WAR ON DRUGS

I decide what goes in my body, you deciding is called rape.

omxus research



Author's Note

> The dealer doesn't check ID.

This paper exists because of OMXUS Goal 7 (regulate drugs):
Regulated supply. Age checks. Pharmacies.

That goal draws on Portugal. In 2001, Portugal decriminalised personal possession of all drugs and sent users to health panels instead of courts. Drug-induced deaths fell from about 80 in 2001 to 16 in 2012. HIV transmission among people who use drugs fell from 52% of new cases to 7%. Treatment uptake increased 60%. Youth drug use did not increase.

Not a pilot programme. More than two decades of national population data from an entire European country.

The goal also exists because of teenagers like this one. He is fifteen when he buys his first pills, not from a pharmacy but from a kid at school who got them from a bloke in a car park. Nobody checks his age. Nobody tells him what is in them, or the dose.

A servo checks ID. A bottle shop checks ID. A pharmacy checks ID. A dealer does not.

A system that makes it easier for a fifteen-year-old to buy pills than a six-pack does not control drugs. Regulated supply with age checks, as for alcohol and tobacco, protects children better than an unregulated market.

This paper provides the evidence: 110+ citations, 25 years of international data, pharmacological analysis, economic modelling, and case studies from five countries. For many drugs, it finds, the harm done by prohibition rivals the harm done by the drug.

Connection, meaning and education, not criminalisation. Treat addiction as health. Sell through pharmacies. Check ID. Print the dose on the packet. Meet personal use with health care, not prison.

Adults decide what goes into their own bodies. The law keeps children safe and the supply clean.

– A.A. & L.N.C., March 2026

Abstract

The global prohibition of psychoactive substances, now exceeding five decades of implementation, has failed to achieve its stated objectives of reducing drug use, improving public safety, or protecting public health. This paper synthesises evidence from pharmacology, public health epidemiology, political philosophy, and health economics to construct a comprehensive argument for evidence-based drug policy reform grounded in three interlocking pillars: body sovereignty as an ethical foundation, the safety paradox whereby illegality manufactures the very dangers prohibition claims to prevent, and risk-proportionate regulatory frameworks drawn from successful international models. Drawing on Portugal's 25-year natural experiment in decriminalisation – which reduced drug-induced deaths from 80 in 2001 to 16 in 2017 (an 80% reduction), collapsed HIV transmission among people who use drugs from 52% to 7% of new cases, and increased treatment uptake by 60% – this paper demonstrates that health-centred approaches produce superior outcomes across every measurable dimension. A detailed case study of gamma-hydroxybutyrate (GHB/Xyrem) reveals how a substance that uniquely preserves and enhances natural slow-wave sleep architecture – the only sleep aid that promotes rather than suppresses the deep sleep stages essential for memory consolidation, cellular repair, glymphatic clearance, and neurological health – has been criminalised while pharmacologically inferior, dependency-creating alternatives dominate the market, because GHB cannot be patented. Extended analyses of Switzerland's heroin-assisted treatment programme (three decades, zero on-site deaths, 80%+ crime reduction), Australia's pill testing debate, Johann Hari's connection thesis, and the racist origins of prohibition (Anslinger, Nixon, Ehrlichman) demonstrate that the drug war was never about safety – it was about control. The paper argues that the state's legitimate regulatory authority extends to behaviour that harms others, not to what an individual ingests; that prohibition creates unregulated supply chains, dosage

uncertainty, stigma-driven isolation, and deaths attributable to policy rather than pharmacology; and that substance-specific, risk-proportionate regulatory frameworks offer a viable pathway from the failed prohibition paradigm to evidence-based public health governance. (290 words)

