THE PHARMACRATIC INQUISITION

A Manifesto Against the Criminalization of Self-Medication

How America's War on Drugs Violates the Rights of the Mentally Ill, Perpetuates Suffering, Serves Empire Over People — and What a Sane Society Would Do Instead

Published by Pneumapsyche, Inc. pneumapsyche.com | lived.pneumapsyche.com | pharmacratic-inquisition.info

Version 4.0 (Complete) — Revised April 2026

EDITORIAL FOREWORD

On the Evolution of This Argument

This manifesto has now undergone four substantial revisions since its initial publication. Each revision has strengthened the argument — not by softening its conclusions, but by confronting the strongest objections to them honestly and engaging the most sophisticated opposition the field can offer. A manifesto that cannot survive its critics is not worth publishing. A manifesto that addresses them transparently — and incorporates the strongest counterarguments into its own framework — earns the right to be read by people who do not already agree with it.

What Changed Across the Versions

Version 1.0 asserted that the War on Drugs violates the Americans with Disabilities Act without addressing a critical statutory limitation: Section 12114 of the ADA explicitly excludes from its protections individuals "currently engaging in the illegal use of drugs." Any opposing counsel would have raised this in the first paragraph of a response brief.

Version 3.0 acknowledged that exclusion directly and reframed the legal theory around the underlying psychiatric disability — not the drug use itself — grounding the claim in *Olmstead v. L.C.* (1999) and Ninth Circuit case law on ADA applicability to law enforcement encounters with mentally ill persons. It also incorporated peer-reviewed data sources for every major empirical claim and added a call to action.

Version 4.0 — this version — does five additional things its predecessors did not:

1. **Engages the strongest opposition.** Earlier versions rebutted weak forms of prohibitionism. This version takes seriously the work of Keith Humphreys on the commercialization of cannabis, Jonathan Caulkins on the difference between decriminalization and commercialization, Sally Satel on the role of legal pressure in recovery, and Kevin Sabet on adolescent vulnerability. None of these critics persuades us to abandon the central thesis. All of them sharpen it.
2. **Anchors the argument in evolutionary biology and comparative philosophy.** The drive to alter consciousness is not a uniquely human pathology. Many mammals seek inebriation. Nearly every human society has used psychoactive substances. Any drug policy that pretends otherwise is not policy — it is denial. A new section addresses this directly.
3. **Concedes what must be conceded.** Some self-medication is maladaptive. Some is fatal. Drunkenness causes accidents, abuse, and family destruction at staggering scale. The medical paradigm that holds *all* drug use to be pathological is naive and punitive in its own way — but the libertarian paradigm that treats drug use as merely a personal choice with no social consequences is also incomplete. A new section explores both failed paradigms and what lies between them.
4. **Addresses the Big Cannabis problem.** Decriminalization does not require commercialization, and conflating the two has produced bad outcomes in several U.S. states. The tobacco playbook — youth-targeted advertising, potency escalation, private equity rollups, regulatory capture — is being reproduced in the cannabis industry in real time. Decriminalization is the right answer. *Commercialization without serious public health guardrails is the wrong one.* A new section makes the distinction.
5. **Speaks to policymakers across the political spectrum.** Drug policy in America has been falsely tribal for half a century. The argument advanced here is not progressive or conservative. It rests on the ADA (signed by President George H. W. Bush), the Eighth Amendment, the Religious Freedom Restoration Act (signed by President Bill Clinton), federalism, fiscal responsibility, and basic medical evidence. New editorial framings throughout invite engagement from any lawmaker willing to think honestly about what works.

> **A note to the policymaker reading this document.** You will find shaded callout boxes throughout marking places where the argument has been refined, qualified, or grounded in new evidence. These are not concessions. They are demonstrations that the argument is strong enough to confront its own weaknesses. The thesis stands: the War on Drugs, as practiced in the United States, is a constitutional and moral failure that punishes the disabled for being disabled, wastes hundreds of billions of dollars annually, kills hundreds of thousands of Americans, and serves no defensible public interest. *What is required now is the courage to replace it with something better.*

I. THE CENTRAL THESIS

The War on Drugs, as practiced in the United States, constitutes a systematic violation of the Americans with Disabilities Act of 1990. It selectively criminalizes the survival behaviors of people living with mental illness — people who, in the absence of adequate psychiatric care, turn to the only pharmacological relief available to them. To arrest, prosecute, and incarcerate a person whose drug use is a direct consequence of an inadequately treated psychiatric disability is not justice. It is persecution. It is the modern iteration of an ancient cruelty: the punishment of the sick for being sick.

We call this system what it is: **the Pharmacratic Inquisition** — an apparatus that declares certain molecules criminal not because of their pharmacological properties, but because they cannot be patented, controlled, and sold at markup by the pharmaceutical industry; not because their users are dangerous, but because their users are politically inconvenient and economically irrelevant. It is an inquisition that serves corporate profit and carceral expansion while millions of Americans with treatable conditions rot in cells, shelters, and unmarked graves.

This manifesto argues that the United States must abandon its punitive model and adopt a framework rooted in human rights, medical evidence, fiscal sanity, and the basic recognition that mentally ill people who self-medicate are patients, not criminals. The model exists. Portugal has demonstrated for two decades that decriminalization combined with serious investment in treatment produces better outcomes on every measurable axis: fewer deaths, fewer infections, less crime, more recovery, and lower public cost.

> ✎ **EDITORIAL NOTE FOR THE POLICYMAKER**
> This argument is not progressive or conservative. The ADA is conservative legislation in the truest sense — it conserves human dignity against bureaucratic dismissal. The Eighth Amendment is a foundational restraint on state power. Federalism counsels against centralized criminal control of personal behavior. Fiscal responsibility forbids spending $43.6 billion annually on a policy that demonstrably worsens the outcomes it claims to address. Religious liberty (RFRA, signed by Clinton; *Gonzales v. O Centro*, 2006) protects entheogenic sacrament. *If you find yourself reflexively dismissing this argument because of its origin, examine your reflex. The argument itself is constitutional, fiscal, scientific, and medical.*

II. WHAT THIS MANIFESTO IS NOT

Before proceeding further, intellectual honesty requires us to clarify what we are *not* arguing. The drug-policy debate in America has been so polarized for so long that any reform argument is immediately mischaracterized. We refuse the mischaracterization in advance.

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> This section is new in Version 4.0. It exists because every prior version was attacked on grounds the manifesto never advanced. Pre-empting the strawmen is now part of the work.

This manifesto is not "drugs are good." Most psychoactive substances carry real risks. Some are catastrophic. Fentanyl in unknown doses is killing tens of thousands of Americans every year. Methamphetamine destroys lives. Alcohol — fully legal, openly advertised, culturally celebrated — kills approximately 178,000 Americans annually and accounts for roughly one-third of all violent crime. Drugs are dangerous. We agree.

This manifesto is not "addiction is benign." Substance use disorder is a real and devastating condition. It destroys families, careers, health, and lives. We do not romanticize addiction. We argue that *the appropriate response to addiction is treatment, not incarceration*.

This manifesto is not "no accountability." Behavior that harms others must be prosecuted regardless of whether the perpetrator was intoxicated. Driving under the influence, violence, neglect of dependents, theft, fraud — these are crimes whether the actor was drunk, high, or sober. The argument here is to prosecute *behavior*, not *biology*.

This manifesto is not "commercialize everything." As Section VIII makes clear at length, decriminalization does not require commercialization, and the commercial cannabis industry is reproducing the worst features of Big Tobacco in real time. *Decriminalize personal possession. Regulate commercial supply with the seriousness of an FDA-grade public health regime.* These are different policies and they should remain different.

This manifesto is not "all psychiatric medication is bad." Modern psychiatry has saved an enormous number of lives. Lithium, clozapine, properly used antidepressants, and modern antipsychotics work for many patients. The critique is not of psychiatric medication itself — it is of the **monopoly logic** that excludes from the formulary every molecule that cannot be patented, regardless of efficacy.

This manifesto is not "all alternatives are safe." Psilocybin, MDMA, ibogaine, kratom, and cannabis carry their own risks. They interact with medications. They produce occasional psychiatric crises. They can be misused. We argue that they should be *researched, regulated, and accessible to clinicians and adult patients* — not that they are universally benign.

This manifesto is not anti-treatment. It is *radically* pro-treatment. We argue for the largest expansion of psychiatric and addiction treatment infrastructure in American history. The current system fails because we have undertreated mental illness for half a century. Punishment is what fills the void where treatment belongs.

What this manifesto *is*: a critique of one specific failed paradigm — prohibition-via-incarceration — and a proposal for a humane, evidence-based, fiscally responsible alternative. Nothing more. Nothing less.

III. WHY MAMMALS GET HIGH: THE EVOLUTIONARY AND PHILOSOPHICAL CONTEXT

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> This section is new in Version 4.0. It addresses a question the prior versions left unanswered: *why does the impulse to alter consciousness exist at all?* The answer matters because if the impulse is fundamentally human — fundamentally *mammalian* — then a policy that tries to eliminate it is doomed by biology, and only a policy that channels it constructively can succeed.

