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**Political Chemicals: Drugs, Rights, and the Good Life**

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Recreational drug use, whether publicly acknowledged or privately hidden, has long been a common activity within human societies. Though this comes with serious hazards, it also produces benefits, which often go unrecognized. Given the current prohibitory policies, it is important to consider whether such use ought to be restricted. I will do just that, focusing on whether recreational drug use can be part of a reasonable conception of the good life, as well as whether restrictions constitute an infringement on freedom. I will argue that, in moderation, recreational drug use constitutes a positive good for a large group of people, and that criminalization places an unfair burden upon these people, which breaches the liberal principle of neutrality.

INDEX WORDS: Drug policy, Well-being, Eudaimonia, Liberal neutrality, Decriminalization, Moderation
POLITICAL CHEMICALS: DRUGS, RIGHTS, AND THE GOOD LIFE

by

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POLITICAL CHEMICALS: DRUGS, RIGHTS, AND THE GOOD LIFE

by

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DEDICATION

This thesis is dedicated to all the people who have been imprisoned for drug crimes, to the addicts who have been demonized for behaviors largely out of their control, to the youths who have been drastically and dangerously misinformed, and to any lawmakers fighting for policy change. I have a dim hope that the arguments herein might encourage more to do so.
ACKNOWLEDGEMENTS

I would like to thank Kyle Frantz, for teaching me about the neuroscience of psychopharmaceuticals; Peter Lindsay, for making me question criminalization as a solution to social problems; Dan Weiskopf, for many useful comments, and for keeping me on schedule; and George Rainbolt, for consistently pushing me to write like an academic, rather than a novelist or poet (or worse!). I would also like to thank my family and friends, for comments, critiques, and moral support, as well as the rest of the faculty and staff of Georgia State University’s philosophy and neuroscience programs. Lastly, I owe recognition to my fellow students, especially those in my cohort. I could not have done this without all of you.
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1 INTRODUCTION

The prohibition on drugs in the United States has put hundreds of thousands of citizens behind bars. In 2016, the Federal Bureau of Prisons indicated that of 181,075 total federal inmates, 83,982 were incarcerated on drug charges. According to the Bureau of Justice Statistics, 208,000 of the 1,325,305 inmates in state prisons in 2014 were there on drug charges, of which 47,400 were possession only (Carson, 2015, p. 30). In 2015, the Drug Enforcement Administration employed over 9,200 people (Drug Enforcement Administration, 2015). The sheer number of impacted persons provides sufficient reason to submit the drug policies to philosophical scrutiny.

The most immediate question is whether or not there should be any kind of governmental apparatus for regulating drugs. In this paper, I will first note the lack of justificatory reasons underlying the modern policies, then argue that there could be at least some potential justification for state control, grounded in the harms drug use can cause to both users and others. However, using Michael Bishop’s “network theory” as a framework, I will also argue that recreational drug use can be partially constitutive of well-being. I will then proceed to rebut the commonly voiced protests that (a) drug use will inevitably be bad for physiological health and (b) that it necessarily constitutes a lack of virtue. For the latter rebuttal, I will use an Aristotelian framework.

Following this, I will argue that any state attempting to act in accordance with the liberal principle of neutrality should focus its drug policy on harm reduction. Such states are supposed to act impartially towards reasonable conceptions of the good life, meaning that, if recreational use can indeed be part of such a conception, the activity ought not be prohibited. To make this argument, I will draw on Douglas Husak’s defense of a right to drug use and call for the
abandonment of the criminal framework as the attempted solution to drug-related problems. I will conclude by investigating the current policies as they relate to the new goals I present, providing a couple of sample cases for consideration.

2 CURRENT POLICY: HISTORICAL DEVELOPMENT

An historical analysis of the rise of drug prohibition in the U.S. does not yield an image of a set of clearly articulated ideals being applied to a variety of scientific data on the effects of drug consumption. Rather, it looks like politics as usual: the current policies appear to be haphazardly grounded in anything from broad misconceptions about the effects of drugs to purposefully directed racism. An example of the latter comes from the first drug law passed in the U.S., an 1875 ban on smokable opium in San Francisco (“The Opium Dens”, 1875). Manderson (1999) argues the specificity of such laws is due to the public conception that only Chinese immigrants smoked opium, while whites typically preferred drinkable opium tinctures [laudanum] (p. 181). Much later, the Reagan administration’s Anti-Drug Abuse Act of 1986 (2015) placed one hundred times stronger penalties on crack cocaine than powder cocaine. While these policies were also arguably underscored by racism, they were partially sold to the public based on claims that crack was substantially more addictive and could lead to a variety of negative health effects not caused by powder cocaine, including serious birth defects. The only pharmacological difference between the two drugs is sodium bicarbonate (baking soda) and the mode of administration, smoking for crack, insufflating (“snorting”) for powder. Under the Obama administration, the disparity was (partially) addressed and crack penalties were reduced, such that they are now only eighteen times harsher than the punishments for possession and sale of powder cocaine (Fair Sentencing Act of 2010, 2015).
Of course, facts about how the drug prohibition arose are only marginally important when determining whether they are good laws. Surely, it does not bode well if the goals of the policy-makers were ill-conceived, but neither does it provide certainty that the laws are either good or bad. To make such a determination, we must turn to questions of principle.

3 GOALS AND METHODS

3.1 Reasons for Restriction of Drugs

The positive question, “Why regulate drugs?” is asked with surprising infrequency in policy debates. Proponents of decriminalization are often prodded to give reasons for changing the laws, implying the default position is to continue the drug prohibition as is. However, this is the question that must be answered if the policies are to have any clear goals.