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22. Direct drug offences (~13,200): Possession, trafficking, manufacturing, importation (ABS, 2024).
23. Acquisitive crime driven by prohibition pricing: Theft, burglary, robbery, and fraud committed to fund drug purchases at prices inflated 10-50x by illegality. A heroin user paying $50-100/day for a substance that costs cents to produce under regulation must generate that income somehow. Prohibition creates the price; the price creates the crime.
24. Drug market violence: Assaults, homicides, and weapons offences arising from territorial disputes, debt enforcement, supply chain conflicts, and the absence of legal dispute resolution mechanisms. Legal markets have courts and contracts. Illegal markets have violence.
25. Drug-impaired offending: Offences committed under the influence of substances where prohibition prevented access to regulated supply, accurate dosing information, and harm reduction support. Contaminated and unpredictably potent supply — a direct product of unregulated markets — produces erratic intoxication that regulated supply would not.
26. Breach offences: Parole and bail violations triggered by drug use or positive drug tests — violations that would not exist under a regulatory framework, since the underlying conduct (ingestion) would not be criminal.
27. 50% of $26.5B = $13.25 billion
28. 65% of $26.5B = $17.2 billion
29. The drug war doesn't cost "part of" the justice system — it basically is the justice system. When 50-65% of all justice activity traces back to drug prohibition, the question is not "how much does drug enforcement cost?" but "what would be left of the justice system's workload without it?"
30. The $32-36 billion total represents a policy that, by every measurable outcome, makes the problem worse. This is not money spent on a failing programme. It is money spent on a programme that actively manufactures the harms it claims to prevent.
31. Alcohol: Therapeutic index approximately 10:1. Approximately 88,000 deaths per year in the US.
32. Tobacco: Approximately 480,000 deaths per year in the US. No therapeutic index (no therapeutic dose).
33. Acetaminophen (paracetamol): Therapeutic index approximately 3:1. Approximately 500 deaths per year from overdose in the US.

34. Aspirin: Therapeutic index approximately 5:1. Approximately 3,000 deaths per year in the US.
35. Cannabis: Therapeutic index exceeding 1000:1. Zero confirmed direct overdose deaths in recorded medical history.
36. Psilocybin: Therapeutic index approximately 1000:1. Fewer than 5 deaths in all recorded history combined.
37. LSD: Therapeutic index approximately 1000:1. No confirmed overdose death has ever been recorded.
38. MDMA: Therapeutic index approximately 16:1. Approximately 50 deaths per year in the US, predominantly from adulteration and poly-substance use.
39. HIV transmission reduced by 30-58% in communities with NSPs (Aspinall et al., 2014)
40. No evidence that NSPs increase drug use rates or initiation
41. Hepatitis C transmission significantly reduced
42. Cost-effective: each HIV infection prevented saves approximately $500,000-$1,000,000 in lifetime healthcare costs
43. Australia's early adoption of NSPs is credited with keeping HIV prevalence among people who inject drugs below 2%, compared to 20-40% in countries without them
44. 100% prevention of on-site overdose death. No one has ever died from an overdose in a supervised consumption facility. Not in the 38 years of their existence.
45. Reduction in local overdose deaths: 35% (Insite, Vancouver; Marshall et al., 2011)
46. Increased referrals to treatment: users are 1.7 times more likely to enter treatment
47. Reduced public injecting and discarded needles
48. No increase in drug use, drug dealing, or crime in surrounding areas
49. 67% of users reported SCFs as their sole access point for health services
50. 21-46% reduction in opioid overdose deaths in communities with naloxone distribution (McDonald & Strang, 2016)
51. Over 50,000 overdose reversals documented in the US since 2000
52. Community distribution programmes achieve higher coverage than pharmacy-only models
53. Take-home naloxone is cost-effective at approximately $1,400 per quality-adjusted life year saved — well below the standard threshold of $50,000

54. 70% reduction in criminal activity (Mattick et al., 2009)
55. Significant reduction in overdose mortality
56. Reduction in HIV and Hepatitis C transmission
57. Improved social functioning and employment
58. Cost-effective compared to incarceration by a factor of approximately 7:1
59. 30-50% increase in emergency calls (Rees et al., 2019)
60. Significant reduction in overdose mortality
61. No increase in drug use or drug-related crime
62. The corollary: in the absence of Good Samaritan laws, people die because they are more afraid of the police than of death
63. 10-25% of users discard dangerous substances when testing reveals contamination (Barratt et al., 2018)
64. Additional users reduce dosage based on purity information
65. Services provide real-time intelligence about dangerous adulterants in the local supply
66. Connect users with health information and services
67. No evidence that drug checking increases drug use
68. All psychoactive substances carry risks that can be substantially reduced through knowledge and practice
69. Different substances require different approaches based on their risk profiles
70. Community wisdom and scientific evidence can combine to create practical guidelines
71. Cultural context strongly influences use patterns and outcomes
72. Education and support are more effective than punishment and stigma

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14. Implementation Pathways

14.1 Phased Transition

A realistic implementation pathway requires phased transition:

Pre-implementation phase (months 1-12): Decriminalisation of personal possession of all substances. Establishment of regulatory authority. Development of initial regulations. Creation of licensing systems. Development of evidence-based education campaigns. Establishment of social equity programs.

