization became the means by which states could eliminate drug use.

Although the moral argument remained strong, this period marked the war on drugs with a more pragmatic tone: the goal was to eliminate all illicit substances. Criminalization served as the tool, not the end.

It was time, in Nixon's view, to adopt a series of domestic measures that would later support international action, and to seek an international legal framework that could facilitate enforcement (Olmo 1990, 42).

A memorandum dated September 29, 1969, sent by Henry Kissinger—then National Security Advisor—to William Rogers, Secretary of State, captures the core of the U.S. drug policy that remains in place today. In the memo, Kissinger warned that President Nixon was convinced that the narcotics addiction

problem had reached levels that endangered national stability. He emphasized that most narcotics—especially heroin—were cultivated or produced abroad and then trafficked into the U.S., and Nixon viewed any country facilitating this traffic as acting against American interests (Woodiwiss 2005).

The memo recommended the immediate development of a program to clearly communicate to opium-producing countries that they were expected to ban all non-medical cultivation. Countries manufacturing heroin would be required to shut down their illegal labs. The program should also consider positive incentives, such as financial aid for cooperation, and retaliatory measures for countries unwilling to comply.

This policy approach culminated in the Narcotics Control Trade Act of 1974, which had significant consequences for the international community in the decades that followed. In summary, the law established that drug-producing or transit countries that failed to cooperate with American anti-drug efforts could face sanctions, including the suspension of aid and increased tariffs and trade barriers. In other words, other states were expected to adopt the United States' policy on psychoactive substances and become its allies in the war on drugs by implementing the criminalization model it promoted, under the threat of financial and economic consequences (Woodiwiss 2005).

Following Richard Nixon, the administrations of Presidents Gerald Ford and Jimmy Carter[11] (to a lesser extent, in Carter's case) continued the fight against drugs in the same mold and with the same biases as their predecessor, maintaining the war that had already been declared. During Gerald Ford's presidency, from 1974 to 1977, U.S. drug policy was marked by the continuation of the prohibitionist approach initiated under previous administrations, particularly that of Nixon. Ford advanced these policies by consolidating and expanding repressive and control measures targeting drug use and trafficking, without introducing major innovations in strategy.

The National Program for Drug Abuse Control, proposed by Ford in 1976, sought to coordinate federal government efforts to combat drug use and trafficking. The creation of the Drug Enforcement Administration (DEA) in 1973, during the Nixon administration, was strengthened under Ford, with an intensification of repressive actions. The DEA operated both domestically and in the fight against international trafficking, coordinating operations in collaboration with drug-producing countries, especially in Latin America. The strategy focused on

[11] Later, Jimmy Carter (2011) published an article titled *Call Off the Global Drug War* in The New York Times (June 16, 2011), in which he criticized the war on drugs and acknowledged its failure.

supply control rather than demand reduction or investment in treatment and prevention programs.

This period was characterized by a concentrated effort to combat drug trafficking, with a focus on repression and the criminalization of activities related to illicit substances. The Ford administration maintained the narrative that law enforcement and border control were the most effective ways to address the drug problem.

One notable aspect of this policy was its international reach, as Ford's government continued partnerships with drug-producing countries in an effort to interrupt the flow of illicit substances into the United States. These initiatives, however, proved to be limited in their effectiveness: despite efforts at supply control, drug consumption among young people continued to rise, particularly with marijuana and heroin use.

The Ford administration focused exclusively on repression, without making significant investments in prevention or treatment programs for individuals with substance use disorders. Unlike later policies implemented in the 1980s, which included efforts in treatment and rehabilitation, Ford followed a hardline approach against drugs, reinforcing the criminalization of drug use and the fight against trafficking without effectively addressing the underlying causes of substance abuse. This perpetuated a cycle of incarceration and marginalization, particularly among minority

populations, without resolving the problems associated with addiction.

In short, the Ford administration's drug policy upheld the prohibitionist approach, reinforcing repressive institutions and pursuing a strategy centered on criminalization and enforcement.

During Jimmy Carter's presidency (1977–1981), the U.S. drug policy saw a slight shift in emphasis compared to previous administrations. Carter adopted a more moderate approach, especially regarding marijuana, reflecting the cultural changes of the time and an attempt to soften the repressive posture of the war on drugs, which had been intensified during the Nixon and Ford years. Carter viewed the criminalization of minor marijuana-related offenses as counterproductive, and his administration made efforts to decriminalize the possession of small amounts of the drug.

In 1977, President Carter delivered a speech to Congress advocating for the decriminalization of possession of up to one ounce (approximately 28 grams) of marijuana for personal use. This stance was supported by segments of the population and reflected growing social acceptance of marijuana, especially among young people. Under his leadership, personal possession of marijuana was widely decriminalized (though not legalized) in several states, allowing individuals caught with small quantities to avoid imprisonment and face fines instead. This policy stood in

contrast to both earlier approaches and the stricter policies that would follow, which again centered on repression.

However, Carter faced significant challenges in implementing this more liberal approach. One major factor that undermined his policy was the increasing use of so-called “harder” drugs, such as cocaine. During his administration, cocaine consumption rose, and the market for more dangerous drugs expanded, provoking a backlash from conservatives and law enforcement advocates who opposed any effort to ease restrictions on illicit substances.

Additionally, Carter’s administration was damaged by scandals involving drug use, such as the case of Peter Bourne, one of his drug policy advisors. Bourne was forced to resign after being accused of recreational drug use at a party, which harmed the government’s public image and weakened its efforts to push forward a broader decriminalization agenda.

By the end of his presidency, Carter’s attempt to pursue a more progressive, harm-reduction-oriented drug policy had failed to gain traction. The softer stance on repression was quickly reversed under President Ronald Reagan, who intensified the war on drugs and reinstated strict criminalization as the central strategy for combating illicit substance use.

Thus, the Carter era represented a brief, largely unsuccessful attempt to strike a balance between enforcement and

a more tolerant, pragmatic approach to drug use—particularly marijuana. His efforts were ultimately undermined by both the social context and internal political scandals.

As a result, the international community continued to follow the U.S. policy of prohibition. The outcomes, however, were negligible. By the end of the 1970s, both drug demand and supply had grown substantially, and the public health consequences of substance abuse had worsened significantly.

3. THE END JUSTIFIES ITSELF

If, in the second phase of drug criminalization, criminal law was established as a means to rid the world of psychoactive substances—promising the protection of the legally protected good (public safety)—then, once it became clear that drug trafficking could not be defeated, punitive intervention in the drug issue, in its third phase, came to represent an end in itself.

After the Cold War faded, and with no ideological justification left to sustain militarization and the exercise of hegemonic power that it entailed, the United States filled this political-ideological void with the escalation of the war on drugs—this time centered on the fight against drug trafficking.

Ironically, the same failure of drug criminalization revealed during the second phase, which led to the intensification of efforts to combat trafficking, gave rise—especially in Europe—to public policies aimed at harm reduction associated with the abuse of illicit substances. These policies focused on treating the user, now seen as someone in need of care, not as a

criminal. Drug criminal law became more lenient with those who generate demand and more severe with those who supply it. On one side, a militarized strategy against the drug trade; on the other, a public health approach toward people who use illicit substances.

3.1. THE MILITARIZATION OF WAR

The 1980s became emblematic for the adoption of the U.S. model of crime control by a wide array of sovereign states[12], but this phenomenon was even more pronounced in relation to psychotropic substances. The strategy "came to incorporate an interventionist and militarized perspective that justified interventions in Latin American countries under the pretext of 'fighting' drug trafficking" (Boiteux 2011, 106).

In this context, Ronald Reagan, President of the United States of America from 1981, early in his term, expressed in public speeches his concern and intention to intensify the war on drugs, tightening the criminal statutes that supported this policy. He declared his commitment to leading the battle against illicit psychoactive substances. Under his administration, penalties for illicit drug trade were significantly increased, and the confiscation

[12] On this phenomenon, its origin and cause, and its effects in Brazil, see Pedro Abramovay and Vera Malaguti Batista (2010).

of assets used in trafficking or acquired through it became standard practice (French and Manzanárez 2004).

During President Reagan's two terms, domestic legislation concerning the use and trade of psychotropic substances became more severe, and the United States Armed Forces began directly participating in the war on drugs. Furthermore, the government adopted a more rigid diplomatic stance on narcotrafficking, even imposing economic sanctions on Latin American countries it deemed responsible for the psychoactive substance crisis—despite the fact that such issues stemmed from high demand within the U.S. and Western European countries, not from the producing nations that ensured supply (Hagen 2002).

At the international level, the control system for illicit psychoactive substances gradually expanded, reaching its peak with the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. This repressive instrument aimed to standardize the definition of drug trafficking, criminalize money laundering, strengthen international cooperation among states regarding psychoactive substances, and unify existing regulations. The militarization of anti-drug efforts is evident in the language used throughout the Convention, with expressions such as "war on drugs," "combating traffickers," and

"repression and elimination," reflecting an "emotional and even irrational appeal" (Boiteux et al. 2009, 19).

Subsequently, in 1989, President George Bush implemented the First National Drug Control Strategy (US President 1989), expanding the prohibition of illicit drugs and standardizing the strategy for combating drug trafficking. He also broadened the militarization of the international war on drugs, promoting a rapid increase in military cooperation with cocaine-producing countries. To grasp the extent of this shift, between 1988 and 1991, the budget allocated to this agenda rose from US$5 million to US$150 million. This was the so-called Andean Strategy, which consisted of technical and military support for narcotrafficking suppression efforts (Hagen 2002). The discourse portraying drugs as a national security threat once again gained prominence:

> The source of the most dangerous drugs threatening our nation is principally international. Few foreign threats are more costly to the U.S. economy. None does more damage to our national values and institutions or destroys more American lives. While most international threats are potential, the damage and violence caused by the drug trade are actual and pervasive. Drugs are a major threat to our national security. (US President 1989, 61)

As a result of the intensification of drug criminalization, between 1980 and 2000, the number of individuals convicted for drug-related offenses in the United States increased fifteenfold

(Levitt and Dubner 2005). There was no significant change in the U.S. approach to drug prohibition, nor in the policies it imposed on other countries, under the administrations of Clinton[13], Bush, Obama, Trump, and Biden—the global war on drugs continued.

Although Bill Clinton advocated a therapeutic rather than penal approach to drug users during his 1992 presidential campaign, in the early months of his administration he adopted the same criminalization strategies as his Republican predecessors, continuing the steady escalation of the drug war.

Under George W. Bush, the militarization of drug enforcement rapidly intensified in support of criminalization. By the end of his term, approximately 40,000 SWAT-style paramilitary raids were conducted annually against U.S. citizens, mainly for non-violent drug law violations.

Although President Obama implemented a syringe distribution program for intravenous drug users and reduced the sentencing disparity between crack and powdered cocaine offenses—measures rejected during the Clinton administration—his steps toward reducing drug criminalization did not go further.

During his first presidency, Donald Trump cited the need to prevent the entry of illicit drugs as one of the justifications for building a wall along the Mexican border. Meanwhile, Attorney

[13] Bill Clinton criticized the war on drugs in a recent documentary titled *Breaking the Taboo* (Andrade, et al. 2011).

General Jeff Sessions argued that states lacked sovereignty to legalize marijuana, asserting that “good people don’t use marijuana” (The Drug Policy Alliance 2017). President Trump also advocated the death penalty for certain drug trafficking offenses (McDonald 2018). The legalization of marijuana in some U.S. states had no direct impact on the country’s international drug policy.

Under President Joe Biden, U.S. drug policy shifted significantly compared to previous administrations, focusing more on public health and harm reduction than on traditional criminal repression. The Biden administration prioritized treating drug use as a public health issue. Rather than emphasizing criminalization, Biden's policy sought to reduce the harms associated with drug use. This includes expanding access to treatment services, providing medications for opioid use disorders (such as methadone and buprenorphine), and supporting harm reduction programs like clean syringe distribution and syringe exchange initiatives.

Moreover, substantial resources have been allocated to drug use prevention and treatment of substance use disorders. The administration has invested in awareness campaigns about opioid and narcotics use and has promoted the training of physicians to prescribe safe and effective treatments.

Nonetheless, despite the public health focus, the Biden administration has maintained strict efforts to combat drug trafficking, particularly the entry of synthetic opioids like fentanyl. This includes international cooperation to disrupt supply chains and intensified border control measures.

What has effectively changed in the international arena over the past three decades is that, intentionally or not, the war on drugs has filled the void left by the Cold War, appropriating all its associated fears and prejudices. It has also co-opted the entire power structure and international influence developed by the United States during its fight against communism. This sphere of influence has shaped the legislative behavior of other sovereign states, their public policies on drugs, their use of military force, and even the rulings of their courts.

According to the official statement of the First National Drug Control Strategy (US President 1989), for example, a comprehensive drug control strategy must include intervention programs and effective attacks on international production and trafficking. These programs, aimed at foreign sources of illegal drugs, were intended to support deterrence and incapacitation by bolstering the criminal justice efforts of participating countries and targeting multinational trafficking organizations beyond U.S. borders. In the government's view, such a strategy would intercept drug cultivation and trade before it reached the United States,

rather than confronting it domestically. The war on drugs, more harmful than drug use itself, would be waged abroad. The underlying narrative is one of exporting the problems of drug criminalization.

Not only the problems but also the costs would be exported, since, as established in the official strategy, "Effective international efforts allow us to enlist the resources of other nations in this battle. Our country cannot alone assume the responsibility or cost of combatting drugs" (US President 1989, 61).

In this sense, the priorities of U.S. criminal justice and its model of criminalization and prosecution have been exported abroad (Linhares 2015). Foreign governments have responded to American pressure, incentives, and examples by adopting new criminal laws on drug trafficking, money laundering, insider trading, and organized crime. This includes changes to financial and corporate secrecy regulations as well as criminal procedural codes, to better align with the policies imposed on them (Nadelmann 1993).

As the U.S. intensified its international drug policy, even involving national security agencies on the basis that "The war against drugs cannot be fought—much less won—without good intelligence" (US President 1989, 87), local police forces began adopting American investigative techniques, while courts and

legislatures followed suit with the necessary legal authorizations. Governments allocated substantial police and even military resources to combat the production and trafficking of illicit drugs. In broad terms, the United States provided the models, and other states adjusted accordingly (Nadelmann 1993).

In this regard, the War on Drugs also functions as a geopolitical strategy of occupation, domination, and control over the global peripheries by the United States. It takes on militarized dimensions because it serves as a pretext for deploying troops, indoctrinating, and co-opting peripheral military elites to align them with U.S. interests and to suppress any nationalist or anti-imperialist discourse. History demonstrates the success of this strategy, which relies on the seemingly benign indoctrination of members of strategic local sectors (Santos Júnior 2016, 226–227).

The influence of what the Global Commission on Drug Policy (2011, 8) calls the "imperialism of drug control" extends to matters traditionally considered local, imposing behavior patterns that often contradict the culture, history, and self-determination of peoples—to the point of criminalizing even longstanding traditions. A current example of this is Bolivia's attempt to lift the ban on coca leaf chewing imposed by the 1961 Convention, which prohibits any non-medical use of the plant. Despite numerous studies showing that this indigenous practice does not exacerbate narcotrafficking harms, and despite

overwhelming local and regional support for the change, most nations—led by the United States and representing major cocaine markets—formally opposed the proposed amendment.

