METH IN THE TIJUANA-SAN DIEGO BORDER REGION: TRACING
THE RISE OF METHAMPHETAMINE ADDICTION IN THE UNITED
STATES AND MEXICO

A Thesis
Presented to the
Faculty of
San Diego State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Latin American Studies

by
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Fall 2016
SAN DIEGO STATE UNIVERSITY

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This thesis is dedicated to my family, who have always been there for me with their support and unconditional love.
ABSTRACT OF THE THESIS

Meth in the Tijuana-San Diego Border Region: Tracing the Rise of Methamphetamine Addiction in the United States and Mexico
by
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San Diego State University, 2016

North America is the largest methamphetamine market in the world. Its meth problem can be traced to the beginnings of the meth trade in the San Diego-Tijuana border region. The confluence of supply-side criminalization drug strategies in both the United States and Mexico, the region’s unique geography as a transborder metropolis, and the illicit economy borders produce, gave rise to a methamphetamine addiction that is affecting communities on both sides. The production and consumption of the drug has moved well beyond the region into the nations’ respective interiors. This thesis traces methamphetamine’s long, interconnected history in San Diego and Tijuana, and examines the flawed strategies on both sides of the border that helped to create North America’s meth crisis. It also argues in favor of a policy alternatives that might mitigate some of the damage that meth addiction inflicts on both societies.
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ACKNOWLEDGEMENTS

This thesis would not be possible without the support of Dr. David Carruthers. I am grateful for his guidance and friendship. I also want to thank all my professors at SDSU, who have been a source of constant inspiration throughout my time at SDSU. I am forever indebted to my thesis committee and can’t thank Dr. Amy Schmitz Weiss and Dr. Reynaldo Rojo Mendoza enough for taking the time to be part of it. I am forever grateful.
INTRODUCTION

It is no coincidence that San Diego, once labeled the “meth capital of the world,” is now witnessing its sister city, Tijuana, assume the mantle it once held (Shafer, 2005). A regional pathology primed the San Diego-Tijuana border for a methamphetamine epidemic. A confluence of interrelated regional factors has fostered a deep and destructive methamphetamine connection between the two cities. These factors include San Diego’s military history, the presence of opportunistic motorcycle gangs, uncoordinated binational drug enforcement, drug cartel ingenuity, migratory flows, deportations, and the southward shift in meth production resulting from supply-side interventions by US law enforcement. The result has set in motion an epidemic that has spanned decades, with impacts felt far from its points of origins in the cities of San Diego and Tijuana, to the interiors of the respective nations. While the arc of production and consumption of methamphetamine has spread far beyond the epicenter cities of San Diego and Tijuana, the addictions consuming citizens of both the United States and Mexico are deeply rooted in what we might call “the meth ecology” of the San Diego-Tijuana region, and in the supply reduction drug strategies of law enforcement in the US and Mexico, from local to federal levels. Borders produce their very own economies, both legal and illicit. Nowhere is this more true than the densest urban cluster along the United States and Mexico’s shared 1,954-mile border. As Andreas (2012) notes:

Just as some countries and regions occupy a special niche in legal trade, so too do different counties and regions have a niche in the illegal trade. The industrialized countries dominate legal trade; illegal trade is an area of significant comparative advantage for many developing countries. (p. 18)

In this thesis, I will explore how the San Diego-Tijuana border region’s “niche” in methamphetamine trafficking is the result of prohibitionist policies that spawned this epidemic. Research on methamphetamine addiction in the US is a widening body of scholarship. However, little of it traces its rise to the destructive symbiosis that existed
between San Diego and Tijuana. There’s also a dearth of academic research both in English and Spanish on meth addiction in Mexico and its root causes.

My main research questions for this thesis are the following: Why did this region become ground zero for such a destructive drug epidemic, and how do national drug strategies in a border region affect their neighbor nations where methamphetamine is concerned? Are there national drug policies that could be more effective in curbing rates of methamphetamine addiction? And how can neighboring nations like Mexico and the United States work together to harmonize their national drug policies so they are more successful in dealing with a transborder addiction scourge like methamphetamine?

In this thesis, I provide historical context and an overview of the process by which the San Diego-Tijuana region was primed to become the center of the US and Mexico’s methamphetamine epidemic. Using secondary sources to construct a timeline of this border region’s meth epidemic and reasons behind it, I argue that the patterns of addiction in both the United States and Mexico were preventable, and the direct result of criminalization drug policy strategies employed at every level of government on both sides of the border.

In Chapter 2, I discuss the four major currents in contemporary drug policy—criminalization, decriminalization, legalization, and harm reduction—along with their histories and ideological roots. In Chapter 3, I show how the economies inherent to this border region—both formal and otherwise—have existed for centuries and created a space that defies myopic attempts to conceive of and implement drug policy in a national context considering the fundamentally globalized nature of the illicit drug trade. I argue that emerging shifts in drug policy both in the Americas and around the globe—like harm reduction and decriminalization strategies—have proven more effective at containing drug addiction and mitigating the problems associated with it than prohibitionist strategies. I discuss the growing consensus among academics, public health officials, and political leaders in the Americas that the “drug war” has failed, and argue that a new direction towards reforming drug laws is already underway. In the conclusion, I propose an accelerated movement in the Americas towards a more inclusive, harmonious results-based drug strategies that treats methamphetamine addiction as a public health issue, not a criminal one.
CHAPTER 1

THE MAKING OF A METH EPIDEMIC

San Diego was perfectly positioned to be the epicenter of the United States’ meth epidemic. In the mid-1980s, “at a time when crack cocaine was garnering all the headlines and crystal meth barely registered as a national trend, local law enforcement officials were already calling San Diego . . . ‘The meth capital of America’” (Owen, 2007, p. 18). But San Diego’s distinction as the birthplace of the most destructive drug epidemic in the nation’s history was a half-century in the making, and the result of a complex confluence of factors that existed in the San Diego-Tijuana region. This set of factors created a “perfect storm” for meth addiction (Warth, 2007b, para. 7).

There are a number of reasons that explain why San Diego became such a happy home for meth manufacturing. In the immediate aftermath of World War II, returning troops took jobs in San Diego’s defense plants, and some of them who had picked up the habit while serving their country continued to use amphetamines to help work longer hours and earn overtime pay. Hence, there was already a well-established blue-collar market for the drug that stretched back decades. In the 1960s, after Methedrine was effectively banned from the state, many of the first-ever clandestine labs constructed in America were located in rural areas outside the city. The proximity to the Mexican border was another factor. Downtown San Diego is only 20 minutes from its sister city, Tijuana. The Tijuana-San Diego corridor, the busiest border crossing in the world, has been a major pipeline for the smuggling of illicit goods into America since the days of Prohibition. One major reason the San Diego area became such a focal point for meth activity in the Reagan years was the presence of the Hells Angels Motorcycle Club (Owen, 2007, p. 134).

San Diego’s place in the rise of the US meth epidemic began a world away, on the European and Pacific fronts of World War II, where the US government, following the lead of its enemies, quickly learned of amphetamines’ potential to aid in warfare. The Axis
powers were the first to understand the drug’s power in its wartime application. Early German battlefield successes, fueled by the issuance of methamphetamine and amphetamines to columns of soldiers by German military leadership, gave the impetus for the wide-scale use of the drugs among the other warring nations (Freye, 2009). The drug was seemingly perfect for warfare. Its hunger- and fatigue-fighting characteristics, in addition to “the aggressive, violent . . . behavior as well as a tendency to lose the very basic human emotions of sympathy and compassion” (Mehling & Triggle, 2008, p. 14) that were the result of its use, made for an efficient soldier. Germany’s march on Europe that caused the outbreak of World War II was fueled by amphetamines. In the months between April and December of 1939, on the orders of Adolf Hitler, German troops were supplied with 29 million amphetamine pills (Menhard, 2006, p. 29). Hitler himself took the drug, reportedly injecting himself with methamphetamine “as often as eight times a day,” an assertion that has led “some historians [to] speculate that he gave meth to his troops to create ‘killing machines’ divorced from human empathy, and that he himself was addicted to the drug” (Mehling & Triggle, 2008, p. 14).

Germany’s decision to issue its armed forces methamphetamine was a fateful one, as it “encouraged other countries to evaluate its utility as well” (McDowell & Spitz, 2001, p. 100). Axis ally Japan quickly followed Germany’s example, and in a wartime one-upmanship, began supplying not only the troops on the battlefield with the drug, but also the Japanese industrial workers, seeking to boost productivity in a war-directed economy. The “German blitzkrieg strikes and suicidal Japanese kamikaze and banzai attacks may have been inspired by something more than fearless nationalism” (Warth, 2007a, para. 24), as both Germany’s and Japan’s military leadership were supplying their armies with Pervitin and Isophan, the brand names for methamphetamine (McDowell & Spitz, 2001). The Allies quickly followed suit, which “led to methamphetamine and amphetamines being widely used by the military in the US [and] Great Britain” (Iversen, 2006, p. 72).

While never approaching the levels of the Axis powers, significant wartime use among military personnel in every branch of the US Armed Forces existed. Amphetamines were “used mainly by the Army for combat situations, by the Air Force for long flying missions, or by the Navy for sailors who needed to stay awake on night watch” (Iversen, 2006, p. 72). The alarming amounts of the drug consumed on both side of the conflict led
“veterans of the war in the South Pacific [wondering] if the protracted, bloody nature of the battles had something to do with the fact that both sides were high on amphetamines” (Owen, 2007, p. 44).

Benzedrine, closely related to methamphetamine,

was used extensively by Army Air Corps personnel stationed in England in the 1940s. It was an open secret that many pilots engaged in bootlegging operation to supply troops in Africa, Europe, and eventually the Pacific. Amphetamines were also easily obtainable from military medical officers and aids. The amount of Benzedrine supplied to the United States servicemen by the British has been estimated at nearly 80 million tablets and pills, and probably another 80 to 100 million were supplied by United States medics. (Grindspoon & Hedblom, 1975, p. 18)

The results of widespread issuance and availability of the drug in the United States Armed Forces had repercussions stateside. “If only 10 percent of American soldiers ever used amphetamines during the war, over 1.5 million men must have returned to this country in 1945 with some firsthand knowledge of their effects” (Grindspoon & Hedblom, 1975, p. 72).

According to Leslie Iversen (2006) of the Department of Pharmacology at Oxford University and author of the book *Speed, Ectasy, Ritalin: The Science of Amphetamines*, “After the war, many soldiers returned home with an amphetamine habit—sanctioned by the military authorities!” (p. 72). The level of amphetamine abuse in the American armed forces was staggering. Iverson cites a 1947 study done at the US Military Prison at Fort Harrison, Indiana, one-quarter of prisoners confessed that they “were abusers of Benzedrine inhalers, and most had probably been exposed to amphetamine through their previous army experience” (p. 72). The trend on amphetamine use and abuse among the ranks of the military only increased after the Second World War. By the time of the Korean conflict, “amphetamines had become general issue to US Army soldiers” (p. 72).

A 1971 Select Committee in Crime congressional report noted the astonishing issuance levels of amphetamine to troops by American military authorities. According to the report:

The US Navy has an active duty “pill-per-person” annual requirement averaging 21 during the period 1966-1969; the Air Force requirement was 17.5 pills per person, and the Army requirement was 13.8. The total consumption of amphetamine by the U.S. Armed Forces during this 4-year period, at 225 million
It is no wonder, then, that in the post-war period, methamphetamine users were largely veterans who had picked up their habits while serving overseas. Whether they were first introduced to the drug through the military issued variety, or on the black markets in Japan and Korea, both of which “had a serious problem with civilians using the military-made drug left over from the war[s]” (Warth, 2007a, para. 32), they brought their habits back to the shores of the United States.

San Diego was at the center of a Venn diagram where southern California’s post-war building boom overlapped with a major U.S. military hub, through which returning soldiers funneled. Thus, it became the adopted home to many returning soldiers, including those struggling with the amphetamine addictions they picked up while serving in the military, setting the stage for the region’s eventual methamphetamine crisis.

The long shadow of World War II’s widespread meth use was influential in the formation of the nation’s meth addiction. During their tours fighting in World War II, experts estimate that American soldiers were administered as many as 200 million amphetamine tablets by military authorities. Ironically, many of the pills were manufactured at a San Diego naval base (Warth, 2007a).

The city’s robust military-centric economy was another root cause in the region’s meth epidemic. The Cold War federal defense spending largess showered on southern California kept San Diego’s shipyards and the factories of military related industries buzzing. Many in the early wave of the drug’s abusers were swing shift workers picking up overtime shifts at San Diego defense plants.

San Diego’s large motorcycle gang presence was another influential factor in its rise as the world’s meth capital. The Hells Angels Motorcycle Club—a biker gang formed by “a group of ex-servicemen who had grown bored with the slow pace of civilian life” (Owen, 2007, p. 133)—was very active in San Diego County. Initially, in the 1960s, the gang’s members were low-level peddlers of the legal version of the drug, produced by pharmaceutical companies, and rerouted through the distribution network they controlled for illicit purposes. San Diego’s geographical location as a border town neighboring Mexico also
helped, allowing for legally produced amphetamine pills to be exported to Mexico, where they were illegally reimported, and distributed by the Hells Angels.

In a pattern that would continue to repeat itself in the meth’s arc, supply-side interventions and criminalization policies aimed curbing the drug’s usage created serious unintended consequences, making methamphetamine much more difficult to control, and spreading its influence far and wide. With the Federal Controlled Substance Act of 1970, methamphetamine became strictly regulated. However, the Hells Angels saw an opportunity in the law’s passage. With methamphetamine “pulled from the pharmacies” (Warth, 2007a, para. 35), the gang struck out on their own, and “modernized their operation so they more resembled a Mafia-on-wheels than a marauding mechanical Visigoths of legend” (Owen, 2007, p. 134). In the reorganization, the gang hired a team of professional chemists, who then schooled Hells Angels members in the science of “cooking” meth. By the 1980s, the Hells Angels had a controlling share of California’s multimillion dollar meth manufacturing industry. The 1980s was a banner decade for San Diego’s meth-making industry. During the decade, there was a twentyfold increase in the discovery of clandestine meth “laboratories” (Owen, 2007, p. 137). Much of the blame for the proliferation of meth labs in the region could be pinned on San Diego-based RJM Laboratories and its founder Robert J. Miskinis, a UCLA chemistry student gone rogue.

While Miskinis’ operation was just one of several local businesses at the time that sought to capitalize off San Diego’s growing meth addiction by selling the drug’s precursor ingredients, it was by far the most sophisticated. Not only did RJM Laboratories knowingly sell precursor ingredients to local meth makers, it had a reach across the United States, supplying more than two thousand labs in five states—California, Washington, Texas, Tennessee, and New Jersey (Warth, 2007b, para. 21).