Phase 1 – Low-risk substances (months 12-24): Licensed cannabis retail. Application processing for retailers. Outcome monitoring system activation.

Phase 2 – Moderate-risk substances (months 24-48): Psychedelic facilitator training and service center licensing. Pharmacy distribution model for GHB and other moderate-risk substances.

Phase 3 – Higher-risk substances (months 48-72): Supervised consumption site establishment. Heroin-assisted treatment for dependent users. Registered access programs. Full spectrum service availability.

14.2 Institutional Requirements

Regulatory agency: Standards development, licensing, compliance monitoring.

Public health authority: Education, early warning systems for dangerous products, trend monitoring, coordination with harm reduction services.

Independent evaluation body: Ongoing research, outcome assessment, policy recommendations free from commercial or political influence.

Social equity office: Administration of equity programs including automatic record expungement, priority licensing for impacted communities, reduced fees, and community reinvestment of tax revenue.

Community advisory boards: Local input and community-specific adaptation.

14.3 Law Enforcement and Criminal Justice Transition

Officer retraining: Education in harm reduction approaches, public health frameworks, and de-escalation.

Performance metric shifts: Moving from arrest-based metrics to community safety and health outcome measures. As long as police performance is measured by drug arrests, institutional incentives will

undermine reform.

Resource reallocation: Gradual shift of personnel and funding from drug enforcement to serious crime investigation and community health partnerships.

Automatic case dismissal and expungement: Immediate dismissal of pending cases for activities now legal. Technology-enabled clearing of historical records. Review of current sentences for retroactive application.

14.4 International Treaty Considerations

National drug policy reform operates within the constraints of international drug control treaties. Approaches demonstrated:

Treaty reinterpretation: Flexible interpretation to accommodate health-focused approaches (Bolivia's coca leaf framework).

Principled non-compliance: Human rights and public health justifications (Uruguay and Canada's cannabis legalisation).

Treaty modification: Coalition-building among like-minded nations for treaty modernization.

The current treaty framework was designed in an era when drug policy was driven by Cold War politics and racial anxieties rather than public health evidence. Its revision is overdue.

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15. Discussion

15.1 Synthesis

The three pillars of this paper — body sovereignty, the safety paradox, and risk-proportionate regulation — are not independent arguments. They are interlocking components of a coherent framework.

Body sovereignty establishes the ethical boundary: the state's authority extends to conduct that harms others, not to the contents of an individual's bloodstream. The safety paradox demonstrates the empirical failure of the alternative: prohibition not only violates autonomy but produces worse outcomes across every measurable dimension. Risk-proportionate regulation provides the practical pathway: substance-specific frameworks that balance access, safety, and public health without defaulting to either prohibition or unregulated commercialisation.

The connection thesis adds the social dimension: addiction is not caused by chemical hooks but by disconnection. Prohibition guarantees disconnection. Legalisation within a community framework restores it.

The racist origins of prohibition add the historical dimension: these laws were never designed for safety. They were designed for social control. The substances selected, the communities targeted, the severity of penalties — all reflect the racial and political agenda of their architects. Defending these laws on grounds of public health requires ignoring the documented reasons they were created.

The GHB/Xyrem case crystallizes all elements. A substance that uniquely enhances the most restorative phase of sleep is criminalized for the general population while being sold at 1000x markup to a narrow patient population through a pharmaceutical monopoly. The criminalisation violates body sovereignty. The absence of regulated access creates the safety paradox. The refusal to create a risk-proportionate regulatory framework perpetuates both the ethical violation and the preventable harm. And the scheduling was driven not by pharmacology but by economics — the unpatentability of a naturally occurring substance that threatened pharmaceutical revenue.