Another example of the hardening of drug legislation and its subsequent militarization is Brazil's enactment of Decree 5.144 (Brazil 2004), which regulates the so-called "Shoot-Down Law" (Brazil 1998). Under this regulation, the aviation authority may use necessary means to compel an aircraft to land, and, if disobeyed and all legally prescribed coercive measures are exhausted, the aircraft may be classified as hostile and subject to destruction. Although the law does not specifically address narcotrafficking, the decree's motivation was precisely that.

Decree 5.144 (Brazil 2004) outlines procedures concerning hostile aircraft or those suspected of drug trafficking, given that such aircraft may pose a threat to public security. Aircraft suspected of trafficking illicit psychoactive substances that fail to comply with coercive measures will be deemed hostile and may be destroyed. The nature of the shoot-down authority, and the officials empowered to enforce it, highlights the warlike nature of contemporary anti-drug policies—demonstrating, once again, the warfare framing of the drug issue.

An even more striking example of the bellicose treatment of psychoactive substances in the third phase of their criminalization is the imposition of the death penalty for drug-

related offenses in countries such as China, Vietnam, Singapore, Iran, Indonesia, Malaysia, and Saudi Arabia (Karam 2009). This is the result of the deepening drug war and the punitive criminal law that supports it. In June 2018, the Chinese judiciary executed two individuals convicted of drug trafficking in front of three hundred schoolchildren, as a deterrent (Cox 2018).

Thus, the most emblematic feature of this period—beginning with Ronald Reagan and continuing to the present—is the new face of drug criminalization. The moral argument still garners popular support (as in the first phase), and the stated goals remain those of eradicating psychoactive substances (as in the second phase), but the war on drugs has ceased to be merely a principle or a means of purging society of illicit substances—it has become its own justification.

Since the early 1980s, for instance, the United States has used drug criminalization as the cornerstone of its policy for the entire American continent. It began propagating terms like "narco-guerrilla" and "narco-terrorism," a clear merging of its "external enemies" (V. M. Batista 2003a, 12). In December 1989, the U.S. invasion of Panama to overthrow Manuel Noriega's government was once again justified mainly by his alleged ties to drug trafficking (Bewley-Taylor and Jelsma 2011).

U.S. national security came to revolve around the drug issue, a model replicated in countries allied with Washington—

while, simultaneously, financial capital and the new international division of labor compelled them to become producers of the highly valued commodity. The Andean countries were transformed into brutalized retail markets for residual illegal drugs (V. M. Batista 2003a, 12).

Yet, in light of the impossibility of defeating narcotrafficking, drug criminalization became an end in itself. In the name of human rights, democracy, humanitarian intervention, anti-communism, counterterrorism, and drug control, among other sensitive concerns, the United States has repeatedly resorted to war as a means of exercising and consolidating its hegemonic power[14].

By the early 1980s, the Cold War no longer required significant investment, and with the fall of the Berlin Wall at the decade's end, that historical chapter closed. U.S. military efforts needed a new justification. The result was a progressive criminalization and militarization of the drug war. From that moment until at least the attacks of September 11, 2001, drug penalization proved especially useful for justifying military operations, bases, and interventions abroad—"filling the ideological void between the Cold War and the war on terror" (Bewley-Taylor and Jelsma 2011, 7797).

[14] The subject is discussed in detail in Jelsma, et al. (2011).

And thus, the proscription of drugs continues today in a process of progressive and systematic criminalization. It is sustained by an ethical discourse claiming to aim at mitigating narcotrafficking and drug consumption until their eradication—but in truth, it serves as an end in itself. Not even the emergence of the new rationale for U.S. militarization—the "war on terror," a recent justification for exercising political, military, and economic hegemony—was enough to halt the fight against illicit psychoactive substances.

Years of prohibition, anti-narcotrafficking propaganda, the persistent insertion of moral narratives into the discourse on drug use, and the misguided association of certain drugs with urban violence have obstructed a rational approach by governments and society—who continue to insist on a lost war that nevertheless still represents a moral and domination-oriented ideal.

3.2. HARM REDUCTION

The third phase of drug criminalization, in light of its failure to protect the legal interest in public health, led to a paradoxically contradictory approach in the penal treatment of the two sides of the illicit psychotropic drug market. On the one hand,

it intensified repression of those who maintain the supply of narcotics; on the other, it progressively decriminalized those responsible for generating demand. For traffickers, criminal law applies—not classical criminal law, but rather the law of enemies. For users, a tendency toward therapeutic treatment, embodied in harm reduction policies, prevails.

Harm reduction strategies represent the first public policy to diverge from the prohibitionist-criminalizing model promoted by the United States, although they neither deny nor oppose the militarization of drug enforcement or the ongoing criminalization of production, distribution, and commercialization of psychoactive substances.

However, it is important to note that seeking alternatives to the criminalization of drugs is no easy task. The difficulty does not lie in proving the effectiveness of non-penal approaches to psychoactive substances, but rather in the ethical-moral bias that often contaminates the discussions and decisions on the matter. When it comes to drug laws, “any action grounded in a moral stance—such as harsh prison sentences for using or selling an illicit substance—is assumed to be effective, while any rational alternative is dismissed” (Rowe 2006, 164).

Interventions addressing dependence and use of psychotropic substances have almost always been debated far beyond the realm of public health. The ethical dimensions

surrounding the issue influence both the objectives and targets of public policies, which should be preventive and therapeutic. Historically, drug policy has often been framed as an ongoing debate between a moral position—in which illicit drug use is portrayed as criminal and deviant—and a public health-based therapeutic approach, in which "drug users are seen as people in need of treatment and help" (Davoli, Simon, and Griffiths 2010, 437).

This moral bias, which underpins drug criminalization, has led to a misguided strategy centered on coercion—typical of a criminal law that seeks legitimacy in itself—and repression, embodied in the war on drugs, to the detriment of initiatives that directly address public health issues arising from substance abuse.

As a result, there are few instances in which states adopt public policies that move in an alternative direction to prohibition and criminalization. The prioritization of penal enforcement has often placed drug policy formulation in the hands of police and military institutions[15].

[15] In Brazil, for instance, the classification of illicit drugs is carried out by the National Health Surveillance Agency (ANVISA), an agency linked to the Ministry of Health—which makes sense, as the legally protected interest is public health. However, according to Milena Soares and Cristina Zackseski (2016, 150-151), the inclusion of substances in illicit categories often stems from the initiative of the Federal Police, whose explicit rationale is not linked to public health but rather to "combating drug trafficking," explained by "the context and ideology of the war on drugs, which leads to the need to undermine the sources of income of criminal organizations."

This trend is mirrored in the international community, where United Nations decision-making bodies are also influenced by these interests. Even when governments acknowledge the need to align current strategies with social and public health programs, the agencies responsible for designing and implementing these policies, as well as the related budgets and operational practices, have not adapted to present realities. This hampers the development of strategies grounded in reliable scientific evidence (Global Commission on Drug Policy 2011).

Nonetheless, despite the scarcity of policies that directly address drug-related public health problems, a few deserve mention. These include the distribution of sterile syringes, medical treatments using methadone and buprenorphine (WHO, UNODC, and UNAIDS 2012)—substances less harmful than heroin—and even the prescription of heroin itself, which helps reduce the risk of overdose and the spread of HIV and other blood-borne infections (EMCDDA 2010).

These are known as "harm reduction policies," where the focus is not on combating drugs themselves, but rather their effects. The aim is to "minimize the adverse consequences of drug use from a health, social, and economic perspective, without necessarily reducing that use" (Reghelin 2002, 74). Some countries have gone further by decriminalizing the possession of drugs for personal use. Europe has been a pioneer in such

measures aimed at mitigating the harms caused by psychotropics (Nadelmann, McNeely, and Drucker 1997).

The foundation of current European drug policy lies in international control conventions, which cannot be contravened—even though states are granted some interpretive freedom regarding their obligations. As such, harm reduction as a central objective is viewed by policymakers as a balanced approach, which also includes tough supply-reduction measures. However, this does not mean the argument is ignored that harms may arise from the prohibition system itself (Davoli, Simon, and Griffiths 2010).

Recognition of this fact is reflected, for instance, in the now common distinction between dealers and users. This has led to policies that aim to divert problematic drug users from the criminal justice system to treatment, or to impose more lenient penalties on those who use drugs (Davoli, Simon, and Griffiths 2010).

This evolution, however, has more to do with arguments for reducing the financial costs of combating psychoactive substances and maximizing benefits. Harm reduction has clearly become part of this agenda but is generally secondary and not positioned in opposition to criminalization strategies (Davoli, Simon, and Griffiths 2010).

Harm reduction policies thus open the door to a public health perspective where the priority is to mitigate the immediate harms caused by the abusive consumption of psychoactive substances. This does not mean that states adopting such policies have renounced coercion and repression in the fight against drug supply.

However, despite extensive evidence of the effectiveness of harm reduction, many governments still refuse to implement such measures for fear that improving the health of drug users might be perceived as condoning or tolerating psychoactive substance use. Instead, they persist in an "illogical model—sacrificing the health and well-being of a group of citizens when effective health protection measures are available is unacceptable, and increases the risks faced by the community as a whole" (Global Commission on Drug Policy 2011, 5).

Although harm reduction policies do not currently oppose drug prohibition and criminalization, they present themselves as alternative measures aimed at the same declared goal: mitigating public health harms stemming from the abusive use of psychoactive substances. Such policies are implemented in countries like Switzerland, the United Kingdom, Germany, the Netherlands, and Portugal, among others. In 2013 and 2018, respectively, Uruguay and Canada went beyond conventional harm reduction measures by legalizing *cannabis* use.

3.2.1. Swiss Precision

A Switzerland provides an illustrative example. In the late 1980s, the country experienced a troubling rise in the rates of injectable drug use (Gouverneur 2018). At the same time, there was also an increase in the number of people infected with the HIV virus. To mitigate this emerging public health crisis, the government engaged the public health sector to address the issue, rather than relying on the criminalization of users.

Until the advent of AIDS, Switzerland had followed a conservative drug policy based on criminalization and strong police repression of both users and traffickers (Killias and Aebi 2000), in line with the traditional war on drugs approach. With the spread of HIV, particularly through needle sharing among intravenous drug users, coercive policies gave way to interventions focused on the health of people with addiction.

Although the use and commercialization of drugs were not decriminalized, the Swiss government established supervised injection rooms, where individuals could inject drugs with access to social support, without resorting to traffickers or risking the consumption of impure substances (Gouverneur 2018).

At these facilities, the state distributes sterile syringes, and since 1992, users who have developed dependence (subject to a few conditions) may be enrolled in heroin-assisted treatment

programs, thereby reducing the risks associated with consumption[16].

These harm reduction actions, in the Swiss case, follow the low-threshold principle, meaning that recipients of such services are not required to meet high barriers to access treatment. For example, individuals are not required to cease drug use to participate in the program, although abstinence remains an ultimate goal.

The heroin prescription and substitution measure had a significant impact on the clandestine demand for the opioid, as it targeted individuals with developed dependency—who make up 10% to 15% of all users but account for 30% to 60% of total demand. Similarly, demand for other drugs also declined due to the program (Killias and Aebi 2000).

Indeed, based on data collected by Swiss police, during the first six months of treatment, individuals enrolled in the program reduced their heroin consumption by an average of 68% compared to the previous six months. When comparing the 24-month periods before and after enrollment, the reduction reaches 71% (Killias and Aebi 2000).

[16] On how Switzerland played a pioneering role in treating dependency by creating a drug policy that includes medical heroin prescription, as well as the role of knowledge-brokering and coalition-building in the various stages of its drug policy development, see Riaz Khan, et al. (2014).

Even cocaine use—despite not being included in the substitution or prescription policy—showed a similar decline. Among heroin-dependent participants, only 15% reported not using cocaine in the six months prior to entering the program. After six months, this figure rose to 28%; after twelve months, to 35%; and after eighteen months, to 41%. Approximately 43% of heroin-dependent individuals admitted into the program had engaged in heroin trafficking in the six months prior to treatment, in order to support their own addiction. This figure dropped to 10% during the first six months of treatment and to 6% after twelve months (Killias and Aebi 2000).

The heroin prescription program effectively distanced participants from drug trafficking and impacted the illicit market for the opioid. It targeted individuals with problematic use—habitual consumers of the substance—who were deeply involved in drug trafficking and other criminal activities. These individuals acted as a bridge between importers (some Swiss) and users (mostly Swiss). Once a legal means to treat and satisfy their dependency was made available, their use of illicit drugs decreased (Killias and Aebi 2000).

This reduced their need to deal heroin and participate in other criminal activities. Thus, the program had three major effects on the drug market: it substantially reduced consumption among problematic users, weakened the viability of the market,

and lowered the levels of criminal activities associated with it. With local traffickers and dependent users removed, casual Swiss users found it harder to connect with sellers (Killias and Aebi 2000).

Despite advances in Swiss drug policy, in 2004 the country's parliament rejected the decriminalization of *cannabis*, and in 2008, although voters approved harm reduction measures in a referendum, they voted against the legalization of cannabinoids.

3.2.2. God save the junkies

A The United Kingdom, in 1999, implemented a public policy aimed at preventing the use of psychoactive substances through a program that offers individuals with problematic drug use—who have committed offenses—treatment for their dependency as a substitute for punishment. This initiative led to a reduction in recidivism rates. Among drug users enrolled in the program, the number of criminal proceedings dropped by 48% when comparing the periods before and after treatment (Millar et al. 2008).

Therapeutic treatment has the potential to reduce the prison population by diverting individuals from the penal system and turning those who would otherwise be inmates into patients

within the healthcare system. Although there are offenses for which the sentence cannot be fully commuted into treatment—requiring incarceration—part of the penalty can be served outside prison, conditioned on the individual's enrollment in the program.

Such measures may be seen as viable alternatives, in line with what Claus Roxin (2001, 466–467) defined as "diversification." It is worth noting:

> In cases where decriminalization is not possible—such as theft—it is still possible to avoid the disadvantages of criminalization by means of alternatives to formal conviction by a judge. These methods of diversification are widely used in Germany, as both courts and prosecutors may dismiss a case involving minor offenses in which there is no public interest in prosecution; such dismissal may also occur in cases of moderate criminality if the accused performs socially useful services, such as donations to the Red Cross or restitution of damages.
>
> These diversification methods are currently applied in almost half of all criminal cases in Germany, having significantly reduced the number of formal punishments. [...] This kind of reaction to criminal offenses should be an essential element of future criminal law.

Thus, in the United Kingdom, the alternative measure of commuting penalties into health treatment—aimed at mitigating the effects of problematic drug use—led to a reduction in crimes associated with the consumption of psychoactive substances, a decrease in the prison population, and lower public expenditure on criminal prosecution. It therefore proved effective in safeguarding public health and safety.

3.2.3. A Clockwork Orange

The Dutch example represents a distinct approach. Although the Netherlands is often regarded, in popular perception, as a model of drug decriminalization and at the forefront of public policy on the issue, the reality is more complex. *Cannabis* is the only psychoactive substance—prohibited under international conventions—whose sale is tolerated (but not legalized) in the country, and even then only in specific venues (coffee shops) and in small quantities[17], as part of a "pragmatic tolerance policy" (Boiteux 2017, 192).

The unauthorized sale of *cannabis* remains a criminal offense. Therefore, it cannot be said that marijuana is legalized in the Netherlands[18]. In fact, Dutch drug policy is comparable to that of Switzerland and, in many respects, less liberal than Portugal's. Nevertheless, the alternative measures adopted in the Netherlands have produced measurable public health gains.