UCLA psychopharmacologist Ronald K. Siegel, in his 1989 book *Intoxication*, called the pursuit of altered consciousness "the fourth drive" — alongside hunger, thirst, and sex. He documented its expression across the animal kingdom with patience and rigor. Elephants seek out fermented marula fruit. Vervet monkeys raid Caribbean rum stills with such consistency that they have been studied as a model of human alcoholism. Reindeer ingest *Amanita muscaria* mushrooms and stagger through the snow afterward. Bighorn sheep wear the rocks down to powder licking narcotic lichens. Bees become disoriented on fermented nectar. Dolphins have been observed passing pufferfish among themselves, each in turn entering a trance-like state before passing the fish along. Cats famously respond to catnip. Birds eat fermented berries and fly drunkenly.

This is not anthropomorphism. It is data. The drive to alter consciousness is not a uniquely human pathology. It is widely distributed across mammals and many non-mammalian species, and it appears to be evolutionarily ancient. *Whatever else drug use is, it is not a moral failure invented by modern humans.*

Within our own species, the cross-cultural evidence is overwhelming. Alcohol has been produced by nearly every agricultural society capable of producing it. Cannabis is documented in archaeological records from China to the Eurasian steppe to North Africa. Coca leaves were chewed by the peoples of the Andes for thousands of years before European contact, with no recorded epidemic of dependency. Ayahuasca, peyote, kava, betel, kratom, opium, tobacco, khat, and dozens of other psychoactive plants form the spine of the world's pharmacopoeias and the ceremonial life of countless cultures. *The Eleusinian Mysteries of ancient Greece, in which initiates drank the kykeon — almost certainly an ergot-derived psychedelic preparation — are credited by classicists with shaping much of Western philosophy.* The Vedic *soma*, the Mazatec mushroom ceremonies of Maria Sabina, the Native American Church's peyote sacrament, the Santo Daime use of ayahuasca, the Rastafarian use of cannabis — these are not aberrations. They are central facts about how human beings have engaged with consciousness for the entirety of recorded history.

Michael Pollan's *This Is Your Mind on Plants* (2021) makes the point bluntly: caffeine, opium, and mescaline — three molecules deeply embedded in human cultural and economic life — represent three different relationships humans have negotiated with three different plants. None of those relationships is purely pathological. None is purely unproblematic. All require ongoing cultural management.

> ⚠ **THE PHILOSOPHICAL POINT**
> If a behavior is observed across many species and across all human cultures, the question is no longer "how do we eliminate it?" The question is "how do we live with it well?" The answer differs by substance, by individual, by context, and by culture — but the underlying question is permanent. *A drug policy that does not begin from this premise is a policy designed to lose.*

This does not mean every form of intoxication is acceptable, nor that any individual should pursue it. **Abstention is always a valid choice and is often the wisest one.** It does mean that treating the *impulse itself* as pathological is a category error. The impulse is human. It is mammalian. It is older than agriculture. It will outlive every prohibition.

What a society can shape — what a society *must* shape — is the **expression** of that impulse: which substances, in what doses, under what conditions, with what supervision, by whom, with what consequences. That is the legitimate domain of public policy. Trying to eliminate the underlying drive has never worked, and will not work, and the attempt produces immense suffering as collateral damage.

IV. THE TWO FAILED PARADIGMS

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> This section is new in Version 4.0. Earlier versions critiqued prohibition without acknowledging that the alternative most often offered — a purely medicalized framework in which all drug use is treated as pathology requiring clinical intervention — is also inadequate. Both paradigms fail. The path forward lies between them.

American drug policy has oscillated between two paradigms, each insufficient on its own.

Paradigm A: Prohibition

The dominant paradigm since 1914. Drug use is criminal behavior. The user is a moral failure or a criminal subject. The response is enforcement, incarceration, and a permanent record. The evidence after a century is unambiguous: prohibition does not reduce drug use, increases drug-related death, creates black markets, fuels organized crime, destabilizes producing nations, and disproportionately destroys communities of color. *This manifesto's primary critique is of this paradigm and the consequences it has produced.*

Paradigm B: Pure Medicalization

The reformist alternative most commonly proposed: drug use is *always* a symptom of underlying pathology. The user is a patient. The response is mandatory treatment, civil commitment, drug courts, and clinical management. This paradigm is more humane than prohibition. It is also incomplete, and in some forms it produces its own injustices.

The Mad Pride and consumer-survivor movements have made this critique with force for fifty years. Thomas Szasz, whatever else one thinks of his work, was right that the medical model can be weaponized to justify coercion. Robert Whitaker's *Anatomy of an Epidemic* documents that the long-term outcomes of psychiatric pharmaceutical treatment are not always what the marketing claims. The forced administration of psychiatric medication, court-mandated rehabilitation, civil commitment without consent, and the redefinition of every form of substance use as a treatable disease — these can become a different cage with softer bars.

> **⚠ THE LIMITATION OF THE MEDICAL MODEL**
> Not every drink of wine is alcoholism. Not every shared joint is cannabis use disorder. Not every recreational psilocybin trip is a cry for help. Most adult human beings who use psychoactives use them episodically and without diagnosable pathology. Treating all use as illness pathologizes ordinary human behavior, and it can be used to justify coercion that prohibition cannot. *A free society distinguishes between use, misuse, and disorder — and responds proportionally to each.*

What Both Paradigms Get Wrong

Both prohibition and pure medicalization fail because they refuse to make a distinction that any honest observer can see: **the impulse to alter consciousness is universal; the consequences of acting on that impulse are wildly variable.**

A glass of wine with dinner is not the same as drinking yourself unconscious in the parking lot of a bar. A weekend hike on a low dose of psilocybin is not the same as smoking crack at 4 a.m. while ignoring your children. A veteran using cannabis to sleep is not the same as a teenager dabbing 90% THC concentrate every two hours. *The substance is not the variable that determines harm. The relationship to the substance is.*

What Must Be Conceded

Intellectual honesty requires the following concessions, which earlier versions of this manifesto did not state plainly enough:

- **Some self-medication is genuinely maladaptive.** A person who uses heroin to manage childhood trauma may be making a rational choice in the short term and a fatal choice in the long term. The same is true of high-dose alcohol use, benzodiazepine dependence, and stimulant dependence.
- **Some self-medication is fatal.** The current illicit fentanyl supply is killing Americans who think they are taking something else. Counterfeit Adderall pressed with fentanyl. Cocaine cut with nitazenes. Black-tar heroin of unknown potency. These deaths are largely *consequences of prohibition*, not of the underlying drug use — but they are deaths, and they are real, and any honest analysis acknowledges them.
- **Alcohol — fully legal, fully commercialized — causes catastrophic harm.** Roughly 178,000 Americans die each year from alcohol-attributable causes. Alcohol is implicated in roughly 30% of homicides, 30% of suicides, large fractions of domestic violence and child abuse cases, and tens of thousands of motor vehicle deaths. *The social burden of alcohol alone exceeds the social burden of all illicit drugs combined.* This is what fully legal commercialization without strong public health guardrails produces. Any honest policy debate must take this seriously.
- **Cannabis is not harmless.** Cannabis-induced psychosis in genetically vulnerable users is real. Adolescent heavy use is associated with lasting cognitive effects and elevated risk of psychotic disorders. Cannabis use disorder affects a meaningful minority of users. The substance is dramatically less lethal than alcohol or opioids, but "less lethal than alcohol" is not the same as "safe."
- **The brain in adolescence is not the brain in adulthood.** Adolescent substance use is associated with worse long-term outcomes for nearly every drug. Brain development continues into the mid-20s. Public health messaging that respects this — without lying, without exaggerating, without scaring users away from honest information — is necessary.

The Better Frame

The right framework is neither prohibition nor pure medicalization. It is a tiered, evidence-based response that:

1. **Recognizes the universal mammalian impulse** without pathologizing it;
2. **Distinguishes use, misuse, and disorder** — and responds proportionally;
3. **Prosecutes harmful behavior** regardless of the substance involved;
4. **Treats addiction medically**, with the patient's consent wherever possible;
5. **Regulates commercial supply** with the same seriousness applied to pharmaceuticals;
6. **Educates honestly**, especially the young, especially about real risk;
7. **Respects abstention as a fully valid choice** — never apologized for, never required.

This is the path. The remainder of this manifesto develops it.

V. THE ADA ARGUMENT: DRUG CRIMINALIZATION AS DISABILITY DISCRIMINATION

A. The Legal Foundation and Its Honest Limitations

The Americans with Disabilities Act of 1990 prohibits discrimination against individuals with disabilities in all areas of public life. Mental illness — including major depressive disorder, bipolar disorder, schizophrenia spectrum disorders, PTSD, and anxiety disorders — unambiguously qualifies as a disability under the ADA.

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Version 1.0 of this manifesto asserted the ADA argument without addressing a critical statutory limitation. Section 12114 of the ADA explicitly excludes from its protections individuals who are "currently engaging in the illegal use of drugs." This exclusion, if not addressed, allows critics to dismiss the central legal claim before engaging with it. Version 3.0 reframed the discrimination claim around the underlying psychiatric disability — not the drug use itself — and grounded the legal theory in Supreme Court and Circuit Court precedent. Version 4.0 adds the *Robinson v. California* line of Eighth Amendment authority and the racial disparate-impact data that strengthens the disparate-impact theory.