Miskinis’ acuity prompted him to hire an industry lobbyist when the California state legislature proposed a law that would require the bulk purchases of ephedrine—the precursor ingredient in meth making—to be tracked with the California Department of Justice. The $22,000 he paid the lobbyist was money well spent initially, as Miskinis’ efforts successfully delayed the law’s implementation by a half-year, until an inquiring local press revealed Miskinis had a meth-making charge on his record from 1978 (Owen, 2007, p. 138).
Before Miskinis’ wholesale meth-making empire was brought down in a DEA raid in August 1988, RJM Laboratories had sold untold amounts of precursor ingredients to meth makers. Perhaps most disturbingly, RJM Laboratories disseminated the knowledge of meth’s chemistry—both locally and across the country—with “already assembled laboratory kits, complete with instruction books that ranged from simple setups suitable for producing a few ounces of the drug at home to the sort of glassware appropriate for industrial-scale production” (Owen, 2007, p. 138). The sum total of meth precursors sold to local meth makers is impossible to calculate, since the chemical wholesaling business was not required to keep records for precursor ingredients at the time. However, in the 1988 August raid, authorities found enough ephedrine to produce 50 tons of meth, leaving one DEA agent to remark, “A great deal of the methamphetamine problem in San Diego can be placed at the doorstep of RJM labs” (R. Serrano, 1988, para. 5).

During this time, the drug’s availability led to a shift in usage patterns. Formerly “the drug of choice for outlaw bikers and the rural poor,” meth was suddenly . . . being used in Southern California by white-collar workers, young mothers, high school students, nurses, teachers and other seemingly unlikely groups. The drug’s popularity soared in San Diego, which became known to many as the methamphetamine capital of the nation in the 1980s. (Warth, 2007b, para. 2)

San Diego’s dubious distinction continued well into the 1990s. According to the Los Angeles Times, during this era, one-quarter of meth lab discoveries in the United States were located in San Diego County (Schachter, 1987, para. 10).

**The Henry Fords of Meth**

For most of the 1990s, the spatial economy of methamphetamine in the United States was a “closed circuit,” characterized by hyper-local production and consumption. That all changed, however, with the visionary Amezcua brothers (Logan & Kairies, 2007, para. 26). The Amezcua brothers’ unlikely rise from poverty to heading a drug trafficking organization with a global reach, started in Pihuamo, Mexico, in the state of Jalisco.

There was nothing about them in the early days to distinguish them from the millions of other poor Mexican peasants trying to scrape out a living or to suggest that they would one day go on to create a global drug trafficking empire—reyes de la metanfetamina [the kings of methamphetamine], as the Mexican media would dub them. (Owen, 2007, p. 142)
Opportunity starved in Mexico, Jésus Amezcua set out for the United States, crossing the border illegally somewhere in the hills east of the San Ysidro Port of Entry. Settling in San Diego, Jésus, along with his brother Luis, started a human trafficking business in the mid-1980s. The brothers purchased a San Diego car repair shop bought with pollero (smuggler) money, and graduated to a small-scale drug smuggling business that trafficked “modest amounts of marijuana and pound bricks of cocaine” over the San Diego-Tijuana border (Owen, 2007, p. 144).

According to confidential files of the Procuraduría General de la República (Attorney General of Mexico) leaked to the Mexican press, Jesús Amezcua was approached by San Diego area meth “cooks,” inquiring if he could procure ephedrine powder in his native Mexico. At the time, there was an ephedrine drought in California, thanks to the new federal law regulating bulk amounts of the drug. In addition, there was an ongoing state crackdown on meth makers. Local meth cooks were having trouble and were clamoring for new sources. Ephedrine was perfectly legal to buy in whatever amounts purchasers wanted at the time in Mexico. (Owen, 2007, p. 144) The brothers began trafficking in meth’s precursor ingredients, buying them at the retail level in Mexico, and selling them to motorcycle gang meth “cooks” in San Diego. “They were making good money, but they were hardly drug kingpins” (p. 144). The dramatic and destructive paradigm shift of the hemisphere’s meth trade because of their astute business sense was still to come.

During a “business” trip to their native Colima, the bothers were introduced to Manuel Salcido Uzeta, a politically connected man who masqueraded as the law-abiding, wealthy businessman and philanthropist Pedro Orozco Garcia, “who would propel them into the major leagues” of drug trafficking (Owen, 2007, p. 144). With a respectable cover as a head of a successful engineering firm, Salcido

often played host to the governor, the state police chief, the mayor and other luminaries [and] rode his palomino in the annual Independence Day parade, bought uniforms for a municipal volleyball team and lent his heavy machinery to pave a rural road. (Miller, 1991, para. 4)

On the upright side of Salcido’s double life, during the years on his Colima ranch, he was the godfather to scores of local children. His altruism was celebrated in local ballads. He even “built a playground with a merry-go-round and slides” along with a “miniature zoo
[that] housed deer, monkeys, llamas and a flock of brilliant peacocks,” for enjoyment of local children (Miller, 1991, para. 19). The complete picture, however, was more complicated. Despite beneficent pretensions, Salcido was the drug kingpin of the Guadalajara cartel. At a time when there was still an air of civility and gentility to the business of drug trafficking, despite the do-gooder public persona his alter ego enjoyed, Salcido foreshadowed the sadistic violence of contemporary Mexican cartels. By tradition, every narcotics peddler must have a moniker, and in his native state of Sinaloa, Salcido, he was considered the most ruthless of his contemporaries. He was known as “El Cochiloco,” or the Crazy Pig, because he didn’t just kill anybody who crossed him, but had his men slaughter them as if they were farm animals, gouging out their eyes, pulling out their fingernails, chopping off their hands and, in some cases, castrating them. (Owen, 2007, p. 144)

Salcido was impressed by the Amezcua brothers, and seeing their potential, quickly placed them on his payroll. When Salcido met his violent end in fusillade of bullets in August 1991, allegedly by his rivals, the Amezcua brothers were positioned to take over Salcido’s cocaine and marijuana smuggling operation. Shortly thereafter, the brothers formed the Colima Cartel (Grayson, 2009).

Unlike the other Mexican cartels during this period, who were primarily logistics contractors shipping Colombian cocaine into the United States, the Amezcua focused a different, innovative tack. Understanding the earnings potential in trafficking meth’s precursor chemicals from his experiences with the motorcycle gangs of San Diego, and conscious of the western United States’ exploding meth boom, Jesús Amezcua focused the bulk of the efforts of the Colima cartel on smuggling the chemical components in meth’s chemistry. Amezcua “realized that he could turn an even bigger profit smuggling ephedrine if he bought the chemical directly from the manufacturers” (Owen, 2007, p. 145), instead of middlemen in Mexico who sold at retail prices.

Scouring Asia in 1992, Amezcua located a factory in India where ephedrine sold for $48 a kilogram wholesale, one-eighth of what he was paying at the retail level in Mexico. With an American Express card in hand, Amezcua paid for tons of ephedrine with plastic, and had meth’s precursor ingredient flown to Mexico City, where Mexican customs officials, “who had been bribed in advance quickly released the consignments without inspection” (Owen, 2007, p. 145).
The Amezcua brothers had bigger plans still. Rather than simply profiting handsomely by supplying the southern California motorcycle gangs with the drug’s precursor ingredients, the Amezcua brothers made a bold move to corner the meth market themselves. Hiring a team of chemists, by 1993, their organization had set up a network of laboratories throughout Mexico, where they manufactured meth with the ephedrine they procured from Asia (Owen, 2007, p. 145).

With their shrewd plan to challenge the motorcycle gang’s methamphetamine monopoly with an economy of scale strategy and efficient, large-scale production, the Amezcua brothers single-handedly invented Mexico’s meth “super lab” phenomenon. These labs, which experts say can produce as many as 10 pounds of the drug in a 24-hour cycle—one ounce of which has the ability to get 120 people high—revolutionized the meth economy.

Their innovative business plan had several advantages. The Amezcua brothers wrestled control of the trade away from US-based motorcycle gangs. Unlike heroin and marijuana, which required fields to produce and pools of labor to harvest, and unlike cocaine, which was supplied by South American producers, methamphetamine was a process that they could control from start to finish. According to the Drug Enforcement Agency (1998):

By exploiting the legitimate international chemical trade, [the Amezcua brothers] held an important key to producing methamphetamine on a grand scale, and more importantly, controlling their own destiny. Unlike the cocaine business where the traffickers from Mexico got a percentage of the profits for distributing the drug, with the methamphetamine trade, they were no longer middlemen. They were traffickers in their own right, and as such, kept 100 percent of all profits. This also allowed them the freedom to expand their trade and territory. (para. 5)

Unlike most of their contemporaries, the Amezcuas formed an alliance with the Arellano-Felix brothers, who ran the Tijuana cartel, and paid fees to them to be allowed to ship their product through the Tijuana-San Diego corridor that the Arellano brothers controlled. The Amezcuas were happy to pay tribute to the Arellano family just as long as the flow of meth into the United States remained uninterrupted. (Owen, 2007, p. 155)

According to investigative journalist Steve Suo (2005), author of The Oregonian newspaper’s award-winning five-part series about methamphetamine entitled “Unnecessary Epidemic,” the Amezcuas’ rise from small time polleros and cocaine traffickers to
“the most prolific methamphetamine and precursor chemical trafficking organization in North America” (Harman, 2005, para. 4) in such a short span of time, dramatically reconfigured the hemisphere’s drug trade.

The Amezcua brothers revolutionized the meth trade. They discovered this unique niche that no other drug cartel in Mexico was looking at. And they discovered that they could create a whole new market for themselves in the United States for a drug that most people had never heard of. They turned it from a small mom-and-pop backyard operation to an industrial-scale production line. They made possible the super lab, which is capable of producing 1,500 times what an ordinary user can make for himself. They were the Henry Ford of the meth trade. (Suo, 2005, para. 13)

While the scale at which the Amezcua’s were able to produce was an impressive feat in and of itself, what really set Mexican meth apart from the American made version was its quality. According to the DEA’s Special Testing and Research Laboratory’s findings, the purity of US manufactured meth hovered around 48%, while the Mexican made counterpart enjoyed purity rates higher than 80% (Case et al., 2008, p. 25).

The Mexicans’ ability to produce massive quantities of high-quality product practically overnight—as much as a hundred pounds per cooking cycle—and have it delivered to practically any state in the union within days revolutionized the meth trade in America. (Owen, 2007, p. 149)

Most importantly, Mexican meth made possible the seemingly irreconcilable—as purity markedly increased, prices plummeted.

With bases located in both of Baja California’s two largest cities, Tijuana and Mexicali, along with the states of Jalisco, Colima, and Michoacán, the Amezcua brothers used their cocaine smuggling routes to export the drug into the United States, without having to share profits with Colombian suppliers (Dillion, 1995). The success of the Amezcua model was judiciously replicated by nearly every Mexican drug cartel, opening the floodgates to one of the most destructive drugs in history on a factory-produced scale. But the paradigm shift in meth production that resulted with the Amezcua brothers “elbowing aside the American motorcycle gangs who once dominated production and trafficking” (Dillion, 1995, para. 94), had disastrous, far reaching consequences, both in the United States and Mexico.

Mexican drug trafficking organizations’ decision to manufacture the drug—first by the visionary Amezcua brothers, and later by their imitators—inadvertently and unexpectedly provided the catalyst for the Mexico’s own crisis of methamphetamine addiction. As the
inundation of meth bound for the United States reached the point of saturation in choke-point border cities like Tijuana, the drug began “seeping into the pores of Mexican society” (Logan & Kairies, 2007, para. 5).

TIJUANA’S TRANSFORMATION FROM PILL CITY TO CRYSTAL CAPITAL

San Diego’s problems with amphetamine and methamphetamine had an early Tijuana connection. In 1965, responding to what US Senator Thomas J. Dodd said was 100,000 “seriously addicted pill-heads” that were an “unsuspected incendiary bomb ready to go off in every community” (Jenkins, 1999, p. 37), Congress passed the Drug Abuse Control Amendment. Before the law’s passage, procuring amphetamines was an easy endeavor. At the time, an estimated 8 billion amphetamine pills [were] produced each year in the US, Federal officials estimate, [with] no more than half this production . . . routinely dispensed by medical prescription. [The remaining pills which were not prescribed were] diverted to criminal channels by loss, theft and misdirected shipments. (Staff Writer, 1969, para. 3)

This seepage left House Select Committee to Investigate Crime’s Committee Chairman Claude Pepper to remark, “it is alarming that more than half of the stimulant and depressant drugs are articles of illicit drug traffic” (as cited in Staff Writer, 1969, para. 3).

Practically anybody could order huge amounts of amphetamines from wholesale mail-order companies whose only addresses were usually P.O. Box numbers. And practically anybody could sell them to you. The pharmaceutical companies were pumping out so many pills, it was almost impossible to keep track of them all, and large numbers were being diverted to the black market at al points in the supply chain—from factories to wholesale to pharmacists to doctors. (Owen, 2007, p. 37)

While the Drug Abuse Control Amendment did make it more difficult to obtain amphetamines within the United States by regulating drug companies’ domestic shipments, the law exempted US-based pharmaceuticals from shipping internationally. In the San Diego-Tijuana region, these so called “pill poppers” simply crossed the border to buy amphetamines, where their sale was not regulated. Resourceful dealers began setting up front companies in Tijuana, where they had the amphetamines legally shipped from the states to the border city’s “drug stores,” which in reality, were nothing more than “way-stations for
smugglers,” who then sent the pills right back to the United States through San Diego’s San Ysidro Port of Entry (Grindspoon & Hedblom, 1975, p. 23).

The scale of this legally export/illegally import model was massive. One US Congressional investigator estimated that as much as 60% of the amphetamine pills exported to Mexico during this period eventually made its way back to the United State through illegal channels. According to the Fourth Report of the Selected Committee on Crime, in 1969, the small Chicago-based drug producer Bates Laboratories alone shipped 15 million amphetamine tablets to the postal address of Tijuana drug store that in reality did not exist (Grindspoon & Hedblom, 1975, p. 23).

Tijuana’s place at the destination for legally shipped American amphetamines in addition to being the source point for its illegal return, prompted Mexican customs officials to label Tijuana “Pill City” (Staff Writer, 1969, para. 5). As early as the 1960s, an interconnected amphetamine economy existed between San Diego and Tijuana, which would continue through the Mexican cartel takeover of the methamphetamine trade. When the United States government finally closed the loophole that allowed for the diversion of massive amounts of amphetamines along with unregulated shipments of the drug to Mexico with the Federal Controlled Substance Act of 1970, San Diego motorcycle gangs simply began manufacturing the drug themselves.