I will assume the historical points just mentioned are bad reasons for engaging in a drug prohibition. Surely, though, better reasons can be offered. When bans are formed based on misconceptions about the health effects of drugs, for instance, the goals of the legislators (assuming they actually believe the data they present) are not inherently bad. The resultant laws are bad because they are based on inaccurate information. But the underlying idea appears to be that there are some kinds of dangers related to drug use and that prohibition might help protect citizens. This places the states interest in the matter in the realm of promoting public health.

That recreational drug use constitutes a public health concern may seem straightforwardly obvious, but I will attempt to give the claim some backing. It is an empirical fact that recreational drug use sometimes harms users. These harms include but are not limited to: accidents while inebriated, acute overdose, addiction, and physiological and psychological damage from both short- and long-term use. In addition to these, recreational drug use sometimes leads to harm to others, including: accidents while inebriated, results of drug-induced aggression,
and the use of drugs to facilitate rape.\textsuperscript{1} The Centers for Disease Control and Prevention (CDC) reported 49,714 deaths related to drug use in the U.S. in 2014, as well as 30,722 deaths specifically related to alcohol\textsuperscript{2} use (Kochanek, Murphy, Xu, & Tejada-Vera, 2016, p. 12-13). In 2011, the Drug Abuse Warning Network estimated that, from a total of over 125 million visits to hospital emergency departments in the U.S., more than 5 million were related to drugs, with about 2.5 million specifically involving drug misuse or abuse (Substance Abuse and Mental Health Services Administration, 2013, p. 7-8). In 2011, the National Drug Intelligence Center estimated drug-related healthcare costs to be around $11,416,232,000, with additional economic costs from drug-related productivity loss at around $120,304,004,000 (p. ix). In 2015, 39,513 diagnoses of HIV in the U.S. were attributed to needle sharing related to injection drug use (Centers for Disease Control and Prevention). In light of the list of harms and these statistics, it should be clear recreational drug use constitutes a public health concern. I will continue on the assumption this point holds, and that it provides justification for state interest in drug regulation, though people with a variety of political leanings may deny the state ought to be involved in promoting public health. Anarchists and libertarians, for instance, might believe even a drug policy of harm-reduction constitutes overstepping by the state. For this paper, though, I will be assuming that concern for public health is within the bounds of legitimate state interests.

\subsection*{3.2 Reasons for Caution in Drug Restrictions}

Since there are serious drug-related harms, and the state could just attempt to eradicate all drug use in a prohibitory fashion, I now want to present arguments for weaker restrictions, based

\footnotesize
\begin{itemize}
\item[\textsuperscript{1}] Throughout this paper I will repeatedly use the term “drug abuse.” By this, I will mean roughly patterns of use likely to lead to some of these harms. I will defer to the DSM for the definition of “addiction” (though “substance use disorder” is now preferred).
\item[\textsuperscript{2}] By “drug,” I mean something like, “a chemical substance that, when consumed, modulates bodily structure or function in some way, excluding nutrients considered to be related to normal functioning.” Though this is a somewhat loose definition, alcohol is included as a drug within it.
\end{itemize}
on the efficacy of the policies in relation to the goals, while also considering possible goods that can come from drugs.

3.2.1 Drugs as medicine

First, if the state’s interest in policing drugs is to minimize or eradicate the harms associated with drug use (versus simply lowering overall use rates), ideal policies should not yield overall negative effects on public health. One obvious way drug policy could damage public health is by restricting access to drugs with medicinal value. This means ideal policies would not do so.³

3.2.2 Drug-related harms and criminal punishments

What punishments may be imposed for breaches of laws is frequently considered a dissociable issue from the rightness of the policies themselves. However, if the goal of the policies is to reduce harms, then there should not be criminal punishments attached. Perhaps if punishing drug users was massively beneficial to society and minimally damaging to the users, it could be justifiable, at least on a utilitarian framework. But it could also be argued on the utilitarian view that the long-term incarceration of users who break laws, many of which have mandatory minimum sentences attached, produces more costs than benefits, especially for drugs that are not particularly dangerous.

There are many problems with using utilitarian calculus here. For instance, there is no clear comparison between the harms constituted by fines, imprisonment, and other punitive measures and the kinds created directly by drug use, like physiological damage, overdose, and addiction. Due to discrepancies like these, it is difficult to tell whether criminal punishment

³ It is likely wholly uncontroversial that there should be no restriction on medicinal access to drugs, but people may disagree as to whether the current laws actually fail in this aspect. I will attempt to show at least one case in which current policies prohibit a potentially therapeutic drug in the comparison cases at the end of this paper.
yields overall benefit or not. More importantly, even if criminalization did yield an overall positive outcome, it would fail to address the appropriate goals of drug policies. Imprisonment does not address either abuse or addiction. And so, even on a simple utilitarian framework, criminalization fails to minimize harms. If the appropriate end-goal of drug policy ought to be the reduction or elimination of drug-related problems, then the state reaction to breaches of the policies should also be tailored to that purpose. Additionally, beyond utilitarianism, if adults have a moral right to use drugs, as Douglas Husak claims, then a positive sum in this case would not even matter. I will consider this possibility in more detail shortly.