A critical clarification is required, and intellectual honesty demands we state it plainly: Section 12114 of the ADA explicitly excludes from its protections individuals who are "currently engaging in the illegal use of drugs." This is a real limitation, and advocates who ignore it do the argument a disservice.

However, this exclusion does not defeat the central thesis. It reframes it. **The discrimination this manifesto identifies does not operate against drug use per se. It operates against the underlying psychiatric disability that drives the drug use when treatment has failed.** The pipeline of discrimination targets people with mental illness at each stage; the drug use is a symptom and a foreseeable consequence, not the protected characteristic itself.

⚖ **LEGAL GROUNDING**

The Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 581 (1999), established that the unjustified institutionalization of persons with mental disabilities constitutes discrimination under the ADA. The carceral pipeline described in this manifesto — where defunded psychiatric systems funnel mentally ill people into jails that have become de facto psychiatric institutions — is the logical extension of *Olmstead* into the criminal justice context.

Several Circuit courts have recognized that the ADA applies to arrests and prosecutorial decisions where the underlying conduct is a direct manifestation of a disability. See *Sheehan v. City and County of San Francisco*, 743 F.3d 1211 (9th Cir. 2014); *Thompson v. Davis*, 295 F.3d 890 (9th Cir. 2002).

The Eighth Amendment doctrine in *Robinson v. California*, 370 U.S. 660 (1962), holds that punishing the *status* of being addicted is unconstitutional. *Powell v. Texas*, 392 U.S. 514 (1968), narrowed but did not overrule *Robinson*. The argument that drug-possession prosecution of self-medicating disabled persons functions as a status crime — punishing the medical condition itself rather than any voluntary harmful act — is a legal theory whose time has come back around.

B. The Discrimination Pipeline

Consider the structure of the discrimination:

1. Society acknowledges that mental illness is a disability.
2. Society fails to adequately fund psychiatric treatment, resulting in a shortage of inpatient beds, outpatient services, and medication access.
3. People with mental illness, unable to access adequate care, turn to substances that provide symptomatic relief.
4. Society criminalizes the possession and use of those substances.
5. People with mental illness are arrested, prosecuted, and incarcerated at disproportionate rates — not for harming others, but for the predictable consequence of a system that refused to serve them.
6. The criminal record then forecloses housing, employment, and educational opportunities — the very stabilizing factors that support recovery and accommodation.

This is not a policy failure in isolation. It is a pipeline. The state creates the condition (inadequate treatment), criminalizes the adaptive response (self-medication), and then punishes the person with the disability for the predictable outcome. *The protected class is not "drug user." It is "person with a psychiatric disability denied adequate care."* That class is unambiguously protected under the ADA, and the pipeline as a whole constitutes discrimination against it.

C. The Racial Architecture

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Earlier versions did not adequately address the racial dimension of drug-war enforcement. Version 4.0 corrects that omission. The disparate racial impact is foundational to both the ADA disparate-impact theory and to a parallel Title VI Civil Rights Act claim.

Black Americans use drugs at rates statistically indistinguishable from white Americans. They are arrested for drug offenses at approximately 3.6 times the rate. They are incarcerated for drug offenses at substantially higher multiples still. The 100-to-1 sentencing disparity between crack cocaine and powder cocaine (reduced to 18-to-1 by the Fair Sentencing Act of 2010, still not eliminated despite years of EQUAL Act introductions) was passed in an explicitly racialized political climate and has had explicitly racialized effects.

John Ehrlichman, Nixon's domestic policy chief, told *Harper's* magazine in a 1994 interview (published in 2016) that the Nixon-era War on Drugs was constructed deliberately to target "the antiwar left and Black people." This is not contested historical interpretation. It is documentary admission from the architect of the policy.

The point is not that every individual prosecutor today acts on racial animus. The point is that the system was designed in part for racially discriminatory purposes, has consistently produced racially discriminatory outcomes, and disproportionately targets people who are simultaneously protected by the ADA (psychiatric disability), Title VI (race), and the Eighth Amendment (cruel and unusual punishment of status). *A system this overdetermined in its constitutional vulnerabilities should not survive.*

VI. MEDICINE IN ITS INFANCY: THE LIMITS OF PRESCRIPTION PHARMACOLOGY

Modern psychiatry, for all its advances, remains a young and imperfect science. The monoamine hypothesis of depression — the theoretical foundation for SSRIs — is increasingly recognized as incomplete at best, misleading at worst. Antipsychotics carry risks of tardive dyskinesia, metabolic syndrome, and neuroleptic malignant syndrome. Benzodiazepines, prescribed freely for anxiety, produce physical dependence indistinguishable from that of the street drugs they are meant to replace. SSRI discontinuation syndrome can be debilitating. Long-acting injectable antipsychotics, once administered, cannot be undone for weeks or months regardless of what the patient experiences.

The side-effect profiles of many psychiatric medications are not minor inconveniences. They are, for many patients, disabling in their own right: weight gain of fifty or sixty pounds, sexual dysfunction that destroys relationships, cognitive dulling that robs a person of their identity, and akathisia — an internal restlessness so unbearable it is itself a documented risk factor for suicide.

> ⚠ **IMPORTANT QUALIFICATION**
> The argument that follows — that self-medication can represent a rational pharmacological decision — does not imply that all self-medication is safe, effective, or without risk. Unregulated substance use carries real dangers: unknown potency, drug interactions, addiction, and acute toxicity. *The point is not that self-medication is always wise, but that the response to it should be medical, not criminal.* The appropriate intervention for a person making a risky pharmacological decision is a physician, not a prosecutor.

When a person with treatment-resistant depression finds that psilocybin provides relief without the disabling side effects of a sixth failed antidepressant, when a veteran with PTSD finds that cannabis quiets nightmares that no SSRI could touch, when a person with chronic pain discovers that kratom manages what opioid prescriptions once did before they were abruptly discontinued under the 2016 CDC guidelines — these are not moral failures. *These are rational pharmacological decisions made by suffering people in a system that has failed them.*

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Version 4.0 acknowledges a complication earlier versions glossed: in August 2024, the FDA Advisory Committee declined to recommend approval of MDMA-assisted therapy for PTSD. This was widely understood as a setback for psychedelic medicine. The decision rested largely on concerns about clinical trial methodology — functional unblinding, expectancy effects, and adverse-event reporting — not on a finding that MDMA was ineffective. *The honest reading is that the science is real but the regulatory pathway is genuinely difficult.* Better trials, not abandonment of the line of research, is the answer. The FDA's caution does not vindicate Schedule I status; it indicates that approval will require extraordinarily rigorous evidence — which the ongoing research is producing.

Paracelsus, the father of toxicology, established the foundational principle of pharmacology five centuries ago:

> *"Alle Dinge sind Gift, und nichts ist ohne Gift; allein die Dosis macht dass ein Ding kein Gift ist."*
> "All things are poison, and nothing is without poison; the dosage alone makes it so a thing is not a poison."
> — Paracelsus, *Die dritte Defension* (1538)

This axiom makes no distinction between patented and unpatented molecules. Aspirin can kill. Acetaminophen destroys livers and is the leading cause of acute liver failure in the United States. Water, consumed in excess, causes fatal hyponatremia. The classification of a substance as "medicine" or "drug of abuse" is not, fundamentally, a pharmacological distinction. It is a political and economic one.

VII. THE PHARMACRATIC INQUISITION: CUI BONO?

Who benefits from the criminalization of unpatentable molecules?

The pharmaceutical industry, which cannot profit from substances that grow in fields or can be synthesized without proprietary processes, has a direct financial interest in maintaining the illegality of competing compounds. Psilocybin, MDMA, cannabis, ibogaine, kratom — these substances have demonstrated therapeutic potential in peer-reviewed research, yet their legal status remains restricted or prohibited. Meanwhile, patented alternatives with inferior efficacy and worse side-effect profiles enjoy FDA approval and insurance coverage.

This is not conspiracy theory. It is documented market economics. The lobbying expenditures of pharmaceutical companies are public record. Their influence on scheduling decisions, FDA advisory panels, and congressional drug policy is documented. The Pharmacratic Inquisition is not a metaphor. It is a business model — and one that conservative critics of "regulatory capture" should find as objectionable as progressive critics of "corporate power" do.

> **i EPISTEMIC CAUTION**
> The claim that pharmaceutical industry lobbying directly drives drug scheduling decisions is supported by documented lobbying records and published research on regulatory capture. It should not be overstated into a claim of coordinated conspiracy.
> The system produces these outcomes through diffuse financial incentives, institutional inertia, and ideological commitments to prohibition that predate modern pharmaceutical lobbying. *The critique stands on economic analysis without requiring intent.*

> **✎ EDITORIAL NOTE FOR THE POLICYMAKER**
> If you are a fiscal conservative skeptical of consolidated industry influence over federal regulation, you should recognize this critique as substantively aligned with your priors. The DEA Schedule I list is one of the most striking examples of regulatory capture in the federal code: a list of substances whose continued illegality benefits a specific industry, maintained by an agency with structural incentives to expand its enforcement remit, immune from the cost-benefit analysis that governs nearly every other federal regulation. *Reforming Schedule I is not a "progressive" project. It is a regulatory hygiene project of the kind any serious good-government reformer should support.*

The doctrine that all non-prescribed drug use is inherently pathological serves this model. It frames the question not as "Does this substance help this person?" but as "Is this substance approved by the institutions that profit from its alternatives?" The patient's experience is rendered irrelevant. The molecule's legal status becomes its moral status. And the person who finds relief outside the approved channels is redefined as a criminal.