15.2 Anticipating Objections

"Legalisation will increase use." The evidence does not support this claim. Portugal did not see increased use after decriminalisation. The Netherlands has lower youth cannabis use rates than the United States despite decades of tolerant policy. Colorado and Canada have not seen the predicted surges. And even if use did increase moderately, the relevant question is not prevalence of use but prevalence of *harm* — and harm is overwhelmingly a function of regulatory environment, not of substance availability.

"Some substances are genuinely dangerous." This paper does not argue otherwise. It argues that regulatory intensity should correspond to actual risk — with the most intensive regulatory frameworks

applied to the highest-risk substances. The Swiss HAT programme demonstrates that even heroin can be managed through a health-centred framework with dramatically better outcomes than prohibition.

"The pharmaceutical industry provides valuable innovation." Undeniably true. The argument here is not against pharmaceutical innovation but against the use of scheduling as a competitive weapon — the criminalisation of natural substances to protect patented alternatives.

"Body sovereignty is incompatible with public health." The opposite is true. Every jurisdiction that has moved toward autonomy-respecting, health-centred approaches has seen improved public health outcomes. Body sovereignty does not mean the absence of healthcare infrastructure — it means the healthcare system serves individuals through support and information rather than coercion and punishment.

15.3 Limitations

This paper has several limitations. First, the evidence base is drawn primarily from Western democratic contexts. Second, the GHB sleep research is based on a relatively small number of studies, and the Alzheimer's prevention hypothesis remains at the proposal stage — precisely because Schedule I classification has impeded the research needed to test it. Third, implementation pathways are described at the level of principle rather than specific legislative detail. Fourth, the pharmaceutical monopoly analysis focuses on pricing and access without fully addressing the legitimate costs of clinical trials, regulatory compliance, and pharmacovigilance.

15.4 Future Research Directions

GHB and sleep health: Independent research on GHB's effects on slow-wave sleep, Alzheimer's prevention potential, and optimal dosing protocols. Currently blocked by Schedule I classification.

Glymphatic clearance and neurodegenerative disease: Investigation of whether GHB-enhanced slow-wave sleep produces measurable improvements in amyloid-beta clearance.

Comparative regulatory outcomes: Systematic comparison of health, social, and economic outcomes across jurisdictions with different regulatory frameworks.

Patent reform and pharmaceutical access: Analysis of regulatory mechanisms to prevent the criminalise-patent-monopolise cycle.

Indigenous and traditional medicine integration: Study of traditional regulatory frameworks for psychoactive substances.

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16. Conclusion

The evidence is not ambiguous. Prohibition has failed. It has failed to reduce drug use. It has failed to improve public safety. It has failed to protect public health. It has succeeded in producing mass incarceration, racial injustice, preventable death, pharmaceutical monopoly, suppressed science, and the violation of bodily autonomy on a civilisational scale.

The alternative is not theoretical. Portugal ran the experiment for 25 years: drug-induced deaths reduced by 80%, HIV transmission among people who use drugs reduced by 86%, youth drug use decreased, treatment uptake increased by 60%. Switzerland ran the experiment with heroin-assisted treatment for three decades: 80%+ reductions in criminal activity, zero on-site deaths, improved health and social outcomes across the board. Canada ran the experiment with cannabis legalisation: stable youth use rates, reduced illicit market activity, significant tax revenue. Oregon is running the experiment with psilocybin services.

The evidence points in one direction: toward health-centred, autonomy-respecting, risk-proportionate regulatory frameworks that treat substance use as a matter of public health rather than criminal justice. Frameworks that regulate behaviour rather than consciousness. Frameworks that provide quality-controlled access with evidence-based education rather than criminalised supply with stigma and contamination. Frameworks that respect the fundamental principle that your body belongs to you.

The GHB/Xyrem case is a microcosm of the entire failure. A substance that uniquely enhances the brain's own restorative sleep processes is criminalised for the public while a pharmaceutical company sells the identical molecule for $50,000-$75,000 per year. The pharmacology did not change. The scheduling was manipulated. The monopoly was constructed. And every person taking a sleep medication that suppresses

deep sleep — every person whose inadequate sleep contributes to cognitive decline, metabolic dysfunction, or neurodegenerative disease — is paying the price for a policy designed to protect revenue rather than health.