**MEXICAN METH PRODUCTION GETS AN ASSIST FROM US LAW ENFORCEMENT**

The inverse lines between the rapid ascension of Mexican meth-producing cartels and the decimation of “mom and pop” meth kitchens of rural America crossed sometime in the mid-2000s. Until 2005, the majority share of American demand for meth was met locally, in small-scale batches. However, the elusive remainder of market share that Mexican cartels could not achieve through outright ingenuity and a better business model, was won with an inadvertent assist by criminalization drug strategies by state and federal regulations aimed at rising rates of addiction in the United States. State-level programs like the 2001 Kansas Meth Prevention Project began monitoring raw meth ingredients at the retail level. The campaign proved so successful that in 2004 it went national. However, the coup de grâce for American-made meth came in 2006 with the passage of the Combat Methamphetamine Act, which
tightly regulated pseudoephedrine, ephedrine and phenylpropanolamine, the drug’s precursor ingredients. According to Don Mandrala, Assistant Special Agent in Charge with the Drug Enforcement Administration’s regional office in St. Louis, Missouri, an area hard-hit by the US meth epidemic, “after the passage of this national bill, meth labs and the seizure of meth labs dropped off to nearly zero” (as cited in Logan & Kairies, 2007, para. 23). However, the law enforcement crackdowns, anti-meth programs, and legislation did not erase demand for the drug. They simply helped facilitate market domination by Mexican producers, who also looked internally for new, lucrative markets, as law enforcement efforts from both sides of the border made trafficking increasingly complicated.

**MEXICO’S NEW EPIDEMIC**

Initially, methamphetamine manufactured in San Diego flowed southward into Mexico, as teenage ravers from San Diego County brought the popular club drug with them while partying in Tijuana’s early-90s rave scene (Rosenburg, 2008). Middle class Tijuanenses, attending the same raves as their American counterparts, also developed a taste for the popular party drug.

The drug that became so popular with teenagers in the rave scene on both sides of the border also had a grip on southern California’s migrant workers from Mexico. Migration to the United States had a causal relationship with methamphetamine use, with drug usage rates for Mexicans nationals living in the US at levels much higher than for those who remained living in Mexico.

One study conducted between 2004 and 2005 examined cocaine and methamphetamine use by Mexican migrants in California and found that 21% of males (i.e., 209 of 985 respondents) consumed either drug. In contrast, the Encuesta Nacional de Adicciones 2008 [Mexico National Drug Addictions Survey] found that overall, only 5.7% of persons ages 12–65 have ever consumed any illicit drug [Mexico’s historically low usage rates]. (Ojeda et al., 2011, p. 105)

Many Mexican migrants brought their vices back home during seasonal migration patterns. An aggressive policy of deportations of Mexican nationals living in the United States found guilty of minor offenses only exacerbated the problem in Tijuana, as the US government dumped waves of deportees into the city, many struggling with methamphetamine addiction. One study reported that 42% of male users in Tijuana who take
drugs via injection were deported from the United States (Ojeda et al., 2011). According to a Reuters report:

Addicts shooting up in the dry ravines in the shadow of the U.S.-Mexico border in Tijuana were the first wave of meth users. Many were deported immigrants who got their first taste of the drug in the United States. (as cited in Rosenberg, 2008, para. 13)

The rise of Mexico’s methamphetamine problems did not reach epidemic proportions until Mexican President Felipe Calderón’s administration, whose 6-year term began December 1, 2006. Days after his inauguration, Calderón declared all-out war on the nation’s drug cartels. “Elected in a disputed, polarizing process with just 35 percent of the popular vote, unrecognized as Mexico’s legitimate president by his principal opponent, he has chosen, despite his soft spoken manner, to rule with an iron fist” (Rosen, 2014, para. 1).

Calderón declared war. “Like a bull in a China shop during an earthquake, determined to do what previous presidents had deemed impossible and unwise” (Grant, 2009, para. 37), the Mexican president took on the four main narcotics-trafficking organizations, the Sinaloa, the Tijuana, the Gulf and Juarez cartels, sending 40,000 soldiers and 5,000 federal police officers into violence-plagued areas to restore order (Grant, 2009, para. 8). Trying to undo the decades of PRI corruption that allowed for the hemispheric drug trade to shift from Colombia to Mexico and flourish with official protection, President Calderón attempted to crush the cartels and the larger narco-culture in Mexico. With a strategy of confronting Mexican police agencies’ proclivity for corruption and the state-challenging power of the country’s cartels, Calderón’s war on Mexico’s drug cartels dramatically disrupted drug supply lines, leaving product originally destined for export trapped on the Mexican side of the border. Facing the combative drug policy of the Calderón presidency, along with increased enforcement by the officials at the US-Mexico border, Mexican cartels once again changed the rules of the game. Realizing the profitability potential in creating new consumers for methamphetamine within Mexico, cartels began to “open up local markets for cheap forms of highly addictive drugs like . . . ice, as methamphetamine is known” (McKinley, 2007, para. 5).

Marcela López, Cabrera, director of the Monte Fenix Center for Advance Studies in Mexico City, asserts that, “with drugs harder to smuggle into the United States, more remain in Mexico, where they are sold to local consumers” (as cited in Hawley, 2008b, para. 6).
And, “as traffickers become less disciplined and as tighter US border security causes a glut of drugs in Mexico,” more drugs are finding their ways onto the streets of Mexico (Hawley, 2008a, para. 20).

According to a study produced by the University of California San Diego’s School of Medicine, “often, drug shipments are delayed in Mexican border towns before delivery to the United States, which has likely contributed to the high rates of local drug consumption in northern border cities” (Brouwer et al., 2006, p. 712). Now, meth is “not only being massively produced in Mexico but also widely consumed” (Logan & Kairies, 2007, para. 4). As a result, meth addiction in Mexico has soared, as the cartels have flooded the country with the cheap, accessible and highly addictive drug. Experts say that methamphetamine is now so plentiful and inexpensive in Mexico it is within the means of a majority of Mexicans. With clusters of super labs located all around the country and a constant stockpile of drugs warehoused and awaiting shipment north backed up at the ports of entry along the border, rising rates of addiction are the result. While nationwide rates of methamphetamine addiction are hard to come by, it is most apparent in Mexico’s north. According to Mexico’s Secretariat of Health, methamphetamine—above all other drugs and alcohol—is cited as the primary reason people seek treatment in addiction centers in northern Mexico (Comisión Nacional Contra las Adicciones, 2011). According to a recent Daily Mail report, “35 percent of Durango’s 500,000 residents admit to consuming the narcotic, which is inexpensive, highly addictive and ‘available on every corner’” (Baverstock, 2016, para. 16).

Nowhere is the addiction more entrenched than in the border city of Tijuana, the center of Mexico’s exploding methamphetamine crisis. According to Victor Clark-Alfaro, director of Tijuana’s Binational Center for Human Rights, Tijuana alone has over 100,000 meth addicts (as cited in Garcia-Navarro, 2006). However, one troubling facet of Mexico’s meth scourge is the speed at which addiction is spreading to Mexico’s interior. Experts fear that like the US model of meth dispersion, which began in inland San Diego County and spread to the US heartland, Mexico will also experience a significant outward drug migration, replicating the patterns the drug had in the United States.

The rise of “methamphetamine use has also become a major public health concern in Mexico as a consequence of the country’s growing role as a major production site” (Brouwer et al., 2006, p. 715). According to an 2008 study by the Mexican healthy ministry, the use of
methamphetamine in Mexico quadrupled in just 6 years (Encuesta Nacional de Adicciones 2008, 2008). This survey also reported 0.5% of the Mexican population having tried meth, twice the 0.2 level found in the United States (Rosenburg, 2008).

One of the most disturbing aspects of Tijuana’s meth crisis is the young age of many of these new addicts. Experts believe thousands of Tijuana’s meth addicts are teenagers or children. “I have seen as much as a 300 percent increase in the number of children coming to our centre for [methamphetamine] treatment,” said Jose Ramon Arreola, director of CIRAD, a rehabilitation center in Tijuana (as cited in San Pedro, 2008, para. 11).

According to a study produced by the University of California San Diego’s School of Medicine, “the perceived availability of drugs has increased locally and has been associated with experimentation and continued use in Mexican adolescents” (Brouwer et al., 2006, p. 712). “It’s really easy to find. First they give it to you for free but later you have to buy it,” said Gilberto, a 10-year-old meth addict at a treatment center in Tijuana (as cited in Rosenberg, 2008, para. 14).

Social worker Lina Raquel Sotres, the head of a government-run rehabilitation center in Mexico City, says the dramatic shift from Mexico as a producer nation to a consumer nation has had profound consequences for the young. “There’s been a big change in society; consumers are as young as 10 years old” (Miller Llana, 2009, para. 4). A distressing observation considering “Mexico has historically reported low levels of drug use” (Ojeda et al., 2011, para. 105). According to Dr. Isaac Alba, Director of Clinica Ser, a drug rehabilitation center in Tijuana, “its cheap price and availability are believed to be major factors leading to its popularity,” making the price of meth within the reach of Mexican children (as cited in Brouwer et al., 2006, p. 716).

As Mexico begins to grapple with the severity of its methamphetamine problem, and the addiction born of a binational region spreads further and further into both nations’ interiors, it is important to examine how policy decisions about drug strategies influence and affect their respective nations, especially between two countries as economically integrated as the United States and Mexico. The methamphetamine niche in the Tijuana-San Diego border region and the addiction it spawned that spread beyond it, was enabled by the confluence of prohibitionist drug policies and the illicit economies inherent to borders. In the
following chapters, I will discuss how this intersection of geography and flawed policies created and exacerbated North America’s methamphetamine crisis.
CHAPTER 2

EXPLORING POLICY ALTERNATIVES

The contentious nature of the debate on drug policy—impassioned, ideologically-charged, and often rife with hyperbole—makes it difficult to formulate a definitive language with which to discuss it and analyze the alternatives. Academics, policy makers, public health officials, and politicians involved in the debate have yet to agree upon a common language for discussing drug policy. Douglas Husak and Peter De Marneffe (2005) note that “commentators on both sides of this debate have contributed to the confusion by using terms . . . in different and inconsistent ways” (p. 2). Historically, many experts involved in the debate surrounding the spectrum of possibilities in drug control policy often seemed to present a simple "dichotomous choice" between prohibition and legalization (Des Jarlais, Friedman, & Paone, 1996, p. 777). However, a nation’s drug policy can be comprised of numerous regulatory instruments to control drug production and usage, with implications within and beyond its borders. The full weight of any nation’s drug strategy can be multifaceted, encompassing everything from the criminalization of selected substances, the criminal justice components, the severity of sanctions, public health responses, plant eradication efforts, and numerous other policy machinations. This “dichotomous choice" overlooks many possible policy alternatives, but it does at the very least provide a starting point by establishing the poles in the drug policy debate. For Husak and De Marneffe (2005), the spectrum in drug policy is a different binary—the “debate is whether drugs should be criminalized or decriminalized” (p. 3):

In principal, the ideas of drug criminalization and drug decriminalization are straightforward. Anyone who proposes that a given drug should be criminalized means simply that the use of that drug should be a criminal offense. By contrast, those who favor decriminalization mean simple that the use of that drug should not be a criminal offense. (p. 3)
I believe it is more helpful to imagine the drug policy debate as a complex continuum with gradations between these endpoints, ranging from the outright legalization of all drugs and drug usage on one extreme, to strict prohibitionist measures bolstered by draconian punishments on the other extreme. Erich Goode (1997) notes that drug policy is a continuum or a spectrum, from a completely libertarian or “hands-off” proposal—with no laws governing the sale of possession of any drug—at one end all the way over to the most punitive policy imaginable, let’s say [former Los Angeles Police Chief] Darryl Gate’s proposal that even casual marijuana smokers be “taken out and shot” at the other end, with every conceivable position in between. (p. 76)

The drug policy regimes in the majority of nations appear somewhere in that middle ground, between a full legalization framework—currently not attempted anywhere in the world—and strictly prohibitionist countries such as Saudi Arabia, where punitive policies for drug possession and/or trafficking can include beheading—a punishment applied in the kingdom at least 63 times in 2015 (Staff Writer, 2016c). Currently, 32 nations have laws on the books that allow prosecutors to employ the death penalty for drug offenses. Of these, China, Iran, Saudi Arabia, Vietnam, Malaysia, and Singapore constitute “high application states” (Gallahue, 2011, p. 6), with sentences of death for illicit drug offenses. In 2014, “at least 753 people were hanged in Iran, of whom more than half were drug offenders” (Dehghan, 2016, para. 5). No nation has yet promoted a policy of full drug legalization, which would put it outside the bounds of international treaties of “the prohibition oriented UN drug control system” (Bewley-Taylor, 2003, p. 171).

While noting the contentiousness both of the drug policy debate and the vocabulary for discussing it, for the purposes of this thesis, I am using the terms criminalization, decriminalization, legalization, and harm reduction to define the major policy traditions in the contemporary drug policy literature, with their defining characteristics to follow.

Professor Robert J. MacCoun, in testimony at the House Government Reform and Oversight Committee Subcommittee on Criminal Justice, Drug Policy, and Human Resources, asserted that:

Decriminalization, legalization, and harm reduction are three distinct concepts. Unfortunately, these terms are often used interchangeably in the policy debate. From a policy standpoint it is unhelpful to blur these distinctions because these three strategies differ in their likely benefits and likely risks. (as cited in MacCoun & Reuter, 2000, p. 1)
While the spectrum is complex, and scholars and policymakers often use these terms with little regard for the actual policies they encompass, in this chapter, I define the stated goals, philosophical underpinnings and the historical contexts of these respective drug policy approaches.

**CRIMINALIZATION**

The strategy of national-level drug criminalization is the policy tradition most familiar to policymakers and citizens in the United States, as well as in much of the rest of the world. In many political, academic, and policy circles, the language of criminalization is used interchangeably with prohibition. Some policymakers and analysts also refer to this policy tradition as a “supply-side approach” or a “supply-reduction policy.”

Criminalization refers to prohibitionist regimes in which the state defines both drug sales and drug usage as criminal acts. These regimes are punitive in nature and sanctions against users and producers fall within the purview of law enforcement. Drug policies in a prohibitionist framework “disallow the consumption of drugs, recognize no difference between soft and hard drugs, ensure that users are targeted with as much vigor as dealers and primarily invest in abstention-based or coercive treatment programs” (Chatwin, 2010, p. 27).