VIII. THE BIG CANNABIS PROBLEM: DECRIMINALIZATION ≠ COMMERCIALIZATION

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> This section is new in Version 4.0. It exists because the most credible and currently unanswered critique of cannabis legalization in the United States is not "drugs are bad" — it is "the commercial cannabis industry is reproducing the worst features of Big Tobacco in real time, and the public health community is rightly alarmed." Stanford psychiatrist Keith Humphreys has been making this argument with rigor and patience for years. We agree with him. Anyone serious about drug policy reform must engage this critique honestly.

The American cannabis market in 2026 is not what reform advocates imagined twenty years ago. It is not a quiet system of adult personal use. It is an aggressively capitalized industry of branded products, glossy advertising, celebrity endorsements, private equity rollups, and potency escalation that would have been unimaginable to the activists who fought for medical cannabis in the 1990s.

Consider what has happened:

- **Average cannabis flower potency has roughly tripled since the 1990s**, and concentrate products routinely exceed 80% THC. The cannabis a college student smokes today is not the cannabis their parents may have smoked in 1985. It is a different drug.
- **Commercial advertising targets young adults aggressively** despite legal restrictions, with brand identities, social media presence, and product placement that deliberately echo the Marlboro and Joe Camel era of tobacco marketing.
- **Edible products are designed in forms appealing to children** — gummies, chocolates, candies — with packaging similar enough to mainstream snack products that pediatric emergency department visits for accidental cannabis ingestion have multiplied.
- **Private equity has moved into the cannabis industry** with the same logic it brought to nursing homes, dialysis clinics, and emergency rooms: roll up regional players, extract margin, scale aggressively, fight regulation.
- **Cannabis use disorder is real and is increasing** among heavy daily users of high-potency products, particularly among adolescents and young adults whose brains are still developing.
- **Cannabis-induced psychosis** in genetically vulnerable users is a documented and growing clinical concern, particularly with high-potency concentrates.

This is not the success story reform advocates wanted. It is the **Big Tobacco playbook**, repeated.

The Correct Distinction

The mistake that many reform jurisdictions made was conflating *decriminalization* with *commercialization*. They are not the same.

- **Decriminalization** removes criminal penalties for personal possession and use. Portugal decriminalized in 2001. There is no commercial cannabis industry in Portugal. There is no Coca-Cola of cannabis selling branded product. People who possess small amounts are not arrested; they are referred to dissuasion commissions. Treatment is funded. Use rates have not exploded.
- **Commercialization** creates a regulated commercial market with for-profit producers, retailers, advertising, branding, and capital markets. Colorado, California, Washington, Oregon, and most other U.S. legalization states followed this model. Outcomes are mixed at best. Public health metrics on adolescent use, cannabis use disorder, and pediatric exposure have moved in the wrong direction.

> ⚠ **THE POLICY POINT**
> Decriminalization without commercialization is the public health victory. Decriminalization with unrestricted commercialization is a public health gamble whose results are now coming in. *We can have the first without the second.* This is the path Portugal took. It is the path American reform should take.

What Honest Cannabis Policy Looks Like

A serious cannabis policy framework — one that respects adult autonomy without surrendering public health to the industry — would include:

1. **Decriminalize personal possession** of small amounts, federally and in every state.
2. **Restrict commercial advertising** to the level imposed on tobacco: no broadcast advertising, no youth-targeted imagery, no celebrity endorsement, plain packaging, mandatory health warnings.
3. **Cap THC potency** in commercial products, particularly for concentrates and edibles.
4. **Restrict edible products** that mimic candy, snacks, or other items appealing to children.
5. **Tax the industry meaningfully** with revenues earmarked for treatment, research, and public health education — the way alcohol and tobacco taxes are supposed to work and rarely do.
6. **Prohibit private equity rollups** of the industry, or at minimum impose ownership concentration limits.
7. **Fund public health research** independent of industry funding.
8. **Treat cannabis use disorder as a serious clinical condition** with adequate treatment infrastructure.
9. **Educate adolescents honestly** about real risks (Section XII).

> ✎ **EDITORIAL NOTE FOR THE POLICYMAKER**
> The position outlined here — decriminalize use, regulate commerce strictly — is consistent with conservative tobacco-control orthodoxy of the 1990s and 2000s. *We do not need to invent a new regulatory philosophy for cannabis. We need to apply the one we already used for tobacco, with the lessons that experience taught us.*

This is not anti-cannabis. It is anti-Big Cannabis. There is a meaningful difference. **Legal does not mean condoned. Available to adults is not the same as marketed to children. Personal use is not the same as commercial promotion.** A society can permit something without celebrating it, regulate something without criminalizing the user, and tax something without subsidizing the industry's expansion.

IX. INCARCERATION AS CRUEL AND UNUSUAL PUNISHMENT

The Eighth Amendment to the United States Constitution prohibits cruel and unusual punishment. Incarcerating a person for drug use alone — for the act of introducing a substance into their own body — meets any reasonable definition of cruelty when that person's use is a direct manifestation of an untreated psychiatric disability. *Robinson v. California* (1962) held that punishing the *status* of being addicted is unconstitutional. The argument that prosecuting drug possession by self-medicating disabled persons is functionally a status crime is doctrinally available and morally compelling.

The evidence is unambiguous: incarceration does not treat addiction. It does not deter drug use. What it does, reliably and predictably:

- Exposes nonviolent people to criminal networks, criminal thinking, and criminal socialization.
- Disrupts employment, housing, and family connections — the very stabilizing factors that support recovery.
- Creates a permanent criminal record that forecloses future opportunity in employment, housing, education, professional licensing, and family integrity.
- Subjects people with mental illness to environments that exacerbate their conditions: overcrowding, violence, solitary confinement, and medication disruption.
- Increases the probability of post-release overdose death, as tolerance lost during incarceration meets supply of unknown potency.

> ⚠ **IMPORTANT QUALIFICATION**
> This argument does not extend to drug-related conduct that harms others. Impaired driving, violence committed under the influence, neglect of dependents, theft to fund addiction at scale — these are legitimate criminal matters regardless of the underlying substance.
> The distinction is between drug use that affects only the user and drug-related behavior that victimizes others. *This manifesto argues for decriminalization of the former category, not blanket immunity from accountability.*

To place a mentally ill person in a cage because they used a substance to manage their symptoms is not correction. It is not deterrence. It is punishment of the disabled for the crime of being inadequately served, and it is cruel.

X. THE INTELLECTUAL DISHONESTY OF "DRUG-RELATED CRIME"

The War on Drugs justifies itself by pointing to "drug-related crime." This framing collapses under honest scrutiny when its components are disaggregated:

- **Crimes caused by prohibition itself.** Trafficking, distribution, territorial violence, money laundering — these are artifacts of the black market, not of the substances. Alcohol prohibition produced organized crime. Drug prohibition produces cartels. *Legalization eliminates these crimes by definition*, in the same way that the end of alcohol prohibition eliminated bootlegging.
- **Crimes caused by poverty and desperation.** Petty theft to fund addiction is a crime of economic desperation created by the intersection of addiction, poverty, and the artificially inflated cost of black-market drugs. Regulated supply at pharmaceutical cost would eliminate most of it.
- **Crimes caused by untreated mental illness.** Erratic behavior, public disturbance, trespass — symptoms of psychiatric crisis that occur in the absence of drugs as well, and are more properly addressed by mental health intervention than by arrest.
- **Crimes genuinely caused by intoxication.** Assault, impaired driving, domestic violence — these are legitimate criminal acts that should be prosecuted based on the harm caused. *We do not prohibit alcohol because some people drive drunk. We prohibit drunk driving.* The same logic must govern other substances.

When the categories are separated, "drug-related crime" largely dissolves. What remains is either prohibition's own creation, addiction's economic externalities, mental illness, or behavior that should be prosecuted on its own terms regardless of substance use. None of these justifies prosecuting personal possession.

XI. THE PORTUGAL MODEL — AND THE OREGON CAUTION

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Earlier versions cited Portugal as the model without addressing the most prominent American attempt to replicate it: Oregon's Measure 110, which was passed in 2020 and substantially recriminalized in 2024 amid visible disorder and a fentanyl crisis. Version 4.0 engages Oregon directly, because any honest case for Portugal-style reform must explain why the American attempt struggled and how to do it correctly the next time.

What Portugal Did

In 2001, Portugal decriminalized the personal possession and use of all drugs under Law 30/2000. Possession of a personal supply — defined as up to a ten-day quantity — was reclassified from a criminal offense to an administrative one. People found in possession are not arrested. They are referred to a "dissuasion commission" (*Comissão para a Dissuassão da Toxicodependência*) composed of legal, social work, and medical professionals, which can recommend treatment, impose minor sanctions, or take no action at all.

Crucially, Portugal *paired* decriminalization with sustained, well-funded investment in treatment, harm reduction, and social reintegration. The decriminalization headline is famous; the treatment investment behind it is what made the policy work.

