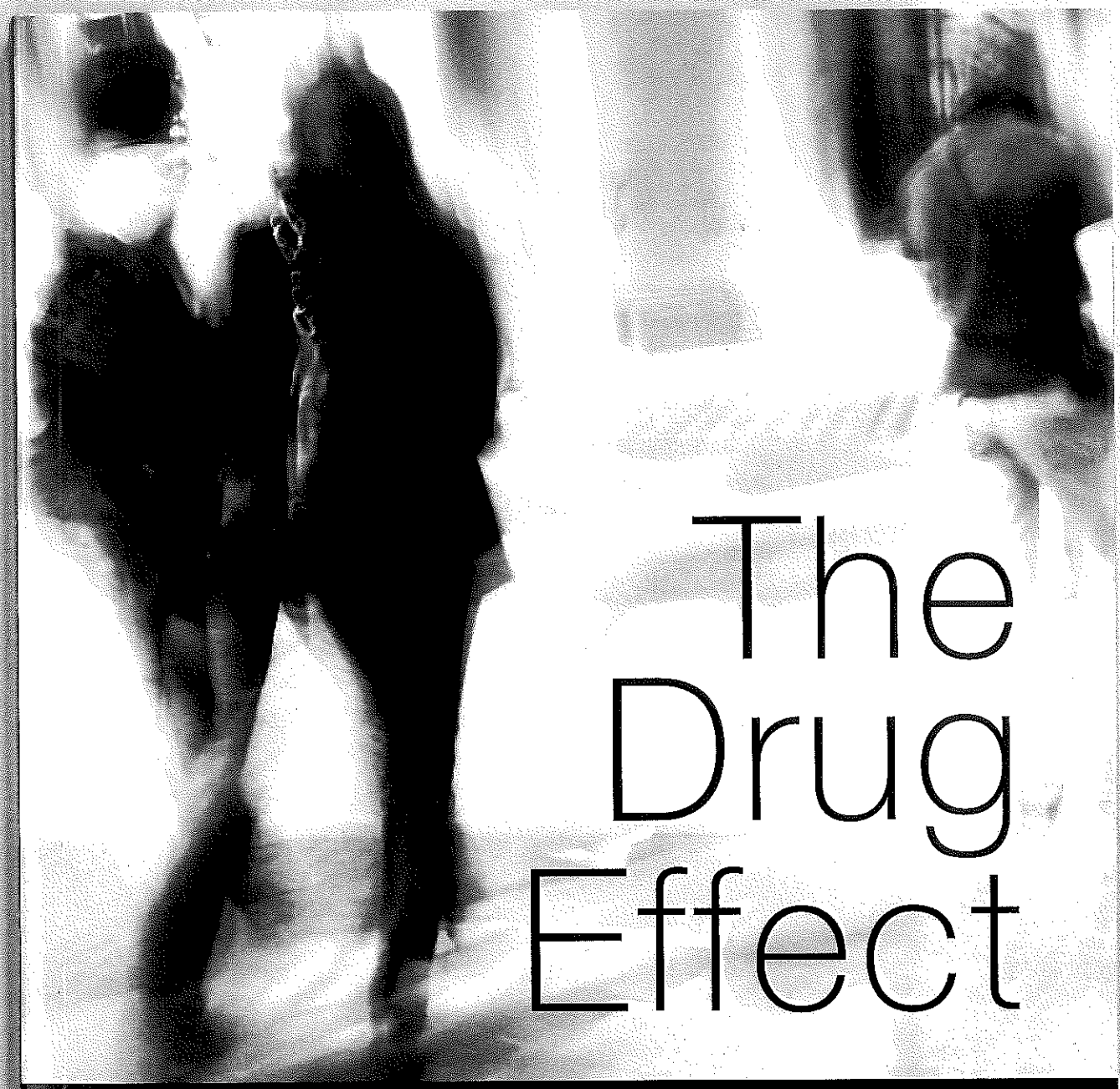
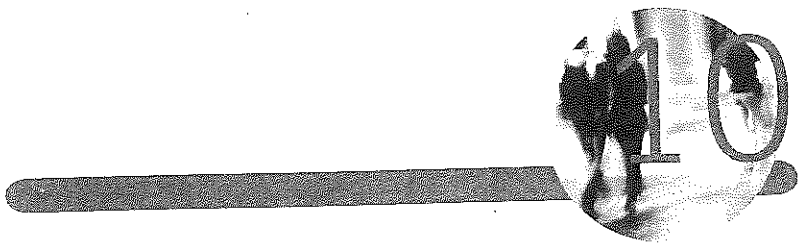