Central to the ideological rationale underlying the criminalization of psychoactive drugs is a shared conviction among policymakers and public health advocates that they are inherently dangerous substances, and that they are harmful, destructive forces in society. “The prohibitionists’ main claim is that criminalization deters drug use, and therefore reduces harm to health, which would exponentially increase under legalization” (Mena & Hobbs, 2010, p. 61). The goal, therefore, is reducing the consumption of drugs through restrictive laws with the ultimate aim of a “drug free society.” In this model of drug policy:

> It is generally assumed that sanctions against drug use also depress the prevalence of drug use through deterrence—i.e., potential users refrain from initiating or continuing use due to fear of being punished. According to the basic postulates of deterrence theory, persons considering using drugs will weigh the expected utility of the behavior against the subjectively perceived risk of punishment. (Manski, Pepper, & Petrie, 2001, p. 140)

State interdiction efforts should presumably reduce the national supply of drugs, ultimately lessening the harmful impacts of those drugs to society.
According to the National Council’s Committee on Data and Research for Policy on Illegal Drugs, the philosophy behind a “supply-reduction policy” is simple:

To many, it seems obvious that reducing the supply of drugs offers an important way to control the drug problem. If there were no drugs to use, there would be no problem. If lesser quantities of drugs reached consumers in the United States, the problem would be diminished. If drugs were harder to find, or riskier to obtain, or simply more expensive, some potential users might be discouraged from starting and some current users might seek treatment or abandon their use. (Manski et al., 2001, p. 139)

The end goal, therefore, becomes a society where supply side drug interdiction efforts make illicit drugs completely unavailable. “The basic assumption of punitive drug prohibition is that it is possible to attain a society free from illegal drug use” (Aoyagi, 2005, p. 568).

**Criminalization: History and Philosophical Roots**

Central to this current in drug policy are conceptions of morality—or more accurately the immorality—surrounding drug use. Thus in practice the policy downplays distinctions between the use versus the abuse of drugs, and across the spectrum of drugs, defined, however imperfectly, as “hard” or “soft.” “This approach to drug use is sometimes referred to as the ‘moral’ or ‘criminal justice’ model because it presumes that ‘illicit drug use is morally wrong’ and thus should be criminalized” (Aoyagi, 2005, p. 568). Historically, these ideas of immorality surrounding illicit drugs have played an influential role in the criminalization model of drug policy.

The belief that reducing the supply of drugs can help control the problem is but one concern that drives public commitment to enforcing drug laws. In addition, the public enthusiasm for enforcement, including imprisonment for offenders, is supported by the view that it is morally wrong to produce and sell drugs, and that those who do so despite laws prohibiting this activity ought to be punished. In short, many people believe not only that enforcement of drug laws helps to solve the problem of drug use, but also that enforcement advances the cause of justice. (Manski et al., 2001, p. 140)

Some analysts refer to criminalization policies as a "temperance mentality.” Influential are its antecedent ideologies of Christianity-rooted religious reformers in 19th and early 20th temperance movements. “Although temperance ideology has its roots in the 1800s, it continues to be a part of contemporary conceptions of alcohol, illicit drugs, and substance abuse treatment” (Schweighofer, 1998, p. 7).
The criminalization of drugs has been the dominant approach for so long in the United States, and US policymakers have been so aggressive about promoting the strategy abroad, that it seems nearly impossible to imagine that it was not always so. However, criminalization is in fact a relatively new approach to drug policy. “The War on Drugs, perceived by many to have always been with us, is actually a fairly recent phenomenon—during much of our history an extremely permissive approach has often been to the societal norm” (Cohen, 2004, p. 38).

Fernanda Mena and Dick Hobbs (2010) note that a major shift from a laissez-faire approach to a restrictive one stemmed from transitions in how policymakers and the public conceived of drugs:

The first step towards prohibition emanated from a change in the way that drugs were perceived, and the shift from economic liberalism, based on the free market, to a prohibitionist stance, based on images of moral degeneration and deviance, laid the groundwork for contemporary prohibitionism. (p. 61)

Thus, in the public’s imagination, drugs were no longer in the realm of traded commodities, but rather harmful substances that lead to societal decay. It was during this era that drug usage became an issue of morality. Governments around the world quickly adopted this “recent phenomenon” of drug prohibition. “In the last 80 years, nearly every political persuasion and type of government has endorsed drug prohibition” (Levine, 2003, p. 147).

Levine (2003) observes that drug prohibitionists were the dominant regimes throughout the globe for much of the last century:

Over the course of the 20th century, drug prohibition was supported by liberal prime ministers, moderate monarchs, military strongmen, and Maoists. It was supported by prominent archbishops and radical priests, by nationalist heroes and imperialist puppets, by labour union leaders and sweat shop owners, by socialists, social workers, social scientists, and socialites—by all varieties of politicians, practicing all brands of politics, in all political systems. National drug prohibition was one of the most widely accepted, reputable, legitimate government policies of the entire 20th century. (p. 147)

The result, Levine argues, is “global drug prohibition,” “a world-wide system structured by a series of international treaties that are supervised by the UN . . . . Every nation in the world is either a signatory to one or more of the treaties, or it has laws in accord with them” (p. 145).
THE BEGINNINGS OF CRIMINALIZATION

Calls for more restrictive drug policies, especially for opium, began in the United States during the latter half of the 19th century. Prior to that the US took a hands-off approach across its history—a period called “a dope fiend’s paradise,” that relegated self-regulation to the pharmaceutical industry. “It was a period of minimal government intervention with virtually no effective regulation of narcotics” (Klingemann & Hunt, 1998, p. 5).

New patterns of addiction in the United States often have a causal relationship with its military. The country’s regulatory drug policies have repeatedly come as a reaction to rising rates of usage directly related to the deployment of US soldiers. After the Civil War, for instance, the addiction to and abuse of morphine became readily apparent as a social problem throughout the war zone. By the closing years of the 19th century, 2% of the population of the United States was addicted to morphine (Recio, 2002, p. 25). Initial regulatory laws against psychoactive substances were a response to opium addiction among US soldiers serving in the Spanish-American War. After principles set forth at the Shanghai Opium Commission in China during in 1909, the first international conference of its kind, the US was one of the signatories of the world’s first international drug control treaty—the International Opium Convention—during the International Opium Convention a few years later in January 1912. As Recio (2002) notes, “One of the main reasons behind US support of the Shanghai Conference was the fact that, once the war with Spain ended in 1898, the country was faced with the need to resolve opium addiction in the Philippines and among US soldiers” (p. 25).

In the early 20th century, legislation to prohibit drugs began.

This era of indiscriminate sale and use of addictive drugs ended during the first two decades of the twentieth century with a new social contract embodied in the Pure Food and Drug Act of 1906, which addressed the labeling of drugs. In 1914, the Harrison Narcotics Act prohibited the sale of narcotics. (DuPont & Voth, 1995, p. 416)

These were followed by other laws. In October of 1937, the 1937 Marihuana Tax Act became law, levying “a nuisance tax on then-legal marijuana distribution,” which eventually “led to the criminalization of cannabis” (Kleiman & Hawdon, 2011, p. 700). The Boggs Act of 1952 established minimum sentenced for drug related convictions (Bonneau, 2013). Along
with “piecemeal” national legislation within the US, drug criminalization became enshrined in international treaties. As Bewley-Taylor (2003) notes, successive United Nations statutes made drug criminalization regimes essentially the global norm:

The present system of worldwide drug control is regulated by three international conventions. These are the 1961 Single Convention on Narcotic Drugs [United Nations, 1961], as amended by the 1972 Protocol, the 1971 Convention on Psychotropic Substances [United Nations, 1971] and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. As of November 2002 179 states are parties to the Single Convention, or are parties to the Convention as amended by the 1972 Protocol. The number of nations signatory to the 1971 and 1988 Conventions is 172 and 166, respectively. The bedrock of the global drug control regime is the Single Convention, so called because it largely replaced the previous international agreements that had been developing piecemeal since the early years of the twentieth century. (p. 171)

Throughout this period, however, drug usage rates in the US still remained relatively low. “Strict prohibition of non-alcohol drugs was broadly respected until the ascendant youth culture integrated drugs as a central element of its new lifestyles” in the 1960s (DuPont & Voth, 1995, p. 416). That was the era when politicians first adopted the war metaphor in the language associated with national drug control policy.

The actual term “War on Drugs” can be traced back to 1971 during the Nixon administration. Due to a concern that many servicemen returning from Vietnam were addicted to heroin, Nixon appointed the first Drug Czar and created the Special Action Office for Drug Abuse Prevention and, in 1973, the Drug Enforcement Agency was established. (Fisher, 2006, p. 4)

In recent decades, public attitudes towards drugs have begun to shift. Several local and state jurisdictions in the US have moved toward “legalizing” or “decriminalizing” marijuana for medicinal and recreational uses. However, at the national level, and in its international policies and treaty commitments, the US still employs a criminalization strategy in its drug policies.

**DECRIMINALIZATION**

As prohibitionist policies failed to reach many of their articulated goals and the unintended consequences of drug violence, mass incarceration and infectious disease became apparent to critics of criminalization strategies, many in policy circles were in search of a less punitive approach to drugs. As Levine (2003) notes, a global shift in the drug policy debate is underway about the efficacy of a criminalization drug policy strategy:
In many countries increasing numbers of people—physicians, lawyers, judges, police, journalists, scientists, public health officials, teachers, religious leaders, social workers, drug users and drug addicts—now openly criticize the more extreme, punitive, and criminalized forms of drug prohibition. These critics, from across the political spectrum, have pointed out that punitive drug policies are expensive, ineffective at reducing drug use, take scarce resources away from other health and policing activities, and are often racially and ethnically discriminatory. Criminalized drug prohibition violates civil liberties, imprisons many nonviolent offenders, and worsens health problems like the AIDS epidemic. (p. 149)

In recent decades, decriminalization has become a policy option for nations looking to radically reform their criminalization drug strategies. The attraction is its ability to enable sovereign nations to liberalize drug laws while still falling within the UN mandated international drug control treaties—global drug prohibition enshrined in the collection of UN treaties mentioned earlier—that have complicated drug policy reform efforts.

Central to the decriminalization is the belief that while drug usage within society is a significant issue, the outcomes in the enforcement of drug criminalization are more damaging than the drug problem itself. Put simply, according the proponents of decriminalization, drug prohibition creates more problems than it solves. While many proponents of criminalization believe decriminalization is simply legalization with a clever title, it is a distinct drug policy strategy that at its heart shifts drug usage outside the realm of criminality. Drug use remains illegal. However, the state’s drug management approach lies outside of the judicial and penal systems. The most concise definition for decriminalization comes from Portugal—a nation that is at the forefront of drug law reform movement—where the codified national drug policy statute states, “The consumption, acquisition, and possession for one’s own consumption of plants, substances or preparations . . . constitute an administrative offense” (Greenwald, 2009, p. 2). Decriminalization therefore eliminates the punitive actions associated with the demand side of drugs with “the removal of all criminal penalties’ from acts relating to drug demand: acts of acquisition, possession, and consumption” (Laqueur, 2015, p. 2).

The supply side—the selling and trafficking of drugs—remains expressly illegal in decriminalization policies.

In the decriminalization framework, drug usage and possession remain prohibited [i.e., illegal] and subject to police intervention. But “decriminalization” means that infractions have been removed completely from the framework of the
criminal law and criminal justice system. Instead, they are treated as purely administrative violations, to be processed in a noncriminal proceeding. (Greenwald, 2009, p. 3)

This approach makes no distinctions made between the perceived severity in different types of drugs—commonly referred in the dichotomous classifications as “hard” and “soft.” Under a decriminalization policy, all psychoactive substances are included.

“‘Decriminalization’ means either that only noncriminal sanctions [such as fines or treatment requirements] are imposed or that no penal sanctions can be” (Greenwald, 2009, p. 3). A central tenet in decriminalization is “an approach that distinguishes between the drug trafficker, who is viewed as a criminal, and the drug user, who is seen more as a sick person who is in need of treatment” (Laqueur, 2015, p. 2). The decriminalization drug policy framework has its roots in Europe, where prohibitive drugs policies were perceived as a failure in curbing both rates of addiction and the spread of contagious pathogens via intravenous drug use.

**DECRIMINALIZATION’S HISTORY AND PHILOSOPHICAL ROOTS**

While European drug policies are less punitive and more liberalized than those of the US, novel continental approaches in limited nations still very much fall within the criminalization strategy for most drugs. Still, several European countries have been at the forefront of drug liberalization efforts. The Netherlands, for example, has had a drug policy in which the state’s goal is not a drug free society. Rather, it places more importance upon reducing the public health problems associated with addiction. “Since the late 1960s, national drug policy [of the Netherlands] has accepted the inevitability of some drug use within society and has therefore aimed to normalize the users of illicit substances, rather than to eradicate them from society” (Chatwin, 2016, p. 3). The Netherlands also has been at the vanguard of drawing distinctions—or “separating the market”—between drugs perceived as less dangerous, like marijuana, and so called “harder” drugs like heroin and cocaine.

Since the 1970s, the use and sale of small amounts of cannabis has been tolerated in the Netherlands under the principle of expediency, which designates that while the sale and possession of cannabis remain illegal, it is never in the public interest to prosecute where relatively small amounts are concerned; this is an attempt to operate within the confines of UN conventions on illicit drugs. (Chatwin, 2016, p. 3)
The Dutch have also implemented needle exchange and supervised maintenance drug therapy programs. The Netherlands was also an early adopter of harm reduction strategies—a distinct, health-based current in drug policy whose components have been implemented in other drug policy regimes—that I discuss below. These strategies for reducing harm are a central part in decriminalization regimes.

Remaining at the forefront of harm reduction developments, the Netherlands also offers some dependent heroin users legal prescriptions of heroin, provides “safe user rooms” for dependent drug users to consume their drugs, and is at the forefront of developing cannabis for medicinal use in Europe. National drug prevention strategies target the dealers and traffickers of drugs rather than the users and prosecute only instances of drug possession (rather than consumption), and even then prosecution is rare. (Chatwin, 2016, p. 3)

While these select European nations have experimented with less punitive drug policies and made distinctions between marijuana and other drugs, no country has implemented a more comprehensive national strategy of drug decriminalization than Portugal.

**Portugal’s Decriminalization**

Portugal, like many other of its European counterparts, was struggling with what to do with what was perceived as an escalating drug problem in the 1980s and 1990s. The country experienced “significant increases in drug-related problems, including a ten-fold increase in acute drug-related deaths” during this era (Hughes & Stevens, 2012, p. 105). Although it was a nation with low usage rates compared to other European nations, Portugal’s leaders witnessed with alarm the rise of drug-related pathologies before they enacted sweeping new decriminalized drug laws on July 1, 2001. With drug related death and infectious disease on rise, the country’s criminalization drug policy came into question.

As Hughes and Stevens (2010) note:

There was in the late 1980s and 1990s a significant population of intravenous heroin users, who obtained their drugs through open-air drug markets that became notorious. Rates of infectious diseases including HIV, AIDS, Tuberculosis, Hepatitis B and C soared. For example, between 1990 and 1997, the number of known drug users living with AIDS increased from 47 to 590. By 1999, Portugal had the highest rate of drug-related AIDS in the European Union and the second highest prevalence of HIV amongst injecting drug users. Drug-related deaths had increased in Portugal to a peak of 369 in 1999 [an increase of 57 per cent since 1997]. There was also growing concern over the social exclusion and marginalization of drug users, and a perception from many areas of society
including the law enforcement and health sectors that the criminalization of drug use was increasingly part of the problem, not the solution. (p. 1001)

Portugal, with an autonomous political bent after years of authoritarian rule, was primed to become at the forefront of drug policy reform in Europe.

