

Addiction 3

How well do international drug conventions protect public health?

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Lancet 2012; 379: 84–91

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This is the third in a [Series](#) of three papers about addiction

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The Single Convention on Narcotic Drugs in 1961 aimed to eliminate the illicit production and non-medical use of cannabis, cocaine, and opioids, an aim later extended to many pharmaceutical drugs. Over the past 50 years international drug treaties have neither prevented the globalisation of the illicit production and non-medical use of these drugs, nor, outside of developed countries, made these drugs adequately available for medical use. The system has also arguably worsened the human health and wellbeing of drug users by increasing the number of drug users imprisoned, discouraging effective countermeasures to the spread of HIV by injecting drug users, and creating an environment conducive to the violation of drug users' human rights. The international system has belatedly accepted measures to reduce the harm from injecting drug use, but national attempts to reduce penalties for drug use while complying with the treaties have often increased the number of drug users involved with the criminal justice system. The international treaties have also constrained national policy experimentation because they require nation states to criminalise drug use. The adoption of national policies that are more aligned with the risks of different drugs and the effectiveness of controls will require the amendment of existing treaties, the formulation of new treaties, or withdrawal of states from existing treaties and re-accession with reservations.

Introduction

2011 marked the 50th anniversary of the Single Convention on Narcotic Drugs.¹ This convention prohibited the production and use of narcotic drugs—specifically cannabis, opioids, and cocaine—except for medical and scientific purposes. The primary policies pursued have been criminalisation of the production, sale, and use of these drugs for non-medical purposes. Subsequent international treaties have extended this approach to synthetic pharmaceutical drugs, such as amphetamine-type stimulants and benzodiazepines, and the chemical precursors used to manufacture these agents.^{2,3}

We briefly describe how the international system has operated and assess how well it has achieved its primary goals—namely, protection of public health and wellbeing through reduced use of prohibited drugs and expedited access to these drugs for medical use. We argue that the international system's provisions have restricted policy experimentation in national and local drug policies. We suggest ways in which the international treaties could be modified to allow the necessary policy experiments to develop more evidence-informed practices that give priority to the protection of public health and wellbeing.

Current international drug control system

The 1961 convention covered drugs derived from three plants: opioids from the poppy (*Papaver somniferum*) and derivatives, cocaine from the coca bush (*Erythroxylum coca*), and cannabis from the cannabis plant (*Cannabis sativa*). A separate 1971 convention made the non-medical use of a wide range of synthetic drugs a punishable offence, although whether a criminal sanction was needed has been disputed.⁴ These drugs were manufactured primarily by pharmaceutical companies in developed countries whose economic power ensured that the treaty imposed less strict controls on manufacture and trade than did the 1961 convention.² A 1988 convention on trafficking consolidated the focus of the control system on suppression of illicit markets by including provisions to prevent money laundering and extending controls to precursor chemicals (panel 1).⁵

The management and enforcement of the drug treaties are done by several international agencies that have overlapping responsibilities and different mandates and sometimes work at cross-purposes.⁶ The international political body that governs drug issues is the Commission

Key messages

- The international drug control system has not ensured adequate medical supply of opioids, particularly in low-income and middle-income countries, but also in some high-income countries.
- The system has not effectively restricted the non-medical use of controlled drugs, and illicit drug production, manufacture, and use is now a global issue. Illicit drug use accounts for a substantial and increasing global burden of disease.
- The system's emphasis on criminalisation of drug use has contributed to the spread of HIV, increased imprisonment for minor offences, encouraged nation states to adopt punitive policies (including executions, extra-judicial killings, imprisonment as a form of treatment, and widespread violations of UN-recognised human rights of drug users), and impaired the collection of data on the extent of use and harm of illicit drugs, all of which have caused harm to drug users and their families.
- The international system precludes policies that are more aligned to the risks of drug use and the adverse consequences of prohibition, such as the regulation of producers, consumers, and the conditions under which drugs are used.
- Policy experimentation requires changes to the international treaties, which are possible in principle but unlikely in practice. Other options include renunciation of the treaties and re-accession with reservations, or adoption of a new treaty.

on Narcotic Drugs, which operates under the remit of the UN Economic and Social Council. The commission is composed of representatives from 53 states chosen by the Economic and Social Council on the basis of geography and interest, and it meets every year in Vienna to negotiate, adopt resolutions, and approve the system's budget. The commission operates on a consensus basis, which makes change very difficult.