The connection thesis tells us why people get addicted: not because drugs are powerful, but because lives are empty. Fix the life. Build the park. Stock the pharmacies. Check ID. Print the dosage on the packet. And stop putting people in cages for what they choose to put in their own bodies.

One approach has evidence. One has ideology.

The path forward requires scientific integrity in scheduling decisions, public health centering in regulatory design, social equity in implementation, and — above all — the recognition that deciding what another person puts in their own body is not governance. It is a violation of the most fundamental autonomy a human being possesses.

Either your body belongs to you, or it belongs to whoever has the power to control it.

There is no middle ground.

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17. The Dealer Doesn't Check ID — An Opinion Piece

An opinion piece. Well-researched. Written from the guts.

Luke was fifteen when he first bought pills. Not from a pharmacy. Not from a doctor. From a kid two years above him at school who got them from a bloke in a car park in Rockingham.

Nobody checked his ID. Nobody asked his age. Nobody told him what was in them. Nobody told him the dosage. Nobody told him what would happen if he mixed them with the three cans of Emu Export he'd

already had. Nobody told him anything, because the person selling them to him was seventeen years old and didn't know either.

His sister Katie knew something was wrong around Easter. Luke stopped coming to family barbecues. He stopped answering his phone. He lost his apprenticeship at the panel beater — just stopped showing up one Monday and never went back. Their mum said he was going through a phase. Their dad said he needed a kick up the arse. Katie drove to his mate's flat and found him on a mattress on the floor with his eyes half shut and a pulse she had to check twice to find.

He was sixteen.

Here is what Katie wants to know: why was it easier for her fifteen-year-old brother to buy pills than it was for him to buy a packet of Winfield Blues?

Because a servo checks ID. A bottle shop checks ID. A pharmacy checks ID. A dealer does not.

The entire argument for drug prohibition — the entire reason these substances are illegal — is that they are dangerous and people need to be protected from them. Fine. But the question nobody in parLukent has ever answered is this: if the goal is protection, why did the system create the one supply chain on earth with zero consumer protections?

No age verification. No ingredient list. No dosage information. No quality control. No refund. No recourse. No regulation of any kind. The black market that prohibition created is the most dangerous retail environment in human history, and it has no minimum age requirement. A child can buy fentanyl-laced pills from a stranger in a car park, and the system that made that possible calls itself "drug control."

Control of what? Not of supply — global drug supply has increased every decade since 1971. Not of demand — drug use rates are roughly the same in prohibitionist countries as in countries that decriminalised. Not of harm — over 100,000 Americans die of overdoses every year, the majority from fentanyl contamination of the illicit supply. Contamination that exists because the supply is illicit. Deaths caused not by the drug but by the law.

So what does prohibition actually control?

Your body.

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.

Luke 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 Luke. 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 Lukes 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."

Katie 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 Luke 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.

Luke 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 Katie 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 Katie wants

Katie 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?

They won't answer it. They can't. Because the answer is that prohibition has never been about safety. It has been about control. Control of bodies. Control of communities. Control of markets. Control of who gets to decide what goes into your body and who profits from that decision.

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.

Luke is twenty-two now. He's alive. Katie 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 for the Opinion Piece

This is an opinion piece. The opinions are Katie 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

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Appendix A: Cross-References to the OMXUS Research Series

This paper is No. 1 in the OMXUS Research Series. The series comprises 19 interconnected papers, each building evidence for the 14 Goals. Every paper in the series proves every other.

Direct Cross-References

PAPER	TITLE / DIRECTORY	CONNECTION TO DRUG POLICY REFORM
(Applebee & Combe, 2026, "*Prevention Over Punishment*")	Prevention Over Punishment (prevention_over_punishment/)	Portugal's 80% reduction in drug deaths cited as proof that crime is not inevitable when prohibition is replaced with health-centred policy. Norway's 20% recidivism vs US 77% demonstrates prevention works across domains.
(Applebee & Combe, 2026, "*Housing First*")	Housing First (housing_first/)	Dual substance/housing crises — prohibition drives homelessness through criminal records, employment barriers, and family separation. Housing First programmes show 80%+ housing retention with no sobriety requirement.
(Applebee & Combe, 2026, "*Trust-First Governance*")	Trust-First Governance (consensus_distillation_trust/)	If institutions should default to trust rather than suspicion, they cannot simultaneously claim authority over what citizens ingest. Body sovereignty is the individual-level expression of trust-first governance.