The results after more than two decades: drug-induced death rates among the lowest in Europe, significant reductions in HIV transmission among people who inject drugs, increased treatment uptake, and no meaningful increase in overall drug use. *Portugal did not condone drug use. It simply stopped destroying lives over it, and built the medical infrastructure to address it.*

What Oregon Tried

In 2020, Oregon voters passed Measure 110, decriminalizing personal possession of all drugs. The intent was to replicate Portugal. The execution did not.

Several things went wrong:

1. **Sequencing failure.** The criminal penalties were lifted before the treatment infrastructure was built. The promised treatment funding was slow to deploy. The result was decriminalization without the medical alternative, which is not the Portuguese model — it is simply removing legal consequences without providing care.
2. **Weak dissuasion mechanism.** The civil citation that replaced criminal possession charges came with a $100 fine and a phone number. There was no functional equivalent of the Portuguese dissuasion commission. Compliance was minimal.
3. **The fentanyl crisis arrived simultaneously.** Oregon implemented Measure 110 just as illicit fentanyl saturated the West Coast supply. Overdose deaths spiked across the region — including in states that did not decriminalize. The political narrative attributed the deaths to the law.
4. **Visible disorder** in Portland and other cities eroded public support, regardless of whether the visible disorder was actually caused by the policy change or by housing costs, mental health system collapse, and post-pandemic dynamics.

In 2024, Oregon substantially recriminalized personal possession. The reform did not survive the political backlash.

What Oregon Teaches

Oregon's experience does not refute Portugal. It refutes *partial* implementation of the Portuguese model. The lessons are clear and important:

1. **Decriminalization without treatment infrastructure is sequencing failure.** Treatment must come first, or simultaneously. It cannot trail behind by years.
2. **Dissuasion mechanisms must have teeth.** A $100 fine and a hotline is not a Portuguese dissuasion commission. Real engagement, real assessment, real follow-up.
3. **Public order concerns are legitimate.** A reform that produces visible street disorder will not survive politically, regardless of whether the disorder is caused by the reform itself.
4. **Fentanyl is a unique challenge** that the Portuguese model in its 2001 form did not have to confront. American reform must explicitly address contaminated supply through regulated safe-supply programs.
5. **The Portuguese model is the right model.** Doing it correctly means doing it completely.

> **⚠ THE POLICY POINT**
> Oregon should be studied as a cautionary tale about implementation, not invoked as evidence that Portugal-style reform cannot work in America. *The lesson of Oregon is to do the full Portuguese model, not the half measure.*

XII. WHAT WE TELL OUR CHILDREN: HONEST DRUG EDUCATION

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> This section is new in Version 4.0. The decriminalization argument is incomplete without an explicit account of what we say to children. The D.A.R.E. program failed because it lied. The replacement must succeed by telling the truth.

D.A.R.E. (Drug Abuse Resistance Education), the dominant American drug education program from 1983 onward, was extensively studied and shown not to reduce — and in some studies to *increase* — adolescent drug use. The program failed for a single fundamental reason: it lied, and adolescents are unusually attentive to lies told by adults.

When children were told that cannabis was as dangerous as heroin, and they then encountered cannabis users who had not died and were not addicted, they reasonably concluded that the rest of the program's claims were also unreliable. The lie about cannabis discredited the truth about heroin.

Honest drug education — for children, for adolescents, for adults — must be built on a foundation that respects the listener's intelligence. The core messages are these:

What honest drug education says:

1. **Most human societies have used psychoactive substances in some form.** This is a fact about how human beings live. It is not a recommendation. It is the context.
2. **Some substances are very dangerous. Some are catastrophically dangerous. The danger varies enormously by substance, by dose, by purity, by context, by user, by frequency.** Lumping all "drugs" together as if they are a single category is dishonest.
3. **Adolescent brains are uniquely vulnerable.** Brain development continues into the mid-20s. Early initiation of substance use is associated with worse long-term outcomes for nearly every drug. *Delaying any substance use until adulthood is strongly recommended on the evidence — and that includes alcohol, which is often used by parents who would be horrified by the same use of cannabis or other drugs.*
4. **Abstention is always a valid choice. Often it is the wisest choice. It is never a choice anyone needs to apologize for.** A person who never drinks, never uses cannabis, never tries any psychoactive substance is not missing out on something they need. Most healthy adults navigate life without illicit substance use.
5. **If you do choose to use as an adult — and many adults do, including most of the parents reading this — practice harm reduction.** Know what you are using. Know the dose. Know the context. Have a sober person present. Never use alone with opioids. Never use alone with anything if you have any psychiatric history that could destabilize. Never drive. Respect set and setting.
6. **Pathological use is real.** When use begins to harm relationships, work, health, finances, or self-image, it has crossed from use into disorder. Recognize the warning signs. Help is available.
7. **Help is available without punishment.** This is the policy commitment that makes everything else possible. A society that punishes people for asking for help drives people away from help.

✎ EDITORIAL NOTE FOR THE PARENT

The instinct to forbid is understandable. The instinct to terrify is older still. Neither works. Adolescents are not deterred by claims they can disprove with their own observation. They *are* influenced by parents who tell the truth, who model healthy relationships with the substances they use (alcohol, caffeine, prescription medication), who explain the real reasons substances are dangerous, and who make clear that asking for help — about a friend, about themselves, about a difficult experience — will be met with care rather than punishment.

This is the message of the responsible parent and the honest educator. It is not the message of the drug warrior. It is also not the message of the drug enthusiast. It is the message that the evidence supports.

XIII. THE FUNDING CRISIS AS A HUMAN RIGHTS VIOLATION: THE NUMBERS

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Earlier versions said the funding crisis was severe. Version 3.0 proved it with data. Version 4.0 explains *why* the funding crisis persists — the specific federal rules that prevent psychiatric beds from being built even when everyone agrees they are needed. These rules are technical, but their effects are not. We will explain each in plain language.

> **A note on acronyms.** Federal health policy is written in initials. We will spell each one out the first time it appears. If you find yourself losing the thread, the problem is not your reading. It is the deliberate impenetrability of bureaucratic language, which keeps these debates inside a small priesthood of specialists. *Part of the work of this manifesto is breaking that priesthood open.*

The Psychiatric Bed Shortage

A 2025 study published in the peer-reviewed journal *PLOS Medicine* analyzed federal hospital data covering the years 2011 through 2023. The data came from the Centers for Medicare and Medicaid Services — known as CMS, the federal agency that pays for hospital care for the elderly and the poor and tracks every certified hospital in the country. The finding was stark: the United States has approximately **28.4 inpatient psychiatric beds for every 100,000 people**. Researchers in the field generally agree that a healthy system needs about **60 beds per 100,000 people**. *We are operating at less than half of what we need, and that figure has not improved in over a decade.*

The picture is even worse for state-run psychiatric hospitals — the public facilities that serve the people least able to pay for private care. According to the Treatment Advocacy Center, a research organization that tracks access to psychiatric care, state psychiatric hospital beds have fallen to about 10.8 per 100,000 people. That is roughly 36,150 beds in a country of 340 million.

And here is the cruel twist: more than half of those state beds — **52%** — are now occupied by people sent there through the criminal court system, usually for evaluation of whether they are mentally competent to stand trial. *The criminal justice system has consumed more than half of America's already inadequate state psychiatric capacity, leaving fewer beds available for ordinary patients in crisis who voluntarily seek help.*

The shortage is not abstract. Seventy-three percent of states report that their psychiatric hospitals are operating above 85% of capacity, the threshold researchers use to identify a system in crisis. Eleven states are above 95%. To reach the level of care other developed nations consider adequate, the United States needs roughly **107,000 additional inpatient psychiatric beds** — more than tripling current state hospital capacity.

The Four Structural Obstacles Earlier Versions Ignored

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Calling for 107,000 new psychiatric beds without addressing the federal financing rules that prevent their construction is unserious. Version 4.0 names the four specific obstacles, and explains each one in plain language.

Obstacle 1: A 1965 Medicaid rule that punishes states for building psychiatric beds.

Medicaid is the federal-state program that provides health insurance to low-income Americans. When Congress created Medicaid in 1965, it included a rule — known among specialists as **the IMD Exclusion**, where IMD stands for "Institution for Mental Diseases" — that says federal Medicaid will not pay for adult patients in any facility with more than 16 beds primarily devoted to mental illness. (For the policy lawyers reading this, the citation is 42 U.S.C. § 1396d(a)(31)(B).)

The original goal was good: Congress wanted to push the country away from the warehouse-style state mental hospitals of the mid-20th century, into smaller community-based care. But the community-based care was never adequately funded. The result, sixty years later, is that any state that wants to build a 50-bed psychiatric hospital today knows that federal Medicaid will refuse to pay for the patients in it. The state has to pay alone, out of state funds. *No state can afford that. So the beds do not get built.*

The fix. Congress can repeal the rule outright. Short of full repeal, the federal Department of Health and Human Services (the cabinet department that oversees federal health programs) can use a tool called a "Section 1115 demonstration waiver" — essentially, written permission to experiment outside the rule — to allow individual states to work around the IMD Exclusion for specific groups of patients. These waivers already exist for substance use disorder treatment. They should be expanded to cover serious mental illness across all states.

Obstacle 2: An insurance parity law that no one enforces.