The UN Office on Drugs and Crime (UNODC) is the specialised UN agency on drug issues that serves as the secretariat for the Commission on Narcotic Drugs. It advises governments on effective law enforcement and treatment systems and methods of estimation of illicit drug production and consumption. The UNODC's annual World Drug Report has become an increasingly useful source of international statistics on illicit drug use and markets.⁷ UNODC is a small agency (about 500 employees) whose work is largely influenced by the governments that contribute most of its funding. In 2009, UNODC's core funding was estimated at US\$13.1 million, whereas funding earmarked by donor governments for particular purposes was \$197.9 million.⁸

The International Narcotics Control Board comprises 13 experts elected by the UN Economic and Social Council. The board is responsible for overseeing the operation of the international drug treaties, management of international markets in medicines controlled by the treaties, and ensuring the supply of opioids for pain and other medical uses. The board deems itself the guardian of the treaties and often publishes interpretations of their provisions and names countries judged to have violated treaty provisions.⁹

Under the 1961 and 1971 international drug conventions, WHO provides medical and scientific advice on which drugs should be under international control and to what extent. According to the 1971 convention, WHO expert committees' assessments "shall be determinative as to medical and scientific matters". WHO provides advice and nominates five candidates for membership of the International Narcotics Control Board (from which the Economic and Social Council chooses three), but the Commission on Narcotic Drugs makes the final decisions about scheduling drugs, subject to review by the council.

Aims and functioning of the international system

The international system has two aims: to suppress the production, distribution, and use of all drugs under its control for all but medical and scientific purposes; and to ensure that controlled drugs (especially the opioids) are made available for medical purposes—eg, pain control. The first goal is intended to promote the health and welfare of mankind by preventing addiction and misuse of drugs. The preamble to the 1961 treaty characterised addiction to narcotic drugs as "a serious evil for the individual" that was "fraught with social and economic danger to mankind" and noted that signatories had a "duty to prevent and combat this evil".¹

Panel 1: International drug control treaties

1961 Single Convention on Narcotic Drugs

- Required nations to make the non-medical use of cannabis, cocaine, and opioids a criminal offence
- Amended by a 1972 Protocol

1971 Convention on Psychotropic Substances

- Extended the system to cover synthetic drugs—eg, amphetamines, benzodiazepines, opioids, lysergic acid diethylamide (LSD)

1988 Convention Against Illicit Trafficking in Narcotics and Psychotropic Substances

- Focus on police suppression of illicit markets
- Extended to cover drug precursor chemicals

For the 1961 Single Convention on Narcotic Drugs see http://www.incb.org/incb/convention_1961.html

For the 1971 Convention on Psychotropic Substances see http://www.incb.org/incb/convention_1971.html

For the 1988 Convention Against Illicit Trafficking in Narcotics and Psychotropic Substances see http://www.incb.org/incb/convention_1988.html

An analysis that tracked the various roles of 33 long-serving functionaries described the international system fairly as a gentlemen's club.¹ The membership has since expanded substantially. Although national governments are the main parties to the system, representation of non-governmental organisations (NGOs) has increased. NGO attendance at meetings of the Commission on Narcotic Drugs increased¹⁰ from 81 in 2007, to over 300 in an NGO forum in 2009. Such organisations cannot vote or contribute to debates; rather they seek to influence the views of national representatives.

In the past, the few NGOs that attended mostly supported drug-free approaches to treatment and agreed with the international treaties. NGOs that now attend the meetings often have a drug reform agenda and some include drug users as members. These new organisations often campaign to increase funding for needle and syringe programmes and opioid substitution treatment. Some¹¹ have advocated for policies that respect the human rights of drug users and some want to change the international system. The international drug control system has had to respond to a broad range of views and growing critical scholarship.^{9,12} So far, however, the effects of civil society organisations in the drug control system have been much less than in other areas of public health such as AIDS, baby formula and breastfeeding, and tobacco control.^{8,13}