3.2.3 Drugs and well-being

I now want to consider the value of recreational drug use within the framework of well-being presented by Mark Bishop in his book *The Good Life*, which he calls the “network theory.” Bishop considers a person to have attained well-being if they are situated within “positive causal networks” (PCNs). These PCNs consist of nodes that feed back into one another, in what Bishop sometimes refers to as “positive spirals.” The identity of these nodes, and the kinds of relationships connecting them, will differ by individual. Bishop (2015) outlines the theory as follows:

A person high in well-being has positive emotions, attitudes, traits, and accomplishments that form an interlocking web of states that build and feed on each other. According to

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4 In some studies of addiction using animal models, rodents are conditioned with a drug reward in a particular place until they show preference for that place, constituting drug-seeking behavior. They are then restricted from drugs in both the conditioned place and a non-conditioned place until the drug-seeking behavior is eliminated, evidenced by a lack of place preference. If they are then reintroduced to the drug, their behavior will return in full, evidenced by their reinstated preference for the place associated with the drug. For a review, see Sanchis-Segura & Spanagel, 2006, especially p. 30-32. Problems with animal models of human disorders aside, the implication is that even if an addict leaves a drug-associated environment and gets clean elsewhere (in prison, for instance), their chance of relapse following a single usage after returning to that same environment is very high.
the network theory, the state of well-being is the state of being in (or, to use philosopher’s jargon, *instantiating*) a positive causal network. (p. 10)

Bishop (2015) prefers his idea to other theories of well-being, such as hedonistic (p. 112-122) or Aristotelian (p. 138-146) theories because, according to him, it captures commonsense judgments just as well as the alternatives, while providing superior explanations of a variety of psychological study data. The general approach is pluralistic and inclusive; high levels of hedonic value might play a part in a PCN, as may a variety of character traits often extolled as virtue—these factors just fail to constitute well-being as a whole.

Bishop does not have a definition of positivity with necessary and sufficient conditions, which might be clearly fulfilled in some cases and not in others. Rather, he provides something like an empirical framework with which one might practically differentiate the valences of causal networks:

A homeostatically clustered network of feelings, emotions, attitudes, behaviors, traits, and accomplishments is positive (rather than negative or neutral) if it consists of relatively more of the following sorts of states: a. psychological states that feel good—that have a positive hedonic tone; b. states (psychological or not) that when present in this network tend to bring about psychological states that have a positive hedonic tone; c. states that the agent values; d. states that the agent’s culture values. (Bishop, 2015, p. 41)

One of the simplest PCNs that Bishop considers is what he calls the “happiness/success cycle,” in which happiness feeds into success, which feeds back into happiness. People with positive affects tend to experience more personal successes than others, and people who succeed tend to gain happiness from doing so (Bishop, 2015, p. 37). Happiness constitutes a hedonically positive psychological state (a in Bishop’s list of possibilities), while success is an
accomplishment that tends to bring about hedonically positive states (b). In addition, both states are more than likely valued by any given individual and their culture (c and d). This two-node network is an extreme oversimplification; Bishop readily admits any actual network would be far too complex to chart out. I mention it to illustrate the feedback nature of such networks generally,

To tie the network theory in with a qualified defense of recreational drug use, I will claim use is not necessarily opposed to well-being, and may even be an important aspect in its development and maintenance, for some individuals. This is not to say drug use never inhibits or destroys well-being, just that it does not have to, in every situation. I do not want to ignore the very serious negative aspects of use. Drug use can constitute a node in the negative alternative to a PCN, in which it may feed into physiological and/or psychological harms, may damage interpersonal relationships, sap finances, lead to addiction, or worse.

Take the case of Owen Flanagan, who became addicted to alcohol and benzodiazepines, which he consumed in conjunction to self-medicate for an anxiety disorder. In his article “What is it Like to Be an Addict?” Flanagan lays out poignantly the first-person experience of addiction. Though he began to use as an attempt to get away from his anxiety, over time he became hooked.

I now spent most conscious, awake, time drinking, wanting to die. But afraid to die. When you’re dead you can’t use...The desire to live was not winning the battle over death. The overwhelming need—the pathological, unstoppable—need to use, was. Living was just a necessary condition of using. (Flanagan, 2011, p. 277)

This, clearly, is not a description of someone instantiating well-being. But somebody could have the same kind of initial problem—overwhelming anxiety—while recognizing the
incapacity of drugs alone to provide a real cure. They could use some kind of drugs (possibly benzodiazepines, which are anxiolytics) as tools, or temporary boosts to set them in the right direction. If they have such tense nerves that they could never make it through the threshold of a psychologist’s office without taking some calming medication to ease their minds, such a drug might be their only real chance to begin on a path to healing.

Though drugs have great potential in some areas of therapy, there are also possible benefits of drug use that are neither medicinal nor therapeutic, but should still not be discounted. Recreational drug use is a valuable part of individual pursuits towards well-being, whenever it is feeding into positive, rather than negative, causal networks. Bishop (2015) writes, “[A] network’s causal drivers are those states that are part of the network that tend to establish, maintain, or strengthen the network” (p. 43). I think it is unnecessary to claim drug use could be a causal driver in a PCN. In fact, the policy claims that arise from the arguments here should be able to rest on a much weaker claim, that use is simply not detrimental to well-being, as use itself is divorceable from the harms related to the activity. However, I will try to give some support to the claim that recreational use frequently constitutes a positive good in people’s lives.

Although recreational usage of drugs has the potential to lead to unwanted craving, tolerance, dependence, addiction, and withdrawal, it also regularly feeds into positive traits and experiences. I want to leave aside the euphoria common to recreational drug consumption as relates to PCNs; that is, one might argue that drug use could constitute a node in a positive network simply because euphoria is a positive affect. However, I believe the euphoria requires a special kind of relationship with drugs if it is to be considered part of a PCN. The euphoria cannot be part of a network in which it feeds into addiction or abuse of drugs. Otherwise, it might be hedonically valuable, but would not constitute part of well-being. For recreational use
to do this, it must feed into other positive traits, experiences, attitudes, etc.—and, as I will argue, this requires it be done in moderation.