In 2008, Congress passed a law called the **Mental Health Parity and Addiction Equity Act**. The law says, in plain terms, that health insurance plans must cover treatment for mental illness and addiction at the same level of generosity as they cover treatment for physical illness. If your insurance pays for ten cardiology visits, it must pay for ten therapy visits. If it covers a hospital stay for a heart attack, it must cover an equivalent stay for a psychiatric crisis.

The law exists. Insurers violate it routinely. They impose limits on therapy visits that they would never impose on cardiology visits. They deny coverage for inpatient psychiatric care that they would approve for medical care of similar severity. They use prior authorization rules and provider network restrictions to make mental health benefits effectively unusable.

Enforcement is divided among three federal agencies: the **Department of Labor** (which regulates the insurance plans most large employers offer), the **Department of Health and Human Services** (which regulates other plans), and the **Department of the Treasury** (which has tax-related authority over employer-sponsored insurance). All three can act. None has acted aggressively. In 2024, the federal government finalized a stronger enforcement rule. Insurance industry lawsuits against it are ongoing.

This is the single most immediately actionable item in mental health policy. No new law is needed. The existing law simply needs to be enforced.

Obstacle 3: We do not have the workforce to staff the beds we need.

The United States has approximately 10.5 psychiatrists for every 100,000 people. Rural areas have far fewer — many rural counties have no psychiatrist at all. The broader behavioral health workforce — psychiatric nurses, psychiatric nurse practitioners (advanced-practice nurses with prescribing authority), licensed clinical social workers, addiction counselors, and peer support specialists (people in recovery themselves who are trained and certified to support others) — is stretched even thinner.

Building 107,000 psychiatric beds without simultaneously training and recruiting tens of thousands of clinicians to work in them produces empty buildings. Federal investment in psychiatry residency slots, in psychiatric nurse practitioner training programs, in social work pipelines, and in rural placement incentives is a non-negotiable part of any serious treatment expansion plan. *Beds without staff are warehouses.*

Obstacle 4: Privacy rules that block coordinated care.

A federal regulation known as **42 CFR Part 2** — meaning Part 2 of Title 42 of the Code of Federal Regulations, the section of the federal rulebook that governs public health — was written in the 1970s to protect the confidentiality of substance use disorder records. The intent was sound: people sought treatment then knowing their records could be turned over to employers or to the police. The rule promised that they could not be.

But the rule was written before the era of integrated electronic health records, and it created barriers between the addiction treatment system and the rest of medicine. A patient's primary care doctor often cannot see whether the patient is in addiction treatment. The addiction treatment provider often cannot see what other medications the patient is taking, which creates real risk of dangerous drug interactions. The rule has been progressively brought into closer alignment with HIPAA, the broader federal medical privacy law (the **Health Insurance Portability and Accountability Act** of 1996), but barriers remain. Targeted reform is needed to allow integrated, coordinated care while still protecting patients from the misuse of their records.

What It Would Cost to Close the Gap

Hospital construction in the United States is expensive. Estimates for psychiatric facility construction range from approximately $500,000 to $1,500,000 per bed, with $1 million per bed serving as a commonly used midpoint. Operating a psychiatric bed costs roughly $800 to $1,100 per day, which works out to between $292,000 and $401,500 per bed per year.

To build all 107,000 needed psychiatric beds:

- **Construction cost:** approximately $53.5 billion to $160.5 billion total. At the $1 million-per-bed midpoint, that comes to **$107 billion** — which works out to about **$10.7 billion per year over a ten-year program**.
- **Operating cost, once built:** approximately **$31 billion to $43 billion per year**.

Where the Money Goes Instead

The federal government's drug control budget — money spent across all federal agencies on drug enforcement, interdiction, and related programs — was **$43.6 billion in fiscal year 2024**. The fiscal year 2025 request was $44.5 billion. ("Fiscal year" refers to the federal accounting year, which runs from October 1 through September 30.)

Within that drug control budget:

- The **Drug Enforcement Administration** (the DEA, the federal agency that enforces drug laws and conducts drug-related criminal investigations) received about **$3.3 billion**.
- The **federal Bureau of Prisons** received about **$4.1 billion** in costs related to drug enforcement and the incarceration of people convicted of drug offenses.

When state and local drug enforcement spending is added in, total American drug-war spending exceeds **$40 billion every year**.

The annual cost to build the psychiatric beds the country needs ($10.7 billion per year) is less than the budget of the DEA alone. The United States is not too poor to fund psychiatric care. It has chosen to fund enforcement instead.

XIV. THE COST OF EMPIRE VERSUS THE COST OF COMPASSION

Operation Epic Fury vs. Operation Heal America: A Fiscal Comparison Added April 2026 — as the United States enters its sixth week of war with Iran

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> This section was added in April 2026 because history handed us an argument we could not have scripted. *Reasonable people disagree about whether the war with Iran is justified.* This section does not ask the reader to oppose the war. It asks only that the reader confront the comparative budget priorities. If America can find $2 billion a day to bomb Iran, the claim that America cannot find $10.7 billion a year to build psychiatric beds is not a fact about America's resources. It is a fact about America's choices.

As this manifesto goes to press, the United States is engaged in active military operations against Iran under the codename Operation Epic Fury, launched February 28, 2026. The fiscal contrast between what the nation spends destroying a country's infrastructure abroad and what it refuses to spend rebuilding psychiatric infrastructure at home is no longer an abstraction. It is happening in real time.

What the War Costs

Mark Cancian, a retired Marine colonel and senior advisor at the Center for Strategic and International Studies (a Washington defense policy think tank), told NPR on April 7, 2026 — Day 39 of the war — that Pentagon spending on the war had reached approximately **$28 billion**. Linda Bilmes, a Harvard Kennedy School professor and co-author of *The Three Trillion Dollar War* (the definitive accounting of the true cost of the Iraq War), estimates that Operation Epic Fury costs approximately **$2 billion per day** in short-term operations alone. She projects that total costs — including veterans' benefits, interest on the debt incurred to pay for the war, and rebuilt military baselines — will eventually exceed **$1 trillion**.

Reported war costs to date:

Period	Cost
First 2 days (munitions alone)	$5.6 billion
First 6 days	$11.3 billion
First 12 days	$16.5 billion
Day 39 (Pentagon spending)	$28 billion
Pentagon supplemental request to Congress	$200 billion
Projected total cost (Bilmes)	More than $1 trillion

The war is being financed entirely through borrowing, on top of an existing national debt of approximately $38 trillion. As *New York Times* columnist Nicholas Kristof calculated in March 2026: the war costs **$1.3 million per minute**.

What Healing Would Cost

Now compare those numbers to what it would cost to fix the American mental health crisis described in the previous section:

Investment	Cost	Days of War Equivalent
Build all 107,000 needed psychiatric beds	$107 billion	~53 days
Annual share of a 10-year construction program	$10.7B/year	~5 days
Operate all 107,000 new beds for one year	$31–43B	~15–21 days
Total annual budget of SAMHSA*	~$7.5B	~4 days
Total annual budget of the DEA	$3.3B	~1.6 days
Housing First program for 500,000 homeless Americans	~$15B/year	~7.5 days
TOTAL: complete national mental-health infrastructure, year one	**~$150B**	**~75 days**
Operation Epic Fury, total cost through Day 39	$28–40B	—
Operation Epic Fury, projected total cost (Bilmes)	More than $1 trillion	—

* **SAMHSA** — the Substance Abuse and Mental Health Services Administration — is the federal agency primarily responsible for funding mental health and addiction treatment services across the country.

The Per-Weapon Comparison

Every Tomahawk cruise missile fired at an Iranian facility costs approximately $2 million. Every Patriot interceptor — the missiles fired to shoot down incoming Iranian missiles aimed at American forces and allies — costs $4 to $6 million. The United States has fired more than 800 Patriot interceptors in the first 39 days of the war. That is more than $3 billion in interceptor missiles alone.

Translated into healthcare terms:

- For the cost of a single Patriot interceptor missile, the United States could **operate a 16-bed psychiatric crisis unit for one full year**.
- For the cost of the Patriot interceptors alone, the nation could **build 3,000 new psychiatric beds.**
- For the cost of a single day of this war, the United States could **fund Naloxone distribution sufficient to reverse every opioid overdose in America for a year**. (Naloxone is the emergency medication that reverses opioid overdoses; it is sold under the brand name Narcan.)

The War Will Make the Crisis Worse

Professor Bilmes estimates that at least one-third of the 55,000 troops deployed to Operation Epic Fury will eventually file for veterans' disability benefits. Many of those claims will be for post-traumatic stress disorder, traumatic brain injury, and toxic exposure — the signature wounds of post-9/11 American war.

These veterans will return to a country that does not have enough psychiatric beds to treat them. They will join the queue behind the civilians who were already waiting. Some will get adequate care. Some will not. Some will self-medicate with whatever they can find on the street. Some will be arrested for it. Some will die.

> ⚠ **THE CYCLE**
> The Pharmacratic Inquisition does not merely punish the mentally ill for being sick. *It creates new patients through wars of choice, and then refuses to treat them when they come home.* The budget is the proof. The priorities are on the page.