The upsurge in international NGO activity is associated with substantial policy changes in several countries, such as decriminalisation measures¹⁴ and a ballot proposition to legalise cannabis in California. But people in the official policy community—ie, on national delegations to the Commission on Narcotic Drugs, or in international bureaucratic positions—have a vested commitment to the existing system and have kept civil society at bay.¹⁵

Informally, the USA has long had a leading role in the international system.¹⁶ The USA has strongly opposed harm reduction approaches to illicit drug problems (eg, needle and syringe programmes, supervised injecting centres, and heroin maintenance treatment), with

support from other nations such as Japan and Russia. The USA now accepts needle and syringe programmes but still objects to use of harm reduction wording in UN documents.^{8-10,16-18} UNODC used to share this objection, but has become more accepting of measures such as needle and syringe programmes.⁸

Since harm reduction is a core principle of public health,¹⁹ the embargo on the use of this term is symbolic of the marginalisation of the role of WHO in the UN drug control system. At the end of the 1990s, WHO moved projects on reduction of HIV infection among drug users to the UN agency on AIDS, which had some protection from direct pressure from individual countries.²⁰

WHO's advice has on occasion been ignored by the UNODC and the Commission on Narcotic Drugs. In 2002, the WHO Director General, under pressure from the UNODC,¹⁰ declined to transmit to Vienna a recommendation by the 33rd expert committee that pharmaceutical delta-9-tetrahydrocannabinol (the main psychoactive constituent of cannabis) should be reclassified from schedule 2 to the lowest schedule of the 1971 Convention. A similar recommendation by the 2006 expert committee was rejected by the Commission on Narcotic Drugs.^{10,21}

WHO and UNODC have resumed cooperation. In 2009, a UNODC and WHO programme¹³ jointly produced drug treatment guidelines and a discussion paper on the role of coercion in the treatment of addiction.²² Nonetheless, the international system devotes more of its resources (as shown in its budget allocations and the topics of debates by the Commission on Narcotic Drugs) to suppression of illicit drug markets than to direct protection of public health and wellbeing.

National drug policies

Despite the substantial uniformity in legal frameworks required by the international drug control system, national drug policies differ in priorities. Some nations (eg, China and the USA) treat drugs primarily as a problem for law enforcement and so prioritise the suppression of trafficking, whereas others (eg, the Netherlands and Portugal) focus on help for drug users and reduction of the adverse consequences of drug use. These variations show national attitudes towards drug use, individual rights, and the role of government; the nature and history of national drug problems; and the different ways in which drug use affects a nation.⁵ For some nations, the drug problem is primarily a domestic one, but for others (eg, Mexico and Nigeria) the greatest damage to public health and safety arises from trafficking to the USA and Europe. For example, in Mexico drug trafficking to the US market has led to 35 000 homicides between 2007 and 2010.²³ By contrast, much less violence is associated with drug markets in many European countries.

Although these variations make it difficult to systematically compare drug policy across all countries, some common features can be seen among developed nations.²⁴

Prevention programmes—primarily school-based— attract modest funding. Treatment for drug dependence is increasingly provided (eg, Australia, the Netherlands, Switzerland, and the UK).⁵ Opioid substitution therapy has become the mainstay of treatment for opioid addiction in western Europe²⁵ and in some developing countries (eg, Iran²⁶). Other countries with large numbers of heroin-dependent people refuse to provide opioid substitution therapy, most notably Russia.²⁷

Assessments of drug programmes have had a marginal role in the formulation of policy even in developed countries that have heavily invested in research (eg, Australia, Canada, the UK, and the USA). The US National Institute on Drug Abuse dominates worldwide funding of scientific research on drugs,^{28,29} but does not fund research on drug policy. The greatest inconsistency between US policy and evidence is the mass incarceration of drug offenders (about 500 000 individuals in 2005).³⁰ A ten-times increase in the number of individuals imprisoned for drug offences has occurred since 1980 despite declines in drug quantities sold, in the number of drug users, and in estimated illicit revenues.³¹ The evidence is clear that incarceration is an ineffective way to increase the price and reduce the availability of drugs.³²

National policy reforms within the international system

The international conventions severely restrict the ability of national governments to experiment with alternative drug control systems by requiring all signatories to criminalise non-medical drug use. This constraint has had different effects on policies for injected drugs like heroin and cocaine and policies for the most widely used illicit drug, cannabis.