Other factors than the raw feel can and should be cited as positive reasons for using drugs recreationally. Some people (and some whole cultures) use drugs for spiritual purposes, often as part of rituals. Others cite drug consumption as a helpful motivator for engaging in creative activities. In addition, some people claim to benefit from the increased sociality that arises from certain drugs’ disinhibitory factors (like empathogens and alcohol). All of these factors (spirituality, creativity, sociality) frequently constitute nodes in positive causal networks in people’s lives.

4 WELL-BEING AND MODERATION

Having now argued that recreational drug use can form a node in a PCN, I will rebut the counterarguments that drug use cannot truly be part of well-being because (a) it necessarily breeds physiological harms that cannot be mitigated in any way and/or (b) it necessarily constitutes a lack of virtue. In establishments where alcohol is served, one can be sure to occasionally hear someone say, “Pick your poison.” Though it is never meant to be taken literally, the phrase holds a hidden understanding: alcohol can be poisonous. But when people drink it knowingly, they do not do so purely from self-destructive urges fueled by a Freudian death drive. Humans have found it can be enjoyable to temporarily disturb regular organic functions with trace amounts of toxins, in order to induce altered states of consciousness. People have engaged in drug use, and alcohol consumption in particular, for thousands of years. Aside from drinking alcohol simply due to the lack of other sanitary liquids, recreational use has long

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5 This kind of usage is often protected legally in the U.S., like the use of peyote by members of the Native American Church, though this may result in loss of unemployment benefits, cf. Employment Division v. Smith (1990), 494 US 872.
been recorded. Alongside this, there seems to have always been a human predilection toward overuse and abuse. Since this has been so common throughout history, I will now engage in a brief discussion about appropriate habits of consumption from the standpoints of medicine and virtue.

4.1 Moderation and medicine

Drugs can do amazing things. They can heal, miraculously. Drugs can do terrible things. They can kill, instantly. But can either of these effects arise purely out of a drug’s identity, or are there other relevant factors? Would problems result from a person taking infinitesimal quantities of a harmful drug each day? If they consumed a single molecule of whatever substance is most toxic to humans, every single day, would it matter? The answer is straightforwardly negative. Paracelsus, the father of toxicology, provided an important observation five centuries ago: “All things are poison and nothing is without poison, only the dose permits something not to be poisonous.” It is a fairly simple concept. If people consume a sufficiently large amount of any substance, it can have detrimental health effects, whereas they will be totally unharmed if the quantity is low enough. Even with its frighteningly small median lethal dose, imbibing individual particles of botulinum toxin (“Botox”) daily would likely yield no noticeable effect. This is certainly the case with substantially less toxic chemical compounds, including all Schedule I drugs.

4.2 Moderation and virtue

I have already argued that drug use constitutes a piece of positive causal networks (and thus well-being) in many people’s lives, using Bishop’s “network theory.” However, not

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6 For an enjoyable example, see Plato’s Symposium.
7 Often paraphrased as: “The dose makes the poison.”
8 This is micrograms for most people. See Arnon SS et al. (2001). Botulinum toxin as a biological weapon: Medical and public health management. The Journal of the American Medical Association, 285(8), 1059-1070
everyone will accept the theory. Hedonists should be partially assuaged by the discussion about medicine and moderation, since it shows drug use does not need to cause pains, and can often and easily cause pleasures. But I would like to also appeal to virtue theorists, who might be hesitant to accept drug use due to the possibility that any amount of use constitutes vice. To do so, I will investigate drug use within an Aristotelian framework.

Using drugs for recreation is using them to gain pleasure. On an Aristotelian account, the virtue concerning appropriate dispositions towards pleasures and pains is temperance. Though the term is now frequently associated with total abstinence, due to nineteenth century social movements, temperance for the Greeks was a virtue of moderation. Aristotle identifies excessive indulgence as “licentious,” but has trouble identifying the relevant deficiency. He writes, “[C]ases of defective response to pleasures scarcely occur, and therefore people of this sort too have no name to describe them, but let us class them as insensible” (EN II.7, 1107b7-9, trans. Thomson). The term translated as “insensibility” is anaisthētos, a predecessor to our “anesthetized,” which brings to mind catatonic or unconscious persons. Aristotle says incredibly little about this deficiency, believing it to be very rare. Though he says nothing about drug use specifically, of course, it is not hard to extrapolate his thoughts on temperance to the current issue.

Certain pleasures are necessarily experienced during life. Quenching thirst with drink and satisfying hunger with food are both pleasures that must be enjoyed, and with some regularity if one is to survive. Of such “natural” pleasures, Aristotle writes, “few people go wrong, and only in one way, in the direction of too much; because to eat or drink indiscriminately until one is full to bursting is to exceed in quantity one’s natural limit, since the natural desire is merely a
replenishment of the deficiency” (III.11, 1118b16-20). Drinking or eating too much could be considered licentious, but Aristotle does not see either as being particularly common:

But with regard to particular pleasures many people go wrong in many ways. Some of those who are called ‘lovers’ of this or that go wrong in enjoying the wrong objects, others in enjoying things with abnormal intensity, or in the wrong way; and the licentious display excess in every form. They enjoy some things that it is wrong to enjoy, because they are odious; and where it is right to enjoy something, they enjoy it more than is right, or more than is normal. (III.11, 1118b22-28, emphasis added)

What then can be said about drug use and temperance? One way a person could go wrong is by gaining an excess of pleasure from consumption (i.e. “enjoying things with abnormal intensity”). A self-aware individual exhibiting such a disposition towards drugs might even recognize it as dangerous, as something that could easily develop into an addiction.