# The Drug Effect

## Health, crime and society

Edited by
Suzanne Fraser
and David Moore

CAMBRIDGE



# Cannabis in cultural and legal limbo

## Criminalisation, legalisation and the mixed blessing of medicalisation in the USA

Craig Reinarman

Use of cannabis or marijuana is a cultural practice that is both common and criminalised. This contradiction has helped spark a growing drug policy reform movement in the USA. Reformers have successfully exposed the high costs and ineffectiveness of punitive prohibition as the dominant drug policy paradigm. As alternatives to criminalisation, reformers have advocated rights-based legalisation, which has not been adopted, and health-based harm reduction strategies, which have enjoyed growing acceptance. Drug policy reformers generally regard various forms of medicalisation as unequivocally positive, both more effective in terms of public health and more humane. These include syringe exchanges; medical marijuana; and addiction treatment in lieu of incarceration, including 'drug courts' that practice 'therapeutic jurisprudence'.

In this chapter, however, I suggest that medicalisation is not a conceptually coherent alternative to criminalisation and that medicalisation discourses are multivalent – as easily deployed by prohibitionists in support of continued criminal punishment for drug use as they are by drug policy reformers in support of legalisation. Shifting the frame around drugs from criminal law to public health has much to recommend it, but this move foregrounds addiction-as-disease and pushes normal drug use into the shadows as deviance, which paradoxically may constrain drug policy reform in the long run.

The first section offers a brief historical sketch of cannabis criminalisation in the US and the drug control industry that created and sustains it. The second section traces the rise of the drug policy reform movement and the harm reduction paradigm. The third section describes some of the forms and consequences of medicalisation and examines, in particular, recent medical research showing a link between cannabis and psychosis. The concluding section outlines the political conjuncture that holds cannabis criminalisation in place in the US – despite, and with the help of, medicalisation.

## Criminalisation and the drug control industry

Medical preparations containing cannabis were widely used in many societies for centuries. Cannabis was prescribed in American medical practice for a variety of conditions from at least the mid-nineteenth century. It was admitted to the *United States Pharmacopoeia* in 1850 and listed as a medicine in the *National Formulary* and the US *Dispensatory*. Extracts of cannabis were sold as therapeutic agents by major pharmaceutical companies.[1]

The moral status of cannabis was transformed from medicine to vice in the context of the Great Depression. A 1934 US Bureau of Narcotics report claimed that 'fifty percent of the violent crimes committed in districts occupied by Mexicans, Turks, Filipinos, Greeks, Spaniards, Latin Americans and Negroes may be traced to the abuse of marihuana'. The report quoted a narcotics officer saying: 'Marihuana has a worse effect than heroin. It gives men the lust to kill, unreasonably, without motive – for the sheer sake of murder itself.'[2] The 1936 film *Reefer Madness* depicted young people taking a few puffs and then engaging in wild sex, assault and murder. *Reefer Madness* has come to be seen as clumsy propaganda, ironically now beloved by cannabis users as a parody. But it influenced public perception and policy for three decades. After the repeal of alcohol prohibition in 1933 and several years of budget cuts,[3] the Federal Bureau of Narcotics advocated cannabis prohibition, which Congress passed in 1937. This law criminalised possession of cannabis for the first time.

As cannabis use became widespread in the 1960s and earlier claims that it caused crime and violence lost credibility, advocates of criminalisation shifted the foundation of their argument to claim that cannabis was dangerous because it had the opposite effect, causing users to lose all motivation.[4] Since then, a variety of new claims in support of dangerousness and criminalisation have been added: rising potency, addiction and mental illness.

Since 1971, when the US government first declared 'war on drugs', drug control activities have expanded continuously into more agencies and levels of the state (see 'Major components of the US drug control industrial

complex'). Drug arrests have become the largest category of arrests, helping to quadruple the US incarceration rate to the highest in the world.[5] The number of Americans imprisoned specifically for drug offences increased ten-fold between 1980 and 2006.[6] The US imprisons more citizens for drug offences than all original member states of the European Union combined imprison for all offences combined, despite the EU's larger population.

In 2008 American police arrested 847 864 Americans for cannabis offences, 754 224 (88.96 per cent) for possession alone.[7] This is half of all drug arrests. Most arrested cannabis users no longer go to prison but are usually held in jail overnight and pay a fine. But this still results in a criminal record that can prevent them getting financial aid for education and makes it more difficult to get jobs. Cannabis arrests also serve as a gateway to deeper legal trouble that does end in incarceration. People on probation or parole or those who have other convictions often are sent to prison for cannabis possession, and prosecutors frequently use cannabis charges as bargaining chips to obtain longer sentences for other offences.