In the case of injected drugs, public health advocates in many developed countries have successfully campaigned to provide clean injecting equipment to prevent HIV transmission. Eight countries (Australia, Canada, Germany, Luxembourg, the Netherlands, Norway, Spain, and Switzerland) have provided supervised injecting centres to reduce blood-borne virus transmission and overdose and to increase drug users' contact with treatment services.^{27,33} These changes, which have largely been made without legislation to remove criminal penalties for use, have been criticised by UNODC and the International Narcotics Control Board as contrary to the treaties. UNODC has now accepted that needle and syringe programmes and treatment diversion programmes comply with the treaties, but the International Narcotics Control Board continues to argue that the status of supervised injection centres is unclear.³⁴

In the case of cannabis, the main legislative experiments in the past 50 years have been to reduce or eliminate criminal penalties, or to substitute civil penalties (eg, fines) for the use or possession of the drug.¹⁴ This

policy has been extended to all illicit drugs in Brazil, Colombia, the Czech Republic, Mexico, and Portugal.¹⁴ Often a statutory criminal penalty is retained to avoid conflict with the international treaties.

The International Narcotics Control Board has argued that decriminalisation of drug use and toleration of drug sales violates the 1988 convention. Governments that have changed penalties and some scholars³⁵ disagree. The UNODC has issued a discussion paper in which it argues that diversion of illicit drug users into treatment is consistent with international treaties,²² as long as criminal penalties are retained in law.

No evidence is available on whether the presence or absence of criminal penalties for use and possession of cannabis substantially affects the prevalence of use or levels of health-related harm.^{6,14} Criminal penalties are frequently enforced in a discriminatory way against socially excluded minorities.^{14,36} Therefore to justify the criminalisation of cannabis use as a strategy to reduce use is difficult.

The reduction of penalties for cannabis possession and use while the international treaties are complied with has often had the converse consequence of so-called net widening. Because the implementation of offences with reduced or non-criminal penalties is not time-consuming for police, more young people might receive police records for failure to pay fines than if criminal penalties had been retained.¹⁴ Studies in North America and many European countries show that arrests for cannabis use have risen substantially in recent years, alongside reductions in the severity of penalties for use.¹⁴

The Netherlands has moved the furthest away from criminal penalties by de facto (but not de jure) legalising

retail sales of small amounts of cannabis in coffee shops. Evidence that this form of legalisation has affected rates of use or harm is scarce, although commercialisation could have done so.³⁷ The prevalence of cannabis use in the Netherlands is less than in countries such as the UK, France, and the USA, which have retained criminal penalties.^{14,38}

No developed nation has formally legalised cannabis supply to address what is known in the Netherlands as the back door problem—ie, that although front door sales of cannabis are de facto legal, the back door supply of the drug is not. In parts of India, however, cannabis shops operate under state government licences, a practice that has so far escaped censure from the International Narcotics Control Board.¹⁴

The liberal definition of medical marijuana use in California is arguably a form of de-facto legalisation of cannabis sales. The Californian and local authorities have partly addressed the back door issue by allowing non-profit cooperatives to supply cannabis to medical dispensaries.³⁹ To legally access medical marijuana, a patient must have a doctor's letter specifying that he or she has a health disorder that could benefit from cannabis use. Over 200 000 patients are claimed to have such letters⁴⁰ (8% of the estimated 2 500 000 past-month cannabis users in the state⁴¹). Doctors in California advertise provision of these letters for under \$100, often for disorders (eg, anxiety, sleeplessness, and pain) for which evidence of benefit from controlled trials is scarce.³⁹

The table provides a summary of the outcomes of five major changes in law with regard to criminalisation of cannabis use at the state or national level, as well as an assessment of the limitations of the key research studies.