The United States could build every psychiatric bed it needs, fund every addiction treatment program it lacks, and house every homeless American whose homelessness is driven by untreated mental illness — for less than the projected cost of a single war.

This is not a question of whether America can afford to treat its mentally ill. *It is a question of whether America chooses to.*

XV. A PROPOSED FRAMEWORK: BALANCING RIGHTS, REDUCING HARM

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> Version 3.0 listed seven planks. Version 4.0 expands to fifteen, adding the structural financial reforms (IMD exclusion, MHPAEA enforcement, workforce expansion), the cannabis commercialization restrictions, evidence-based drug education, religious liberty recognition, drug court reform, and centering of lived experience. The framework is now comprehensive enough to constitute an actual policy program.

1. Federal Decriminalization of Personal Possession

Personal possession of any substance in quantities consistent with personal use (up to a ten-day supply) becomes a civil, not criminal, matter. Police encounters generate mandatory referral to a community-based dissuasion commission with real assessment authority and follow-up — not a $100 fine and a hotline number. *This is the Portuguese model, done correctly.*

2. ADA Section 12114 Repair

Either legislative amendment of § 12114 to clarify that the "currently using" exclusion does not foreclose protection for the underlying psychiatric disability, or DOJ/EEOC joint enforcement guidance interpreting the exclusion narrowly. *The discrimination pipeline cannot be litigated effectively under the current text without one of these two clarifications.*

3. Massive Investment in Treatment Infrastructure

The 107,000-bed expansion. $107 billion over a decade in capital investment. $31–43 billion annually in operations. Funded by redirecting enforcement spending and supplemented by new appropriations. Including:

4. Repeal or Substantial Reform of the Medicaid IMD Exclusion

42 U.S.C. § 1396d(a)(31)(B). Either full repeal for adults with SMI and SUD, or systematic expansion of 1115 SUD/SMI demonstration waivers to nationwide scope. *This is the single largest federal financing obstacle to psychiatric capacity. It must be addressed.*

5. Vigorous Enforcement of MHPAEA (Parity)

The 2008 parity law and the 2024 NQTL Final Rule. DOL, HHS, and Treasury joint enforcement strengthened. State insurance commissioner coordination. Private right of action enhancement. *This is the most immediately actionable item in mental health policy and requires no new statute.*

6. Workforce Expansion

Federal investment in psychiatry residency slots, psychiatric nurse practitioner training, peer support specialist certification and reimbursement, social work pipelines, and rural placement incentives. *Beds without staff are warehouses.*

7. Regulated Safe Supply Programs

Pharmaceutical-grade safe supply access under medical supervision, modeled on British Columbia and Switzerland with adjustments for the fentanyl-saturated supply. This eliminates poisoning deaths, reduces black-market crime, and brings people into contact with healthcare. *This is the specific intervention that addresses the fentanyl crisis Oregon was unable to navigate.*

8. Cannabis Commercialization Reform

Decriminalize personal possession federally. Apply tobacco-grade restrictions to commercial cannabis: advertising restrictions, plain packaging, potency caps, prohibition of products designed to appeal to children, ownership concentration limits, taxation with revenue earmarked for treatment. *Decriminalization without commercialization. Tobacco regulation, not Coca-Cola regulation.*

9. Behavioral Accountability Without Diagnostic Criminalization

Drug use that produces no harmful behavior is not a criminal matter. Drug use that produces harmful behavior — violence, impaired driving, neglect of dependents — is addressed based on the behavior, not the substance. *This is exactly how we treat alcohol.*

10. Evidence-Based Scheduling Reform

Remove barriers to research on Schedule I substances with demonstrated therapeutic potential. Fast-track rescheduling of psilocybin, MDMA, ibogaine, and other compounds where clinical evidence supports medical use. Break the regulatory capture that allows pharmaceutical industry interests to dictate which molecules are legally available. *Restore scientific judgment to the scheduling process.*

11. Religious Liberty Recognition

Codify protection for traditional and emerging entheogenic religious practice under RFRA principles, building on *Gonzales v. O Centro* (2006). Protect Native American Church peyote use unambiguously. Provide clear administrative pathways for sincere religious use. *Religious liberty is a conservative value. The drug war has steamrolled it for fifty years.*

12. Honest Drug Education

Federal investment in evidence-based drug education replacing failed D.A.R.E.-style approaches. Honest about real risks. Respectful of adolescent intelligence. Anchored in harm reduction principles. *Includes alcohol and tobacco; treats them as the dangerous drugs they are.*

13. Drug Court Reform

Drug courts have mixed evidence — some effective, some coercive in ways that produce worse outcomes than treatment-as-usual. Reform mandates evidence-based treatment, ends the "graduate or prison" coercion that drives unstable participation, and ensures medications for opioid use disorder are available rather than prohibited (as they have been in many drug courts).

14. Housing-First and Community Diversion

Invest in housing-first programs that provide stable shelter without preconditions of sobriety, paired with voluntary access to treatment and psychiatric services. *The evidence base is robust, and these programs are more cost-effective than the cycle of emergency rooms, jail stays, and shelter turnover.*

15. Lived Experience at the Center of Policy

Mandate inclusion of people with lived experience of mental illness, addiction, and recovery in policy advisory bodies, regulatory rulemaking, and service design. Peer support specialist certification and reimbursement at parity with other behavioral health professions. *The people most affected by these policies should help write them.*

XVI. THE CRUELTY OF THE CURRENT LAW

Let us be direct about what the current system does.

It takes a person with schizophrenia who smokes methamphetamine because it quiets the voices when their Medicaid-approved antipsychotic makes them too sedated to function, and it puts them in a cell.

It takes a veteran with PTSD who uses cannabis because the VA prescribed them an SSRI that made them suicidal, and it revokes their benefits.

It takes a mother with treatment-resistant depression who microdoses psilocybin because three prescription antidepressants failed, and it separates her from her children.

It takes a teenager with undiagnosed bipolar disorder who self-medicates with opioids because no one recognized what was happening, and it gives them a felony record before their twenty-first birthday.

It takes a person in chronic pain whose prescription was abruptly terminated under the 2016 CDC guidelines, who turned to kratom and then to street opioids when kratom was threatened, and it adds them to the overdose statistics.

It takes a Black American who used the same drug in the same dose as a white American, and it gave one a diversion program and the other a prison sentence.

And then it calls this justice.

The current iteration of drug law in the United States is not merely misguided. It is ignorant — ignorant of pharmacology, ignorant of psychiatry, ignorant of the lived reality of mental illness, ignorant of evolutionary biology, ignorant of the cross-cultural human relationship with psychoactives. It is cruel — cruel in its indifference to suffering, cruel in its preference for punishment over healing, cruel in its racial selection. And it is a fundamental failure of compassion — the basic human recognition that a person in pain will seek relief, and that the form of that relief is a medical question, not a moral one.

XVII. CONCLUSION: FROM INQUISITION TO ENLIGHTENMENT

The Pharmacratic Inquisition must end.

Not because drug use is harmless — it is not. Not because addiction is benign — it devastates lives. Not because accountability should be abolished — it should not. Not because the commercial cannabis industry has earned our trust — it has not. Not because every alternative medicine is safe — none is, fully.

But because the response to a health crisis cannot be a criminal one. Because the punishment of the disabled for the inadequacy of the systems meant to serve them is an abomination. Because a nation that spends more on Patriot interceptors than on psychiatric beds has lost its moral authority to lecture anyone about law and order. Because the impulse to alter consciousness is older than agriculture and will outlive every prohibition, and the only honest question for public policy is *how*, not *whether*, that impulse is engaged.

Paracelsus told us the poison is in the dose. The poison in America is not the drugs. *It is the dosage of cruelty, indifference, and willful ignorance administered daily by a system that has chosen profit and punishment over healing and humanity.*

The path forward exists. Portugal demonstrated it. The science supports it. The Constitution requires it. The fiscal arithmetic demands it. The only thing missing is the political will to implement it correctly — to decriminalize without commercializing, to regulate without criminalizing, to treat without coercing, to teach without lying, to respect adult autonomy without surrendering public health, to confront the Big Cannabis problem without recriminalizing the user, to fund treatment with the seriousness we currently fund war.

The mentally ill of this nation deserve better. The addicted deserve better. The veterans returning from Operation Epic Fury will deserve better. The human beings sleeping on sidewalks and dying in cells deserve better.

> **It is time to stop the war on the most vulnerable among us and start the work of actually helping them.**

XVIII. WHAT YOU CAN DO

> ✎ **EDITORIAL NOTE ON ARGUMENT EVOLUTION**
> A manifesto that ends without telling its audience what to do is an essay. Version 3.0 added a basic call to action. Version 4.0 expands it into specific guidance for different audiences.

For Citizens

Educate. Share this manifesto. Discuss it with your representatives, your community organizations, your faith communities, your professional associations, and your networks. The first step in ending the Pharmacratic Inquisition is refusing to accept its premises.