The people who work in drug control agencies share intelligence, equipment, technical knowledge, professional lore and an anti-drug ideology. They also share material interests. The budgets of these agencies and the careers of the drug control agents who work in them depend financially on a perpetual threat of 'drugs' and on the inference that only more stringent criminalisation will finally stem the tide. The Federal Bureau of Narcotics helped create cannabis criminalisation, and cannabis criminalisation in turn helped create a drug control industry. Taken together, this network of interlinked agencies constitutes a *drug control industrial complex.*

**In focus**

**Major components of the US drug control industrial complex**

- Drug Enforcement Administration, US Department of Justice
- Office of National Drug Control Policy (Drug Czar), White House
- Federal Bureau of Investigation
- Central Intelligence Agency
- Bureau of International Narcotics Matters, US State Department
- Drug control units in the Army, Navy, Air Force, Coast Guard, National Guard
- Immigration and Customs Enforcement
- Federal and state prisons and prison guard unions
- State police drug squads
- Local police drug squads
- Narcotic officers' associations
- Private sector drug testing companies
- Drug Abuse Resistance Education, Inc.

The drug control industrial complex is the most important force sustaining the criminalisation of cannabis. After the crack cocaine scare faded in the early 1990s,[8] cannabis arrests skyrocketed to new records each year, doubling between 1980 and 2010.[9] This sharp rise was *not* caused by increased prevalence of use, which was stable or declining, but rather appears to have been driven by the increased capacity of drug law enforcement. The Reagan and Bush-I Administrations expanded and escalated the drug war. The Clinton Administration further increased drug war funding, contingent upon effectiveness as measured by drug arrests. With cannabis being the most commonly used illicit drug, cannabis users were the low-hanging fruit.

The Drug Enforcement Administration has continued to raid medical marijuana dispensaries in defiance of President Obama's statements and his Attorney General's policy of non-interference with such dispensaries.[10] When drug policy reform activists gathered enough signatures to get a marijuana legalisation measure on the 2010 ballot in California, the California Police Chiefs Association, the California Narcotic Officers' Association and police union lobbyists led the opposition. Whenever criminalisation has faced such threats, the drug control industry has defended it.

## Legalisation and the drug policy reform movement

Despite the four-decade war on drugs and tens of millions of cannabis arrests, the US government's latest national survey found that 102 404 000 Americans – that is, 41 per cent of the population older than 12 years of age – have used cannabis at least once, a quarter of them in the past year.[11] There are hundreds of references to cannabis in all genres of popular music from Louis Armstrong through Bob Dylan, the Beatles, Willie Nelson and Dr Dre. Cannabis use is depicted in dozens of major films, including *It's Complicated, Wonder Boys, Eyes Wide Shut, The Big Chill, American Beauty, The Big Lebowski* and *How to Make an American Quilt*. Some anti-drug organisations claim that these references are a key cause of cannabis use. But it is just as likely that music and movies contain so many references to cannabis because widespread use has become inscribed in popular culture. In a major international review of cannabis policy, Room, Fischer, Hall et al. concluded that 'cannabis is an enculturated drug',[12] and survey evidence from Western societies shows that cannabis use has become 'normalised'.[13]

On top of the normalisation of cannabis, the escalating war on drugs has swelled American prisons without reducing American drug problems, leading more people to see punitive prohibition as a costly failure. This has given rise to a variety of drug policy reform efforts that have coalesced into a drug policy reform movement that takes legalisation or decriminalisation of cannabis as

a central goal. This movement has grown in size, scope, institutional capacity and influence.[14]

Drug policy reform organisations emerged in the wake of the 1960s, but a drug policy reform *movement* did not develop until the 1980s, when evidence began to mount that the sharing of syringes among injection drug users was a vector of HIV/AIDS transmission. This deadly epidemic helped give rise to 'harm reduction', a set of pragmatic public health practices and policies that began in the Netherlands and in Liverpool, England, with syringe exchange programs. Harm reduction was not designed as a direct challenge to prohibition, but it explicitly avoids taking a moral position against all drug use, unlike 'zero tolerance' and other drug war policies whose objective is a 'drug-free America'. Rather, harm reduction aims at the less utopian goal of reducing the harms associated with illicit drug use – and with drug policy – whether or not it reduces drug use.[15] Harm reduction policies have spread to 70 countries in the past 25 years.