	Description	Outcomes (key studies)	Assessment of research
Australian cannabis decriminalisation	South Australia (1988) and Western Australia (2004) substituted fines for criminal penalties for cannabis possession and home cultivation for personal use	No evidence of increased prevalence of cannabis use compared with other states ^{42,43}	Weak design and small sample sizes
Portuguese drug decriminalisation	2001: possession of small amount of any drug subject to non-criminal penalties or diversion to treatment or education programme, decided by a non-judicial three-person panel	Small increases in illicit drug use among adults; reduced illicit drug use among problematic drug users and adolescents detected from 2003; reduction in opioid-related deaths and infectious diseases ⁴⁴	Many other factors changed over this period so the effect of legal change cannot be isolated
Czech Republic recriminalisation	1999: possession of any drug criminalised again; small amounts classed as a violation, large quantities classed as a crime	No evidence of decreased drug use; use continued to rise in early 2000s and then levelled off. Czech teenage drug use rates after recriminalisation are among the highest in Europe ⁴⁵⁻⁴⁷	Quantitative data primarily from school surveys of teenagers; no systematic comparison with control sites
Dutch decriminalisation and coffee shop system	1976-1984: possession of cannabis not subject to any penalties, with few and inconspicuous non-profit legal outlets. 1984: municipalities allowed to license coffee shops to sell small amounts of cannabis	No increase in prevalence of cannabis use 1976-1984; possible increase in prevalence following commercialisation ^{37,48} from 1984 to 1992	Lack of controls; inference based on differences between the Netherlands and other countries
California medical cannabis	Easy medically approved access to cannabis quasi-legally provided through locally licensed facilities. Chaotic regulation from 1996 to roughly 2006; regulation still in transition in 2011	Up to 2010, changes in prevalence of use in California similar to other states; no increase in use among samples of arrested people or in marijuana-related emergency department admissions in chaotic era ^{49,50}	Implementation is inconsistent over time and across the state

Table: Assessment of changes to laws about criminalisation of drug use

How successfully has the international system achieved its goals?

Access to pain medication

The international system has ensured supplies of opioids for medical need in developed countries, but WHO has estimated that 80% of the world's population has either no or inadequate access to effective pain medication.⁵¹ The International Narcotics Control Board acknowledges that such difficulty with access "continues to be a matter of concern".⁵² One factor seems to be that the international system's emphasis on policing has encouraged nations to give a greater priority to prevention of diversion of prescribed opioids to the black market than to provision for pain control.⁶

Reduction of illicit markets

The system has failed to achieve its original goals of elimination of illicit markets and the non-medical use of controlled drugs. In 1998, the UN system set the more restricted but still ambitious goal of "eliminating or significantly reducing the illicit cultivation of coca bush, the cannabis plant, and the opium poppy by the year 2008". However, by 2009, this goal was as distant as it was in 1998.⁵³ Between 1998 and 2009, the production of synthetic drugs such as 3,4-methylenedioxymethylamphetamine (MDMA) and metamfetamine increased, as did domestic cannabis cultivation in many developed and developing countries.⁵⁴

According to the UNODC, between 172 million and 250 million people worldwide were estimated to have used an illicit drug in 2007.⁵⁵ Cannabis is the most commonly used prohibited drug and accounts for nearly three-quarters of users. Mass markets for cocaine, heroin, and some other prohibited drugs exist in many developed and some low-income and middle-income countries. Injecting drug use has become a worldwide issue that has contributed to the spread of HIV/AIDS.²⁷ The non-medical use of prescription opioids, benzodiazepines, and stimulant drugs has also increased since the early 2000s, particularly in North America and Australasia.⁵⁶⁻⁵⁸

Health and wellbeing

The goal of increasing health and wellbeing by eliminating drug-related harm has also not been met. Injecting drug use of heroin and other opioids, amphetamines, and cocaine is the least common form of drug use but harms the most users through fatal overdose, HIV infection, and injury. As discussed in detail in the first report in the Series,⁵⁵ although global health burden related to cannabis use has not been estimated, estimates in countries with high rates of use (such as Australia and Canada) suggest that cannabis accounts for a small part of the health burden attributable to illicit drugs.^{59,60} Diverted prescription drugs have had a growing role in illicit drug use, although the global burden has yet to be quantified.⁶¹

The spread of non-medical drug use has been accompanied by steady reductions in illicit drug prices and increases in drug purity in many countries.⁶ This situation has occurred despite increased expenditure on law enforcement in most developed countries (most notably in the USA, which has the best time series data on price and purity).⁶²

Has the international system improved human health and wellbeing?