Interestingly, another of Aristotle’s descriptions of licentiousness sounds remarkably like a modern account of addiction: “the licentious man is so called for being unduly distressed by the absence of what is pleasant, or by abstinence from it. … he is so carried away by his desire that he chooses them before anything else” (III.11, 1118b30-1119a3). In this passage, Aristotle was almost certainly referring to psychical pains, arising in the form of powerful and unfulfilled urges. But the claim seems all the more accurate when considering how overindulgence can lead to physiological dependence. Withdrawals indicate excessive urges are not merely behavioral; the brain regulates in response to drug use to reinforce such longing.

Of course, with a modern account of addiction, we might say a person is not as responsible for his or her actions as would be required to rightfully refer to his or her intemperance with moral condemnation—but even so, it can be said that their intense desires are
contradictory to their well-being, whether they can change them or not. And that is Aristotle’s concern anyways, the attainment of *eudaimonia*. It is important to recall, though, that Aristotelian virtues are a mean state, lying somewhere between a deficiency and an excess. To consider the deficiency contra licentiousness, take the following:

Cases of deficiency in respect of pleasures, that is of enjoying them less than one ought, hardly occur; because such insensibility is *subhuman*. Even the *lower animals* discriminate between different foods, and enjoy some but not others. If there is any *creature* to whom nothing is pleasant and everything indifferent, he must be *very far from being human*; and because such a type hardly occurs, it has not secured itself a name. (III.11, 1119a6-11, emphasis added)

In Aristotle’s thought, the lack of *any* appetite does not merely appear *wrong*, but freakish, inhuman. Note, too, he refers to enjoying certain pleasures “less than one ought,” meaning the failure to appreciate pleasure appropriately does, in fact, constitute a lack of virtue.

While he says little about having improperly weak responses to pleasures, believing it incredibly rare, from what he does say, it seems a person could be considered intemperate in the deficient sense if they never had desire for food or drink. To consider it again within the general framework of virtue ethics, it seems highly likely *eudaimonia* is unattainable if one cannot find enjoyment in anything. For instance, though he does not say it, Aristotle would likely agree that a person who takes no pleasure from any kind of art is failing to exhibit virtue regarding pleasure. Even if aesthetic value were considered wholly subjective, so that we could not say failure to feel pleasure in response to any particular work is wrong, we might claim it is impossible to attain a genuine state of well-being without being moved by anything. To look at any painting, any sculpture, any architectural marvel, to listen to any music, to read any work of
literature, to watch any performance, and to feel nothing, ever, would seem to indicate a level of dysthymia that would be detrimental to well-being.

Of course, consuming drugs for recreation is not the same as enjoying artwork, nor can pleasures from drug consumption be considered obviously appropriate in the way those from food and drink are—it is not necessary for survival to consume drugs for pleasure. Though Aristotle would say excessive interest in drug use would be wrong (again, “enjoying things with abnormal intensity”), another question remains: is the pleasure associated with drug use the wrong kind of pleasure to enjoy? Is it, in Aristotle’s terms, “odious”? There is a relevant passage to assist in this judgment, by providing some criteria:

[S]uch pleasures as conduce to health and bodily fitness he [the temperate man] will try to secure with moderation and in the right way; and also all other pleasures that are not incompatible with these, or dishonourable or beyond his means. For the man who disregards these limitations sets too high a value on such pleasures; but the temperate man is not like that: he appreciates them as the right principle directs. (III.11, 1119a17-21, emphasis added)

Recreational drug use is not the kind of pleasure all people ought to enjoy; however, for many people, a moderate amount of recreational use is valuable. Disagreement with this point would require an illustration of how moderate recreational drug consumption, use that is explicitly compatible with health and bodily fitness, is somehow intrinsically dishonorable.

The point about moderation is very important. It sits well with Paracelsus’ claim, but also with Aristotle, who provides this example to illustrate the importance of accounting for individual variation when judging temperance:
Supposing that ten pounds of food is a large and two pounds a small allowance for an athlete, it does not follow that the trainer will prescribe six pounds; for even this is perhaps too much or too little for the person who is to receive it – too little for Milo [the renowned wrestler] but too much for one who is only beginning to train. (II.6, 1106a37-1106b4 p.40)

Put simply: moderation is vital, not total abstinence. This a common thread throughout all of Aristotle’s ethics; the Golden Mean is a balance between extremes. Sitting amidst the dogmatic imposition of Nancy Reagan to “Just Say No” and the encouragement of rappers like Ice Cube towards reckless abandon⁹ can be found the philosophical, reflective equilibrium: know thyself, and know thy limits.

5 WELL-BEING, LIBERAL NEUTRALITY, AND DRUG POLICY

Now, having argued that recreational drug use is often a part of the positive causal networks that constitute well-being, and having rebutted counterarguments about use necessarily being problematic for health and for virtue, I will consider policy implications. Though medical value may provide stronger reasons for lessening restrictions, health is not the only value in life, and drugs can be used beneficially in non-medicinal capacities. It may hold more heft to say somebody should be allowed to access a drug if they will die without it than to say they ought to be allowed just because they think it is fun. But recreation is an important part of many positive causal networks, making it part of well-being.

Though not endorsed universally, this seems to be a claim few would debate. According to 2013 and 2014 survey data, over half of the adult American population had consumed an alcoholic drink within a month of being asked, and over seventy percent had one within the year (Substance Abuse and Mental Health Services Administration, 2014). Though alcohol is

⁹ “We don’t just say no, we’re too busy saying 'yeah!'” (Jackson, 1988).
minimally regulated, the limitations that do exist seem to have been designed to address the harms associated with its use. People are not permitted to drive motor vehicles after drinking, and alcohol vendors are not allowed to sell to minors. The former makes sense because alcohol heavily impairs driving abilities, the latter because alcohol consumption by adolescents can stunt brain development. If, instead of these narrowly articulated rules, there were a law requiring mandatory minimum prison terms for any individual caught consuming any amount of alcohol, this regulation would appear blind to the relevant problems related to the specific drug, alcohol.