Medical marijuana ballot initiatives did not derive directly from harm reduction, but within the harm reduction paradigm, depriving patients of a medicine from which they derive therapeutic benefit is a harm of criminalisation. Local campaigns for medical marijuana became the most visible front in the drug policy reform movement in the 1990s. Since 1996, voters in 15 states and Washington, DC, have passed medical marijuana initiatives. A growing number of patients and their physicians have rediscovered the range of therapeutic uses that were widely known in medical practice before criminalisation.[16]

The drug policy reform movement has more organisations, activists, funding and media coverage than ever before. For example, the National Organization for the Reform of Marijuana Laws (NORML) was founded in 1970. By 2010 it had 128 chapters in 35 states and 14 400 paid members, up tenfold since 1990. Nearly a million people have donated to support its work. The Drug Policy Alliance was formed in a merger of two drug policy reform organisations in the 1990s and plays a leading role in a broad array of drug policy reform efforts, with offices in several states and 130 000 subscribers to its 'Action Alerts'. DPA holds regular conferences that attract more than a thousand activists from dozens of countries, knitting together the disparate drug policy reform organisations into a more coherent movement.

Other key organisations include Students for Sensible Drug Policy, which has grown since 1998 to more than a hundred chapters in 41 of the 50 US states. Medical marijuana patients and their caregivers founded local advocacy organisations that became Americans for Safe Access in 2002. By 2010 it had 30 000 active members in 40 states. Law Enforcement Against Prohibition (LEAP) was started in 2002 by former narcotics officers and other police whose experience of futility on the front lines of the drug war persuaded them that legalisation was the only solution. Approximately 10 000 former

police have joined LEAP across the US and in 90 other countries. And for the first time, mainstream civil rights organisations have been moved by the extreme racial skewing of cannabis arrests to endorse legalisation.[17] So, too, have the National Black Police Association and a growing number of labor unions.

**In focus**

**Major organisations in the US drug policy reform movement**

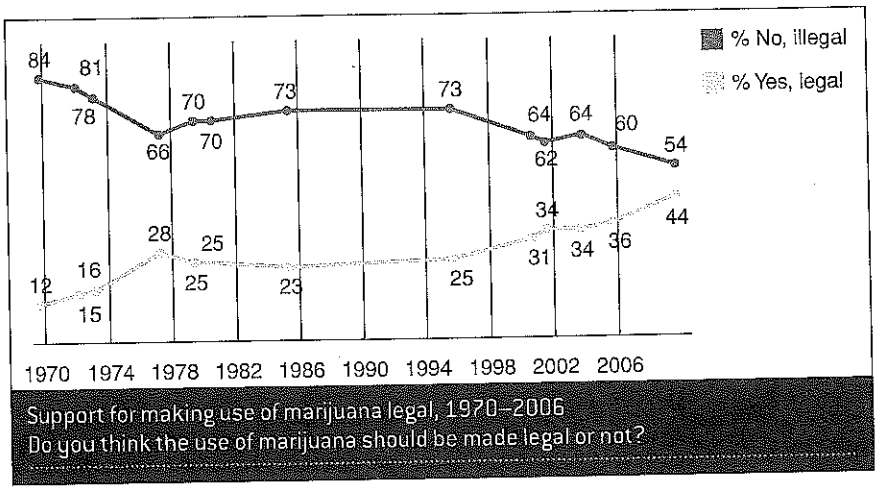
- National Organization for the Reform of Marijuana Laws
- Drug Policy Alliance
- American Civil Liberties Union
- Harm Reduction Coalition
- Students for Sensible Drug Policy
- Americans for Safe Access
- Marijuana Policy Project
- Law Enforcement Against Prohibition
- North American Syringe Exchange Network

## Shifts in public opinion and public policy

The drug policy reform movement has made headway. Opinion polls show greater public support for legalising marijuana in the US than ever before. An ABC News/*Washington Post* poll found that the percentage of Americans who favour legalisation had more than doubled, from 22 per cent in 1997 to 46 per cent in 2009.[18] A 2009 Zogby poll found 52 per cent of Americans agreed that 'marijuana should be legal, taxed and regulated'. A Gallup poll found that the percentage who favour 'making use of marijuana legal' rose from 31 per cent in 2000 to 44 per cent in 2009. Gallup (2009) characterised these results as 'the most tolerant in at least 40 years' and concluded, 'If public support were to continue growing at a rate of 1% to 2% per year, as it has since 2000, the majority of Americans could favor legalization of the drug in as little as four years.'[19]

When the question is marijuana for medical purposes, repeated polls show that a strong majority of Americans already favour legalisation.[20] This shift in public opinion has been mirrored in the media. In 2009 positive stories about the legalisation of cannabis have appeared in the *New York Times*, *Newsweek*, the *Washington Post*, the *Wall Street Journal*, *Forbes Magazine*, *Texas Monthly*, *National Review* and on numerous television news and talk programs.