Major challenges exist in assessment of the effects of the international control system on human health and wellbeing. First, to separate the effects of the treaties from the effects of the national policies implemented in accordance with their provisions is impossible. Second, criminalisation of the non-medical use of these drugs ensures that we have poor data on the extent of and the harm caused by their use.⁵⁵

These challenges notwithstanding, to argue that the effects have been beneficial is difficult. Illicit drug use and the contribution of illicit drugs to the burden of disease have increased worldwide over the past decade.⁵⁵ Anti-trafficking efforts have harmed many nations where these drugs are produced and through which they are transshipped. Criminalisation of drug use has many adverse consequences for drug users and their families.⁶³ The system's emphasis on criminalisation has substantially increased imprisonment, with drug offences accounting for a large proportion of all imprisonments in most high-income countries. Evidence that the adverse effects of imprisonment of drug offenders can be justified by reductions in availability of illicit drugs or in rates of use is absent.⁶⁴

Extremely punitive national responses have also flourished under an international system that has given greater priority to control of drug markets than to human rights. Iran, for example, might have executed as many as 10 000 drug traffickers in the 1990s. A Thai crackdown in 2003, known as the Thai war on drugs, resulted in 2275 extrajudicial killings in 3 months.⁶ These responses are not directly encouraged by the international drug control system, but the system's vilification of drug trafficking and criminalisation of drug users have created a moral environment that legitimises these responses.⁶⁵

The main defence provided for the international system is that illicit production and drug use and harm would have been an even bigger problem had the system not been in place.⁶⁶ This claim is difficult to assess for two main reasons. First, to predict which national policies would replace the existing system is impossible. Many nations would probably leave policies unchanged. However, we believe that some nations would experiment with reduction of criminalisation, at least with regard to use of illicit drugs. If these innovations were successful, many nations might lower criminalisation. Second, to estimate what rates of drug use and drug harms would be under these new systems is a challenge.³⁸ Research

summaries⁶ suggest that the effects of increased criminalisation on prevalence of drug use is negligible. The proposition that the international drug control system has had a positive effect on human health and wellbeing is difficult to defend, even if precise accounting for the system's aggregate effects is impossible.

Moving towards risk-based drug control systems

Options within the international system to improve the wellbeing of drug users are few. Research³³ lends support to harm reduction services for problem drug users (eg, opioid substitution treatment, needle and syringe programmes, antiretroviral treatment, and other psychosocial interventions), most of which the international system now supports. These developments in harm reduction are welcome, but a more radical overhaul of the international system is needed to attune it to differences in the risks posed by different prohibited drugs.

Four main models of drug control exist (panel 2); control systems under these models differ in how much they limit or structure the free choices of adults, in how severely they punish individuals who contravene the rules, and in how effective they are at minimising rates of use and drug-related harm.³⁸

A rational and evidence-based system of drug control that aims to improve public health should differentiate between psychoactive substances (and the circumstances of their use) on the basis of the risks of each drug to users and others. Such a system would also take account of the harm that could arise from the social policies (such as criminalisation of use) introduced to reduce drug use.^{63,69}

The necessary evidence for such a risk-based approach is accumulating. The comparative risk analysis of the global burden of disease estimates for 2000 found that, on the basis of patterns of use at that time, alcohol and tobacco were about equally harmful to users in terms of the total disability-adjusted life-years lost worldwide. Illicit drugs (mainly opioids) accounted for about one-fifth as much harm as did alcohol and tobacco.⁷⁰ Evidence has also been accumulating on the effectiveness of different policies that aim to minimise harm from psychoactive substances.^{6,14,71}

Neither international nor national systems of drug control are based on estimations of risks from drug use, or on the consequences of different control mechanisms. Conspicuously, few international controls are in place on the two most harmful substances in the comparative risk analysis of global burden of disease: alcohol and tobacco. No international agreement exists for alcohol and the provisions of the Framework Convention on Tobacco Control are far weaker than those of the international drug treaties.⁷² Prohibition of the non-medical use of substances covered by the treaties precludes regulation via market and availability controls. That which is prohibited cannot easily be regulated.¹⁴

Cannabis is the drug whose inclusion in the international system is most often seen as anomalous because it is widely used by young adults in many

countries, and its health effects are much less harmful than those of the opioids and stimulants.^{46,73} However, the treaties prevent any experimentation with alternative policies for reduction of harm associated with this drug.

