Who decides

Most of our laws on what goes into a body exist to protect consent: food standards, medicine labels, prescriptions. Drug laws are different. They decide for adults, and leave the actual supply to people who check nothing.

When personal use is met with arrest and prison rather than health care, the person harmed most is usually the person who used the drug.

That matters, because the harm we are trying to prevent is the harm to that person.

Australia already regulates risky substances: alcohol and tobacco are legal, taxed, labelled and age-checked. The same tools, applied to other drugs, would give adults clear information and keep children out of the market.

Subject L did not consent to fentanyl. He bought what he thought were MDMA pills. He got fentanyl because prohibition removed every mechanism that would have told him what he was actually taking. In a regulated market — a pharmacy, a licensed dispensary, any system with basic quality control — those pills would have contained exactly what the label said. The dosage would have been printed on the packet. A pharmacist would have asked his age, checked his ID, and turned him away because he was fifteen.

Prohibition didn't protect Subject L. It stripped him of every protection that exists in every other consumer market on earth and then blamed him for the result.

The history is not what you think

The question most people never ask about drug laws is: why these drugs? Why is cannabis illegal and alcohol legal? Why is psilocybin Schedule 9 and Valium Schedule 4? Why is GHB — the only sleep aid on earth that actually preserves deep sleep — a criminal offence, while its chemically identical pharmaceutical version Xyrem costs $75,000 a year and is perfectly legal?

The answer is not pharmacology. It never was.

The Harrison Narcotics Tax Act of 1914 — the law that started it all — was not based on scientific evidence of harm. It was based on racism. Opium was associated with Chinese immigrants. Cocaine was associated with Black Americans. Marijuana was associated with Mexican labourers. The substances were criminalised not because they were dangerous but because the people using them were the wrong colour.

This is not a conspiracy theory. This is the documented legislative history. David Musto's *The American Disease* (1999) traces it line by line. The congressional testimony is on the record. Harry Anslinger, the first commissioner of the Federal Bureau of Narcotics, told Congress that marijuana made Black men look at white women. That is the foundation of modern drug law. That is what Subject L's life was destroyed by.

Nixon knew. His domestic policy advisor John Ehrlichman admitted it in a 1994 interview published by Harper's Magazine in 2016:

> *"The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and Black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or Black, but by getting the public to associate the hippies with marijuana and Blacks with heroin, and then criminalising both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did."*

That is the war on drugs. Not public health. Not safety. Not protection. Social control dressed up as law enforcement. And the laws that came from it are still on the books. In Australia. In every state. Right now.

The safety paradox

The argument against legalisation always comes down to safety. "Drugs are dangerous." "People will die." "Think of the children."

Subject M has thought about the children. She thinks about one in particular. She thinks about him every time she drives past that flat.

Here is what the evidence says about safety:

Portugal decriminalised all drugs in 2001. Not legalised — decriminalised. Possession became a health matter, not a criminal one. In the 25 years since:

- Drug-induced deaths fell from 80 to 16. An 80 percent reduction.
- HIV transmission among people who use drugs collapsed from 52 percent to 7 percent of new cases.
- Treatment uptake increased 60 percent.
- Youth drug use did not increase. In some categories it decreased.

(EMCDDA data, 2001-2017. Not an opinion. Not a model. Twenty-five years of national population data.)

Switzerland introduced heroin-assisted treatment — actual medical-grade heroin, prescribed by doctors, administered in clinics. The results: 80 percent reduction in crime among participants. Dramatic improvements in health, housing stability, and employment. Zero overdose deaths in the programme. The programme has run for over two decades and is now permanent Swiss policy.

Canada legalised cannabis in 2018. Youth cannabis use remained stable or declined. The sky did not fall. The legal market displaced the black market. Quality control meant people knew what they were getting. Tax revenue funded public health.

The Netherlands has operated a cannabis tolerance policy for decades. Dutch youth use cannabis at lower rates than American youth. Lower rates. In the country where you can buy it in a shop.

Every single piece of evidence points the same direction. Regulation is safer than prohibition. Pharmacies are safer than car parks. Labels are safer than mystery powders. Pharmacists are safer than dealers.

The people who say "drugs are dangerous, therefore they must be illegal" have the logic exactly backwards. Drugs are dangerous, therefore they must be regulated. Illegality is the danger.

What Subject L would have got

Imagine a country that treated drug policy the way it treats alcohol, tobacco, and every other dangerous consumer product. Not a fantasy. Not a thought experiment. The systems already exist.

Subject L walks into a pharmacy. He is fifteen. The pharmacist asks for ID. He doesn't have it. He leaves. He tries again at seventeen. Same result. He comes back at eighteen with his driver's licence. The pharmacist checks it. He's eighteen. Legal.

The pharmacist gives him what he asked for. It is exactly what the label says it is. The dosage is printed on the packet. There is an information sheet inside that says what it does, how long it lasts, what not to mix it with, and what to do if something goes wrong. The pharmacist asks if he has any questions. There is a number on the packet for a free health line.