The reform movement also has won incremental changes in drug policy aside from medical marijuana. In 2000 the Drug Policy Alliance mounted a successful ballot initiative in California to divert non-violent, first-time drug offenders to treatment in lieu of prison. In his 2008 election campaign, Barack Obama supported this idea, saying he wanted to move drug policy




Support for making use of marijuana legal, 1970–2006
Do you think the use of marijuana should be made legal or not?

out of criminal justice and into public health. Although he does not support marijuana legalisation, he said he would not interfere with medical marijuana in states where voters have made it legal. Syringe exchange programs now operate in 160 US cities, and the Obama Administration has removed a long-standing ban on using federal funds for this purpose. In 2010 Congress passed the Fair Sentencing Act of 2009 (S. 1789), which reduced sentencing disparities between crack cocaine offences (for which mostly African Americans are arrested) and powder cocaine offences. The New York legislature repealed the notoriously punitive Rockefeller drug laws. Voters in 15 cities have passed ballot measures making marijuana possession the 'lowest law enforcement priority'. Denver has effectively decriminalised marijuana. In El Paso, Texas, the US city most affected by the violence surrounding Mexican drug cartels, the City Council unanimously passed a measure calling for a halt to the drug war and consideration of alternatives.

In the context of recession and state fiscal crisis, the mounting costs of imprisonment have strengthened the drug policy reform movement and given momentum to the shift away from criminalisation.

## Medicalisations

Syringe exchange, medical marijuana, treatment in lieu of prison and other reforms march under the banner of medicalisation. Many drug policy reform activists, service providers and health professionals have been drawn to medicalisation because it seemed the only politically acceptable way to make US drug policy less harsh and to get help for those who need it. But defining drug issues within medicalisation discourse carries consequences.

The quintessential model for what became the harm reduction paradigm is syringe exchange, which is justified in terms of epidemiological evidence

of its effectiveness in reducing the spread of HIV/AIDS and hepatitis C to the general population. Many lives have been saved, but this public health logic neither challenges the criminalisation that led to risky syringe sharing in the first place nor asserts the human rights of injecting drug users.

Medical research has shown a variety of therapeutic benefits from cannabis, and medical marijuana advocates have pushed for the legalisation of cannabis for such medical uses. This provides moral legitimation to those who suffer from medical conditions for which physicians are willing to recommend cannabis. Yet it also restricts a drug widely used for quotidian pleasures to the terrain of medicine, where such pleasures are pushed outside the bounds of moral legitimacy, leaving non-medical cannabis use either deviant or implicitly pathologised.

All modalities of drug treatment rest on the notion of addiction-as-disease. But this genre of medicalisation is a mixed blessing, too. First, most drug users, particularly cannabis users, are not addicts and neither need nor want treatment. Second, even for addicts, conceiving of their behaviour as caused by a disease individualises it and narrows the aperture such that the contributions of the social contexts of use fall out of view. Third, defining addiction as a disease that prevents addicts from controlling their drug use is often a self-fulfilling denial of their human agency.

Although labelling addiction a disease has justified expanded treatment, the same dreaded disease is then invoked to justify imprisonment.[21] Many treatment providers once imagined treatment as an *alternative* to criminalisation, but they lost this policy argument to the more politically powerful drug control complex. When treatment providers opposed criminalisation, they lost resources; when they supported criminalisation, they gained resources.[22] Addiction-as-disease has helped get services to many people who need them, but rather than leading to a fundamental shift of gaze towards public health approaches it has instead become an *adjunct* to criminalisation.

Similarly, under the heading of 'therapeutic jurisprudence', specialised 'drug courts' dispense a contradictory blend of treatment and punishment. Treatment is based on the assumption that addiction-as-disease prevents drug users from thinking rationally, but punishment is based on the assumption that they rationally weigh the consequences of their actions. In the context of a criminal court, this form of medicalisation coerces a guilty plea as a condition of getting treatment and deprives drug offenders of the procedural protections afforded other offenders. Drug court judges are not impartial arbiters who ensure that the state has proven its cases but leaders of 'treatment teams'. By defining drug use as disease, drug courts have helped many get treatment, but at the same time widened the net of criminalisation.