Amending the treaties

The international drug conventions allow for their amendment, but the conditions that have to be met to do so make change difficult. Nonetheless, without amendment, other ways for a country, or group of countries, to move forward are possible in principle. The least disruptive way would be for countries to reassert their authority to adopt a regulatory rather than prohibitory system domestically for one or more drugs, while continuing to meet their obligations under the treaties to control international trade in drugs.¹⁴

The most feasible way for an individual country to do so would be to withdraw from one or more of the treaties and then re-accede with specified reservations.^{74,75} For example, Switzerland and the Netherlands ratified the 1988 treaty with a reservation against the provision that required the criminalisation of use and possession.

Panel 2: Models of drug control

- 1 Prohibition
- 2 Prescription systems, in which a licensed health practitioner controls access to the drug
- 3 Market regulation, in which the state distributes or licenses producers and retailers to sell the drug under various conditions (often includes contexts of use)
- 4 Regulation of consumers—eg, by setting age limits, requiring ration cards, or prohibiting certain behaviours, such as driving after drug use^{14,67,68}

Panel 3: How to move to a regulated market in cannabis without conflicting with the international control system?

Any system that allowed the regulated availability of controlled substances for non-medical use would contravene the international drug conventions. Hence, any government that wished to experiment with such a system for cannabis must either ignore international legal obligations or go beyond the conventions in one of the following ways:¹⁴

- Countries such as the USA with a constitution in which national law has equal status with international law could pass a new national law that conflicted with the treaties. Under the constitution, this new law would take precedence. A country that adopted this option would have to withstand substantial international opprobrium.
- A nation wishing to establish a regulated cannabis system could withdraw from the applicable conventions and then re-accede with specific reservations.^{14,74,75} This procedure is recognised in international law.
- A group of nations could adopt a new treaty in conflict with the existing treaties; under international law this treaty would take precedence between the signatory nations. A framework convention on cannabis control has been drafted along these lines, modelled on the Framework Convention on Tobacco Control.¹⁴

Bolivia is using the strategy of withdrawal and re-accession to allow internal legalisation of coca leaf chewing.⁷⁶

Alternatively, a group of like-minded countries could agree on a new international treaty which would then take precedence with respect to their internal markets and their dealings with each other. Panel 3 sets out the options, for instance, for a group of nations that proposed a move to a regulated cannabis market.

Conclusions

During the time that international drug control treaties have been in place, the stringency and complexity of the international system and the number of substances controlled have substantially increased. No evidence suggests that illicit drug production or use have lessened, but the system has had many adverse effects on human health and wellbeing.

National experimentation in approaches to prevention and reduction of drug-related harm should be allowed. The international drug treaties in their present form seriously constrain governments' capacities to engage in such policy experiments. They have restricted the freedom of action to change penalties for personal use, with the result that reduction in penalties has sometimes counterproductively increased the numbers of young people penalised for drug offences. Countries that wish to experiment with different ways of regulating drug use and reducing drug-related harm will need to consider opting out of provisions of the existing drug control treaties.

The cultural positions of different drugs vary enough to preclude universal policies on how to deal with all illicit or indeed licit drugs. From the perspective of public health, we need to move towards a control system that is more aligned with the risks that different drugs pose to users and shows an understanding of the effects of different regulatory approaches on drug use and harm.

Contributors

Both authors contributed equally to the writing and review of this report.

Conflicts of interest

RR has been provided with support for travel by the Beckley Foundation for drug policy research project meetings and reports. RR's professorship is supported by the Victorian Department of Health and the Foundation for Alcohol Research and Education (FARE), and his research by FARE and government research grants. PR has been provided with travel support and honoraria by the Beckley Foundation for drug policy research project meetings and reports.

Acknowledgments

We are grateful to Louisa Degenhardt, David Bewley-Taylor, John Strang, and Keith Humphreys for their comments and suggestions, to Sarah Yeates for her help in referencing and formatting, and particularly to Wayne Hall for his advice and help.

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