The country's harm reduction policy includes syringe distribution, methadone and heroin prescription as treatment for dependence, supervised drug consumption rooms, and medical

[17] The coffee shop is not allowed to sell more than five grams of *cannabis* at a time to the same person; it cannot sell other drugs; and it cannot sell to individuals under eighteen years old.
[18] Possession of *cannabis*, even for personal use, constitutes a criminal offense if not carried out in designated areas, punishable by a fine.

supervision. Heroin prescription, as a therapeutic intervention, has reduced petty crime and public disturbances, and has had positive effects on the health of individuals struggling with addiction (Global Commission on Drug Policy 2011).

There is no specific program addressing cocaine users—for example, no medical prescription of the substance. As a result, cocaine consumption in the Netherlands is slightly above the European average: just over 5% of Dutch adults have used cocaine, and nearly 2% have used it recently (Netherlands National Drug Monitor 2011). By comparison, in the United States, approximately 16% of the population over age twelve has tried cocaine (Substance Abuse and Mental Health Services Administration 2023).

Regarding opioid use—the main focus of the Netherlands' harm reduction strategy—there has been a measurable decline in the number of problematic users (those who develop dependency, illness, violent behavior, or other disorders) over time (Netherlands National Drug Monitor 2011).

This effectiveness becomes even more evident when comparing the Netherlands' current situation with other European countries in terms of the number of problematic "hard drug" users[19]. According to the Netherlands National Drug Monitor

[19] Dutch law considers "hard drugs" those that pose "unacceptable risks" to society, including heroin, cocaine, amphetamines, LSD, and ecstasy.

(2011), in 2007, the Netherlands had a rate of 1.6% of problematic drug users among the adult population (ages 15 to 64), second only to Spain (1.35%), and significantly lower than most European countries, such as the United Kingdom (10%), Italy (9.8%), Luxembourg (7.7%), and Ireland (7.2%).

These data are significant not only because they reflect the Netherlands' privileged position in terms of the relative number of problematic users of high-risk psychoactive substances, but also because they demonstrate a progressive decline in such users—a key indicator of public health success.

This is because the total number of non-problematic drug users—those who do not develop dependency, illness, violent behavior, or disorders directly related to drug use—is less relevant than the number of problematic users, whose addiction poses a direct threat to public safety.

Thus, any measure that reduces the number of problematic psychoactive substance users, even if it results in a slight increase in non-problematic use, should be considered effective in mitigating the public health harms associated with drugs.

Another notable outcome—stemming from the needle exchange program (in which the government replaces used syringes with sterile ones), as well as from the prescription of methadone and heroin—is the significant reduction in HIV infections resulting from unsafe drug use. A marked decrease in

the percentage of HIV-positive drug users was observed over two decades (data from 2007), especially among young people (under 30 years old). The incidence of new HIV diagnoses among intravenous drug users dropped from 8.5% in 1986 to 0% in 2000, with a slight increase in 2005, when two such users were diagnosed with AIDS. From then until 2009, no new infections were recorded. The decline in virus transmission among drug users can be partially attributed to the reduction in shared injection practices, although high-risk sexual behavior remains prevalent (Netherlands National Drug Monitor 2011).

In summary, the harm reduction program implemented in the Netherlands has proven effective in reducing opioid use, drug-related health harms, overdose deaths, and HIV infections resulting from unsafe psychoactive substance use. Additionally, by ensuring proper treatment for individuals who have developed dependency, the policy has enabled the country to address problematic drug use from a perspective grounded in human dignity.

3.2.4. The Frankfurt Way

During the 1980s, unlike countries such as the Netherlands and Switzerland, West Germany had implemented one of the most repressive drug regimes in Europe (Stöver 2013). As a reflection

of this, approximately seventy thousand individuals were arrested annually for drug-related offenses. Possession for personal use was punishable by up to four years in prison, while trafficking could result in sentences of up to fifteen years. Around 30% of incarcerated women in the German prison system had committed drug-related crimes (Fischer 1995).

Despite the strict control implemented by a society known for its efficiency, the objectives of eliminating drug supply and consumption were not achieved. Demand for drugs continued to rise, as did the physical suffering and social marginalization of users. Meanwhile, the illicit trade in psychotropic substances expanded, generating extraordinary profits, increasing urban fear, and contributing to rising crime rates (European Cities on Drug Policy 1990).

Even as drug enforcement intensified in cities like Berlin, Frankfurt, and Hamburg, the number of individuals dependent on illicit substances continued to grow. By the end of the decade, there were approximately 100,000 users of so-called hard drugs, and around 2,000 people died annually from abuse-related causes. Major urban centers saw entire areas overtaken by drug users. In these locations, property crimes, violence, and prostitution increased significantly (in Frankfurt, 80% of women using heroin engaged in sex work). In central Frankfurt, near the main train station and the Taunusanlage park, for example, there was an area

of nearly two square kilometers where approximately five thousand people circulated daily to buy, sell, and use drugs (Fischer 1995).

As the public health crisis in these areas became increasingly visible—marked by open drug consumption, overdose deaths, and high rates of HIV and hepatitis infections, which peaked in the late 1980s—the need for a new, more humane and harm-focused approach became urgent. Repressive methods were then redirected to focus on illicit trafficking, rather than targeting dependent individuals and the communities in which they lived (Stöver 2013).

At the beginning of the 1990s, German drug policy underwent a significant shift, with the city of Frankfurt emerging as a pioneer in adopting alternatives to the criminalization of drug users.

What became known as the "Frankfurt Way"—a model later followed by other German cities—prioritized actions aimed at humanizing individuals with problematic drug use, and even casual users, by focusing on harm reduction. Notable measures included the establishment of supervised drug consumption rooms, shelters, medical care, social assistance, and housing programs for this population.

To reduce the risk of HIV transmission, the German government began distributing sterile syringes to intravenous

drug users. This syringe exchange program, combined with heroin substitution using methadone (implemented subsequently), led to a significant decline in the proportion of HIV-positive individuals among drug-related deaths in Frankfurt—from 65% in 1985 to 12% in 1992. In Hamburg, where approximately 10,000 syringes were distributed daily, there was a substantial reduction in HIV and hepatitis transmission (Fischer 1995).

As a result of Germany's harm reduction policy, the number of new users of hard drugs such as heroin and cocaine in Hamburg dropped by 42% in just three years. Between 1992 and 1994, overall crimes committed by psychoactive substance users in the city declined by 34%. Equally significant were the reductions in specific offenses during the same period: robbery decreased by 24%, theft by 45%, and motor vehicle theft by 62%. In Frankfurt, by 1993, heroin-related overdose deaths had declined by 60% compared to rates prior to the implementation of alternative measures (Fischer 1995).

Although the use of psychoactive substances was not decriminalized, the implementation of policies focused on mitigating the harms inherent in illicit drug use proved effective in addressing public health and safety challenges that traditional strategies—typical of the war on drugs—had failed to resolve.

3.2.5. A Portuguese Fado

In Portugal, drug use remains prohibited—legalization is not possible due to international treaties by which, like many other countries, Portugal is bound to combat it (Domosławski 2011). However, since July 1, 2001, following the enactment of Law 030 (Portugal 2000), the acquisition, possession, and use of any psychoactive substance have ceased to be addressed through the criminal law's *ultima ratio*. Thus, "control over drug use was transferred to an administrative system, while harsh criminal penalties for illicit drug traffickers were maintained" (Boiteux 2017, 191).

By the late 1980s, one in every hundred Portuguese had developed problematic heroin addiction, resulting in the highest HIV infection rate in the European Union. The city of Olhão, on the Algarve coast in southern Portugal, was one of Europe's drug capitals. However, the official policy of decriminalizing possession and use of psychoactive substances enabled the government to offer a broad range of services (including healthcare, psychiatry, employment, housing), whose integrated resources and expertise proved effective in reducing drug-related harms (Ferreira 2017).

Indeed, under Law 030 (Portugal 2000), the use, acquisition, and possession of illicit substances for personal use[20] are classified as administrative infractions subject to a fine. Judgment is issued by a panel composed of social workers, psychologists, and legal professionals, known as the Commission for the Dissuasion of Drug Addiction, under the authority of the Portuguese Ministry of Health. Moreover, the fine may be waived if the offender seeks assistance from public or private health services, with confidentiality regarding the treatment guaranteed.

According to Fernando Henrique Cardoso (2011), Portugal broke a paradigm when it decriminalized psychoactive substances. Instead of persisting in ineffective and often counterproductive repressive measures, it adopted more citizen-centered and efficient policies grounded in human dignity.

The logic of decriminalization adopted by Portugal aligns with the framework generally proposed by Claus Roxin (2001), who argues that decriminalization is appropriate in two situations: (1) when criminal provisions are unnecessary for maintaining social peace, particularly for conduct that only affects morality, religion, political correctness, or the offender themselves without harming society; and (2) when, although social harm is possible,

[20] "Personal use" is defined as a quantity not exceeding the average individual consumption over ten days. According to the law, this means: *cannabis*, 25 grams; hashish, 5 grams; cocaine, 2 grams; heroin, 1 gram; LSD or ecstasy, 10 pills.

the same level of legal protection can be achieved through non-criminal measures. The example given by Roxin for the second case aligns with Portugal's rationale:

> This path was initiated in German law, for instance, with the creation of administrative offenses. Thus, minor social disturbances—such as petty traffic violations, unauthorized noise, or community nuisances—are no longer criminally sanctioned but rather punished as administrative infractions, subject only to a fine (*Geldbuße*). Here lies a broad scope for the criminal law of the future—especially concerning the numerous special laws—for decriminalization. (Roxin 2001, 466)

In addition, the decriminalization of drug use enabled the government to implement, more effectively, syringe and needle exchange programs, methadone substitution for heroin, psychiatric and psychological treatment, and social assistance.

Whereas in Switzerland, adherence to harm reduction programs follows the low-threshold principle, in Portugal it occurred even more effectively through decriminalization. Since drug use is not a crime, people with substance dependence do not feel intimidated or ashamed to seek state assistance, even if their only interest is methadone prescription without intending to recover from addiction.

Thus, adherence to harm reduction programs in Portugal has been greater than in Germany, the Netherlands, or Switzerland.

In 2010, “around forty thousand drug-dependent individuals received treatment” (Domosławski 2011, 32).

As a result, although there was a slight increase in the number of adults using illicit substances in Portugal, the alternative measures succeeded in reducing drug-related offenses among problematic users and adolescents, lowering public spending on police operations, prison infrastructure, and court proceedings, and decreasing opioid-related deaths, infectious diseases, and heroin demand (Hughes and Stevens 2010).

Another positive outcome of Portugal’s harm reduction policy was the decrease in HIV infections resulting from unsafe intravenous drug use. In 2000, there were 2,758 new HIV diagnoses, of which 1,430—52%—were among drug users. By 2008, new diagnoses had declined to 1,774, with 352—22%—related to drug use (Domosławski 2011). This downward trend has continued to the present.

Another important aspect relates to the behavior of drug demand after decriminalization. A significant increase in the number of users had been anticipated, but it did not occur. The rise in use was modest for most drugs (Malinowska-Sempruch 2011) and mostly limited to adults (Hughes and Stevens 2010).

In fact, the minor variation in drug use in Portugal after decriminalization is not different from what has been observed in other European countries that continue to criminalize such

conduct. This demonstrates that the legal innovation introduced in Portugal not only represents progress in the penal and judicial spheres but was not responsible for any increase in drug consumption rates.

This pattern also holds when comparing Portugal to other European Union member states in terms of psychoactive substance use. Decriminalization of possession for personal use in Portugal did not lead to any negative impact on illegal drug consumption rates (Hughes and Stevens 2010).

3.2.6. The Uruguayan Experience

Just over a decade ago, in a humorous tone and with evident double meaning, José Alberto Mujica Cordano—better known as *Pepe Mujica*—then President of Uruguay, declared that "to live is to experiment" (BBC 2014), and in December 2013, legalized *cannabis*.

By declaring as a matter of public interest all actions aimed at protecting, promoting, and improving public health through a policy designed to minimize the risks and reduce the harms of *cannabis* use—while promoting proper information, education, and prevention regarding its adverse effects, as well as treatment, rehabilitation, and social reintegration of problematic drug users (Uruguay 2013)—the State took control (previously

held by drug traffickers) and began regulating the import, export, planting, cultivation, harvesting, production, acquisition, storage, commercialization, and distribution of *cannabis* and its derivatives, either directly or through duly authorized institutions.

The stated objective was to protect the population from the risks associated with the user's contact with the illicit market and, through state intervention, to address the devastating health, social, and economic consequences of problematic psychoactive substance use, while simultaneously reducing the influence of drug trafficking and organized crime.

To this end, Uruguay created the *Instituto de Regulación y Control del Cannabis (IRCCA)*, tasked with regulating the activities of planting, cultivation, harvesting, production, processing, storage, distribution, and sale of *cannabis*, in addition to promoting and proposing actions aimed at reducing the risks and harms associated with problematic *cannabis* use.

Thus, personal cultivation and harvesting of *cannabis* became authorized, provided it is for individual consumption (prohibited for individuals under 18) or shared within a private residence. The law allows up to six plants, with the total annual yield not exceeding 480 grams.

With proper authorization from the Executive Branch and under IRCCA oversight, cultivation is also permitted for *cannabis* clubs (ranging from 15 to 45 members), with a maximum of 99

plants and an annual yield limited in proportion to the number of members and according to a contractual agreement for non-medical use.

An important provision of the law (Uruguay 2013) authorizes licensed pharmacies to sell *cannabis* for non-medical purposes, addressing the needs of users not involved in personal cultivation or *cannabis* clubs. In all cases, advertising, promotion, sponsorship, or any form of publicity for recreational *cannabis* is strictly prohibited.

The immediate effects of legalization in Uruguay have been clear: the dismantling of the *cannabis* illicit market, the humanization and de-stigmatization of users, and fewer risks and harms associated with the consumption of this particular substance.

One of the central goals of legalization was to weaken the underground market controlled by criminal organizations and to reduce the violence associated with drug trafficking. Legalization allowed consumers to obtain *cannabis* safely and legally, reducing contact with traffickers. However, the exact impact on public safety is still under evaluation, and there remains caution about the potential diversion of legal *cannabis* into the illicit market, particularly if regulation and pricing fail to remain competitive.

What can be affirmed with certainty is that *cannabis* legalization in Uruguay was not followed by a significant increase in use. A study conducted by the *Junta Nacional de Drogas* (Uruguay 2015), a governmental body under the Office of the President, revealed that 9.3% of the adult population reported *cannabis* use in the past 12 months (2014 data), compared to 8.3% in 2011—the smallest increase recorded in 14 years. In other words, the most common argument against legalization—that it would lead to increased use—did not materialize in the Uruguayan case.

3.2.7. Separating the Wheat from the Chaff

Harm reduction policies have produced important outcomes for public safety and, most notably, for public health—the legal interest under protection. However, their most tangible result has been the mitigation, or even complete elimination, of the possibility of incarceration for drug users due to the decriminalization or depenalization of recreational use.

These policies could advance further if they also considered drug traffickers as subjects eligible for alternative, non-criminal approaches. The mitigation of risks would be more substantial if the commercialization of psychoactive substances, like their use, were treated as a social issue—one to be addressed

outside the scope of criminal law. By treating the user as a patient, the risks posed to the individual by drug consumption are reduced. If this same state posture were extended to traffickers, it could minimize the broader social harms associated with drug-related criminality.