## The case of cannabis and psychosis

The most recent instance of medicalisation supporting criminalisation is the claim that cannabis is associated with psychosis. Since 2000 an array of new, government-funded studies have reported evidence of such an association.[23] This research has been pressed into political service.[24] In a press conference on 3 May 2005, for example, Director of the US Office of National Drug Control Policy (or 'Drug Czar') John Walters claimed there was 'growing and compelling evidence... that regular marijuana use can contribute to depression, suicidal thoughts and schizophrenia'. He told of a 15-year-old whose marijuana use had driven him to suicide, and he brought the teen's grieving parents to the press conference. The parents later revealed on a radio talk show, however, that four drug tests in the months before their son's suicide and a toxicology test in the hospital afterward found no trace of cannabis, only alcohol.

Similarly, the day after a gunman in Tucson, Arizona, shot a Congresswoman in the head and killed a judge and five others, a conservative columnist wrote that the shootings 'should remind us why we regulate marijuana'. He cited research which he said showed that 'People who smoke marijuana are twice as likely to develop schizophrenia as those who do not smoke'.[25] A week later, another anti-drug crusader took the media to task for 'its tendency to overlook or underplay' the 'relationship of marijuana use to psychotic illnesses', implying that marijuana triggered the Tucson killings.[26]

Leaving aside its uses as propaganda, the association between cannabis and psychosis should not be dismissed. There are limitations in these studies and the strength of the correlations between cannabis use and psychotic symptoms varies, but the relationship persists across studies using different methods in different societies. Some show that the correlation becomes stronger with higher doses or longer use. Several knowledgeable researchers have argued that both the dose-specific response and the persistence of the association suggest the relationship is causal.

Given the history of politicised claims about cannabis, however, the nature of the evidence of a link to mental illness warrants critical reflection. The invocation of disease categories like 'psychosis' or 'schizophrenia' does a kind of 'cultural work'.[27] It brings questions about cannabis use into the realm of medicine and science, where experts are presumed to employ 'value-free' methods and measures. But certain values have been built into the methods and measures used to construct the indicators of the disease categories that are then linked to cannabis. These then become sedimented into 'statistical risk factors' and finally appear simply as 'facts' in the media and public discourse.

For example, authors of such studies tend to write of 'psychosis' as if it were a single, discrete disease entity that, once 'caused', a person 'has'. But

that is not the case. Diseases 'are usually presented as if a disease were a constant, timeless biological entity uninfluenced by the larger social context' when it is usually impossible to 'directly apprehend the biological core of disease unadulterated by attitudes, beliefs, and social conditions'.[28] As Mol shows, even a common physical disease like atherosclerosis is constructed by the ongoing 'enactments' of various medical specialists in interaction with patients, each with different experiences of symptoms, which change over time.[29]

This is even more so with a disease category like 'psychosis'. Most of the cannabis/psychosis studies measure indirect indicators of psychosis that are interpreted as 'symptoms' of the underlying disease even when they are transient or without consequence. One frequently cited longitudinal study found that daily cannabis users were 1.6 times more likely than non-users to report psychotic symptoms that can indicate schizophrenia.[30] But in this study, as in several others, neither psychosis nor schizophrenia were actually diagnosed or directly measured; rather, survey respondents checked any of ten 'symptoms' they had experienced in the month before interview. The act of translation whereby responses to a self-administered questionnaire become 'psychotic symptoms' and then come to stand for 'psychosis' itself is camouflaged by the conventions of scientific presentation.

Such responses could indeed be symptoms, but they are open to other interpretations. 'Hearing voices that other people do not hear' could be a sign of psychosis, but one in five Americans describe themselves as born-again, fundamentalist Christians who regularly hear the voice of God. 'Feeling that you are being watched or talked about by others' could be a paranoid delusion, but many normal high school students would check this box, too. 'Having ideas and beliefs that are not shared by others' fits all contrarian characters and most great leaders in history.[31]

The measures of cannabis use in these studies also bear scrutiny. They vary markedly: having tried cannabis at age 18; any cannabis use at age 15; cannabis dependence at age 18; daily cannabis use at any point; even any cannabis use at all. The follow-up intervals range from one to 27 years, so it is impossible to control for all the events and influences other than cannabis use – in some studies a single use episode years ago – that might cause 'psychotic symptoms'.

Many of the studies statistically controlled for other possible causes; but the hypothesis that such symptoms and cannabis use share a 'common cause' cannot be ruled out.[32] A recent analysis of ten key prospective cohort studies found that after controlling for some other possible causes, only five showed a significant association between cannabis use and psychosis, and two did not determine 'whether the psychotic symptoms... occurred only whilst intoxicated, or whether they persisted'.[33]

Some researchers found that 'regular' cannabis use increased the probability of developing schizophrenia or schizophreniform symptoms.[34]

Schizophrenia is not generally understood as a disease one can 'catch' or cause by virtue of behaviour. A recent review of six longitudinal studies in five countries concluded that it is 'plausible that cannabis use precipitates schizophrenia' in those who are already 'vulnerable because of a personal or family history of schizophrenia'.[35] Precipitation of a disease one already has, however, is different from causation.