If the state’s interest in regulating drugs is based on public health concerns, and harmless recreational drug use is considered by many to be part of a reasonable conception of the good life, then ideal drug policies should be narrowly tailored to mitigate the harms of drug use while leaving limited access for recreational purposes. If the state is supposed to be neutral towards reasonable conceptions of the good life, and some (any) people hold that recreational drug use constitutes part of a good life, then the state may be obligated to act neutrally towards drug use. This means it should not create an undue burden upon any person attempting to engage in what they consider a potentially life-fulfilling activity.

Neutrality toward reasonable conceptions of the good life is not an aspect of all political positions, but it is common enough to review relevant implications at length. I will situate it within the liberal framework of Douglas Husak. Philosophers have been largely silent about drug prohibition; Husak is one of few who has spoken and published on the issue.\textsuperscript{10} He provides a defense of drug use in the liberal tradition, claiming people have a right to use drugs. This, he says, means drug use should not be made into a criminal activity by the law. Husak is not

\textsuperscript{10} In a speech in 2014, Husak provided the following explanation on the general air of silence: “Why do philosophers not have much to say here? Probably because the topic is so incredibly fact-sensitive. If you’re gonna say much about drugs, you’d better know a lot of facts, and philosophers, you know, are notoriously allergic to facts” (Tulane University, 5:57-6:10).
concerned whether or in what ways drugs should be regulated, as I am in this paper. He is preoccupied with decriminalization. Much of his writing is on the lack of reasons behind treating drug use as a specifically viable activity for prohibition:

Suppose that a new food were discovered that was no more or less dangerous or subject to abuse than cocaine and had exactly the same side effects. The fact that this new substance is a food rather than a drug is not, I think, relevant to the decision about whether it should be prohibited. (Husak, 1992, p. 26)

If drug use is to be considered dramatically different from the consumption of other substances, there needs to be a clear defining line. In the brain, sugar has been found to activate similar regions to many recreational drugs (Colantuoni, et al., 2001). High sugar intake can result in behavioral dependency comparable to that seen in drug addiction via alterations in the activity of the endogenous opioid system, and the secretion and functioning of endorphins (Colantuoni, et al., 2002). It has also been indicated in an MRI study that analogous neural circuits activate for food and drug cravings (Pelchat, Johnson, Chan, Valdez, & Ragland, 2004). Husak makes a similar point about recreational activities generally; if there were a recreational activity more dangerous and addictive than drug use, would it be of any real concern that the activity was drug-free when considering appropriate legislation?

Keeping in mind the lack of justification for treating drug use as a special activity, Husak provides three criteria that must be met for drugs to be legitimately banned (on paternalistic grounds):

First, this drug would have to create significant harms to a great many persons who use it.

Second, few persons would regard the use of this drug as especially significant in their
lives. Finally, attempts to minimize the health hazards of this drug below the tolerable threshold must be deemed unsuccessful. (Husak, 1992, p. 100)

If we accept this schema but attempt to apply it to activities other than drug use, freedom appears increasingly relevant. Many dangerous recreational activities, such as skydiving, boxing, and motor vehicle racing, are allowed with minimal restrictions. The third condition is especially telling when considering freedom, as it implies criminal punishment for engaging in an activity ought to be the very last resort when handling social problem. Food additives are regulated, not banned. People are legally required to wear seat belts in cars, not universally denied the right to drive. Martial artists are made to use a variety of protective gear, not told to stop fighting altogether.

Refusing to treat drug use as criminal does not preclude the existence of a regulatory body, assuming it is properly focused. But neutrality demands that lawmakers refrain from giving preference to any particular conceptions of the good life. Prohibition places an unfair burden on people whose conception of the good life includes moderate recreational drug use. These people have less freedom in their pursuit of happiness than those taking different routes to well-being. Prohibition and the attached criminal punishments are not merely ill-suited for addressing drug-related harms, they constitute an infringement upon freedom, via a breach of the liberal principle of neutrality.

5.1 Policy implications and the current laws

Though it might not be quite so clear when looking at the application of the current policies, the letter of the law does appear to be directed at minimizing these kinds of harms. Consider the guidelines for federal scheduling (Controlled Substances Act of 1970). 11

11 See appendix.
Comparing the factors listed in the guidelines, there are clear trends present across the board, based on relational properties. As the schedules ascend in number, the abuse potential drops (high, less, low) and acceptance for medical use in the U.S. grows (no accepted use, accepted use with restrictions, accepted use). It is almost the same for the likelihood of developing dependence (severe, moderate, low, limited), except the statement for Schedule I, which does not refer to dependence but turns instead to accepted safety of use under medical supervision.

The principles underlying the scheduling guidelines can be easily articulated. Abuse and addiction\textsuperscript{12} should be fought. At the same time, no beneficial drugs should be regulated so strongly as to make them inaccessible to those who need them for medicinal purposes. While the basic ideas underlying scheduling appear to be in line with the appropriate goals of drug policy, this fails to be reflected in the implementation of the law. Some portions are properly tailored, but for drugs in the lowest schedules, the policies are prohibitory.