Perhaps in reaction to the years of dictatorship, current Portuguese political philosophy favors providing a strong degree of both individual liberty and autonomy to subnational government; the latter is especially true for social services such as health, education, and the prevention and treatment of drug use. (Loo, Van Beusekom, & Kahan, 2002, p. 51)

Responding to what was described as an escalating problem with drug use in the 1990s, Portugal formed the Comissão para a Estratégia Nacional de Combate à Droga, or Commission for a National Anti-Drug Strategy, an elite body of experts to study and then recommend a more effective national drug policy. The conclusion of the Commission’s 1998 report was to shift towards a new drug policy, employing “a strong harm-reductionist orientation” with “the flagship of these laws . . . the decriminalization of the use and possession for use of drugs” (Greenwald, 2009, p. 6). As Greenwald (2009) notes in his Cato Institute’s study of Portugal, there was “relatively little political resistance” (p. 6) to the Commission for a National Anti-Drug Strategy’s recommendations of implementing a radical new drug policy framework.

The political impetus for decriminalization was the perception that drug abuse—both in itself and its accompanying pathologies—was becoming an uncontrollable social problem, and the principal obstacles to effective government policies to manage the problems were the treatment barriers and resource drain imposed by the criminalization regime. Put another way, decriminalization was driven not by the perception that drug abuse was an insignificant problem, but rather by the consensus view that it was a highly significant problem, that criminalization was exacerbating the problem, and that only decriminalization could enable an effective government response. (Greenwald, 2009, p. 6)

Portugal’s drug decriminalization, and the perceived successes of their approach, which I discuss further in Chapter 3, is proving the be a model worthy of study as other nations debate the future of their drug policies.

**LEGALIZATION**

Advocates for the legalization current within drug policy, much like proponents of decriminalization, believe that the prohibition of drugs has been an unmitigated disaster that
not only has failed by its own metrics in defining success in the War on Drugs, but has also produced negative unintended consequences—from violence and mass incarceration to rising rates of infectious disease and overdoses—that proponents of legalization believe are far more destructive than drug addiction. Of the four policy frameworks I discuss in this chapter, legalization is the most contentious, and the least cohesive. While legalizers have criticized criminalization and declared drug prohibition a policy failure, there has been little serious study about what a legalization framework could or would look like. As MacCoun and Reuter (2001) note, “Many legalizers . . . argue that US Drug laws are hypocritical, too draconian, or that they infringe on a individual’s rights to take drugs” (p. 55). Yet, there is not a wide body of study for a legalization alternative to criminalization drug policies:

There is a vast literature—indeed, many different literatures—on psychoactive drugs and their consequences. Yet remarkably little empirical work directly informs the legalization question. Evidence on the costs and follies of drug prohibition tells us little about what life would be like in its absence. (MacCoun & Reuter, 2011, p. 62)

As DuPont and Voth (1995) note, "Drug legalization is neither a simple nor singular public policy proposal” (p. 462). A policy of legalization, at least at this point in its development, is less defined by what it is than what it is not. Unlike the decriminalization approach, which shares many of the same criticism of criminalization, but has implemented a coherent policy based on its strategic principals, there is little consensus among the legalization camp on a policy framework.

For many proponents of legalization, the US’s foray into alcohol prohibition in the early part of the 20th century is an influential, informative experience that has parallels in contemporary criminalization policies. Therefore, for some advocates of legalization, policy implementation would mirror the reintroduction of alcohol after the end of prohibition—highly regulated, with laws controlling where it can be sold, to whom it can be sold, with strict standards for production and purity levels, in addition to heavy taxation producing revenues to fund healthcare, education and treatment programs. According to legalizers, tobacco and alcohol are empirically two of the most destructive substances used in the US. If those are now legal (alcohol following a period of prohibition), why should drugs currently criminalized not instead be legalized under a highly regulated framework? For the American
Civil Liberties Union, which opposes criminal prohibition of drugs, legalization would look a lot like the current framework for regulating alcohol and tobacco.

Some people, hearing the words “drug legalization,” imagine pushers on street corners passing out cocaine to anyone—even children. But that is what exists today under prohibition. Consider the legal drugs, alcohol and tobacco: Their potency, time and place of sale and purchasing age limits are set by law. Similarly, warning labels are required on medicinal drugs, and some of these are available by prescription only. After federal alcohol prohibition was repealed, each state developed its own system for regulating the distribution and sale of alcoholic beverages. The same could occur with currently illegal drugs. For example, states could create different regulations for marijuana, heroin and cocaine. (Staff Writer, 1995, para. 27)

Drugs within a legalization policy, therefore, could fall under the purview of governments (at local, state, or even the federal levels) much in the way the US currently manages tobacco and alcohol usage.

Still, there is disagreement on what legalization would look like. According to Caulkins, Kasunic, Kleiman, and Lee (2014), there is a wide spectrum of possibilities within a legalization framework where policy is concerned:

Legalization could take on different forms. One question is which drug, or drugs, to legalize. The options are not limited to either legalizing everything or prohibiting everything. Policy is already substance-specific (with alcohol, tobacco, and caffeine legal) and there is no reason not to pick and choose among the currently illicit drugs if some of them are to be permitted. Another question is how much of a role, if any, the government wants to play in the market for the drug it is legalizing. Even some of the staunchest advocates of legalization balk at pure laissez-faire markets. The government might want to impose taxes, penalize public use, restrict sales from minors, mandate product testing and labeling, limit marketing, or require licenses for suppliers and vendors. (p. 288)

The question in this scenario becomes what substances become legal and how involved does the government get in terms of their regulation.

Central to the drug legalization movement is the idea of “undermining the black market” (Donohue, Ewing, & Pelopquin, 2010, p. 41). Proponents of legalization believe that the most significant harms from drugs stem from their illicit status, and the underground, unregulated economy that status produces. Taking drug production out of the informal economy, where it is dominated by drug trafficking organizations, should reduce many of the problems associated with drugs. Proponents of legalization believe that problems such as
drug violence, health hazards such as addiction, overdoses, and the spread of disease, would be mitigated under a regulatory framework that legalized drugs.

Drugs are at their most dangerous when consumers of them are at the mercy of unscrupulous types all the way down the supply chain, who often use adulterant additives—due to the illicit, unregulated nature of drug trafficking—that are more hazardous than the actual drug. While inherently dangerous, drugs are less so, according to proponents of legalization, when they are brought out of the criminal realm and become regulated by the government in the way pharmaceutical drugs are. As Caulkins et al. (2014) conclude:

Many of the effects of legalization are simply the inverse of those of prohibition. Over time, legalization would lead to sharp declines in production costs and, hence, (pretax) drug prices. That in turn would increase drug use and dependence. But legalization would also eliminate black market crimes and violence, save the public the cost of having to enforce prohibition, and allow the government to institute market regulation, thus delivering more reliable and less contaminated drugs to consumers. (p. 287)

Caulkins et al. further note:

Illicit markets have no regulation, so the products can be impure and unsafe—unsafe even relative to the intrinsic risks stemming from the chemicals that the user intended to buy and use. This can result in users unwittingly consuming a more dangerous or potent substance than intended. (p. 288)

In the criminalization model, adulterants added to drugs to increase their street value make them more dangerous. In theory, the regulations of drugs—like those currently affecting alcohol and pharmaceutical drugs—would ensure that products are labeled with actual ingredients and levels. In a legalization scenario, government standards could be set, like they are with alcohol, tobacco, and pharmaceutical drugs.

LEGALIZATION’S HISTORY AND PHILOSOPHICAL ROOTS

Philosophically, the legalization movement has diverse antecedent roots. A wide cross section of the political spectrum—from the most conservative to the most liberal factions—has voiced support for legalization. As Erich Goode (1998) notes, “The political landscape is a maze of contradictions; politics, we are told, make for ‘strange bedfellows’ Perhaps nowhere is this more apparent than in the issue of drug legalization” (p. 18). Drug legalization is one of those rare issues where ideologues from varying backgrounds—who disagree on just about everything else—agree, albeit for completely different reasons. Goode
offers a remarkably detailed breakdown delineating the “ideological landscape of the debate over what to do about the drug problem” (p. 18) and the agreements among disparate political ideologies—ones he classifies as free market libertarians, radical constructionists and progressive advocates of legalization—that make up the proponents of legalization.

Some of the most strident criticism of the criminalization of drugs has come from conservative thinkers. There are strong elements within the legalization movement with roots in libertarianism, a current defined as free market libertarians. In its most ideologically pure form, libertarianism believes drug laws should be abolished, and replaced instead with the unregulated, free-market system that existed in 19th-century America prior to the creation of national restrictivist drug laws. In the words of academic and psychiatrist Thomas Szasz (1996), the aim is “not a ‘drug free America,’ but an ‘America free of drug laws’” (p. 149). Milton Friedman, the conservative economist who won the Nobel Memorial Prize in Economic Sciences, would be included in this camp, believing that the state should not regulate morality and the problems associated with their criminalization are far more problematic than their usage. “I'm in favor of legalizing drugs. According to my values, if people want to kill themselves, they have every right to do so. Most of the harm that comes from drugs is because they are illegal” (as cited in Duronio, 2012, para. 2). Other right-wing intellectuals, like the late William F. Buckley, known as the evangelist of libertarian Republicanism, favored drug legalization coupled with education about their health and societal risks. However, Buckley still believed the government had a small role to play in establishing a legalization framework (Wren, 1996, para. 11). “The cost of the drug war is many times more painful, in all its manifestations, than would be the licensing of drugs combined with intensive education of non-users and intensive education designed to warn those who experiment with drugs” (Staff Writer, 2014c, para. 18).

Gary Johnson, the former two-term Republican Governor of New Mexico and the 2016 US presidential candidate for the Libertarian Party, has voiced support for a measured transition towards legalization, starting with marijuana. “I believe that our war on drugs has been a dismal failure. We are putting more and more money into a war that we are absolutely losing” (as cited in Boaz, 1999, para. 3). Governor Johnson also stated that a significant majority of problems associated with drugs stem for their criminalization:
Would the world be better off if all drugs were legal? Yes. The world would be better off, that 90 percent of the drug problem is prohibition-related, not use related. But what I’ve said is, look, let’s legalize marijuana first and when we do that, I think the whole country takes a quantum leap toward understanding substance abuse. Quality, quantity unknown. Dirty needles. That’s what kills. Prohibition kills. (as cited in Barkan, 2016, para. 10)

On the left side of the drug legalization spectrum are those that Goode (1998) defines as “radical constructionists” and “progressive advocates of legalization.” Goode argues that:

Radical constructionis do not deny that drug abuse is a problem for the society. But they do argue that it is a less serious problem than a number of far more damaging conditions, about which very little fuss is made—such as alcoholism and tobacco addiction, not to mention poverty, racism, and gross inequalities in the distribution of society’s resources. (p. 23)

It’s the belief of the radical constructionists that while drug use can be problematic for society, drug laws are concerned with maintaining the status quo, not protecting society from harmful substances. Drug laws, in their view, “reinforce existing power and economic arrangements” (p. 23). Radical constructionists believe that “the recent ‘war on drugs’ emerged specifically at a time when the severity of the drug problem was declining and hence, it must have served symbolic functions; it was, in fact, a war against the poor” (p. 23).

The other currents on the left side of the movement are those Goode (1998) defines as progressive advocates. Goode argues that:

Progressive advocates of legalization see the drug problem as a human rights issue. What they are talking about when they discuss drug reforms is treating drug addiction as a health problem, much like schizophrenia or alcoholism—not as a crime or law enforcement problem. (p. 24)

This camp also believes that drugs are defined arbitrarily under the law. They “hold a definition of drugs that is based on their psychoactive quality, not their legality” (p. 24). Therefore, there should not be discrepancies between the manner by which the law treats alcohol, marijuana, cocaine, heroin, etc. Progressive advocates of legalization believe drugs have been selected out for criminal penalization when other dangerous activities that could result in bodily harm like drinking, driving, or golfing, are not. Goode argues that, “It is a philosophical tenet of these progressives that it is unjust to penalize one activity in which the participant harms no one while, at the same time, other, not significantly safer, activities are left legally uncontrolled” (p. 24). Progressive advocates therefore believe that the
government should—in some manner and to varying degrees—be involved in the drug market with “state control of the dispensation of psychoactive substances” (p. 24).

Legalization’s proponents are still engaged in a philosophical debate about the delicate minutia of building a viable framework for legalizing drugs. As Levinson (2003) notes, there are several “fundamental and important regulatory matters that are not discussed in legalization debates” (p. 127) that need to be seriously considered in the formulation and implementation of a drug legalization policy.

For this, Levinson (2003) created a list for the legalization debate, entitled “One Hundred Questions in Formulating a Drug Policy Proposal,” where he ponders the most important issues about how the regulatory framework of legalization would work, that “reveal some hidden complexities connected with drug legalization and perhaps increase our appreciation of the difficulties involved in construction a viable legalization plan” (p. 126). Included here are the first 13 questions, to illustrate the kind of hard questions that analysts and policymakers would need to address in order to advance legalization as a viable policy alternative:

—What drugs will be legalized—heroin, marijuana, cocaine, LSD and other psychedelics?
—Who will manufacture the drugs—the government, private industry, or a quasi-governmental entity such as the post office?
—If private industry is chose to produce the drugs, how will individual companies be selected to do the manufacturing?
—How aggressively will private industry be allowed to market drugs—will there be coupons, physician’s samples, and so on?
—If private industry is involved in marketing drugs, what sort of limitations will there be on price competition?
—Where will drugs be sold—drug stores, clinics, mail-order outlets, special drug distribution centers, vending machines?
—Where will drugs be dispensed—in restaurants, on planes, at catered parties?
—Will drug “saloons” similar to bars be permitted—which drugs could served and in which quantities.
—Where will advertising be permitted—on billboards, TV, in print media, on radio?
—What will the content of drug ads look like?—“Have a hard day? Mellow out and smoke a joint.” “Can’t afford a vacation to Europe? Take an LSD trip instead.” “Tired and depressed? A little cocaine will get you going”
—Will drugs be marketed in dosages and potencies similar to the way prescription drugs are sold?
—Will marijuana be sold by the potency of its active ingredient THC [5%, 8%, 10%], will drugs be prescribed as tabs, lids, ricks, lines, and so on?
—Will drug paraphernalia, such as freebase cocaine kits, bongs, needles, and syringes, also be made legal?
—Where will drug paraphernalia be sold—in super markets, department stores, specialty shops, etc.? (pp. 127-128)

With 77 more questions that are equally thought provoking, it is obvious that at this point in its history, drug legalization proponents have yet to put forward operationalizable policy framework for a drug legalization.