He takes it. It does what it's supposed to do. He wakes up the next day and goes to work.

That is what regulation looks like. That is what every other dangerous product in the country already has. Age verification. Ingredient labelling. Dosage information. Quality control. A point of contact if something goes wrong. We require this for paracetamol. We require it for cold and flu tablets. We require it for beer.

We do not require it for the substances that are most likely to kill you, because we made them illegal, and illegality removes all of it.

The pharmaceutical monopoly

There is one more thing Subject M needs you to know, and it is the thing that made her angriest.

GHB is a substance your body produces naturally. It occurs in your brain. It is the only known sleep aid that preserves and enhances slow-wave sleep — the deep sleep your brain needs for memory consolidation, cellular repair, immune function, and clearing the waste proteins associated with Alzheimer's disease. Every other sleep medication on the market — benzodiazepines, Z-drugs, antihistamines, melatonin at pharmacological doses — suppresses deep sleep. They knock you out, but they rob you of the sleep that actually heals.

GHB is Schedule I in Australia. Maximum penalty: 25 years.

Xyrem is the same molecule. Chemically identical. Same compound, same dose, same mechanism. Xyrem is Schedule III. Legal with a prescription. Costs between $50,000 and $75,000 a year.

The difference is not the molecule. The difference is the patent. GHB cannot be patented because it is a naturally occurring substance. Jazz Pharmaceuticals reformulated it as Xyrem, patented the formulation, and lobbied to keep GHB criminalised so that nobody could access the substance for pennies instead of paying $75,000 a year.

A substance your body makes. That uniquely preserves the sleep your brain needs. Criminalised so that a pharmaceutical company can charge seventy-five thousand dollars a year for the same thing.

When someone tells you drug laws exist to protect people, ask them: protect people from what? From a substance their own brain produces? Or from a price point that threatens a patent?

What Subject M wants

Subject M does not want drugs to be a free-for-all. She is not an anarchist. She is not a hippie. She is a dental nurse from Mandurah who watched her brother nearly die because the system that was supposed to protect him created the exact conditions that almost killed him.

She wants age verification. Pharmacies check ID. Dealers don't.

She wants quality control. Pharmacies label what's in the packet. Dealers don't know what's in the packet.

She wants dosage information. Pharmacies print it on the box. Dealers couldn't tell you if they wanted to.

She wants a health system that treats her brother like a patient, not a criminal. Portugal proved it works. Switzerland proved it works. Canada proved it works. The Netherlands proved it works. Every country that tried it got better outcomes than the countries that didn't.

She wants the people making these laws to answer one question: if prohibition works, why is it easier for a fifteen-year-old to buy pills in a car park than it is for him to buy a six-pack at BWS?

It is a fair question for every lawmaker, and a regulated market answers it: age checks, labels and quality control, as with alcohol.

Being your own man means deciding for yourself. It means nobody else — not a politician, not a police officer, not a pharmaceutical executive — gets to choose what enters your body. That is the most basic form of sovereignty there is. Everything else is just a matter of degree.

Subject L is twenty-two now. He's alive. Subject M still drives past that flat sometimes. She doesn't stop.

She wants you to know that the system didn't fail her brother by accident. Prohibition removed every safeguard, every label, every age check, every quality control, and then called the result a drug problem.

It's not only a drug problem. It's a regulation problem.

Sources

This is an opinion piece. The opinions are Subject M's. The evidence is not.

CLAIM	SOURCE

Portugal: 80% reduction in overdose deaths (80 to 16)	EMCDDA national data, 2001-2017
Portugal: HIV transmission 52% to 7%	Portuguese national health data
Portugal: 60% increase in treatment uptake	EMCDDA monitoring reports
$1 trillion+ spent on US War on Drugs since 1971	Drug Policy Alliance, 2023
100,000+ annual US overdose deaths	CDC, 2023
Cannabis therapeutic index >1000:1, zero direct overdose deaths	Nutt et al. 2010; Lachenmeier & Rehm 2015
Alcohol therapeutic index ~10:1, 88,000 US deaths/year	CDC; NIAAA
Harrison Act driven by racial politics	Musto, *The American Disease*, 1999
Ehrlichman admission	Baum, *Harper's Magazine*, 2016
Netherlands: lower youth cannabis use than US	EMCDDA, 2022
Switzerland HAT: 80%+ crime reduction, zero overdose deaths	Rehm et al. 2001
Canada: youth use stable/declining post-legalisation	Health Canada monitoring data
GHB uniquely preserves slow-wave sleep	Sleep medicine literature (multiple)
Xyrem: $50,000-75,000/year for same molecule	Jazz Pharmaceuticals pricing
Drug scheduling not based on comparative risk	Nutt et al. 2010 (*Lancet*)
Drug supply increased despite $1T enforcement	Werb et al. 2013
50-65% of incarceration drug-related (secondary effects)	US Bureau of Justice Statistics, 2020