The notion that a psychoactive drug might trigger an acute episode of already-present mental illness is certainly plausible. However, the epidemiological evidence on mental illness does not support this. Lifetime prevalence of cannabis use has increased steadily from a few per cent before the 1960s to nearly half the adult population in 2009.[36] The hypothesis that cannabis causes psychosis or schizophrenia would predict a rise in the rates of these disorders. But population-level rates of psychosis and schizophrenia have not increased and do not generally correlate with cannabis use rates.[37]

One review of this research noted, 'The contentious issue of whether cannabis use can cause serious psychotic disorders that would not otherwise have occurred cannot be answered based on the existing data.'[38] Authors of studies suggesting an association between cannabis and psychosis carefully qualify their findings in scientific journals. But they have little control over the inferences drawn from their research by the media, politicians and the public as these findings find their way into the broader culture. As deployed in the drug war in support of the criminalisation narrative, correlation becomes causation.

Yet even if the evidence could establish that cannabis causes psychosis in those with no history of disorder, it does not follow that criminalisation is the appropriate policy. An analysis of the World Health Organization's Mental Health Surveys concluded, 'Globally, drug use is not... simply related to drug policy, since countries with stringent user-level illegal drug policies did not have lower levels of use than countries with liberal ones.'[39] The European Union sponsored a major assessment of the effectiveness of drug control policy between 1998 and 2007, when arrests and imprisonment of users had increased sharply. The authors concluded, 'We found no evidence that the global drug problem was reduced... In aggregate... the problem became more severe.'[40] It seems fair to say that the evidence may support warnings about an increased risk of 'psychotic symptoms' among those already vulnerable to psychosis, but it does not support the inference that criminalisation is an effective means of reducing that risk.

## Conclusion

Medicalisation discourse is multivalent. It helped create the discursive space in which it was possible to legitimate syringe exchanges, medical marijuana

licensing systems, expanded addiction treatment and other reforms that have made US drug policy less draconian. But this has come at the cost of putting the imprimatur of 'science' and the presumption of 'objectivity' on contested definitions of 'risk' and 'disease', which reinforce criminalisation and strand normal drug use in the realm of deviance.

Medicalisation also leaves certain key questions off the table. More than 200 studies have been funded on potential mental health *risks* of cannabis but almost none on the potential mental health *benefits* of cannabis. Yet when researchers on occasion have asked users what effects they get from cannabis, they far more frequently report 'relaxation', 'stress relief' and 'improved sleep' than symptoms of psychosis.[41] This is especially so for medical marijuana patients.[42]

Even the most rigorous medical research is designed, funded, conducted and interpreted in a cultural context dominated by criminalisation discourse. The new research on a cannabis–psychosis link is only the most recent form of medicalisation that has been marshalled in support of criminalisation. Despite the growing drug policy reform movement and public opinion that is increasingly disenchanted with the war on drugs, medicalisation has not developed into an alternative drug policy regime. A powerful conjuncture of pressures holds criminalisation in place:

- *Institutional.* As noted earlier, the drug control industrial complex zealously defends its ideological and material interests in criminalisation. Police departments use claims about the risks of drug use to justify budget requests and deploy drug laws as a means of social control of subaltern groups.[43] Cannabis arrests are used as evidence of effectiveness and therefore a warrant for continued drug war funding to fiscally strapped local police departments. The drug control complex remains the source of official, expert information about the nature and extent of America's drug problem for policy-makers.
- *Constitutional.* Article VI of the US Constitution states that federal law 'shall be the supreme Law of the Land'. Legal reforms in the US can most easily be made at the local level, and least easily at the more distant federal level. This is why medical marijuana initiatives arise at the state level. In 2010 California voters nearly passed a cannabis legalisation initiative. But when early polls showed it leading, the Attorney General in Washington asserted federal supremacy, warning that if it passed he would order all necessary law enforcement to ensure that national drug laws were fully enforced. A constitutional structure in which federal law trumps state law has been a brake on drug policy reform and a structural source of support for continued criminalisation.
- *Cultural.* When the Federal Bureau of Narcotics first pushed Congress to criminalise cannabis, it could rely on several widely shared cultural values, including the idea that ingesting a substance simply for pleasure