Seemingly contradictory, harm reduction and the militarization of drug enforcement are, in fact, two facets of the same phenomenon. Depenalizing or decriminalizing the use of psychoactive substances—adopting a social and therapeutic approach directed at the user and relinquishing criminal law precisely where the protected legal interest (public health) is located—reveals the hollowing out of the official justification for the war on drugs. It exposes its true nature: war for the sake of war, criminalization as an end in itself.

Once the user is removed from the reach of criminal sanctions, militarization becomes both possible and socially acceptable, precisely because it targets only traffickers—an approach that appeals to public opinion. To the user: social and medical therapy; to the trafficker: criminal prosecution. Demand is treated; supply is punished—a contradiction difficult to reconcile with the stated objectives, though perhaps compatible with underlying, latent purposes[21].

[21] On the symbolic functions of drug criminal law, see Hamilton (2019).

4. THE ENEMY

Society, at times threatened by violence and crime, finds itself cornered. In its perception, it cannot afford a criminal justice system aimed at protecting individual liberty, as a "Magna Carta for the offender." Its fear demands instead a "Magna Carta for the citizen," an arsenal for the effective fight against crime and repression of violence. Certain offenders tend to be transformed into enemies, and criminal law into the "criminal law of the enemy" (Hassemer 1997, 448).

Today, one observes a dramatization of violence and threat. The result is the intensification of criminal policy and criminal law, which become mere instruments of state coercion. In this process, the principles that guide criminal law are undermined, and over time, the law itself becomes unrecognizable (Hassemer 1997).

This is precisely what has occurred in drug law. From the outset, the criminalization of the use and trade of psychoactive substances deemed harmful to individuals and society served as

the legal foundation for the war on drugs. Beyond serving as a foundation, criminalization also became a method—the main front of the fight against psychoactives. Beyond a method, penalization also became the result—a response to the moral anxiety surrounding the issue. That is, criminalization, grounded in a moral argument, is the core of the war on drugs; without it, the war would be devoid of substance.

This prohibitionist-criminal model, designed to address the harms associated with psychoactive substance use, finds its foundation in what Günther Jakobs (2012) termed the "criminal law of the enemy," whereby the State, in situations that pose serious threats to the collective, may deny a specific category of offenders—the enemies—the guarantees inherent to what he calls the "criminal law of the citizen," subjecting them only to coercive measures.

Under this logic, the law governs relationships among individuals who hold mutual rights and obligations, while the enemy's relationship with the State is regulated solely by coercion. Although coercion is intrinsic to the law, it is more severe in the realm of criminal law—even when directed at citizens—and even more intense when applied under the criminal law of the enemy, as it becomes the only instrument governing the relationship between the State and the offender (Jakobs 2012).

According to this theory, the guarantees of a rights-based criminal law apply only to the citizen. The criminal law of the enemy, on the other hand, is directed at those who betray the legal order and commit acts considered by society to be the most harmful—the enemies. By committing such acts, the enemy effectively terminates the social contract and thus forfeits the protections that shield individuals from the totalizing power of the State.

Criminal law, then, operates on two poles or tendencies. On one hand, it deals with the citizen, waiting for unlawful conduct to be expressed before reacting, in order to affirm the normative structure of society. On the other hand, it treats the enemy preventively, acting upon the mere suspicion of dangerousness, and neutralizing preemptively. The criminal law of the citizen preserves the rule of law, while the criminal law of the enemy (in the broader sense, including security measures) combats dangers (Jakobs 2012).

According to this reasoning, violence—legitimately monopolized by the State[22]—must be used against the enemy, who is subject to it even before committing the act that qualifies them as hostile. The fight against crime, when the criminal is an enemy, is not conducted through conventional legal means but

[22] On the idea that violence is a legitimate monopoly of the State, see Max Weber (2003). For a contrary view, see Slavoj Žižek (2014).

through war—justified by the criminal law of the enemy: "Against the enemy, it is only physical coercion, all the way to war" (Jakobs 2012, 317).

This is exactly what happened with the issue of drugs, which were declared by Richard Nixon to be the number one enemy of the United States (Nutt 2012, 264), a designation that justified launching "a new, all-out offensive," on a global scale, with the support of the United Nations and its member states.

> The prohibitionist criminal regime targeting illicit drugs, expressed in the "war on drugs" policy, makes explicit—through its very terminology—the militarized framework guiding the current global expansion of punitive power, intensifying the harms, suffering, and failures caused by the penal system's intervention against its selected "enemies" (Karam 2009, 7).

All other possibilities for resolving the issue were rejected. Not even rights-based criminal law was acknowledged as capable of addressing the drug problem. Violence—monopolized by the State—had to be invoked against the enemy. "Those who win the war define what the rules are, and those who lose must submit to those rules" (Jakobs 2012, 395).

The elimination of danger justifies acts of war. The philosophy behind the criminalization of illicit drug activities aligns perfectly with Jakobs's reasoning (2012, 376): "Punishability expands far into the realm of preparation, and

punishment is aimed at preventing future acts rather than sanctioning those already committed," while the notion of harm is sustained merely by the persistent perception of threat posed by the enemy.

Thus, drug criminalization was established globally under the logic of the criminal law of the enemy and shaped, based on moral and ethical standards, by the foreign policy of a hegemonic State. And so it continues—fueling war, with no prospect of peace or even an honorable exit. It persists despite never having delivered the promised results—results that are no longer expected and have long been forgotten, even though they are still formally stated in drug legislation.

5. THE FAILURE

The legal interest protected by the criminal treatment of activities related to illicit drugs is collective safety, specifically as it pertains to public health. As previously discussed, the criminalization of psychoactive substances underpins the war on drugs, which manifests as a campaign of prohibition and international military intervention. This campaign, rooted in the criminal law of the enemy, was initiated by the United States government, with the support of various other countries, and has the stated objective of defining and reducing the illegal drug trade (Cockburn and St. Clair 1998), thereby progressively mitigating its associated harms until achieving total eradication.

However, drug criminalization has proven extremely costly—in every sense, especially socially and economically. Thus, as David Nutt (2012) argues, it is imperative to determine whether it has achieved its stated goals. To evaluate the success of this penal policy, Nutt proposes three questions: Has criminalization reduced the supply of illicit substances? Has it

reduced demand for psychoactives? Has it mitigated drug-related harms?

Any scientific study that seeks to answer these questions will inevitably conclude that drug criminalization has failed. What is observed is "the failure of the repressive model, at least regarding its declared objectives of eradicating the cultivation and production of illicit substances and reducing their consumption" (Boiteux 2017, 197).

When the 1961 United Nations Single Convention on Narcotic Drugs was adopted and, a decade later, President Richard Nixon declared war on drugs, there was a belief that strict repression of psychoactive substances—through public policies targeting their production, distribution, and consumption—would reduce the illicit market to the point of complete eradication, resulting in a drug-free world (Global Commission on Drug Policy 2011). However, the actual result has been the opposite: an exponential expansion of the international drug market, largely controlled by organized crime (Commission of the European Communities 2009).

In fact, the homicide rate in the United States over a century (1900–2000) shows a direct correlation with investments in drug enforcement. Historically, increased funding for the war on drugs has almost always coincided with a rise in violent crime (Werb et al. 2010).

As a consequence of decades of severe prohibition in the U.S., while total arrests increased by 28% during the 1980s, arrests for drug offenses rose by 126% compared to the previous decade (Austin and McVey 1989).

In Brazil, as of December 2023, 27.65% of the male prison population was incarcerated for drug trafficking (SISDEPEN 2023). Among incarcerated women—mostly Black (Borges 2018)—54.85% were serving sentences for drug-related offenses (SISDEPEN 2023). This situation is exacerbated by several factors inherent to Brazil's prison system (Queiroz 2015), which is even more degrading for women, due to "poor prison conditions, discriminatory treatment, and violations of fundamental rights, especially in health and maternity" (Castilho 2007, 39).

Returning to the United States, between 1972—when the war on drugs strategy began—and 2002, the number of people incarcerated for drug offenses increased tenfold, from fewer than 50,000 to nearly 500,000 (Werb et al. 2010).

The global scenario mirrors that of the United States, as the American model has shaped drug legislation across many countries. Today, approximately two million people worldwide are incarcerated for drug offenses, representing one-fourth of the global prison population, without any meaningful reduction in supply or demand. Most of those imprisoned are low-level dealers with no ties to violent activity (Nutt 2012).

In addition to swelling the prison population, criminal law has also turned users and people with substance dependency into criminals, as possession for personal use has been criminalized. This has been true since the very beginning of prohibition. The criminalization of drugs has effectively transformed mere addicts into delinquent addicts (Rowe 2006).

It is estimated that since the beginning of the war on drugs, governments have spent between US$1 trillion and US$2.5 trillion (Nutt 2012) on eradication, repression, and criminalization efforts. Yet even this investment has failed to reduce drug supply—or consumption. Temporary victories, such as the elimination of particular production centers, have consistently been offset by the emergence of new criminal organizations or shifts in the geography of drug production (Global Commission on Drug Policy 2011).

Criminal organizations linked to drug trafficking are constantly adapting in order to evade enforcement efforts. They seek new sources of raw materials, export routes, and markets. The clandestine nature of their operations prevents the formation of structured organizations with identifiable leadership (Woodiwiss 2005).

Moreover, regardless of how much states spend on criminalization and enforcement, these investments pale in comparison to the profits of the drug trade. Estimates suggest the

illicit drug industry generates between US$426 billion and US$652 billion annually (Global Financial Integrity 2017). According to Nutt (2012), drug trafficking moves £300 billion per year—about 1% of global GDP—making it the second-largest economy in the world, behind only the oil industry.

This enormous volume of illicit funds—representing 1% of the global economy—when funneled through front companies, tax havens, or even entire nations, causes severe disruptions to the international financial system, which is already fragile due to speculative forces.

Drug trafficking proceeds, once laundered through shell companies and offshore accounts, reenter the legitimate banking system, enabling criminal organizations to access 'clean' funds. Methods include micro-transfers and false invoicing. For instance, Panama reportedly has a £1 billion gap between its capital inflows and export volumes—an imbalance believed to reflect criminal proceeds, primarily from drug trafficking (Nutt 2012).

Numerous studies (Rowe 2006; Cockburn and St. Clair 1998; Courtwright 2002; Escohotado 2002; Klotter 2001; Rodrigues 2017; Szasz 1996; Werb et al. 2010) show that the more punitive the enforcement and the more intense the criminalization, the riskier and therefore more profitable the drug trade becomes. As the war on drugs intensifies, so too does the

number of individuals willing to engage in the trade due to the lucrative rewards.

Systematic reviews show that criminal justice interventions are ineffective in reducing drug-related violence. Contrary to conventional wisdom, increasing criminalization does not reduce violence. On the contrary, prohibition contributes to higher homicide rates within the illicit market. More sophisticated interdiction efforts may inadvertently increase violence by creating power vacuums, which incentivize others to step in (Werb et al. 2010).

While repression has intensified, drug production has become simpler, more rationalized, and cheaper. Knowledge about production, refinement, adulteration, and distribution has advanced faster than law enforcement capabilities. Most importantly, profit margins have made drug trafficking extraordinarily lucrative—especially in nations weakened by conflict or corruption. In this sense, global prohibition has provided the financial foundation for international organized crime (Woodiwiss 2005).

It is thus clear that criminalizing the production, distribution, and sale of drugs has not reduced supply. The same failure can be observed in regard to demand: criminalization, even when directed at users, has not been able to suppress demand for psychoactive substances.

Today, nearly 300 million people—about 5.6% of the world population aged 15 to 64—use illicit drugs, a 20% increase over the previous decade (UNODC 2024). The U.S. government alone spends US$40 billion annually on drug control at home and abroad. Still, around 1.5 million people are arrested each year in the U.S. for drug-related offenses, and over 500,000 are currently incarcerated for such crimes (Will 2009).

Between 1998 and 2008, during the height of the international drug war, the number of opioid users rose 34.5% (from 12.9 million to 17.35 million); cocaine users increased by 27% (from 13.4 million to 17 million); and *cannabis* users grew by 8.5% (from 147.4 million to 160 million) (Global Commission on Drug Policy 2011).

This data demonstrates no correlation between legal severity (i.e., criminalization) and drug use. Citizens living under the harshest laws do not consume less than those under more lenient regimes. Cultural differences also do not explain this discrepancy.

George Will (2009) points to the comparison between Sweden and Norway—two countries with similar legal traditions. Although Sweden's drug laws are stricter, both countries report similar consumption rates. Will also highlights that the most significant progress in reducing drug use has occurred with

tobacco—a drug with higher addiction potential than many banned substances.

Likewise, decades of criminalization have failed to reduce the health harms associated with drug use. Repressive actions targeting users often restrict access to public health services, increasing the likelihood of overdoses and the spread of diseases such as HIV (Global Commission on Drug Policy 2011).

This failure is exemplified by the high number of HIV-positive injection drug users worldwide, and by the fact that in many countries, harm reduction strategies—like syringe distribution—are blocked by prohibitionist policies (Nutt 2012). The intention to reduce harm through criminalization has, in practice, produced the opposite effect.

This critique is not new. It echoes the findings of the Wickersham Commission (National Commission on Law Observance and Enforcement), created in 1931 to evaluate the effects of U.S. alcohol prohibition. That historical experience offers valuable insight into the pitfalls of drug criminalization.

> The constant cheapening and simplification of production of alcohol and of alcoholic drinks, the improvement in quality of what may be made by illicit means, the diffusion of knowledge as to how to produce liquor and the perfection of organization of unlawful manufacture and distribution have developed faster than the means of enforcement. But of even more significance is the margin of profit in smuggling liquor, in diversion of industrial alcohol, in illicit distilling and brewing, in bootlegging,

> and in the manufacture and sale of products of which the bulk goes into illicit or doubtfully lawful making of liquor. This profit makes possible systematic and organized violation of the National Prohibition Act on a large scale and offers rewards on a par with the most important legitimate industries. It makes lavish expenditure in corruption possible. It puts heavy temptation in the way of everyone engaged in enforcement or administration of the law. It affords a financial basis for organized crime. (National Commission on Law Observance and Enforcement 1931, 92)

Thus, as a direct result of its inherent criminalization, despite having consumed at least US$1 trillion, caused the deaths of hundreds of thousands, and imprisoned millions, it is clear that the criminalization of drugs—and the war that ensued—has not reduced supply, demand, or the associated harms.

As the Global Commission on Drug Policy (2016, 11) suggests, the criminal approach has failed to delineate and eliminate the illegal market. While it claims to protect public health, it has instead resulted in "devastating social and health consequences for drug users, other actors in the drug trade, and society as a whole." Under the banner of drug control, numerous violations of fundamental rights are committed daily, including "the death penalty, extrajudicial executions, torture, police brutality, and inhumane treatment programs for drug users."

However, despite the clear failure of the criminalization that underpins the war on drugs, there remains significant resistance—among the public and policymakers, both nationally

and internationally—to acknowledging the collapse of repressive strategies or engaging in discussions on more effective and humane alternatives. A methodological shift is needed, beginning with the recognition that drug-related issues are interdisciplinary challenges concerning public health and social safety, rather than a war to be won (Global Commission on Drug Policy 2011).