**HARM REDUCTION**

As Wayne Hall (2010) notes, “The popularity of societal policies towards drug problems is often inversely related to evidential support of their efficacy” (p. 105). As public health officials became aware of the collateral damage of drug addiction under prohibition, with skyrocketing rates of HIV/AIDS from intravenous drug use threatening both drug users and the communities beyond, a movement towards a public health-centric, evidence-informed approach to drug policy has begun to coalesce.

Harm reduction is “a framework for incorporating science into drug policy” with an “explicit public health perspective” (Des Jarlais, 1995, p. 11). It is an approach that at its very core is “a call for the primacy of public health over drug control” (Ball, 2007, p. 685). As Alex Wodak (2009) defines it, the harm reduction approach proposes “policies and programmes aimed primarily at reducing the health, social and economic costs of psychotropic drugs without necessarily reducing drug consumption” (p. 343). The primary purpose of this public health-based approach, therefore, is not to dramatically curb the availability of drugs or their consumption, but rather to mitigate the problems associated with drug addiction that threaten the community as a whole.

According to Levine (2003), harm reduction “has become a large, non-dogmatic international, public health movement emphasizing services for drug users and addicts that reduce the harmful effects of drug use” (p. 147). As Ball (2007) notes, “The term ‘harm reduction’ has been used variously to describe a principle, concept, ideology, policy, strategy, set of interventions, target and movement” (p. 685). As a current in drug policy, it is defined by its “realistic pragmatism” (Des Jarlais, 1995, p. 11), understanding that the use of intoxicating substances will always be part of a society, and that the goal therefore is to
reduce the dangers both to individuals and to society at large, through programs and policies that mitigate drugs’ detrimental impact. Central to harm reduction is a shift in policy away from moralistic debates and towards the realm of an empirical, evidence-based model rooted in science. As Keane (2003) notes, “one of the distinguishing elements of harm reduction has been its commitment to an amoral approach to drug use” (p. 227). Drug policy therefore, theoretically, becomes informed not by the messages particular policies send, but rather by their efficacy and outcomes. Science—not ideology—becomes the core component by which policy is informed. As Drucker (2013) argues, “Drug control policies must be based on scientific evidence” (p. 686).

Like many terms in the spectrum of the drug policy strategies I discussed in this chapter, harm reduction lacks rigidly defined parameters and is not neatly encapsulated. Ball (2007) notes, despite attempts, no “socio-empirical” definition for the term has yet emerged. “There is still no universally accepted definition for, and use of, the term ‘harm reduction’” (p. 686). “The proliferation of other terms, such as ‘harm minimization’, ‘risk reduction’ and ‘vulnerability reduction’, confuse matters further” (p. 686). Despite an inability to reach a consensus on its definition, according to Ball, harm reduction is a trend in drug policy that continues to gain ground.

Few terms in the world of drug policy evoke such extremes of emotion as “harm reduction.” Drug policy conservatives shudder, believing that traditional values and drug control will be undermined. Drug legalizers see opportunities for radical law reform. Somewhere in between, service providers and community advocates hold to a hope for more pragmatic, evidence-based interventions. These emotions are stirred by the lack of a clear definition, complicated further by a dynamic discourse that has often generated more heat than light. Despite diverse interpretations of the term, its use is expanding globally and is now imbedded in international policies and commitments. (p. 686)

For Obot (2007), a wide spectrum of thought exists within harm reduction.

Harm reduction has, indeed, been used to characterize a broad range of positions—at one extreme it is a set of interventions aimed at reducing harm from drug use, and at the other extreme it is everything under the rubric of control, including supply reduction. In between, harm reduction might refer to a strategy or health policy and, from the perspective of a growing number of adherents, it can be construed as a social movement. Harm reduction therefore continues to mean different things to different people. (p. 686)
Within this sometimes confusing, ill-defined space, the principles of harm reduction have granted it the flexibility to fit into the spectrum of currents in national drug strategies. As Ball (2007) notes, “Some welcome the ambiguity of harm reduction terms arguing that it allows for greater flexibility in implementing policies and programmes to respond to critical public health problems” (p. 687). For many proponents of harm reduction, its ambiguity is an asset. According to Reinarman (2004), “Ambiguity helps create a large political tent under which our unwieldy coalition can fit, maximizing our appeal, increasing membership, allowing for local autonomy so that unique local conditions can be addressed” (p. 240).

For Levine (2003), harm reduction is a malleable concept that can exist in every gradation of drug policy.

Harm reduction’s message to drug users is: “we are not asking you to give up drug use; we just ask you to do some things (like use clean syringes) to reduce the harmfulness of drug use (including the spread of AIDS) to you and the people close to you.” In precisely the same way, harm reduction’s message to governments is: “we are not asking you to give up drug prohibition; we just ask you to do some things (like make clean syringes and methadone available) to reduce the harmfulness of drug prohibition.” Harm reduction offers a radically tolerant and pragmatic approach to both drug use and drug prohibition. It assumes that neither are going away anytime soon and suggests therefore that reasonable and responsible people try to persuade those who use drugs, and those who use drug prohibition, to minimise the harms that their activities produce. (p. 149)

While it makes for some seemingly strange bedfellows, as a result of its flexibility, “harm reduction is now the mainstream global drug policy” (Wodak, 2009, p. 343), even in nations with strict prohibitionist regimes. Improbably, policies falling under the rubric of harm reduction have been implemented in varying degrees in nations like China, Iran, Vietnam, and Malaysia—which I described earlier as “high application states” that regularly invoke the death penalty for drug crimes—as well as in Portugal, a country at the forefront of drug law reform. Despite the rancorous debate about national drug strategies in many countries, harm reduction is now the global norm, widely accepted by policy makers in many countries around the world as an important component in their nation drug strategies:

Harm reduction is now supported by virtually all major relevant United Nations organizations, including WHO, Joint United Nations Pro gramme on HIV/AIDS [UNAIDS], United Nations Office on Drugs and Crime [UNODC], United Nations Children’s Fund [UNICEF] and the World Bank. Major international organizations strongly supporting harm reduction include the Red Cross and the Global Fund for AIDS. (Wodak, 2009, p. 344)
Even in the US, where criminalization is still the law of the land, harm reduction strategies are supported by the US National Academy of Medicine and the American Medical Association and have been implemented in communities throughout the country.

**Harm Reduction’s History and Philosophical Roots**

Harm reduction as a principle is not a new phenomenon by any means. As Ball (2007) notes:

> As one can imagine that harm reduction principles have been practiced by communities since psychoactive substances were first used. For centuries, traditional use of opium in Asia and hallucinogens and coca products in Latin America has been guided by rituals and taboos aimed at protecting individual and community health. (p. 685)

It was the rise of the countercultural movements, recreational drug taking, and protest politics of the 1960s that provided the foundations for contemporary harm reduction. As Roe (2005) chronicles it, harm reduction’s origins started in 1960s, when activists began to challenge prohibitionist drug policies. It became professionalized decades later during the rise of HIV/AIDS.

The story begins with the activists, workers, doctors, programmers and policy-makers committed politically and socially to opposing the legal suppression of drug use and the oppression of drug users in the 1960s and 70s. In the mid-1980s these alternatives began to be referred to collectively as part of the “risk reduction,” “harm reduction” and “harm minimization” solution to the health problem of HIV/AIDS amongst injecting drug users. Harm reduction has since become identified with HIV/AIDS prevention but also with addictions treatment, and is now generally defined by medical programmes, professionals and policies. (Ball, 2007, p. 685)

Even as early as 1973, the Twentieth World Health Organization Expert Committee on Drug Dependence voiced its support for harm reduction principles, stating:

> The broad purpose of preventive measure should be to prevent or reduce the severity of problems associated with the non-medical use of dependence-producing drugs. This goal is at once broader, more specific, and with respect to certain drugs in many countries, more realistic than the prevention of non-medical use per se. (as cited in Ball, 2007, p. 685)

Harm reduction really began to gain currency as a concept with the spread of infectious diseases through intravenous drug use. It was “mainstreamed” during the HIV-AIDS crisis of the 1980s and 1990s, as the epidemic began to threaten public health as the disease spread.
beyond traditionally marginalized communities. The movement, initially activist in nature with its intellectual roots in challenging drug prohibition, “formed a coalition with public health as well other ‘mainstream’ groups to address the crises engendered by HIV/AIDS” (Roe, 2005, p. 245). During this era, a shift began to occur in public health circles wherein the definition of community was expanded to include the most marginalized within it.

Health authorities in North America began to work around the laws, and, through activists or members of the affected communities, to prevent HIV/AIDS moving from intravenous drug users and sex workers to the general population. Criminal subcultures were now presented as “communities” with specific medical needs that could not be isolated or ignored. Health authorities were now more willing to defy the letter of drug laws, and to risk the penalties for possession of criminal “paraphernalia,” including syringes and condoms (Blackwell, 1988; Pascal, 1988). Community activists provided them with an arms-length means to evade the law while developing new techniques to address the spread of HIV/AIDS. This unlikely coalition of public health authorities and activists challenged the enforcement of drug laws. (Roe, 2005, p. 244)

The HIV-AIDS crises facilitated the transitional process that led away from its radical roots towards its mainstreaming and the professionalization of harm reduction. As Roe (2005) notes:

What began as a “bottom-up” movement became “top-down” policy. Harm reduction as a “mature and coherent paradigm” stayed away from larger political issues (what Cheung calls the “wrong message”) and adopted a more saleable emphasis on medical benefits. This harm reduction sought to “accept that drug-taking cannot be prevented, and instead to concentrate on reducing its consequences for health and crime” (Reporter, 2003). The focus on individual consequences and societal costs rather than their social causes separated medical harm reduction from the more activist advocates of harm reduction. (p. 245)

As harm reduction became “newly mainstreamed,” it became “reluctant to engage in political criticism of drug prohibition and prefers to express opposition to the social marginalization of drug users in terms of medical outcomes” (Roe, 2005, p. 243). However, elements of this tension between its activist roots and its mainstream adoption still remain, and that tension limits its breadth. The result of this hybridity, says Reinarman (2004), is “a moveable mix [that] can adapt to country-specific conditions, which are themselves ever-changing” (p. 241).
CHAPTER 3

METH IN THE BORDERLANDS: ALTERNATIVE FUTURES

The weight of a nation’s drug policy is weakest at the very edges of its political boundaries. Geography continues to conspire against drug prohibition. Borders, by their very nature, produce “illicit globalization,” a phenomenon that is apparent at the line that separates the United States and Mexico. As Andreas (2012) notes:

The US-Mexico boundary is the busiest land border in the world, the longest and most dramatic meeting point in a rich and a poor country, and the site of the most intensive interaction between law enforcement and law evasion. Nowhere else has the state been so aggressively loosening and tightening its territory grip at the same time. Nowhere else do the contrasting state practices of market liberalization and criminalization visibly overlap. (p. xiv)

Smuggling along the US-Mexico political boundary is a story as old as the border itself. As Reuter and Ronfeldt (1992) note, “Smuggling from Mexico into the United States has been a natural phenomenon of geography, history and economics” (p. 99). While smuggling has been a part of the border’s history since the lines were drawn, this illicit economy of drug transactions between the two countries really began develop as the laissez-faire era I discussed in Chapter 2 came to an end, and drug prohibition began at the turn of the 20th century. The urbanization of the once sparsely populated border region and increased economic integration between Mexico and the United States has only heightened the scale of this illicit symbioses.

These “contradictory tendencies within globalization that foster the growth of transnational crime” result from increased economic linkages (Wonders, 2007, p. 35). It is no coincidence that the rise of methamphetamine in the binational border region coincided with the signing of NAFTA, the trilateral free trade agreement between Canada, the United States, and Mexico. Mockingly called the “North American Free Trafficking Agreement” by a
Texas former attorney general, many in law enforcement agencies have admitted that the boosting of intraregional and transnational trade resulted in a world of possibilities for drug trafficking organizations (LaRue, 2000).

As Phil Jordan, a former Drug Enforcement Administration employee noted:

For Mexico's drug gangs, the NAFTA was a deal made in narco-heaven. But since both the United States and Mexico are so committed to free trade, no one wants to admit it has helped the drug lords. It’s a taboo subject. While I was at DEA, I was under strict orders not to say anything negative about free trade. Now it's come back to haunt us. (as cited in Staff Writer, 1998, para. 4)

In the run-up to at the agreement’s signing, a confidential report by US Customs stated that drug trafficking organizations were setting up front companies to hide illicit drugs among legitimate products and hiring consulting firms to strategize about the types of cargo that were least prone to inspections. The reported stated, “Sophisticated drug gangs are investing in everything from trucking companies and rail lines to warehouses and shipping firms to shield their trafficking activities” (as cited in Staff Writer, 1998, para. 2). By a large majority, the drugs now entering the United States are coming from its southern border with Mexico, often hidden among legitimate trade. As Cottam and Marenin (2005) note:

Drugs are part of the traffic. It is estimated that about 70% of all illicit drugs smuggled in the country enter across the Mexico-U.S. border, including 60% of all cocaine, more than 85% of amphetamines, and a substantial proportion of marijuana and heroin (about 14% of which is grown in Mexico). (p. 8)

The problem of illicit contraband smuggled among the products of legitimate trade has been especially challenging in the San Diego-Tijuana region, the busiest crossing along the US-Mexico line. An article by the National Institutes of Health noted the possibility of free trade incentivizing legitimate business to move towards criminality:

The transition of Mexican-based groups from “small-time” smugglers to major traffickers was perhaps facilitated by the increase in cross-border trade with the advent of the North American Free Trade Agreement (NAFTA). In particular, the San Ysidro border crossing at the junction of Tijuana, Baja California, Mexico and San Diego, California, U.S.A. is reportedly the busiest land border crossing in the world, with 46 million persons and 14 million vehicles crossing annually (U.S. Customs Service, 2004). It is unknown to what extent increased trade flow may have facilitated drug transport, however in some cases the economic changes inherent with free trade may have led certain groups to become involved in the drug trade. (as cited in Brouwer et al., 2006, p. 710)
In the era of globalization, when last year Mexico exported $236 billion worth of goods to the United States, its largest trading partner, and the United States sent goods and services trade totaling $583.6 billion to Mexico, our third largest trading partner, it is not surprising that drug trafficking organizations are engaging in, and taking advantage of, the economic integration between the respective nations (Staff Writer, 2016d). As Andreas (2002) notes:

Many developing countries have been the most competitive in the criminalized sectors of the global economy, such as the smuggling of drugs. In the global marketplace dominated by transnational corporations from the industrialized world, criminal organizations stand out as some of the developing world’s most successful—though least celebrated—transnationals. Regardless of their illegal status, the economic activities of transnational criminal organizations are in many ways the quintessential expression of the kind of private-sector entrepreneurialism celebrated and encouraged by the neoliberal economic orthodoxy. As producers or transit-points of illegal exports, many developing nations have in essence taken the advice of the International Monetary Fund and the World Bank literally, through specialization based on comparative advantage. Here, ironically, it is the advanced industrialized countries that have been most resistant to economic liberalization, and most in favor of strong (and often punitive) state intervention. But even as prohibitionist policies are aggressively promoted, the uncomfortable reality in many places is that the criminalized economy has been a crucial source of both revenue and employment, on that has even helped to cushion the shocks of economic restructuring. (p. 37)