(Applebee & Combe, 2026, "*Cooperative Capitalism*")	Cooperative Capitalism (cooperative_capitalism/)	Body sovereignty economics — the right to decide what enters your body is inseparable from economic sovereignty. Pharmaceutical monopoly (GHB/Xyrem) is a cooperative capitalism problem.
(Applebee & Combe, 2026, "*Signal Inversion*")	Signal Inversion (constructed_guilt_signal_inversion/)	Human deception detection at 54% accuracy (N=24,483) means drug convictions based on police assessments are epistemically compromised. 91.3% of credibility cues are inverted. False confessions 12-30% of exonerations. Drug convictions built on broken instruments.
(Applebee & Combe, 2026, "*The Bullshit Jobs Phenomenon*")	Bullshit Jobs / Labour Economics (bullshit_jobs/, labor_economics_22hr_week/)	22-hour work week eliminates the economic desperation that drives both drug market participation and problematic use. Connection is the opposite of addiction; overwork is the opposite of connection.
(Applebee & Combe, 2026, "*Wanted Attention for Unwanted Results*")	Policing Origins and Costs (community_policing_alternatives/)	Drug prohibition manufactures the crime that justifies policing. Remove prohibition, and the primary justification for the $17B policing apparatus collapses. The drug war is the police workload.
(Applebee & Combe, 2026, "*The Inverted Burden*")	Precautionary Food Safety (food_toxicology_safety/)	Same regulatory capture pattern: substances scheduled not by evidence of harm but by unpatentability. GHB/Xyrem demonstrates the identical mechanism documented for food additives — profitable alternatives

		with worse safety profiles remain legal while effective natural options are criminalised. NZ Psychoactive Substances Act (reversed burden of proof) is the model (Applebee & Combe, 2026, "*The Inverted Burden*") argues should apply to food.
(Applebee & Combe, 2026, "*The Invisible Network*")/25	Emergency Response / Direct Personal Alerts (emergency_response/, direct_personal_alerts/)	The $29 ring (60-second community response) can respond to overdoses faster than ambulances. Drug decriminalisation + community emergency response = overdose deaths approach zero.

The Convergence

Drug prohibition manufactures the crime that justifies policing ((Applebee & Combe, 2026, "*Wanted Attention for Unwanted Results*")), the policing that justifies punishment ((Applebee & Combe, 2026, "*Prevention Over Punishment*")), and the punishment that produces the recidivism used to argue crime is inevitable (Conclusion #16) — remove the prohibition, and the entire punitive chain loses its anchor.

The $32-36 billion annual cost of Australia's drug war (Section 2.2.2) feeds directly into the $19 trillion global misallocation documented in the economic framework (`$19t/`). The savings from ending prohibition fund the citizen dividends, universal mental health care, and community infrastructure that make the 14 Goals possible.

Related Research Directories

DIRECTORY	CONNECTION
omxus_solution/	Goal #7: Regulated, age-checked supply
omxus_solution/portfolios/drugs/	Drug policy portfolio with recreational use models

$19t/	Economic framework — drug war savings feed into citizen dividends
ideological_rorschach/	Cross-cultural viability of drug reform
sleep_science/	GHB and slow-wave sleep evidence base
health_diet_book/	Body sovereignty applied to food and health
environmental_determination/	Addiction as environmental response, not individual pathology
death_terror_management/	Why people cling to punitive frameworks despite evidence

Appendix B: Comparative Substance Risk Profiles

SUBSTANCE	LEGAL STATUS	THERAPEUTIC INDEX	ANNUAL DEATHS (US)	ADDICTION POTENTIAL	SCHEDULING RATIONALE
Alcohol	Legal	~10:1	88,000	High	Cultural familiarity
Tobacco	Legal	N/A (no therapeutic dose)	480,000	Very High	Cultural familiarity
Paracetamol	OTC	~3:1	500	Low	Pharmaceutical
Aspirin	OTC	~5:1	3,000	None	Pharmaceutical
Cannabis	Schedule I / Illegal	>1000:1	0 (direct overdose)	Low-Moderate	Racial politics (1937)

Psilocybin	Schedule I / Illegal	~1000:1



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