was sinful.[44] Americans tend to approach even therapeutic drugs with a kind of 'pharmacological Calvinism';[45] it is morally acceptable to take a drug to bring oneself up from illness to normal, but not to bring oneself up from normal to better-than-normal. When cannabis was initially criminalised during the Depression, Congress found it easy to condemn a practice that was depicted as cutting against the grain of the Protestant work ethic. The American middle class has long feared losing self-control or work discipline and falling into the lower classes.[46] Fear of downward mobility, particularly given the diminishing job prospects for young people, was only heightened in the recession of 2008. By this logic, drugs are especially feared because they are thought to 'cause' one to lose self-control or work discipline. Such deep cultural values have formed the backdrop for a series of drug scares, all of which bolstered the criminalisation narrative.[47]

Since 1990, the drug policy reform movement has gone some way towards dislodging criminalisation from its hegemonic position, forcing it to contend openly with medicalisation and legalisation. Reforms rooted in health-based discourse like medicalisation have been more successful than reforms rooted in rights-based discourse like legalisation. Perhaps because it does not directly challenge criminalisation but in some respects reinforces it, medicalisation remains more politically palatable than legalisation.

As such, medicalisation may be a necessary stage through which US cannabis policy must pass to get to something else. But the word 'stage' implies a teleological trajectory, as if cannabis policy had a clear direction and an ultimate end. I am not sure that this is true. If US cannabis policy can be said to be travelling a road from criminalisation to legalisation, it is a road riddled with potholes, drawbridges in the up position and long detours. Given the forces holding criminalisation in place, it does not seem safe to assume that US drug policy is moving inexorably towards some form of legalisation. The old shows signs of dying, but the new still cannot be born. Cannabis remains caught in a cultural and legal limbo in the US, entangled in conflicting webs of meaning from which it will not be easily extricated. The only thing safe to predict is increasing contestation.

Medicalisation will be of limited help in settling the debate over cannabis policy because the issues ultimately do not hinge on technical knowledge of health risks. Much of what Americans eat, a lot of the ways in which they play and many of the technologies of the self they use entail health risks. In the last instance, the debate is not about 'objective' assessments of such risks but rather the morality of pleasure seeking, a political issue about which medical science is mostly mute. Cannabis may be suspended in this contradictory space for a long time.

## Acknowledgements

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## Notes

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29 Mol, *The Body Multiple*.
30 Fergusson, Horwood & Ritter, 'Tests of causal linkages between cannabis use and psychotic symptoms'.
31 Studies of how specific and sensitive such questions are 'suggest that the psychosis and paranoid scales of the instrument do not identify psychotic patients in clinical samples, and that participants who are not psychotic may have elevated scores on this scale' (McLaren, Silins, Hutchinson et al., 'Assessing evidence for a causal link between cannabis and psychosis', p. 14).
32 Room, Fischer, Hall et al., *Cannabis Policy*, p. 36.
33 McLaren, Silins, Hutchinson et al., 'Assessing evidence for a causal link between cannabis and psychosis', p. 14.
34 For example, Arseneault, Cannon, Witton et al., 2004.
35 Degenhardt & Hall, 'Is cannabis use a contributory cause of psychosis?', p. 556.
36 Office of Applied Statistics, *Results from the 2008 National Survey on Drug Use and Health*.
37 For example Degenhardt, Hall & Lynskey, 'Testing hypotheses about the relationship between cannabis use and psychosis'; Frisher, Crome, Martino & Croft, 'Assessing the impact of cannabis use on trends in diagnosed schizophrenia'.
38 McLaren, Silins, Hutchinson et al., 'Assessing evidence for a causal link between cannabis and psychosis', p. 17.
39 Degenhardt, Chiu, Sampson et al., 'Toward a global view of alcohol, tobacco, cannabis, and cocaine use', p. 1053; cf. Reinarman, Cohen & Kaal, 'The limited relevance of drug policy'.
40 Reuter & Trauttman, *A Report on Global Illicit Drugs Markets 1998–2007*.
41 For example Reinarman & Cohen, 'Law, culture, and cannabis'.
42 Grinspoon & Bakalar, *Marijuana, the Forbidden Medicine*; Institute of Medicine, *Marijuana and Medicine*.
43 For example Levine & Small, *Marijuana Arrest Crusade*.
44 Becker, *Outsiders*.
45 Gaylin, 'Feeling good and doing better', p. 3.
46 Ehrenreich, *Fear of Falling*.
47 Reinarman & Levine, *Crack in America*, pp. 5–8.

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