The issue goes beyond the lack of protection of the legal good. It also concerns the very legitimacy of the good purportedly being protected. The historical construction of drug criminal law demonstrates the arbitrariness in labeling certain substances as legal or illegal—whether driven by ideological domination or selective moral judgment—thus violating the theory of legal good.

Similarly, the prohibition and criminalization of psychoactive substance use, allegedly to protect individual health and restore dignity supposedly compromised by conscious self-harm (i.e., drug use), exceed the limits of what can be safeguarded through criminal law. The notion of a legal good cannot be stretched to such broad and abstract levels.

The criminalization of psychoactive substances aims to protect public health in three areas: (1) reducing the supply of illicit substances; (2) reducing drug demand; and (3) mitigating the harms caused by drug use. Within the prohibitionist model, "the adverse effects on public health must be addressed through criminal repression" (Boiteux 2017, 185).

Therefore, the analysis of utility and adequacy should be organized according to this breakdown. Criminalization policies must be grounded in solid and reliable scientific evidence, where the principal criterion is "reducing harm to the health, safety, and well-being of individuals and society" (Global Commission on Drug Policy 2011, 5).

Yet, criminalization has failed to reduce supply, demand, or harm. More than forty years after Richard Nixon promised a drug-free world, there is still no meaningful control over illicit substances. Governmental enforcement measures are seen by traffickers merely as business costs—not existential threats. Public investments in education, prevention, and user imprisonment have failed to stem the relentless rise in global drug use (Nutt 2012).

By its own standards, criminalization has failed. The evidence shows that it is the wrong strategy for harm reduction. Moreover, the perverse and intentional effects of the drug war have spread disease, obstructed medical research, discredited the law, and destroyed millions of lives (Nutt 2012). Not only has it failed in its stated objectives—there is no realistic prospect that it will ever succeed in the future.

Since the 1950s, when the United Nations established a global prohibition regime, much has been learned about the nature of drugs, and the dynamics of their production, distribution, use,

and dependency. It is understandable that, fifty years ago and with limited data, policymakers believed prohibition and eradication to be sound strategies (Global Commission on Drug Policy 2011). The prognosis then suggested utility in criminalizing psychoactives, hence the justification of a global drug war[23].

However, experience has unequivocally shown that the criminalization of drug use and supply has failed. Both current evaluations and forward-looking projections indicate that the measure is inadequate—it has not achieved its stated aims.

Thus, accumulated evidence and experience must not be ignored. Drug policies and strategies remain strongly influenced by prejudice, ideological bias, and political expediency, disregarding the increasing complexity of drug markets and the social dynamics of use and addiction (Global Commission on Drug Policy 2011).

As noted, the more governments invest in suppressing the drug trade, the riskier and more profitable it becomes—attracting more individuals to take part in the market.

Criminalizing drug commerce limits supply and raises risk, thereby increasing prices. In theory, this should reduce demand.

[23] Indeed, "an important issue concerning prognostic judgment relates to its limits, since during the legislative process, it is impossible to predict all the outcomes resulting from the existence of the incriminating norm, which is meant to adapt over time to society. The critical point lies in the possibility that the legislator may be mistaken about the consequences of their analysis, and concerns the implications this has for the proportionality assessment of the law" (Gomes 2003, 132).

However, “experience shows that this is not how things work. People continue to buy drugs, even if they have to steal to afford them” (Gomes 2003, 147).

Profits from trafficking are so high that they outweigh, in traffickers' minds, the risk of punishment. In a business where competitors are prepared to kidnap, extort, and kill, criminal law lacks the coercive force to deter behavior—no matter how harsh or feared it may be (Rowe 2006).

The same applies to demand. Even the criminalization of users has failed to reduce the search for drugs. Despite being a crime, 5% of the global adult population uses some illicit substance at least once a year—a figure that has remained stable since the early 20th century, from the Pure Food and Drug Act of 1906 to the Harrison Narcotics Tax Act of 1914 and beyond.

Even the rise in drug prices resulting from criminalization is not a significant deterrent—further evidence of the inadequacy of punitive drug policy.

As Mariângela Gomes (2003, 146–147) observes, a similar effect is observed when the sale of controlled substances is criminalized. Commerce, in general, involves voluntary transactions between buyers and sellers. Demand for a product can fluctuate based on various economic factors—consumer preference, income, price of substitutes, quality, etc. When demand is elastic, price increases reduce consumption. But for

items like medicine, salt, or narcotics, demand is inelastic—buyers are so determined to acquire the good that price becomes irrelevant.

In addition, the decision to begin using psychoactive substances is more strongly influenced by fashion, peer pressure, and socio-economic context than by the drug's legal status, the risk of imprisonment, or public prevention campaigns (Global Commission on Drug Policy 2011).

Even massive anti-drug campaigns have proven ineffective—or worse. It would be naïve to assume that drug policies are driven solely by empirical assessments of effectiveness. Many examples show the opposite: large sums are spent on media campaigns that increasingly show little to no impact—or even backfire (Davoli, Simon, and Griffiths 2010).

Just as it failed to curb supply and demand, the drug war has not reduced drug-related health harms. On the contrary, outcomes have often been worse than expected. Fernando Henrique Cardoso (2011, 3) affirms:

> All available evidence shows that punitive measures alone, no matter how harsh, do not reduce consumption. Worse, they often have harmful consequences. By stigmatizing users, fear of police and prison makes treatment access more difficult.

Criminalization also introduces grave new risks to users' health. The lack of quality control in illicit markets results in contaminated and adulterated products that are far more dangerous.

Thus, if the goal is to reduce harm, legalization—followed by regulation—is a more appropriate policy solution than criminalization (Hamilton 2016).

Regulated markets would deliver tangible public health benefits. Today, users must rely on clandestine sources and have no way to verify substance strength or purity. A heroin user expecting 20% purity might receive a dose with half or double that—posing a lethal risk (Rowe 2006). Street heroin is often cut with highly toxic additives.

Injecting users often lack access to clean needles, exposing them to risks unrelated to the drug itself, but to its illegality. Under regulation, they could acquire controlled products from licensed pharmaceutical companies and use sterile equipment—or access heroin through government-supervised medical programs.

Moreover, the main factors behind problematic use—addiction, disease, violence—are more closely tied to childhood trauma, poverty, social marginalization, and emotional distress than to moral weakness or hedonism (Global Commission on

Drug Policy 2011). These cannot be resolved through criminal law.

The history of drug prohibition thus demonstrates its failure to protect public health. The drug war continues to be justified by an underlying moral narrative—despite its failure on every front.

Law exists to ensure justice—not to enforce morality. It must be just, not moralistic. Prohibitionism rests on a moral ideology that "legitimizes" criminalization as an ethical imperative, ignoring the difference between the nature of psychoactive substances and the social effects of their use (Pizano 2013).

The very concept of crime must be viewed pragmatically, not morally. Clarence Darrow (1922) described crime as "an act prohibited by law, serious enough to justify punishment"—not necessarily good or bad in moral terms.

Criminal law, as an *ultima ratio*, must protect constitutionally guaranteed legal goods—not moral judgments, which are subjective, volatile, and contextual.

Therefore, despite the taboo surrounding drug policy, political leaders and opinion makers must have the courage to publicly say what many acknowledge in private: that research irrefutably shows repressive strategies cannot and will not solve the drug problem. The drug war has not and cannot be won. It is

the responsibility of governments to adopt broader policies suited to their national realities—to reduce violence and crime linked to drug trafficking, and to mitigate the harm drugs cause to people's health and well-being (Global Commission on Drug Policy 2011, 10).

Regardless of legality, people will continue to use psychoactive substances. The political choice lies in whether they buy from a bartender in a coffee shop or an armed criminal in a ghetto. After all, drug circulation cannot be governed by legal formalism or the idealization of human behavior—"there is no schooling, lifelong education, or training that imposes a categorical 'no' to the experimentation of life" (Passetti 2017).

In conclusion, the war on drugs has failed. Its continuation is emblematic of laws that "in many ways, are no longer capable of transformative impact and instead assume merely symbolic functions" (Hill 1982, 37).

6. ON HERBS AND POISONS

Given that the war on drugs is uniformly implemented across the international community, the list of proscribed psychoactive substances is nearly identical among various states, with minimal variations. “Drug laws are essentially the same worldwide” (Scheerer 2012). Thus, the list of illicit psychotropics in Spain closely mirrors that of the United States, China, Pakistan, New Zealand, and Egypt.

Similarly, the inherent risks associated with each psychoactive substance, whether legal or illegal, are virtually consistent across different societies and cultures—the potential harm of crack cocaine to public safety is comparable in England, Switzerland, and Argentina. Therefore, to understand the irrationality behind the prohibition of certain drugs, it is crucial to conduct a comparative analysis of the risks each poses, particularly concerning their potential to harm others.

In theory, the harms resulting from drug use would justify their criminal treatment, with the extent of harm informing the

severity of penalties. Each psychotropic substance possesses its own harmful potential, necessitating a specific evaluative judgment regarding its criminalization and corresponding penalties, in comparison with other illicit substances and their unique risks.

Understanding how a particular drug alters mental states is insufficient; it is imperative to assess both the potential and actual damages to the user and, more importantly, to the social structure—representative of individual rights and interests. When considering drug users, one must recognize that harm is not limited to physical injuries; psychological, emotional, and even spiritual consequences must also be considered. Similarly, societal risks encompass a broader range than typically acknowledged, including impacts from drug-impaired driving, family breakdowns, lost workdays, healthcare costs, and drug-related criminality, among other factors (Rowe 2006).

Therefore, it is unreasonable to impose similar penalties for drug trafficking when the substances involved present varying levels of societal risk. It is illegitimate for the law to prescribe identical punishments for those who traffic marijuana and those who sell heroin, given the significantly higher harmful potential of opioids compared to cannabinoids.

An even greater irrationality is observed when the legal system prohibits certain psychotropic substances while others,

despite being more harmful to individuals and society, remain legal and are subject only to administrative regulation. Considering that several drugs are deemed legal while others are criminalized, it is essential to evaluate the harmful potential of each.

Numerous studies have aimed to measure the various types of harm that drugs can inflict on individuals and society. Some focus on a single aspect, while others offer a more comprehensive analysis. Nonetheless, all tend to yield similar results.

The potential to induce psychological dependence in users is one of the most commonly used criteria in scientific studies assessing drug-related harms. It is also a frequent argument for justifying the protection of public health as the legal good safeguarded by drug laws.

In this context, Glen R. Hanson, Peter J. Venturelli, and Annette Fleckenstein (2012) conducted a scientific study to determine the potential for psychological dependence inherent in various drugs (both legal and illegal). On a scale from 0 to 100, nicotine scored 100, smoked methamphetamine 98, crack cocaine 96, Valium 85, alcohol 82, heroin 80, and cocaine 75. Marijuana, ecstasy, mescaline, and LSD scored below 20.

However, while the potential for dependence is a significant criterion for assessing the risks associated with each

drug, a more comprehensive investigation is necessary—one that considers additional aspects, especially when seeking criteria and arguments for criminalization.

In this regard, as early as the mid-20th century, Maurice Seevers (1958) proposed a classification of drug risks based on six criteria: tolerance, physical dependence, psychological dependence, physical deterioration, and antisocial behavior. Each criterion was rated on a scale from 0 to 4, resulting in a total risk score ranging from 0 to 24 for each substance. According to these criteria, alcoholic beverages scored 21, barbiturates 18, heroin 16, cocaine 14, marijuana 8, and mescaline 1.

Both the findings of Hanson, Venturelli, and Fleckenstein (2012) and Seevers (1958) focus on the harms experienced by drug users due to consumption. While these studies are valuable for understanding the intrinsic risks of drugs, they have limited influence on assessing the rationality of criminalization, as the harms considered for legal protection are those affecting third parties, not the users themselves. Self-inflicted harm should not be subject to criminal penalties.

Nevertheless, these data are relevant for evaluating the proportionality of legislative or administrative measures concerning psychotropics, such as control, regulation, taxation, and compensation. They also help demystify moral arguments, as

some socially accepted drugs (alcohol and tobacco) are more harmful to individuals than some prohibited substances.

Therefore, to assess the utility of penalties in protecting public health, one can refer to the study coordinated by Jan van Amsterdam, Antoon Opperhuizen, Maarten Koeter, and Wim van den Brink (2010), which investigated the individual and societal harms associated with psychoactive substances. A group of nineteen experts evaluated the harmful effects of seventeen illicit and two legal drugs, using data from the Netherlands and relevant literature, focusing on criteria such as acute toxicity, chronic toxicity, addictive potential, and social harms. Each drug was rated on a scale from 0 to 3 for its potential harm to individuals and society.

While the detailed findings of the study are of interest to various fields of law and science, the results specifically addressing harms to social structures that uphold individual rights are particularly relevant here. As previously mentioned, harms experienced solely by users should not be the focus of criminal law.

In this context, the substances most harmful to society, in descending order, according to the study (Van Amsterdam et al. 2010), are: alcohol (2.76), tobacco (2.28), crack cocaine (1.89), heroin (1.78), cocaine (1.66), cannabinoids (1.47), benzodiazepines (1.32), amphetamines (1.18), ecstasy (1.13),

GHB (0.92), methadone (0.68), methamphetamine (0.56), anabolic steroids (0.45), hallucinogenic mushrooms (0.39), ketamine (0.39), methylphenidate (0.33), buprenorphine (0.29), LSD (0.26), and khat (0.13). Notably, the most harmful substances to society are legal: alcohol and tobacco.

Another significant study on drug-related harms is the one led by David Nutt, Leslie King, and Lawrence Phillips (2010), involving professionals from various fields. They used sixteen criteria (nine related to user harms and seven to societal harms) to evaluate the risks associated with twenty different drugs[24].

[24] The criteria are: "Drug-specific mortality – the intrinsic lethality of the drug expressed as a proportion between the lethal and the standard dose (for adults); Indirect drug-related mortality – the extent to which drug use shortens life expectancy (excluding drug-specific mortality), e.g., traffic accidents, lung cancer, HIV, suicide; Direct physical damage – drug-specific damage to physical health, e.g., cirrhosis, seizures, injuries, cardiomyopathy, stomach ulcers; Indirect physical damage – physical health consequences such as unwanted sexual activity, self-harm, blood-borne viruses, emphysema, or injuries from sharp objects; Dependence – the extent to which a drug causes compulsion or the desire to continue use despite negative consequences; Direct impairment of mental functioning, e.g., amphetamine-induced psychosis, ketamine intoxication; Indirect impairment of mental functioning related to addiction, e.g., mood disorders associated with drug use or lifestyle; Loss of tangible goods – e.g., income, housing, employment, education, criminal record, imprisonment; Loss of relationships – family or friendship losses; Injury to others – both directly and indirectly, e.g., violence (including domestic), traffic accidents, fetal harm, abuse, secondary virus transmission; Crime – the extent to which drug use leads to or is associated with criminal activity (excluding drug possession/use per se), at a population level; Environmental damage – local damage from drug use or production, e.g., toxic waste from meth labs, discarded needles; Family adversity – economic, emotional, and developmental harm to families caused by drug use; International damage – damage caused by UK drug consumption abroad, e.g., deforestation, political destabilization, international crime and markets; Economic cost – direct (healthcare, law enforcement, prison, social services, insurance, crime) and indirect (productivity loss, absenteeism) costs to the country; Community – erosion of community cohesion and reputation" (Nutt, King, and Phillips 2010, 1560).