If drug policies ought to focus on abuse and addiction, on harms associated with drug use and not use itself, then really there should be no criminal punishment for use, nor for simple possession. This point is further supported if drug use is part of a reasonable conception of the good life, as I have argued, since a neutral liberal state should not make potentially life-fulfilling activities into criminal acts. In cases of rape, murder, assault, or any violent crime, the act in itself is the problem, and thus is the thing prohibited. Drug abuse and addiction are very harmful, and it makes sense to want to fight against them. But these problems are complex and need to be addressed with specificity—they cannot be reduced to use or possession. There are a variety of tactics for reducing many problems surrounding drug abuse: equipping police with naloxone allows them to prevent deaths from opiate overdoses, opening clinics which provide clean

\textsuperscript{12} The federal guidelines do not define either of these terms. I will continue to use my own definition for abuse and the DSM definition of addiction/substance use disorder.
needles for injecting drugs reduces the spread of diseases related to needle sharing (such as HIV), encouraging people who drink heavily to take B-vitamins might reduce their chances of developing brain damage\textsuperscript{13}, the use of stomach pumps saves many people from death by alcohol overdose.

None of these methods get to the base of the problem, as they will not lower the rates of abuse itself—but they can be incredibly beneficial for reducing harms. They ought to be a major part of the state’s focus. There are many factors, both social and psychological, contributing to the phenomenon of drug abuse, and reducing its prevalence is a difficult task. Addiction, too, is a complex, multi-faceted problem that will not have a simple solution. Yet one thing remains clear: imprisoning drug users, even tens of thousands of them, fails to specifically target either abuse or addiction. Perhaps abuse can be lessened through a regimen of educational campaigns consisting of facts and harm-reduction methods, rather than scare tactics, alongside treatment options for addicts such as rehabilitation centers. It might be useful to put grant money for drug research towards the development of new recreational drugs with similar psychoactive properties to those already commonly used, but less physiological risk and addictive potential. A longer-term project could be building an understanding of the kinds of cultural factors contributing to abuse and addiction and seeking to change them, as well as researching ways to treat the genetic side of addiction.

6 OTHER HARMS

Before concluding, since abuse and addiction are not the \textit{only} drug-related harms, some of the others should be addressed. DUI is a leading cause of death in this country, with rates far higher than for overdose. The state has every reason to be concerned with this. Technological

\textsuperscript{13} Wernicke’s encephalopathy/Karsakoff’s syndrome is a neurological disorder found in many alcoholics that stems from long-term alcohol-related thiamine deficiency in the brain.
advancements may soon provide a solution via self-driving cars, but for now there are measures that can be taken. While there is a right to use drugs, there is no such right to drive while heavily impaired, so the state is justified in its current prohibitory DUI policy. It may even be legitimate to enforce this policy with the strictness of current drug prohibition. Of course, appropriate tactics would have to take into consideration which states constitute serious driving impairment. Drunkenness certainly counts, but so does heavy sleep deprivation, whereas not all drugs hinder the capacity to operate vehicles.

Unfortunately, there are even more harms related to drugs. If the drugs typically used for recreation were also commonly used in poisonings, it would be worth devoting part of this paper to the issue. They are not, though. But there is an incredibly heinous crime that is often facilitated by psychotropic drugs: sexual assault. This is common and vicious enough to deserve somber consideration during any discussion on drug regulation. Even if a right to recreationally consume drugs is recognized, it is still tempting to claim this right ought to be superseded in light of the immense danger of drugs falling into the hands of people who would use them for rape. I am sympathetic to this claim. It is only upon careful consideration that I have come to believe prohibition is still not the answer. Drugs can be used in beneficial ways, medicinally and recreationally, and criminalizing their manufacture, sale, and possession will prevent all possible good that may come from them.

But this just means part of the state’s concern in regulation should be fighting the use of drugs in certain capacities. In fact, it might be a wise reallocation to take the funds currently spent enforcing the drug prohibition and directing them instead towards fighting sexual assault generally. Perhaps in the public schools, rather than using scare tactics to divert children away

\[14\] It might even be acceptable to enforce mandatory minimums for the reckless endangerment of the lives of citizens. And if not, it should be obvious such penalties are wrong for the current drug policies.
from drug use, they should be educated about consent and motivated to speak up about sex crimes. Perhaps “America’s Public Enemy Number One”\textsuperscript{15} is not people trying to get high, nor even the very real and frightening threats of drug abuse and addiction, but rather the rape culture. Perhaps instead of a “War on Drugs,” the nation ought to be engaged in a “War on Rape.”

As when addressing DUI, while considering drugs and rape, the variation in individual properties of different drugs should be taken into account. One of the most common drugs used to facilitate sexual assault is alcohol, now nearly unregulated. Meanwhile, there is a Schedule I drug which may provide solace to some victims who develop post-traumatic stress disorder (PTSD) from their traumas—and which fails to substantially impact driving abilities. Unfortunately, this drug is also sometimes used to facilitate sexual assault (drugs that substantially reduce inhibitions are the kinds typically used in this capacity). In conclusion, while keeping in mind the dangers but also the potential benefits, I want to compare these two drugs, in an attempt to drive home the depth of irrationality behind the current state of drug policy.

7 BACKGROUND FOR COMPARISON CASES

7.1 Ethanol

Alcohol consumption can cause serious physiological damage to users. Heavy use (what I have referred to as abuse) can lead to brain lesions and liver damage. Alcohol is carcinogenic and a teratogen. It is highly addictive and the withdrawal syndrome is incredibly strong, sometimes leading to death. Harper (1998) reviewed pathological changes in the brains of alcoholics, finding reduced brain weight and volume, with the amount of atrophy corresponding to the rate and amount of lifetime alcohol consumption. In a review of neuroimaging and pathological studies, Kril & Halliday (1999) found abuse of ethanol leads to a decrease of both grey and white matter volumes, particularly in the frontal lobes. Harper & Matsumoto (2005)

\textsuperscript{15} This is what Nixon called drug abuse.
noted analysis of MRI data shows the cognitive deficits in alcoholics relates to damage in non-cortical regions, including the cerebellum, pons, and thalamus.