As I noted in Chapter 1, “Just as some countries and regions occupy a special niche in legal trade, so too do different counties and regions have a niche in the illegal trade” (Andreas, 2002, p. 18). While it is impossible to calculate the scale of this illicit trade monetarily, considering its clandestine nature, the FBI estimates that drug trafficking organizations are sending anywhere between 18-39 billion US dollars annually back to Mexico from their sales in interior of the United States (Perkins & Placido, 2010). As Andreas (2012) notes:

The economic importance of smuggling demonstrates that there is not just a formal, aboveground dimension of regional and global interdependence but and informal, underground dimension as well. For some countries, it is the smuggling-based part of the economy that is most responsive to [and integrated into] global markets. (p. 19)

The comparative advantage in the San Diego-Tijuana metropolis had created a transborder region with a methamphetamine “niche.” Methamphetamine, unlike other drugs
whose elemental ingredients are climate specific and can only be grown in special geographic zones, has demonstrated it is especially adaptable to supply-side interventions, as it can be produced anywhere. From as early as the 1960s, the fluidity of the US-Mexico border in the San Diego-Tijuana region has proven to be the perfect place for methamphetamine to thrive. As a result, “Mexico and the U.S. combined are a meth powerhouse” (Kelly, 2013, para 9). North America now dominates both the production and consumption of methamphetamine. According to the Organization of American States:

The United Nations Office on Drugs and Crime estimated the global retail market for amphetamines at $28 billion in 2003, with $17 billion (60 percent) of this market concentrated in North America and less than one percent in South America. More recently, the 2010 World Drug Report cites a very wide range of global production estimates for amphetamines (149 to 577 metric tons). Supply-side estimates for amphetamines are calculated by tracking amounts of precursor chemicals, but this can be problematic since the precursor chemicals also have legitimate industrial uses. A more recent study using a demand-side approach estimates that the annual retail value of the U.S. methamphetamine market is between $3 and $8 billion, with a best guess of $5 billion. (Insulza, 2013, p. 11)

With an industry that profitable, innovative drug trafficking organization will continue to find ways to meet North America’s insatiable demand. According to the 2012 National Survey on Drug Use and Health (NSDUH), “over 12 million people (4.7 percent of the population) have tried methamphetamine at least once. NSDUH also reports that approximately 1.2 million people used methamphetamine in the year leading up to the survey” (Volkow, 2003, para 1). It is estimated that 400,000 in the United States are addicted to methamphetamine (University of California, Los Angeles, 2015). And in Mexico, addiction rates are skyrocketing. According to the latest study available by the country’s Comisión Nacional contra las Adicciones (Nation Committee Against Addiction), methamphetamine use among 12- to 65-year olds doubled countrywide between 2011 and its last report in 2008 (Villatoro-Velázquez et al., 2013).

The costs society incurs are also staggering. In a comprehensive study, RAND estimated the price of methamphetamine addiction by calculating “a wide range of consequences due to meth use, including the burden of addiction, premature death, drug treatment, and aspects of lost productivity, crime and criminal justice, health care, production and environmental hazards, and even child endangerment” (Nicosia, Pacula, Kilmer, Lundberg, & Chisea, 2009, p. vii). The RAND study found that “the cost of meth in the
United States in 2005 is $23.4 billion,” a figure that “translates into $26,872 for each person who used meth in the past year or $74,408 for each meth-dependent user” (Nicosia et al., 2009, p. 103).

AN AWAKENING IN LATIN AMERICA

Latin America has been ground zero for the horrific violence caused by drug prohibition. The “war on drugs” is not hyperbole, with parts of the region experiencing as much killing as war zones. However, a strong drug policy reform movement is now underway, with influential supporters who have served at the highest levels of government. Latin America’s violent drug war realities are quickly transforming it into the region that “may lead the world in decriminalizing drug use” (A. Serrano, 2012, para 1). For a long time now, Latin America has had to deal with the negative consequences of US drug prohibition and Americans’ unrivaled appetite for illicit substances. As The Guardian notes, “politicians across Latin America are asking if the price of war has been too high for their nations while consuming nations, especially in the west, escape with far less damage to their institutions” (Mullhouland, 2013, para. 10). At a surprising pace, in a region with generally conservative attitudes about drug use, there has been an “awakening” in Latin America, as the region is gradually moving towards liberalizing its drug laws, despite differing political persuasions, with reforms that signal a new path for drug policy for the Americas (Mullhouland, 2013).

In May, 2014, Uruguay’s president José Mujica signed legislation making it the first South American country to legalize the sale of marijuana. According to the statute:

Uruguayan citizens and legal residents 18 or older may now register for licenses to cultivate up to six marijuana plants per household and harvest 480 grams a year, or join a marijuana growing club with 15 to 45 members and no more than 99 plants. Pharmacies are expected to stock government-approved marijuana cigarettes for sale by year’s end. Licensed buyers will be able to purchase up to 10 grams a week or 40 grams a month, at a cost starting at about 90 cents a gram, to be adjusted to compete with illegal marijuana. (as cited in Staff Writer, 2014b, para. 1)

While one small South American nation with less than four million people could be viewed as an outlier, Hannah Hetzer at the Drug Policy Alliance notes that Uruguay’s experience with legalization is foreshadowing a larger movement in the Americas:

It’s one thing if Uruguay decides to legalize marijuana, where they’re not as affected by drug trafficking and the drug trade; it’s another when Mexico or
Colombia stands up and says, “We have tried everything. This approach hasn’t worked, so now we’re going to look for alternative approaches.” (as cited in Delman, 2015, para 10)

This is exactly the direction one of Latin America’s giants is heading. Former President Vicente Fox has come out in favor of legalizing all drugs—from marijuana to crystal meth—in Mexico. “Legalization all the way—all drugs and in all places” (as cited in Bandow, 2012, para. 10). After Mexico’s recent Supreme Court decision to legalize “the growing, possession and use of marijuana for recreational purposes,” Fox predicted it was only a matter of time—within a decade to be exact—before Mexico achieved full legalization of all drugs (as cited in Agren, 2015). “I think marijuana [legalisation] is a first step. It’s now irreversible. The other drugs will take a longer cycle, say five to 10 years” (Staff Writer, 2015, para. 2). Former Mexican President Ernesto Zedillo also came out against the “war on drugs,” calling it “an unmitigated disaster,” in an op-ed piece penned with former Brazilian President Fernando Henrique Cardoso and former Colombian President Cesar Gaviria:

Outdated drug policies around the world have resulted in soaring drug-related violence, overstretched criminal justice systems, runaway corruption and mangled democratic institutions. After reviewing the evidence, consulting drug policy experts and examining our own failures on this front while in office, we came to an unavoidable conclusion: The “war on drugs” is an unmitigated disaster.

Dramatic changes in drug policy are also taking place across the Americas. In the U.S., 23 states have legalized marijuana for medicinal purposes and four for recreational use. Most Latin American governments are taking steps, albeit timid ones, to decriminalize the consumption of some drugs. Uruguay has gone the furthest: it regulated its cannabis market from production to distribution to sale, with human rights at the center of the country’s strategy. (as cited in Cardoso, Gaviria, & Zedillo, 2009, para. 1)

Even Felipe Calderón, the Mexican president who unleashed the country’s current wave of violence when he confronted the nation’s powerful cartels head on, and “made fighting drug traffickers the centerpiece of his administration” (Malkin & Lacey, 2008, para. 1) has had a change of heart, proposing legislation “that would decriminalize the possession of small quantities of cocaine and other drugs for addicts who agreed to undergo treatment” (para. 1).

In another surprising about face, after condemning the push for medicinal marijuana in his country, current Mexico President Enrique Peña Nieto said that Mexico will move towards its legalization, calling drugs a public health problem, adding that his administration
will increase the amounts of the marijuana allowed for personal use (Charbonneau, 2016). Peña Nieto also admitted that the current model of criminalization has not been working.

We, Mexicans, know all too well the range and the defects of prohibitionist and punitive policies, and of the so-called war on drugs that has prevailed for 40 years. Our country has suffered, as few have, the ill effects of organised crime tied to drug trafficking. Fortunately, a new consensus is gradually emerging worldwide in favour of reforming drug policies. A growing number of countries are strenuously combating criminals, but instead of criminalising consumers, they offer them alternatives and opportunities. (Staff Writer, 2016b, para. 4)

Central American nations became some of the most violent places in the world, after the cartel crackdown in Mexico pushed operations southward. There, leaders are now questioning the logic of criminalization strategies. Central American leaders are beginning to examine the incongruencies of US policies, which expect them to maintain a restrictive, supply side approach, even as several US states have broken ranks with federal drug law and legalized recreational marijuana use.

Guatemala’s President Otto Pérez Molina has been one of the most outspoken critics of the US-backed drug war in Latin America, before he resigned and was imprisoned for corruption. Pérez had proposed drug legalization at the UN General Assembly in September of 2012. He spoke forcefully that the four decade “war of drugs” had failed. “The prohibition paradigm that inspires mainstream global drug policy today is based on a false premise: that global drug markets can be eradicated” (Doward, 2012, para. 3). Pérez argued for a robust debate on a new way forward for his nation and the region, based firstly on reducing the destabilizing violence associated with drug trafficking

Our proposal, as the Guatemalan government, is to abandon any ideological position (whether prohibition or liberalisation) and to foster a global intergovernmental dialogue based on a realistic approach – drug regulation. Drug consumption, production and trafficking should be subject to global regulations, which means that consumption and production should be legalised but within certain limits and conditions. And legalisation therefore does not mean liberalisation without controls. A dialogue on drug markets regulation should address some of the following questions: how can we diminish the violence generated by drug abuse? How can we strengthen public health and social protection systems in order to prevent substance abuse and provide support to drug addicts and their relatives? How can we provide economic and social opportunities to families and communities that benefit economically from drug production and trafficking? Which regulations should be put in place to prevent substance abuse (prohibition of sales to minors, prohibition of advertising in mass
media, high selective consumption taxes for drugs etc)? (Pérez Molina, 2013, para. 5)

Guatemala’s Vice President Roxana Baldetti, echoing the president’s views, remarked that “Central Americans must not continue dying from a problem that at the end of the day isn’t of our creation” (Boddiger, 2012, para. 4). As Time Magazine notes, Latin America “seems bent on advancing reform, with or without international support” (A. Serrano, 2012, para. 11):

Latin American Presidents across the political spectrum have joined Pérez in spearheading a hemispheric debate on drug legalization—unprecedented for sitting heads of state. Traditional drug policy focused solely on prohibition—a method dictated by the U.S. since Richard Nixon created the Drug Enforcement Administration 40 years ago—has run its course, they argue. In its place, Latin America has proposed a series of measures focusing on alternative strategies, emerging as the key player in the global reform movement. (A. Serrano, 2012, para. 3)

Even in countries that have not witnessed the horrors of the drug war directly are rethinking criminalization policies. Costa Rican President Laura Chinchilla said she supports change too, noting:

If we’re the ones sacrificing an entire generation, if gangs have gotten out of hand, and if we’re jeopardising government institutions because of corruption and intimidation, then the least Central America can do is have a dialogue and evaluate what we’ve been doing up to this point. (as cited in Boddiger, 2012, p. 6)

As John Otis of the GlobalPost noted:

Ten years ago, it would have been almost blasphemous to go against US policy and say “no, I want to take a softer approach toward drugs.” But now almost every president in the region is saying “this isn’t working” and they need to try something else. (as cited in Epatko, 2012, p. 3)

The drug reform movement in Latin America is still very much in its infancy. The destabilizing forces in the region, from violence, forced disappearances, narco money fueled corruption, and the state-challenging threat of criminal gangs, are proving to be a threat to the young democracies in the Americas. Leaders in the region are being driven to forefront of reform. With a growing consensus among heads of state, even among holdouts like Mexican President Enrique Peña Nieto, that prohibitionist policies are not working, drug reform in the Americas is inevitable. The only question becomes how fast the transition happens and how far new reforms will go.
THE PORTUGUESE MODEL

As nations in the Americas push ahead with drug law reform, it would behoove them to look towards Portugal, the first country to completely decriminalized drugs, with the sweeping 2001 reforms I discussed in Chapter 2. Despite pronouncements of “nightmare scenarios touted by preenactment decriminalization opponents—from rampant increases in drug usage among the young to the transformation of Lisbon into a haven for ‘drug tourists’” (Greenwald, 2015, para. 5), Portugal charted a radical new course with its decriminalized drug policy, with enviable results. More than a decade and a half after its implementation, it is not credible to assert that Portugal’s policy of decriminalization is not working as planned. By nearly every metric, from lowering rates of infectious pathogens to rates of overdose, the nation’s decriminalized, public health-centric laws are having the desired results. As The Guardian notes:

Before the law, which decriminalised (or depenalised) possession of drugs but still prohibited their use, the story of drug addiction in Portugal was a familiar one. More than 50% of those infected with HIV in Portugal were drug addicts, with new diagnoses of HIV among addicts running at about 3,000 a year. These days, addicts account for only 20% of those who are HIV infected, while the number of new HIV diagnoses of addicts has fallen to fewer than 2,000 a year.

Other measures have been equally encouraging. Deaths of street users from accidental overdoses also appear to have declined, as—anecdotal evidence strongly suggests—has petty crime associated with addicts who were stealing to maintain their habits. Recent surveys in schools also suggest an overall decrease in drug experimentation.

At the same time, the number of those in treatment for their addiction problems has risen by about a third from 23,500 in 1998 to 35,000 today—helped by a substantial increase in available beds, facilities and medical support. (Beaumont, 2010, para. 9-11)

Within Portugal, across its ideological spectrum, the nation’s drug policy has been viewed as nearly universally successful and irreversible. As Greenwald (2015) notes, in a study of Portugal’s drug decriminalization policy:

The political consensus in favor of decriminalization is unsurprising in light of the relevant empirical data. Those data indicate that decriminalization has had no adverse effect on drug usage rates in Portugal, which, in numerous categories, are now among the lowest in the EU, particularly when compared with states with stringent criminalization regimes. Although postdecriminalization usage rates have remained roughly the same or even decreased slightly when compared with other EU states, drug-related pathologies—such as sexually transmitted diseases and deaths due to drug usage—have decreased dramatically. Drug policy experts
attribute those positive trends to the enhanced ability of the Portuguese government to offer treatment programs to its citizens—enhancements made possible, for numerous reasons, by decriminalization. (p. 1)

While the Portuguese model has worked well, it is a small country with just over ten million people. It lacks the kind of societal diversity and complexity found in many countries in the Americas. That makes it difficult to extrapolate from their experience in managing addiction with a decriminalization policy. However, the Portuguese experience proves worthy of study as nations in the Americas navigate reforms to their drug laws. As Greenwald (2009) notes:

By freeing its citizens from the fear of prosecution and imprisonment for drug usage, Portugal has dramatically improved its ability to encourage drug addicts to avail themselves of treatment. The resources that were previously devoted to prosecuting and imprisoning drug addicts are now available to provide treatment programs to addicts. Those developments, along with Portugal’s shift to a harm-reduction approach, have dramatically improved drug-related social ills, including drug-caused mortalities and drug-related disease transmission. Ideally, treatment programs would be strictly voluntary, but Portugal’s program is certainly preferable to criminalization.