Each criterion was scored for each drug using the Multiple Criteria Decision Analysis (MCDA) method[25] [26], and the scores were summed to determine an overall harm index (personal and social) on a scale from 0 to 100. The study (Nutt, King, and Phillips 2010) ranked the substances as follows: alcohol (72), heroin (55), crack cocaine (54), methamphetamine (33), cocaine (27), tobacco (26), amphetamines (23), cannabinoids (20), GHB (19), benzodiazepines (15), ketamine (15), methadone (14), mephedrone (13), butane (11), anabolic steroids (10), khat (9), ecstasy (9), LSD (7), buprenorphine (7), and hallucinogenic mushrooms (6).

These results highlight the contribution of each criterion to the overall harm index of the studied psychoactive substances. When considering only the seven criteria related to societal harms, the four most harmful substances are, in descending order: alcohol, heroin, crack cocaine, and tobacco (Nutt, King, and Phillips 2010).

In other words, when evaluating both individual and societal harms together, alcohol and tobacco—legal substances—

[25] The multi-criteria decision-making methodology "consists of a set of techniques designed to support a decision-maker—be it an individual, group, or committee of experts—in evaluating and selecting alternatives to a complex problem, using different criteria and perspectives" (Jannuzzi, Miranda and Silva 2009, 71).

[26] "Multi-Criteria Decision Analysis (MCDA) is a technique often used in situations where decision-making involves various types of criteria, with so many dimensions that conclusions cannot be easily reached through simple discussion. MCDA examines a question through multiple criteria and then compares them to assess their relative importance. These may include both objective measures and subjective value judgments. Uncertainty may also be incorporated" (Nutt 2012, 35).

rank as the first and sixth most dangerous, respectively. When focusing solely on societal harms, alcohol remains the most harmful, and tobacco ranks fourth, ahead of cannabinoids, cocaine, ecstasy, methadone, LSD, and others.

Indeed, across all studies presented, alcoholic beverages and tobacco consistently appear among the most harmful drugs to society. Alcohol's harm is associated with family breakdowns, violence, various accidents, lost workdays, and crime. Compared to cigarettes, alcohol-related health costs are significantly higher. In the United States, for example, alcohol-related diseases are the third leading cause of death (Rowe 2006).

Even when considering individual-level criteria, such as deaths and diseases indirectly resulting from drug use, the numbers associated with alcohol and tobacco are so substantial that they constitute societal harms.

For instance, in 2019, alcohol consumption was responsible for 2.6 million deaths worldwide, accounting for 4.7% of all deaths that year (WHO 2024). Comparatively, in 2000, over 3% of global deaths were linked to alcohol consumption (Rehm et al. 2003).

According to the World Health Organization (WHO 2023), tobacco use causes more than 8 million deaths annually worldwide. Of these, over 7 million are due to direct tobacco use, while approximately 1.3 million result from exposure to

secondhand smoke. Tobacco remains one of the greatest threats to global public health, causing diseases such as cancer, cardiovascular, and respiratory illnesses.

Tobacco use is extremely harmful to humans. The link between smoking and lung cancer is universally recognized. Research indicates that smoking increases the risk of developing lung cancer by twenty-five times and is responsible for 95% of all deaths from this disease. It also elevates the risk for other types of cancer. It is estimated that 47% of all cancer deaths are caused by tobacco use. More importantly, smoking accounts for about half of all deaths from cardiovascular diseases. Overall, smoking is responsible for approximately 25% of adult deaths in the United States. Medical treatments for cancer, cardiovascular, and pulmonary diseases related to smoking cost tens of billions of dollars annually (Rowe 2006).

Observing that two of the most harmful drugs to society are legal reinforces the notion that the prohibition and criminal treatment of drugs are grounded more in moral and political considerations than in technical and scientific data regarding the harms of various psychotropics.

It is not the harm to others inherent in psychoactive substances that underpins the war on drugs, as official discourse suggests, but rather society's moral perception of these substances. Alcohol and cigarettes are legal for political reasons, not because

they are harmless—they are not. Similarly, proscribed drugs are illegal also for political reasons, not solely because they are harmful. The current approach to psychoactive substances lacks proportionality. It would only be proportional if applied equally to all recreational or addictive substances (Rowe 2006) or, alternatively, to none.

A given substance causes massive levels of health problems of all kinds and millions of premature deaths per year, yet it is legal in any quantity for any adult. The only restrictions relate to where and at what age it can be used. Likewise, another substance permitted for all adults is widely recognized around the world as the most harmful in history. When sufficiently abused, it causes death by gradually destroying the user's body. Even when not heavily abused, it induces aberrant behaviors that can ruin families and cause harm to society. Tobacco and alcohol, respectively (Rowe 2006). Meanwhile, less harmful substances are deemed illegal.

7. THE HANGOVER

It is already known that the war on drugs has failed to fulfill its promise of mitigating the public health harms caused by substances rendered illegal. However, to fully grasp the extent of what drug criminalization represents, it is important to examine its side effects—the unintended consequences of this policy.

To that end, it is important to focus on its results: the expansion of the criminal underground market, financed by the increasingly growing profits of drug trafficking; diversion of public resources to fund repressive actions against the illicit trade in psychoactive substances; geographic displacement of drug production across countries, eluding control systems; migration of consumption toward more harmful substances due to restricted access to certain drugs; and the stigmatization and marginalization of individuals who develop problematic use (Nadelmann 1991, European Cities on Drug Policy 1990, Erickson, Adlaf, et al. 1994, Costa 2008, Global Commission on Drug Policy 2011).

Drug abuse is harmful. The war on drugs is exponentially worse (Frye 2012). In Latin America, for instance, drug repression policies have led to the complete replacement of artisanal production and small-scale trafficking by criminal organizations, such as the Medellín and Cali cartels, whose resistance to enforcement arises from both the professionalization of their operations and the complex web of political ties that stabilize and destabilize various countries across the continent (Escohotado 2002).

In addition to producing no positive effects on public health in Latin America, the war on drugs has exacerbated misery and corruption. Just as in many Colombian cities, drug trafficking has turned regions such as Rio de Janeiro and São Paulo, for example, into literal war zones. Across Latin America, many farmers have seen their lands and lives destroyed—the herbicides used to eliminate illegal crops often cause environmental damage and render farmland unusable. The massive economic shift toward clandestine activities and increased social unrest in the region have, more often than not, resulted from drug criminalization, not from the psychoactive substances themselves (Nadelmann 2003).

These collective harms result from the operation of the incriminating legal norm itself. Some legislative measures are inherently criminogenic, triggering societal effects contrary to

their intent. The norm that criminalizes psychoactive substances belongs to this group, as it encourages the emergence of numerous crimes revolving around drug trafficking.

In a similar vein, Escudero Moratalla and Frígola Vallina (1996) argue that the repressive, prohibitive law is more corrupting than corrective, as it exacerbates marginalization by steering young people with no prior social problems toward problematic trajectories and opening the door to various offenses (fraud, coercion, homicide, among others).

The war on drugs, therefore, "prevents society and governments from recognizing the wide range of reasons why people use drugs, whether in a controlled or problematic manner" (Dreifuss 2016, 5). Through this strategy, the prohibition of psychoactive substances, driven by criminal law, has turned mere users into individuals engaged in criminal behavior (Rowe 2006). Thus, drug criminalization has become fertile ground for criminal organizations involved in activities that support drug trafficking, such as human trafficking (often akin to slavery), corruption, kidnapping, terrorism (Nutt 2012), and money laundering.

Even setting criminalization aside, prohibition inherently provokes a series of negative consequences, including increased violence, harm to the health of drug users, transformation of users into offenders, and erosion of civil liberties. Proscription of psychoactive substances exacerbates many of the very problems

it claims to solve. Reducing drug use is generally not a rational policy goal. Even if desirable, prohibition is the worst strategy for achieving it (Miron 2004).

Regarding the negative impact of drug criminalization on public health, for example, 80% of deaths associated with heroin and cocaine (including crack) result not from drug abuse itself, but from the illegal nature of the market. An analysis of crack-related homicides in New York City indicates that 85% of the cases were systemic, meaning they arose from the inherent dangers of the illicit market and not the drug itself (Eldredge 2000).

Another issue must be highlighted: the criminalization of drugs and subsequent efforts to combat illicit trade have contributed to the militarization of the state as a repressive agent, as well as of drug trafficking, resulting in increased homicides related to the clandestine market. As an example, following the intensification of the war on drug cartels in Colombia, one in every thousand Colombians was murdered in 1991—a rate three times higher than that of Brazil or Mexico and ten times higher than the United States during the same period (Werb et al. 2010).

More recently, after 2006, when a full-scale anti-drug campaign was launched throughout Mexico, violence metrics increased dramatically, with approximately seventeen thousand drug trafficking-related homicides recorded between that year and

2010 (Werb et al. 2010). Additionally, Mexican drug cartels are responsible for other criminal activities such as kidnapping, counterfeiting, and extortion (Nutt 2012).

The illicit nature of the activity is the main factor behind drug-related violence. Legal and regulated product markets, while not without issues, do not offer the same opportunities for organized crime to generate substantial profits, challenge the legitimacy of sovereign governments, or finance insurgency and terrorism (Global Commission on Drug Policy 2011).

Moreover, government actions to combat drugs are also harmful to society (Rowe 2006), largely due to the lack of criteria in crafting laws that criminalize psychoactive substances and the state's indifference to the social consequences of such legislative measures.

The imposition of poorly conceived laws results in increased violence, intimidation, and corruption associated with the drug market. Government agencies and drug-related organized crime end up engaging in an “arms race,” intrinsic to the war itself, wherein state coercion is promptly countered by enhanced force and violence from traffickers (Global Commission on Drug Policy 2011, 15).

Urban violence, another side effect of criminalization, is directly tied to the war on drugs rather than to the illicit substances themselves, such that the more is invested in combating it, the

more insecure society becomes. Indeed, research by Dan Werb et al. (2010) demonstrates that in the United States, from 1900 to the late 1990s, investment in the war on drugs was directly proportional to the homicide rate, supporting this assertion. Increases in financial investment against drugs repeatedly correlate with rising homicide rates. This scientific investigation into the consequences of psychoactive substance prohibition, particularly regarding its associated violence, highlights the gravest outcome of drug criminalization.

The same conclusion arises from various studies compiled by Jeffrey A. Miron (2004), who found that drug prohibition (including alcohol) coincided with increased homicide rates, as disputes inherent to any kind of competition in illegal trade are settled with weapons rather than through negotiation or legal proceedings. All available scientific evidence, according to the author, demonstrates the relationship between prohibition and violence across numerous countries.

There is a direct proportional relationship between the war on drugs strategy and the price of illicit substances. Likewise, the more expensive drugs become, the more violent society grows. According to Travis Wendel, Geert Dhondt, Ric Curtis, and Jay Hamilton (2016), for instance, the drop in crime in New York City between 1985 and 2016 generated an academic literature incapable of explaining the phenomenon. Based on ethnographic

and econometric research, the authors argue that these studies overlooked the simplest explanation: the simultaneous increase in supply and decrease in demand led to a drop in the price of illegal drugs, resulting in reduced crime rates.

It is also clear, as previously mentioned, that the illicit psychoactive drug market fuels urban violence, since users and dealers obviously do not resolve their disputes through courts, lawyers, or arbitration but through the use of weapons. Furthermore, it fosters corruption, as bribing police officers, prosecutors, judges, and prison staff is inherent to clandestine operations. If that weren't enough, the illegality of the trade makes quality control of the substances impossible, increasing the risk of accidental overdose (Miron 2014).

On this criminogenic nature of the penal norm that proscribes psychoactive substances, it is worth quoting:

> Drug trafficking also falls among those offenses in which the very legal good purportedly protected ends up being endangered. It becomes clear that criminalizing drug commerce ends up generating more serious public health problems than those it sought to prevent, as drug consumers are forced into clandestinity and face not only the inherent risks of the substance they wish to use but also the real possibility that the drug is adulterated and full of various impurities—and such adulterations render the substances actually consumed far more dangerous to health than the originals. Moreover, the fact that consumers are marginalized hinders public health programs from reaching this important segment of the population (Gomes 2003, 149).

As a result of this criminogenic nature of drug criminalization, with few exceptions, prisons around the world are overcrowded with people convicted of offenses related to substances deemed illicit. Many became involved with consumption or trafficking due to issues of dependency and poverty. High incarceration rates have negative consequences beyond the lives of inmates, affecting their families and placing a huge economic burden on society. Punishment is often grossly disproportionate, with long prison sentences handed down to small-scale dealers (Malinowska-Sempruch 2011).

All this has occurred without any decrease in the demand or supply of illicit substances. The current situation regarding drug prohibition and its consequences led Luigi Ferrajoli (1993) to advocate for the repeal of what he considers the absurd and criminogenic drug law.

Another aspect that reveals harm to society caused by drug criminal law concerns the difficulty of establishing new and more effective public policies based on harm reduction measures, while the legal treatment of psychoactive substances remains centered on criminalization. Controlling production and distribution, as well as regulating the sale of currently illegal substances—measures capable of mitigating social harms—are not viable in the present climate of prohibition and criminalization.

In other words, the current criminal approach to drugs not only causes harm to the population at large but also prevents public health problems from being addressed properly. As "the criminalizing prohibitionism aimed at illicit drugs obscures the failure of its explicit goals, conceals paradoxes such as increased health risks and harms—deceptively presented as the object of protection—and even promotes violence" (Karam 2009, 8).

Ultimately, when the war on drugs was declared, its aim was to mitigate the public safety risks related to the abusive consumption of psychoactive substances. The penal norm was intended to protect this constitutionally guaranteed good. However, in addition to worsening public health outcomes, the criminalization of drugs has caused serious problems in the realm of public security, another constitutionally protected value. Concerning drugs, humanity was once dealing with one serious problem. Now, it must contend with two. For this reason, it has been argued that "the time has come for States to fully assume their responsibility and remove drugs from the hands of organized crime. It is time to take control" (Dreifuss 2016, 6).

Causing society greater harm than the one intended to be avoided is not what should be expected from criminal norms. It is also irrational from a strategic standpoint of war. The goal of war is achievement, said Sun Tzu (2015)—a victory that has never been attained in the war on drugs.

CONCLUSIONS

To investigate the irrationality of the war on drugs, the main reference was the process of proscription developed in the United States and exported, through the international community, to other sovereign states. This is because the global war on psychoactive substances mirrors the strategies promoted in that country, based on the prevailing moral sentiment. Its method—the progressive criminalization of activities related to psychotropics—contaminated the legislation of several nations, presenting itself uniformly in their respective legal systems.

The history of the war on drugs demonstrates its complete inadequacy in safeguarding public health. Despite having consumed vast financial resources and hundreds of thousands of human lives, and having promoted mass incarceration, leading millions to prison, the penal intervention in drug-related issues has neither reduced the supply of so-called illicit substances nor mitigated their consumption or resulting harms. On the contrary, it has had the opposite effect: it has made the criminal market

more lucrative, stabilized demand, and exacerbated the public health problem related to drug abuse.

Another aspect of the irrationality of the war on drugs lies in the unnecessary nature of criminal intervention to protect public health. Comparing the consequences of criminal law enforcement on drugs with the results obtained or potentially achievable by alternative state measures—already tested or envisioned—it can be confidently affirmed that criminal regulatory intervention is unnecessary. Public policies that address the issue from a perspective other than criminalization, adopting a humanized approach aimed at mitigating the harms related to drug use, though still modest, yield exponentially better public health outcomes than those achieved by the war strategy.