Behaviorally, alcohol is known to increase aggression in users (Duke, Giancola, Morris, Holt, & Gunn, 2011), being implicated in over half all homicides and assaults (Advokat, Comaty, & Julien, 2014, p. 136). Alcohol also heavily impairs driving; according to the CDC, nearly a third of all traffic deaths in 2014 were due to alcohol (National Center for Statistics and Analysis, 2015). Alcohol has no documented therapeutic value, though it is not unhealthy in moderate doses, like a single glass of red wine in a sitting.

7.2 3,4-methylenedioxymethamphetamine (MDMA, “ecstasy”)

MDMA is generally considered to be neurotoxic to serotonergic neurons in humans in a dose-dependent fashion (Hall & Henry, 2006; Win, et al., 2008; Gouzoulis-Mayfrank & Daumann, 2009) and may specifically damage the hippocampus (Hollander, et al., 2011). There is some behavioral evidence to support hippocampal damage (Wagner, Becker, Koester, Gouzoulis-Mayfrank, & Daumann, 2012), although there are also contradictory behavioral results (Halpern, et al., 2011). However, according to a recent meta-analysis of neuroimaging research on MDMA neurotoxicity, moderate use has not been significantly correlated with either structural or functional brain damage (Mueller et al., 2016), illustrating the current state of debate over the extent of MDMA’s neurotoxicity.

MDMA is hepatotoxic and can lead to acute hepatitis (Andreu, et al., 1998). Though this may spontaneously resolve in some cases (Fidler, Dhillon, Gertner, & Burroughs, 1996), possibly to full recovery (Guneysel, Onur, Akoglu, & Denizbasi, 2008). In rare cases, extreme measures are needed such as liver transplants (De Carlis, et al., 2001). MDMA does not impair driving (Bosker, et al., 2011).
MDMA-assisted psychotherapy has recently been studied, with positive results for the treatment of post-traumatic stress disorder (PTSD) (Mithoefer, Wagner, Mithoefer, Jerome, & Doblin, 2010; Mithoefer, et al., 2012; Oehen, Traber, Widmer, & Schnyder, 2012). It is important to note that these studies treat MDMA as a therapeutic tool. Rather than long-term, daily administration of a psychotropic drug—SSRIs, for instance, are commonly prescribed for patients with PTSD—in these studies patients took the drug only a few times, in medically supervised environments. They then underwent therapy after the drug effects had set in. It is also incredibly important to point out that the results do not indicate a difference barely over statistical significance. The ability of MDMA-assisted psychotherapy to treat PTSD is around three times as effective as psychotherapy alone. Considering how many people suffer from PTSD—soldiers, police, firefighters, victims of rape or domestic abuse—alongside the insufficiency of current methods to consistently yield psychological healing, it seems horribly wrong to deny a possible cure to people who need it. In fact, it seems downright criminal.

8 CONCLUSION

The example cases are to provide evidence that the current federal scheduling of substances fails to genuinely account for related harms. A full analysis of all legal and illicit drugs would be far beyond the scope of this paper. What is important in these examples is the following: alcohol is unscheduled while MDMA is Schedule I, even though alcohol is far more dangerous than MDMA, both directly, through physiological effects, and indirectly, in terms of behavioral changes like driving impairment and increased aggression.

Criminalization has been tried for a long time, and has failed. This is largely because the policies have been formed without clearly articulated principles. A comprehensive drug policy grounded in a principle of harm reduction, the kind for which I have argued, would require
extensive analysis of possible harmful factors of all drugs. The separation of drugs into categories based on dangers would not be there to assign users of more dangerous drugs longer prison sentences. Instead, it would be to ensure the proliferation of honest information about these drugs, as well as increased research into the mitigation of related harms.

Beyond state policy, there appears to be something about our culture that is driving people towards reckless behaviors regarding drugs. Harm reduction in terms of laws would be a great first step in addressing the problems related to drug use. However, complementary changes to the social and cultural structures might be necessary extensions of this project. Widespread misuse of drugs is bolstered by a variety of cultural influences, for instance the glorification of drug abuse in books, music, movies, and so on. Finding and removing the motivations that drive people towards the misuse of drugs would be an appropriate continuation of my project. This, unfortunately, is a far more complex issue than the one I have addressed. I do not have any well-developed idea of how to find the root of the social problem of the misuse of drugs. For now, I will only claim that harm-reduction policies would be superior to the current ones, because the modern prohibition is an infringement upon rights, one which unfairly targets people with a particular conception of the good life, a life in which the engagement of moderate usage of recreational drugs constitutes part of a positive causal network that constitutes well-being.

REFERENCES


APPENDICES

Appendix A: Federal Scheduling Guidelines

(1) Schedule I.—
(A) The drug or other substance has a high potential for abuse.
(B) The drug or other substance has no currently accepted medical use in treatment in the United States.
(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

(2) Schedule II.—
(A) The drug or other substance has a high potential for abuse.
(B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
(C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

(3) Schedule III.—
(A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.
(B) The drug or other substance has a currently accepted medical use in treatment in the United States.
(C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

(4) Schedule IV.—
(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.
(B) The drug or other substance has a currently accepted medical use in treatment in the United States.
(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

(5) Schedule V.—
(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.
(B) The drug or other substance has a currently accepted medical use in treatment in the United States.
(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.