The Portuguese have seen the benefits of decriminalization, and therefore there is no serious political push in Portugal to return to a criminalization framework. Drug policy-makers in the Portuguese government are virtually unanimous in their belief that decriminalization has enabled a far more effective approach to managing Portugal’s addiction problems and other drug-related afflictions. Since the available data demonstrate that they are right, the Portuguese model ought to be carefully considered by policymakers around the world. (p. 28)

**A NEW WAY FORWARD**

There is no “one size fits all” strategy for a national drug policy. Every country must address its own different contexts and patterns of addiction. However, a non-ideological understanding of the nature of drug addiction and drug trafficking is essential to a successful strategy. As the Americas have proven, under policies of criminalization, supply-side intervention success stories in one country come at the expense of another. Colombia’s fight with narco gangs and the DEA’s successful closure of Caribbean routes into the United States shifted drug trafficking to Mexico. Legislation in the United States designed to fight meth addiction here likewise pushed production into Mexico, creating a nightmare scenario in both countries, with cheaper drugs, higher purity, and the expansion of addiction from its San Diego-Tijuana epicenter towards the interiors of both nations.
Now, Mexico is preparing to fight methamphetamine production within its borders with the same strategy of curbing the procurement of its precursor chemicals. We have seen that Mexico’s restrictive policies have already pushed drug violence towards Central American nations that lack the institutional resources to effectively combat it. We have also seen that meth production will effectively adapt to any new realities. A temporary win for Mexico is likely to be a loss for Central America. If the US-Mexican experience is any guide, supply sided strategies could very well produce new patterns of addiction in both Central American and in Mexico’s center and southern regions that have yet to encounter its scourge.

Methamphetamine is a particularly difficult addiction to cure. As the *Journal of the American Medical Association* notes, “more than two decades of concerted efforts have failed to produce broadly effective pharmaceutical medications for meth dependence and that behavioral treatments, while effective, have high dropout rates” (Mitka, 2013, p. 1912). It is also a drug with high correlations to the spread of infectious disease, not only because of delivery of the drug via intravenous injections, but also because propensity of the high to cause users to engage in risky sexual behavior. According to Maxwell and Rutkowski (2008):

> Many methamphetamine users are at high risk of sexually transmitted and blood-borne diseases, and drug treatment is a primary human immunodeficiency virus (HIV) prevention strategy for this population. Use of methamphetamine and sex are not only connected integrally, but participants have reported sex on methamphetamine as “compulsive” and “obsessive,” with loss of control over their sexual expression. The use of methamphetamine is associated strongly with sexual behaviors that put men at risk for HIV infection. (p. 233)

The methamphetamine crises in the United States and Mexico demand a robust public health response in the form of centers specializing in addiction treatment, and in the implementation of harm reductions strategies to stop the spread of disease. Proactive policies, rather than reactive ones, are needed. Governments must channel resources away from criminalization and law enforcement, and towards programs supporting “the range of treatment options available for methamphetamine users including brief interventions, counselling, behavioural approaches, mutual support groups, residential rehabilitation, and medications” (Jenner & Lee, 2008, p. 53). Massive investment in coordinated public health programs as well as medical research is needed, to better understand how to treat and cure methamphetamine addiction.
CONCLUSION

A nation’s drug policy has repercussions beyond its boundaries.

In response to the logic of escalation produced by US anti-drug strategies, drug-trafficking organizations have proven flexible and adaptable. Because the cartels are constantly responding to US moves, it can be argued that the drug war only makes the cartels even more flexible and adaptable. (Payan, 2006, p. 869)

As I demonstrated in Chapter 1, decisions made on both sides of the US-Mexico divide have real world consequences for the US and its Latin American neighbors. As Recio (2002) notes, “Whether a country decides to ban (or for that matter permit) narcotic distribution, . . . the consequences are hard felt not only by its citizens but also by those living in adjacent countries” (p. 41). After decades of a drug war and more than a century of prohibition, it is evident that citizens of the United States and Mexico have borne the brunt of failed drug polices for far too long. In an interconnected, globalized world, where both trade and money cross borders with relative ease, it is impossible to expect political boundaries to be an enforceable line against their illicit counterparts. According to a RAND study:

Globalization has affected the illegal drug industry just as it has others. Advances in communication and transportation and the lowering of trade barriers have made it more difficult for national governments to control what passes through their borders, and the growing integration of the global financial system has facilitated money laundering. Producers have shown flexibility in diversifying the drug groups they grow, and refiners in switching their sources between countries, which has made it harder for the United States to isolate its domestic drug market. (Caulkins, Reuter, Iguchi, & Chiesa, 2005, p. 14)

As the frequency of economic engagement increases, and nations in the Americas get pulled into the economic orbit on the United States, it will only become more difficult to interdict illicit traffic. As Andreas (2011) notes:

In today’s era of illicit globalization, there is clearly a huge gap between placing goals and results. There are inherent limits to how much states can deter and interdict illicit cross-border economic activities, especially if they wish to maintain open societies and keep borders open for legitimate cross border flows. (p. 423)
With newer regional trade agreements like the Dominican Republic–Central America Free Trade Agreement (CAFTA-DR) already totaling $60 billion in two way trade in 2013, and the hopes of incorporating into a larger bloc, such as the proposed 34-nation, hemisphere-wide Free Trade Area of the Americas trade agreement (FTAA), regional integration will once again prove to be an even bigger boon to drug traffickers in the Americas, with even more intense fallout, unless the region crafts a new approach to drug policy (Staff Writer, 2016a).

Strategies that do not take into consideration the global nature of drug trafficking have been detrimental on the both sides of the US-Mexico border. In the United States, these policies have resulted in higher quality methamphetamine that is now cheaper and more addictive. According to the *Daily Mail*:

> Chemists in Mexico have refined the process to the point where the meth is both potent and cheap. The purity of Mexican meth increased from 39 percent in 2007 to essentially 100 percent today, said Jim Shroba, special agent in charge for the DEA’s St. Louis office. The price over that same period has fallen sharply, from $290 per pure gram to around $100 per pure gram. (Staff Writer, 2014a, para. 18)

Conversely, in a remarkably short time span, Mexico went from a country of nominal drug usage rates to one of epidemic levels of addiction. Still, the Mexican meth crisis is in its infancy. Now, like the missteps taken in the United States, Mexico’s leaders have chosen to fight a war on meth, with a supply-side strategy that too will fail. As the economic linkages between Mexico and the United States increase dramatically, the respective countries need to rapidly transform their national drug strategies. Leaders should look to policies that are coherent and work in concert, founded on programs informed by evidence and based on results. Policies of harm reduction and decriminalization aim to curb drug use not by cutting supply, but by containing addiction while mitigating the myriad of problems associated with it. Unless both the US and Mexican leaders choose a more pragmatic approach that provides adequate resources aimed at treating addiction and reducing demand, Mexico’s meth epidemic will simply follow the destructive example set forth in the “voracious US market” (Padgett, 2011, para. 2).

We have seen that Central America spiraled into violence when Mexico got serious about combating organized crime. Methamphetamine addiction too can spread there, just as it did from the US to Mexico, if Mexican law enforcement takes the same interdiction
approach. It is a frightening scenario to consider. Resource-strapped Central American nations are even less equipped than Mexico to deal with an epidemic of methamphetamine addiction. Mexico’s rapid descent into the chaos of methamphetamine addiction was not an improbable confluence of events. Rather, it was the failure of the governments of the United States and Mexico to understand the interconnected nature of the clandestine border economy, and to underestimate the resourcefulness, sophistication and wherewithal of Mexico’s drug trafficking organizations in their quest to monopolize the world’s largest methamphetamine market. The border between the United States and Mexico begs for a shared strategy on drug policy. However, even if the two nations were to abandon their myopic views and achieve harmonious policies that work in concert, it still would likely not be enough. The drug crises in the Americas are just too profound to think in terms any smaller than hemispheric. Until every nation in the Americas starts to take steps together towards pragmatic decriminalization and harm reduction policies and comprehend the drug trade as a globalized business, with the flexibility to adapt to market pressures and the capacity to radically reconfigure supply chains if need be, meth’s devastation will continue to disregard political boundaries.

A holistic, hemispheric approach is needed not only to contain the spread of methamphetamine, but most importantly, to stop the collateral damage that drug prohibition policies have brought. Of the world’s 50 most violent cities, 46 of them are in the Americas (the remaining four are in Apartheid-scarred South Africa; Calderwood, 2016). A significant amount of murders in the western hemisphere can be directly attributed to the drug trade. Young men go to war for corner drug sales in the US’s most violent cities, and their deaths are all too often obfuscated with the misleading term “urban violence.” Bodies hang from bridges in Mexico to mark out turf rivalries between cartels. This range of violence is taking place in different theaters of the drug war raging across the Americas. While many people living in the United States do not believe the drug war reaches them, it does. Four US cities are among the 50 most violence places on earth and a significant part of homicides countrywide are drug related. As The Atlantic notes:

Reliable statistics on the number of drug-related murders in the United States are hard to come by. A 1994 Department of Justice report suggested that between a third and a half of U.S. homicides were drug-related, while a recent Center for Disease Control study found that the rate varied between 5% and 25%. Part of this
variance is that “drug-related” murders are hard to define. There are murders committed by people on drugs, murders committed by addicts to get money for drugs, turf-war murders by drug suppliers, and murders committed by gangs whose principal source of income is drug sales. (Smith, 2012, para. 14)

This market related violence—the “turf-war murders by drug suppliers, and murders committed by gangs whose principal source of income is drug sales” (Smith, 2012, para. 14) discussed in The Atlantic—are also noted in a study by RAND (Caulkins et al., 2005):

It has been estimated, for example, that almost two-thirds of the drug related homicides in the United States are market-related, as opposed to murders committed “under the influence” or for purposes of supporting the killer’s drug habit, as during a robbery. (p. 10)

The market for illicit drugs in the Americas—approaching nearly half of all global sales—is just too vast and the trade too profitable to expect that anything other than radical new approaches to drug policy will work. According to the Organization of American States:

Estimates have been made of the economic size of retail markets for some of the more widely distributed drugs. Taking a demand-side approach, the United Nations Office on Drugs and Crime (UNODC) estimated that the total retail value of the global illicit drug trade was US$320 billion for the year 2003, equivalent to 0.9 percent of global GDP. Retail drug markets in the Americas were estimated to be worth $151 billion, or around 47 percent of the global total. The largest retail markets in dollar value were North America (approximately 44 percent of the global total) and Europe (33 percent), whereas South America, Central America, and the Caribbean were approximately 3 percent of the global total. (Insulza, 2013, p. 55)

At a time when Latin America’s democracies need to strengthen their rule of law and human rights, revenue streams of the illicit drug trade threaten to overwhelm their weak state institutions. The drug war, and the money made from it, are real threats to democratic governance in the region. According to a 2013 report by the Organization of American States:

These huge profits also represent huge volumes of cash, which trigger additional serious problems in our region—albeit, once again, mainly in the producing and transit countries—by feeding two forms of corruption. One is the corruption of individuals—public or private employees—who end up as facilitators or operators at some point in this economic process. The other is the corruption of institutions, particularly financial institutions, which become increasingly entangled in activities seeking to “launder” that money, thereby establishing dangerous linkages between legal and illegal spheres. The evidence shows that the illicit drug problem had led, chiefly at the production and transit stages, to the corruption of government officials at various levels. When drugs are banned, the
illegal drugs economy requires bribery and collusion, as well as omissions, on the part of civil servants in order to protect its operations and guarantee that its actions go unpunished. One finding that everybody agrees on, with respect to the illegal drugs economy, is that it and organized crime cannot survive without corruption. Both violence and corruption can only thrive in a context of extensive impunity, in which there is no certainty that the law will be enforced and the State lacks the capacity to identify and try those responsible for breaking the law. As the Inter-American Commission on Human Rights (IACHR) pointed out in its “Report on Citizen Security and Human Rights,” “In various countries of the region, corruption and impunity have enabled criminal organizations to develop and establish parallel power structures.” The IACHR underscores the fact that in most countries in the region not enough resources are allocated to endow the justice system with the human resources and infrastructure it needs to be able to investigate, try, and punish. Corruption and impunity form part of the structural weaknesses of States in Latin America and the Caribbean and organizers of the drug trade exploit that state of affairs and expand its scope and consequences. (Insulza, 2013, p. 55)

By any and every metric, the drug war has failed. Nowhere is that more evident than in the Americas, where rampant meth addiction is apparent from rural Missouri to Durango, Mexico, and drug violence can be found in cities from Chicago to Porto Alegre, Brazil. As The Guardian notes, “Since the 1970s, the US has spent more than a trillion dollars attempting to dismantle drug cartels in Latin America” (Huey, 2014, para. 1). Each year, the US spends 40 billion dollars on drug prohibition (Staff Writer, 2009, para. 6). There is little calculable success to show for this sum. As drug prohibition in the Americas loses its currency, even among leaders at the highest levels of government, it is imperative that the largesse previously spent on the drug war be redirected towards policies that are evidence based, rooted in decriminalization. Drugs should be completely taken out of the criminal justice system and managed administratively as the public health threats that they are, with a full scale shift towards the principles of harm reduction.

When Portugal transitioned from a criminalization regime, a panel of experts in their respective fields unencumbered by ideology, assembled to recommend an “optimal strategy for combating Portugal’s growing abuse and addiction problems” (Greenwald, 2009, p. 6). Nations in the Americas should similarly gather the very best and brightest in their respective fields to shape a logical drug policy. The hemisphere must move judiciously towards implementing empirically-based, scientifically-informed decriminalization drug strategies. Drug prohibition has resulted in a myriad of problems including: mass incarceration,
violence, death, and disease. These issues are measurably more harmful to society’s wellbeing than those wrought by drug consumption itself. Portugal’s experience demonstrates that a new way forward is possible in the Americas. While charting this radical new course in drug policy will be a challenging endeavor, it is a more prudent investment than the current model of pouring trillions of dollars into policies that have proven unsuccessful in achieving any of their stated goals.
REFERENCES