There is also an arbitrary disproportionality in the classification of psychoactive substances as legal or illegal and, in these cases, in the establishment of their respective statutory penalties. When considering the requirement of equality under criminal law—examining the legal treatment given to activities related to alcohol and tobacco consumption in contrast to that applied to other psychoactive substances—based on their intrinsic harmful potential, it becomes evident that the criminalization of the latter does not fulfill its stated objectives. Scientific research reveals that alcohol and tobacco are among the most harmful substances to public health, whereas marijuana and LSD, for

instance, are among the least harmful—yet the logic of criminalization does not adhere to this criterion.

Moreover, the war on drugs, as a strategy to address the problems associated with illicit substances, has not only increased public health harms—highlighting its ineffectiveness—but also brought serious consequences to public security, another constitutionally protected right.

The militarization of the state, justified by the discourse of enforcing drug laws, has led to the militarization of drug trafficking, making society more violent and unsafe. The illegality of consuming certain psychoactive substances often drives users to crime, including drug dealing, as a means of financing their dependency. There is a direct proportional relationship between the resources invested in the fight against drugs and the number of violent deaths across various countries.

Therefore, the war on drugs is characterized by producing greater harm than that which it claims or intends to prevent. Its declared goals include resolving or at least mitigating public health issues caused by drugs. However, the unequivocal result is the emergence and consolidation of a more harmful social context—a severe public security problem.

In the course of this research, these findings were treated as evidence that the war on drugs has served, from its inception,

purposes other than those stated in the official discourse, namely the protection of public health.

Insisting on a strategy that is unfit for its declared aims only makes practical sense if the normative function is to fulfill undisclosed goals.

Likewise, opting for a less effective and more harmful approach to individuals is only coherent if the normative function is a different, non-explicit one—foreign to the declared teleological program—and demands a harsher means to achieve its hidden effect.

Punishing beyond reason or in violation of equality, in turn, constitutes the exercise of a function unauthorized under the penal system, as it fails to effectively safeguard the legal interest, which is its condition of legitimacy.

The same can be said about the persistence of criminalization, even though it is more harmful than what it seeks or claims to avoid, suggesting the existence of latent effects that are, in fact, consistent with the chosen criminal repressive mechanism.

It has been demonstrated that ineffectiveness is a defining feature of the war on drugs, present in all three of its phases. The performance of drug criminal law has proven incapable of mitigating public health harms stemming from the abusive use of illicit substances. Despite the successive and progressive

toughening of criminal treatment for drug-related activities, no positive outcome has been observed in public health that could be credited to the policy of criminalization and repressive strategy. In fact, the effect has been the opposite, with serious public health damages directly resulting from the enforcement of drug laws—a clear case of anti-effectiveness.

The mass incarceration of users and dealers from the mid-1910s through the late 1960s, the global war on drugs throughout the 1970s, the surge in incarceration rates, seizures, expropriations, and military interventions during the 1980s targeting international drug trafficking and related organized crime, and the stigmatization of deviants since the early 20th century—all misled the general public regarding the effectiveness of the war on drugs: 'if criminals are being imprisoned, the law is working.'

The war on drugs is, without a doubt, the greatest war humanity has ever waged, and its effects are also the worst. It is the longest military undertaking recorded in history and likely the most costly in both economic and human terms. Worst of all, it was never truly about psychoactive substances. The war is about race, religion, social class, money, and power.

BIBLIOGRAPHY

Abramovay, Pedro Vieira, and Vera Malaguti Batista. 2010. *Depois do grande encarceramento.* Rio de Janeiro, RJ: Revan.

2007. *American Film Institute.* 06 20. Accessed 11 13, 2016. http://www.afi.com/100years/movies10.aspx.

American Psychiatric Association. 2015. *Manual Diagnóstico e Estatístico de Transtornos Mentais.* 5a. Edição. Translated by Maria Inês Corrêa Nascimento, Paulo Henrique Machado, Regina Machado Garcez, Régis Pizzato and Sandra Maria Mallmann da Rosa. Porto Alegre: Artmed.

Andrade, Fernando Grostein, Thomaz Souto Correa, Cosmo Feilding-Mellen, Carolina Kotscho, Ricardo Setti, and Ilona Szabo. 2011. *Breaking the Taboo.* Directed by Fernando Grostein Andrade and Cosmo Feilding-Mellen. Produced by Sam Branson. Performed by

Fernando Henrique Cardoso, Jimmy Carter, Bill Clinton, Paulo Coelho, Ruth Dreifuss, Gro Harlem Brundtland, Anthony Papa and Dráuzio Varella.

Austin, James, and Aaron David McVey. 1989. "The 1989 NCCD prison population forecast: the impact of the war on drugs." National Council on Crime and Delinquency, San Francisco.

Batista, Vera Malaguti. 2003a. *Difíceis ganhos fáceis: drogas e juventude pobre no Rio de Janeiro.* 2a. Edição. Rio de Janeiro: Revan.

BBC. 2014. *Mujica legaliza maconha e diz que 'viver é experimentar'.* 05 07. Accessed 11 20, 2016. http://www.bbc.com/portuguese/noticias/2014/05/140507_mujica_entrevista_fl.

Beccaria, Cesare Bonesana. 2001. *Dos delitos e das penas.* Ridendo Castigat Mores.

Bewley-Taylor, David, and Martin Jelsma. 2011. "La internacionalización de la guerra contra las drogas: las drogas ilícitas como un mal moral y un valioso enemigo." In *Casus Belli: cómo los Estados Unidos venden la guerra*, by Martin Jelsma, Phyllis Bennis, David Sogge, Mariano Aguirre, Zia Mian, Susan

George, Mike Marqusee and Walden Bello, edited by Achin Vanaik, translated by Beatriz Martínez Ruiz. Amsterdam: Transnational Institute (Kindle).

Boiteux, Luciana. 2017. "Modelos de controle de drogas: mapeando as estratégias de política de drogas em busca de alternativas ao modelo repressivo." In *Drogas & sociedade contemporânea: perspectivas para além do proibicionismo*, by Regina Figueiredo, Marisa Feffermann and Rubens Adorno, 183-201. São Paulo: Instituto de Saúde.

—. 2011. "Política Internacional de Drogas e Redução de Danos: o fim do 'Consenso de Viena'?" *Versus : Revista de Ciências Sociais Aplicadas do CCJE/UFRJ*, 04: 104-108.

Boiteux, Luciana, Ela Wiecko Volkmer de Castilho, Beatriz Vargas, Vanessa Oliveira Batista, Geraldo Luiz Mascarenhas Prado, and Carlos Eduardo Adriano Japiassu. 2009. *Série Pensando o Direito: Tráfico de Drogas e Constituição.* Vol. 1. Brasília: Ministério da Justiça - Secretaria de Assuntos Legislativos.

Borges, Juliana. 2018. *O que é: encarceramento em massa?* Belo Horizonte: Letramento: Justificando.

Brasil. 1921. *Decreto 4.294.* Estabelece penalidades para os contraventores na venda de cocaina, opio, morphina e seus derivados; crêa um estabelecimento especial para internação dos intoxicados pelo alcool ou substancias venenosas; estabelece as fórmas de processo e julgamento e manda abrir os creditos necessarios.

Brasil. 2004. *Decreto 5.144, de 16 de julho de 2004.* Regulamenta o Código Brasileiro de Aeronáutica, no que concerne às aeronaves hostis ou suspeitas de tráfico de substâncias entorpecentes e drogas afins.

Brasil. 1998. *Lei 9.614, de 5 de março de 1998.* Altera o Código Brasileiro de Aeronáutica, para incluir hipótese destruição de aeronave.

Cardoso, Fernando Henrique. 2011. "Prefácio à edição portuguesa." In *Política da Droga em Portugal: os benefícios da descriminalização do consumo de drogas*, by Artur Domosławski, translated by Nuno Portugal Capaz. Warsaw: Open Society Foundations.

Carter, Jimmy. 2011. "Call off the global drug war." *The New York Times.*

Castilho, Ela Wiecko Volkmer de. 2007. "Execução da pena privativa de liberdade para mulheres: a urgência de regime especial." *Justitia*, 37-45.

Chaloult, Louis. 1971. "Une nouvelle classification dês drogues tòxicomanogenes." *Revue Toxicomanies*, 371-375.

Cockburn, Alexander, and Jeffrey St. Clair. 1998. *Whiteout: The CIA, Drugs & the Press.* London: Verso.

Comissão Global de Políticas sobre Drogas. 2016. "Avanços na reforma de políticas sobre drogas: uma nova abordagem à descriminalização."

Comissão Global de Políticas sobre Drogas. 2011. "Guerra às Drogas: Relatório da Comissão Global de Políticas sobre Drogas."

Commission of the European Communities. 2009. "A Report on Global Illicit Drug Markets 1998-2007." European Communities, Amsterdam, 69.

Comprehensive Drug Abuse Prevention and Control Act. 1970. Public Law 91-513, 84 Stat. 1236 (10 27).

Cook, Dee, and Barbara Hudson. 1993. *Racism and criminology.* London: Sage Publications.

Costa, Antônio Maria. 2008. "Making drug control 'fit for purpose': Building on the UNGASS Decade." Report by the Executive Director of the United Nations Office on Drugs and Crime as a contribution to the review of the twentieth special session of the General Assembly, Commission on Narcotic Drugs, Viena.

Courtwright, David T. 2002. *Forces of habit: drugs and the making of the modern world.* 3rd Edition. Edited by Kindle. Cambridge: Havard University Press.

Cox, James. 2018. *Two Chinese meth dealers sentenced to death on a sports ground in front of 300 schoolkids before being executed.* 06 28. Accessed 07 02, 2018. https://www.thesun.co.uk/news/6644102/china-death-sentence-death-row-meth/.

Darrow, Clarence. 1922. *Crime: its cause and treatment.* New York: Thomas Y. Crowell.

Davoli, Marina, Roland Simon, and Paul Griffiths. 2010. "Current and future perspectives on harm reduction in the European Union." In *Harm reduction: evidence, impacts and challenges*, by European Monitoring Centre for Drugs and Drug Addiction EMCDDA, 437-446. Luxembourg: Publications Office of the European Union.

Domosławski, Artur. 2011. *Política da Droga em Portugal: os benefícios da descriminalização do consumo de drogas.* Translated by Nuno Portugal Capaz. Warsaw: Open Society Foundations.

Dreifuss, Ruth. 2016. "Carta da Presidente." In *Avanços na reforma de políticas sobre drogas: uma nova abordagem à descriminalização*, by Comissão Global de Políticas sobre Drogas. Relatório.

Dufton, Emily. 2006. "The War on Drugs: How President Nixon Tied Addiction to Crime." *The Atlantic.*

Einstein, Albert. 2007. "Some Notes on my American Impressions." In *The World As I See It*, by Albert Einstein, translated by Alan Harris, 37-41. San Diego: The Book Tree.

Eldredge, Dirk Chase. 2000. *Ending the war on drugs: a solution for America.* Edited by Kindle. New York: Bridgeworks.

EMCDDA. 2010. *Harm reduction: evidence, impacts and challenges.* Edited by European Monitoring Centre for Drugs and Drug Addiction. Luxembourg: Publications Office of the European Union.

Erickson, Patricia G., Edward M. Adlaf, Reginald G. Smart, and Glenn F. Murray. 1994. *The Steel Drug: Cocaine and Crack in Perspective.* 2nd Edition. New York: Lexington Books.

Escohotado, Antonio. 2002. *Historia general de las drogas.* 5a. Edición. Barcelona: Espasa.

Escudero Moratalla, José Francisco, and Joaquin Frígola Vallina. 1996. "Enfoque criminológico de la drogodependencia y otros conceptos penitenciários." *Cuadernos Jurídicos*, 06. Accessed 08 02, 2016. http://noticias.juridicas.com/articulos/55-Derecho%20Penal/200108-8551727610152071.html.

European Cities on Drug Policy. 1990. "Frankfurt Resolution." Frankfurt.

Fahey, David M., and Jon S. Miller. 2013. *Alcohol and drugs in North America: a historical encyclopedia.* Vol. 1. 2 vols. Santa Barbara: ABC-CLIO.

Ferrajoli, Luigi. 1993. "Per un programma de diritto penale minimo." In *La riforma del diritto penale: garanzie ed effettività delle tecniche di tutela*, edited by Livio Pepino. Milano: Franco Angeli.

Ferreira, Susana. 2017. *Portugal's radical drugs policy is working. Why hasn't the world copied it?* 12 05. Accessed 04 25, 2018. https://www.theguardian.com/news/2017/dec/05/portugals-radical-drugs-policy-is-working-why-hasnt-the-world-copied-it.

Fischer, Benedikt. 1995. "Drugs, Communities, and "Harm Reduction" in Germany: The New Relevance of "Public Health" Principles in Local Responses." *Journal of Public Health Policy*, 389-411.

Fortune Business Insights. 2024. *Alcoholic Beverages Market Size, Share & Industry Analysis, By Type (Beer, Wine, Distilled Spirits, and Others), By Distribution Channel (Retail and Food Service), and Regional Forecast, 2024-2032.* Pune: Fortune Business Insights.

French, Laurence, and Magdaleno Manzanárez. 2004. *NAFTA and neocolonialism: comparative criminal, human and social justice.* Lanham: University Press of America.

Freud, Sigmund. 1884. "Über Coca." *Therapie*, 07: 289-314.

Frye, Stephen. 2012. *Monumental Fiasco. Our drug war: twenty five reasons to end it.* Kindle.

Gerber, Rudolph Joseph. 2004. *Legalizing marijuana: drug policy reform and prohibition politics.* Westport: Greenwood Publishing Group.

Global Financial Integrity. 2017. *Transnational Crime and the Developing World.* Washington: Global Financial Integrity.

Gomes, Mariângela Gama de Magalhães. 2003. *Princípio da Proporcionalidade no Direito Penal.* São Paulo: Revista dos Tribunais.

Gouverneur, Cédric. 2018. "Heroína com receita médica." *Le Monde Diplomatique Brasil* 12 (135): 28-29.

Hagen, Bernard. 2002. *The war on drugs: the Reagan, Bush and Clinton Administracion - a comparative analysis.* New Orleans: University of New Orleans.

Hamilton, Olavo. 2019. *Drogas: criminalização simbólica.* Natal: OWL Editora Jurídica.

—. 2016. "Legalizando as drogas: uma abordagem conforme a regulação responsiva." *Revista de Direito Setorial e Regulatório - Journal of Law and Regulation*, 10: 139-160.

Hanson, Glen R., Peter J. Venturelli, and Annette E. Fleckenstein. 2012. *Drugs and society.* 17. New York: Jones&Bartlett.

Harrison Narcotics Tax Act . 1914. Ch. 1, 38 Stat. 785 (12 17).

Hassemer, Winfried. 1997. *Crítica del derecho penal de hoy.* Edited by Kindle. Translated by Patricia S. Ziffer. Bogotá: Universidad Externado de Colombia.

Hawkins, Darnell F. 1995. *Ethnicity, race, and crime: perspectives across time and place.* Albany: State University of New York Press.

Herer, Jack. 2010. *The Emperor Wears No Clothes: Hemp and the Marijuana Conspiracy.* 12th Edition. Edited by Leslie Cabarga, Jeannie Herer and Roland A. Duby. Van Nuys: Ah Ha Publishing.

Hill, Hermann. 1982. *Einführung in die Gesetzgebungslehre.* Heidelberg: C.F. Müller Juristischer Verlag.