Advocate. Contact your federal and state representatives. Demand increased funding for psychiatric beds and substance abuse treatment. Oppose legislation that criminalizes addiction. Support ballot initiatives for decriminalization paired with treatment investment. *Be specific about pairing.*

Support. Volunteer with or donate to organizations working on these issues:

- **Treatment Advocacy Center** (tac.org) — Research and advocacy for psychiatric bed access
- **Drug Policy Alliance** (drugpolicy.org) — Drug law reform and decriminalization
- **National Alliance on Mental Illness / NAMI** (nami.org)
- **National Harm Reduction Coalition** (harmreduction.org) — Evidence-based harm reduction services
- **Multidisciplinary Association for Psychedelic Studies / MAPS** (maps.org) — Psychedelic medicine research
- **Mental Health America** (mhanational.org)

Connect. Join the Pneumapsyche community at lived.pneumapsyche.com — a peer support platform for people navigating mental health challenges.

Speak. If you have lived experience with self-medication, mental illness, and the criminal justice system, your story matters. Sharing it — safely, on your terms — is one of the most powerful tools for changing hearts and policy.

For Policymakers

The most immediately actionable items, requiring no new authority:

1. Direct DOJ Civil Rights Division to investigate state and county systems where the discrimination pipeline is operating.
2. Direct DOL/HHS/Treasury to vigorously enforce MHPAEA and the 2024 NQTL Final Rule.
3. Direct HHS to expand Section 1115 SUD/SMI demonstration waivers nationwide as an interim measure pending IMD exclusion repeal.
4. Direct DEA to act on pending rescheduling petitions on the merits, with scientific advisory input independent of industry lobbying.
5. Direct VA to clarify cannabis policy for veterans and to expand access to clinical trials of psilocybin and MDMA-assisted therapy.

Legislative vehicles that already exist or are in active circulation:

- IMD Exclusion repeal (multiple bills introduced across recent Congresses)
- EQUAL Act (eliminates remaining crack/powder sentencing disparity)
- Mainstreaming Addiction Treatment Act (MATA) (X-waiver elimination already accomplished; expand)
- MORE Act (cannabis decriminalization at federal level — must be amended to *prohibit* aggressive commercialization)
- Restoring Hope for Mental Health and Well-Being Act (treatment infrastructure)
- Bipartisan Safer Communities Act (mental health title — expand)

Bipartisan entry points specifically:

- **Veterans care** — psilocybin/MDMA for PTSD has bipartisan champions; expand the coalition.
- **Religious liberty** — RFRA-grounded entheogen access is a conservative-coded path that progressive advocacy has neglected.
- **Federalism** — let states experiment with the Portuguese model; remove federal barriers.
- **Fiscal responsibility** — the cost arithmetic favors reform on every honest accounting.
- **Regulatory capture critique** — Schedule I as a case study in industry-aligned regulatory inertia is an argument the populist right can engage as easily as the progressive left.

For Clinicians

Document, in your clinical records, when patients are using substances to manage symptoms that prescribed medications have failed to address. Build the empirical record. Engage with policy through your professional associations (APA, AAFP, ACEP, AANP). Refuse to participate in coercive treatment that lacks an evidence base.

For People with Lived Experience

You are the most credible witness this argument has. Your story, told safely and on your terms, will move policymakers in ways that no manifesto ever could. The Pneumapsyche community exists in part to support that storytelling. *Your testimony is the evidence that turns the legal and statistical case into a moral one.*

SOURCES AND REFERENCES

Primary Legal Sources

[1] Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. [2] 42 U.S.C. § 12114 — ADA exclusion for current illegal drug users (acknowledged and addressed in Section V). [3] *Olmstead v. L.C.*, 527 U.S. 581 (1999); *Sheehan v. City and County of San Francisco*, 743 F.3d 1211 (9th Cir. 2014); *Thompson v. Davis*, 295 F.3d 890 (9th Cir. 2002). [4] *Robinson v. California*, 370 U.S. 660 (1962); *Powell v. Texas*, 392 U.S. 514 (1968). [5] Religious Freedom Restoration Act, 42 U.S.C. § 2000bb et seq.; *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418 (2006). [6] Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a; 2024 Final Rule on Non-Quantitative Treatment Limitations (DOL/HHS/Treasury). [7] 42 U.S.C. § 1396d(a)(31)(B) — Medicaid IMD exclusion.

Psychiatric Bed Shortage Data

[8] Lindenfeld, Z. et al. (2025). "Inpatient psychiatric bed capacity within CMS-certified U.S. hospitals, 2011–2023." *PLOS Medicine*, 22(7), e1004682. [9] Treatment Advocacy Center. (2024). *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds.* [10] NRI, Inc. (2025). *Use of State Psychiatric Hospitals, 2025.* [11] McBain, R.K. et al. (2022). "Estimating Psychiatric Bed Shortages in the US." *JAMA Psychiatry*, 79(4), 279–280. [12] American Psychiatric Association. (2023). *The Psychiatric Bed Crisis in the United States.* APA Presidential Task Force Report. [13] Hudson, C.G. (2021). "Benchmarks for needed psychiatric beds." *Int. J. Environ. Res. Public Health*, 18(22), 12205.

Cost Data

[14] Montana Legislative Branch. (2014). *Building and Operating a 16-Bed Inpatient Facility.* HJR16 Report. [15] Autodesk Construction Blog (2025); Zintego (2025); Erecre Group Realty (2022). Hospital construction cost analyses.

Drug Control Spending

[16] U.S. GAO. (2025). *ONDCP: Experts' Views on Developing a National Media Campaign.* [17] ONDCP. (2024). *FY 2025 Budget Highlights.* [18] Open Society Foundations / Count the Costs (2013). *Wasting Billions, Undermining Economies.*

Overdose Death Data

[19] Spencer, M.R. & Ahmad, F. (2026). "Drug Overdose Deaths in the U.S., 2023–2024." *NCHS Data Brief* No. 549. [20] CDC NCHS. (2025). *Provisional Drug Overdose Death Data.* [21] CDC NCIPC. (2025). *Statement on Provisional 2024 Overdose Data.* [22] Overdose Lifeline. (2025). *2024 Opioid Overdose Data Report.*

Scholarly Sources Engaged

[23] Khantzian, E.J. (1985, 1997). The self-medication hypothesis of addictive disorders. *American Journal of Psychiatry.* [24] Hart, C. (2021). *Drug Use for Grown-Ups: Chasing Liberty in the Land of Fear.* [25] Szalavitz, M. (2016). *Unbroken Brain: A Revolutionary New Way of Understanding Addiction.* [26] Alexander, B. (2008). *The Globalization of Addiction: A Study in Poverty of the Spirit.* [27] Maté, G. (2008). *In the Realm of Hungry Ghosts.* [28] Kleiman, M.A.R. (1992). *Against Excess: Drug Policy for Results.* [29] Caulkins, J.P. & Reuter, P. Various works on drug policy at RAND. [30] Humphreys, K. Various works on cannabis commercialization. [31] Satel, S. Various works on coercion in addiction treatment. [32] Roth, A. (2018). *Insane: America's Criminal Treatment of Mental Illness.* [33] Ben-Moshe, L. (2020). *Decarcerating Disability.* [34] Harcourt, B. (2011). On the asylum-to-prison hypothesis. [35] Alexander, M. (2010). *The New Jim Crow.* [36] Hansen, H. & Netherland, J. Various works on race and drug policy. [37] Bagenstos, S. Various works on disability rights and the ADA. [38] Whitaker, R. (2010). *Anatomy of an Epidemic.* [39] Szasz, T. (1961). *The Myth of Mental Illness.*

Comparative and Historical Context

[40] Siegel, R.K. (1989, rev. 2005). *Intoxication: The Universal Drive for Mind-Altering Substances.* [41] Pollan, M. (2021). *This Is Your Mind on Plants.* [42] Pollan, M. (2018). *How to Change Your Mind.* [43] Courtwright, D. (2001). *Forces of Habit: Drugs and the Making of the Modern World.* [44] Courtwright, D. (2019). *The Age of Addiction.* [45] EMCDDA. *Country Drug Reports: Portugal.* [46] Paracelsus. (1538). *Die dritte Defension wegen des Schreibens der neuen Rezepte.* [47] SAMHSA. (2024). *Key Substance Use and Mental Health Indicators: 2023 NSDUH.* [48] WHO. *Principles on the Right to Health.*

Iran War Cost Data (Section XIV)

[49] Cancian, M. (CSIS). NPR Interview, April 7, 2026. [50] Bilmes, L. Harvard Kennedy School. Interview, April 6, 2026. [51] CSIS Updated Analysis. McCusker, E. (AEI). [52] Pentagon Classified Briefing to Congress (NYT, *Guardian*). [53] Kristof, N. "Iran Is a $1.3-Million-a-Minute War." *New York Times*, March 21, 2026. [54] Warren, E. Quoted in *Time*, "What US Spending on the War Could Fund Instead," March 16, 2026. [55] UPI. Pentagon $200B supplemental request. March 24, 2026. [56] *The Intercept.* "Trump's War on Iran Could Cost Trillions." March 17, 2026. [57] Bilmes, L. "The real cost of the war with Iran." *Boston Globe*, March 10, 2026.

On the Nixon-Era Origins

[58] Baum, D. "Legalize It All." *Harper's Magazine*, April 2016 (Ehrlichman interview disclosure).

This manifesto is published under the advocacy of Pneumapsyche because the breath of the soul should not be criminalized.

pneumapsyche.com | lived.pneumapsyche.com | pharmacratic-inquisition.info

Pneumapsyche, Inc. — Version 4.0 — April 2026