Horton, Donald. 1943. "The functions of alcohol in primitive societies: a cross-cultural study." *Quartely Journal of Studies on Alcohol*, 9: 199-320.

Hughes, Caitlin Elizabeth, and Alex Stevens. 2010. "What Can We Learn from the Portuguese Decriminalization of

Illicit Drugs?" *British Journal of Criminology*, 07 21: 999-1022.

Iversen, Leslie L. 2016. *Drugs: a very short introduction.* 2nd Edition. Oxford: Oxford University Press.

Jakobs, Gunther. 2012. "Direito penal do cidadão e direito penal do inimigo." In *Direito penal do inimigo: noções e críticas*, by Gunther Jakobs and Manuel Cancio Meliá, edited by Kindle, translated by André Luís Callegari and Nereu José Giacomolli. Porto Alegre: Livraria do Advogado.

Jannuzzi, Paulo de Martino, Wilmer Lázaro Miranda, and Daniela Santos Gomes Silva. 2009. "Análise multicritério e tomada de decisão em políticas públicas: aspectos metodológicos, aplicativo operacional e aplicações." *Revista Informática Pública*, 69-87.

Jay, Mike. 2012. *Emperors of Dreams: Drugs in the Nineteenth Century.* 2nd Edition. London: Dedalus.

Jelsma, Martin, Phyllis Bennis, David Sogge, Mariano Aguirre, Zia Mian, Susan George, Mike Marqusee, and Walden Bello. 2011. *Casus Belli: Cómo los Estados Unidos venden la guerra.* Edited by Achin Vanaik.

Translated by Beatriz Martínez Ruiz. Amsterdam: Transnational Institute (Kindle).

Karam, Maria Lúcia. 2009. *Proibições, riscos, danos e enganos: as drogas tornadas ilícitas.* Rio de Janeiro: Lumen Juris.

Khan, Riaz, Yasser Khazaal, Gabriel Thorens, Daniele Zullino, and Ambros Uchtenhagen. 2014. "Understanding Swiss drug policy change and the introduction of heroin maintenance treatment." *European Addiction Research*, 200-207.

Killias, Martin, and Marcelo F. Aebi. 2000. "The impact of heroin prescription on heroin markets in Switzerland." *Crime Prevention Studies*, 83-99.

Klotter, Jule. 2001. "War on Drugs." *Townsend Letter for Doctors and Patients*, 07: 59.

Labrousse, Alain. 2011. *Géopolitique des drogues.* 3e Édition. Paris: Presses Universitaires de France.

Levitt, Steven D, and Stephen J Dubner. 2005. *Freakonomics: o lado oculto e inesperado de tudo que nos afeta.* Translated by Regina Lyra. Rio de Janeiro: Elsevier.

Lima, Rita de Cássia Cavalcante. 2009. "Uma história das drogas e do seu proibicionismo transnacional: relações

Brasil-Estados Unidos e os organismos internacionais." Rio de Janeiro.

Linhares, Paulo Afonso. 2015. *Legislação e Comportamento do Usuário de Drogas.* Vol. 3, in *Prevenção ao Uso Indevido de Drogas (PREVINA)*, by Elisaldo Luiz de Araújo Carlini, 166-182. São Paulo: Universidade Aberta do Brasil/Universidade Federal de São Paulo (UNIFESP).

Machado, Sulamita Crespo Carrilho. 2005. "O direito enquanto instrumento de propagação memética." *Revista Eletrônica de Direito do Centro Universitário Newton Paiva*, 1-45.

Malinowska-Sempruch, Kasia. 2011. "Prefácio." In *Política da Droga em Portugal: os benefícios da descriminalização do consumo de drogas*, by Artur Domosławski, translated by Nuno Portugal Capaz. Warsaw: Open Society Foundations.

Marihuana Tax Act. 1937. Public Law 238, 50 Stat. 551 (08 02).

McDonald, Tommy. 2018. *Experts React to Trump's Plan to Escalate Drug War and Impose Death Penalty for Drug Offenses.* 03 19. Accessed 7 2, 2018. http://www.drugpolicy.org/press-

release/2018/03/experts-react-trumps-plan-escalate-drug-war-and-impose-death-penalty-drug?spMailingID=33693715&spUserID=NTY4MTY1MjA1NjM1S0&spJobID=1243769963&spReportId=MTI0Mzc2OTk2MwS2.

McGovern, Patrick E, Donald L Glusker, Lawrence J Exner, and Mary M Voigt. 1996. "Neolithic resinated wine." *Nature*, 6 6: 480-481.

Millar, Tim, Andrew Jones, Michael Donmall, and Malcolm Roxburgh. 2008. "Changes in offending following prescribing treatment for drug misuse." National Treatment Agency for Substance Misuse, London.

Miron, Jeffrey A. 2004. *Drug war crimes: the consequences of Prohibition.* Edited by Kindle. Oakland: Independent Institute.

—. 2014. "Why all drugs should be legal. (Yes, even heroin.)." *The Weekly Wonk*, 07 28.

Nadelmann, Ethan Avram. 1993. *Cops across borders: the internationalization of U.S. criminal law enforcement.* Penn State University Press.

—. 2003. "Addicted to Failure." *Foreign Policy*, Jul. - Aug.: 94-95.

—. 1991. "Drug Prohibition in the United States: Costs, Consequences, and Alternatives." *Notre Dame Journal of Law, Ethics & Public Policy*, 783-808.

Nadelmann, Ethan Avram, Jennifer McNeely, and Ernest Drucker. 1997. "International perspectives." In *Substance abuse: a comprehensive textbook*, by Joyce H. Lowinson, Pedro Ruiz, Robert B. Millman and John G. Langrod, 22-39. Baltimore: Williams and Wilkins.

Narcotics Control Act. 1956. ch. 629, 70 Stat. 567

Narcotics Control Trade Act. 1974. Public Law 93-618, 88 Stat. 1978

National Commission on Law Observance and Enforcement. 1931. "Report on the Enforcement of the Prohibition Laws of the United States." National Commission on Law Observance and Enforcement, Washington.

National Prohibition Act. 1919. Public Law 66, 66 Stat. 305, 323 (10 28).

Netherlands National Drug Monitor. 2011. *NDM Annual Report 2010.* Netherlands Institute of Mental Health and Addiction, Utrecht: Trimbos-instituut.

Neves, Marcelo da Costa Pinto. 2011. *A constitucionalização simbólica.* São Paulo: WMF Martins Fontes.

Niemann, Albert. 1860. "Ueber eine neue organische Base in den Cocablättern." *Archiv der Pharmacie*, 129–155.

Nutt, David. 2012. *Drugs - Without the Hot Air: Minimising the Harms of Legal and Illegal Drugs.* Cambridge: UIT Cambridge Ltd.

Nutt, David, Leslie King, and Lawrence Phillips. 2010. "Drug harms in the UK: a multicriteria decision analysis." *The Lancet*, November 1: 1558-1565.

Olmo, Rosa del. 1990. *A face oculta da droga.* Translated by Teresa Ottoni. Rio de Janeiro: Revan.

ONU. 2007. "Programa de prevenção às drogas e HIV/AIDS." Escritório das Nações Unidas contra Drogas e Crimes (UNODC), Organização das Nações Unidas, Brasília.

Passetti, Edson. 2017. "Guerra sem fim?" In *Política e drogas nas Américas: uma genealogia do narcotráfico*, by Thiago Rodrigues, 7-18. São Paulo: Desatino.

Pizano, Ernesto Samper. 2013. *Drogas: prohibición o legalización.* Edited by iBooks. Debate.

Portugal. 2000. *Lei 030 de 29 de novembro de 2000.* Define o regime jurídico aplicável ao consumo de estupefacientes e substancias psicotrópicas, bem

como a proteção sanitária e social das pessoas que consomem tais substancias sem prescrição médica.

Public Law 221. 1909. U.S. 60th Congress

Pure Food and Drug Act. 1906. Public Law 59-384, 34 Stat. 768 (06 30).

Queiroz, Nana. 2015. *Presos que menstruam: a brutal vida das mulheres - tratadas como homens - nas prisões brasileiras.* Rio de Janeiro: Record.

Rahtz, Howard. 2012. *Drugs, Crime and Violence: From Trafficking to Treatment.* Lanham: Hamilton Books.

Reghelin, Elisangela Melo. 2002. *Redução de danos: prevenção ou estímulo ao uso indevido de drogas injetáveis.* São Paulo: Revista dos Tribunais.

Rehm, Jürgen, Robin Room, Maristela Monteiro, Gerhard Gmel, Kathryn Graham, Nina Rehn, Christopher T. Sempos, and David Jernigan. 2003. "Alcohol as a risk factor for global burden of disease." *European Addiction Research.*

Ribeiro, Maurides de Melo. 2013. *Drogas e redução de danos: os direitos das pessoas que usam drogas.* São Paulo: Saraiva.

Robinson, Matthew B, and Renee G Scherlen. 2007. *Lies, Damned Lies, and Drug War Statistics: A Critical Analysis of Claims Made by the Office of National Drug Control Policy.* New York: State University of New York Press.

Rodrigues, Thiago. 2017. *Política e drogas nas Américas: uma genealogia do narcotráfico.* São Paulo: Desatino.

Rowe, Thomas C. 2006. *Federal narcotics laws and the war on drugs: money down a rat hole.* Edited by Kindle. New York: Routledge.

Roxin, Claus. 2001. "Tem futuro o direito penal?" *Revista dos Tribunais*, 08.

Santos Júnior, Rosivaldo Toscano dos. 2016. *A guerra ao crime e os crimes da guerra: uma crítica descolonial às políticas beligerantes no sistema de justiça criminal brasileiro.* Florianópolis: Empório do Direito.

Scheerer, Sebastian, interview by Denise Paro. 2012. *Droga não é assunto do Direito Penal.* Edited by Gazeta do Povo. Curitiba, (08 01).

Scheerer, Sebastian. 1993a. "Estabelecendo o controle sobre a cocaína (1910-1920)." In *Drogas, é legal?: um debate autorizado*, by Francisco Inácio Bastos and Odair

Dias Gonçalves, translated by Francisco Inácio Bastos, 169-194. Rio de Janeiro: Imago.

Seevers, Maurice. 1958. "Drug Addictions." In *Pharmacology in medicine: a collaborative textbook*, edited by Victor Alexander Drill, 236-252. New York: McGraw-Hill.

Silva Júnior, Walter Nunes da, and Olavo. Hamilton. 2024. *Drogas e punitivismo: superpopulação carcerária, aumento da criminalidade e fomento das organizações criminosas.* Natal: OWL Editora Jurídica.

Sirin, Cigdem V. 2011. "From Nixon's War on Drugs to Obama's Drug Policies Today: Presidential Progress in Addressing Racial Injustices and Disparities." *Race, Gender & Class*, 82-99.

SISDEPEN. 2023. *Relatório de Informações Penais.* Segundo Semestre de 2023, Brasília: Ministério da Justiça.

Soares, Milena Karla, and Cristina Maria Zackseski. 2016. "Proibicionismo e poder regulatório: uma pesquisa documental sobre o processo administrativo de classificação das drogas." *Cadernos Ibero-americanos de Direito Sanitário*, 135-156.

Stöver, Heino. 2013. "Multi-agency approach to drug policy on a local level: 'The Frankfurt Way'. Briefing paper for 2013 International Conference on Drug Policy and Policing (in Open Society Foundation, Frankfurt)." *Open Society Foundation.* 11 14. Accessed 04 28, 2018. https://www.opensocietyfoundations.org/sites/default/files/The_Frankfurt_Way.pdf.

Straight, Benjamin Aaron. 2005. *The two finger diet: how the media has duped women into hating themselves.* Lincoln: iUniverse Inc.

Substance Abuse and Mental Health Services Administration. 2023. *2022 National Survey on Drug Use and Health (NSDUH) Releases.* Rockville: SAMHSA.

Szasz, Thomas. 1996. *Our Right to Drugs: The Case for a Free Market.* New York: Syracuse University Press.

The Drug Policy Alliance. 2017. *A Brief History of the Drug War.* Accessed 06 16, 2017. http://www.drugpolicy.org/facts/new-solutions-drug-policy/brief-history-drug-war-0.

Tonry, Michael. 1997. *Ethnicity, crime and immigration: comparative and cross national perspective.* Chicago: University of Chicago Press.

Tzu, Sun. 2015. *A arte da guerra.* São Paulo: Novo Século.

Uniform State Narcotic Drug Act. 1934. Public Law 488, 46 Stat. 585

UNODC. 2015. "World Drug Report 2015." United Nations Office on Drugs and Crime, New York.

UNODC. 2024. *World Drug Report 2024.* New York: United Nations Publication.

Uruguay. 2013. *Ley 19.172.* Marihuana y sus derivados – control y regulación del estado de la importación, producción, adquisición, almacenamiento, comercialización y distribución.

Uruguay. 2015. "VI Encuesta Nacional en Hogares sobre Consumo de Drogas." Junta Nacional de Drogas, Presidencia de la República, Montevideo.

US Constitution, amend. 18. 1919. (United States Constitution, 01 16).

US Constitution, amend. 21. 1933. (United States Constitution, 12 05).

US President. 1989. "First National Drug Control Strategy." Washington: The White House, 09 05.

Van Amsterdam, Jan, Antoon Opperhuizena, Maarten Koeter, and Wim van den Brink. 2010. "Ranking the harm of alcohol, tobacco and illicit drugs for the individual and the population." *European Addiction Research*, July 2: 203-207.

Weber, Max. 2003. *A política como vocação.* Brasília: UnB.

Welles, Orson. 1941. *Citizen Kane.* Directed by Orson Welles. Produced by Orson Welles. Performed by Orson Welles, Joseph Cotten, Dorothy Comingore and Agnes Moorehead.

Wendel, Travis, Geert Dhondt, Ric Curtis, and Jay Hamilton. 2016. "'More drugs, less crime': why crime dropped in New York City, 1985–2007." *Dialect Anthropol*, 3 2: 319–339.

Werb, Dan, Greg Rowell, Gordon Guyatt, Thomas Kerr, Julio Montaner, and Evan Wood. 2010. "Effect of Drug Law Enforcement on Drug-related Violence: Evidence from a Scientific Review." International Centre for Science in Drug Policy, Vancouver.

WHO. 1981. *5th Review of psychoactive substances for international control.* World Health Organization, Geneva: WHO Press.

WHO. 2024. *Global status report on alcohol and health and treatment of substance use disorders.* Geneve: WHO Press.

—. 2023. *Tobacco.* July 31. Accessed setembro 20, 2024. https://www.who.int/news-room/fact-sheets/detail/tobacco.

WHO. 2011. *WHO report on the global tobacco epidemic, 2011: warning about the dangers of tobacco.* World Health Organization, Geneva: WHO Press.

WHO, UNODC, and UNAIDS. 2012. *WHO, UNODC, UNAIDS technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users – 2012 revision.* World Health Organization; United Nations Of ce on Drugs and Crime; United Nations Programme on HIV/AIDS, Geneva: WHO Press.

Will, George Frederick. 2009. "A reality check on drug use." *Washington Post.*

Woodiwiss, Michael. 2005. *Gangster Capitalism: The United States and the Globalization of Organized Crime.* New York: Carroll & Graf Publisher.

Zizek, Slavoj. 2014. *Violência: seis reflexões laterais.* Translated by Miguel Serras Pereira. São Paulo: Boitempo.