

The Development of International Drug Control

Lessons learned and strategic challenges for the future

By Martin Jelsma¹

The emergence of more pragmatic and less punitive approaches to the drugs issue may represent the beginning of change in the current global drug control regime. The spread of HIV/AIDS among injecting drug users, the overcrowding of prisons, increasing levels of violence in drug markets, the reluctance in South America to remain a theatre for military anti-drug operations, and the ineffectiveness of repressive anti-drug efforts to reduce the illicit market have all contributed to the global erosion of support for the United States-style war on drugs.

Over the last decade rapidly widening cracks have begun to split global drug control consensus. The zero-tolerance ideology is increasingly challenged by calls for decriminalisation, harm reduction and embedding human rights principles in drug control. And in recent years the merits of a regulated legal market for cannabis has been accepted as part of the mainstream debate about a more effective control model.

This paper describes how the foundations for the global control system were established, the radicalization of the system toward more repressive implementation, consequently leading to soft defections and de-escalation efforts becoming more widespread; and in the last section projects a future for the ongoing reform process toward a modernization and humanization of the control system's international legal framework as laid down in the UN drug control conventions.



KEY POINTS

- Over time the international drug control system has degenerated into a war on users, farmers and petty traders. The excessive negative consequences and negligible effectiveness have now been broadly acknowledged and a process of de-escalation is in full motion in many places.
- The current UN treaty system is plagued with inconsistencies. Its ambiguities are an obstacle to policy improvements. Sooner than later the current set of drug control conventions need to be revised.
- What the world needs is a group of countries willing to declare that the current treaty framework is no longer fit for purpose. A small group of countries initiated the development of an international drug control system a century ago. In 2012 another small group of countries could initiate its needed reform and design the outlines of a new legal framework for the next century, based on the many lessons learned over the past hundred years.

THE FOUNDATIONS OF INTERNATIONAL DRUG CONTROL

The construction of an international legal framework has gone through several stages in the past century since in February 1909, when the International Opium Commission brought together twelve countries in Shanghai to discuss options for international controls on the opium trade. The first 1912 Hague Opium Convention and the treaties negotiated subsequently in the League of Nations era were more regulatory than prohibitive in nature, aimed to control the excesses of an unregulated free trade regime, substantially regarding opium.

Restrictions were imposed on exports to those countries in which national laws had been introduced against nonmedical use of opiates, but there were no treaty obligations to declare drug use or cultivation illicit, let alone to apply criminal sanctions. The early series of conventions in effect established administrative import and export regulations for opiates, cocaine and, from 1925, cannabis, without criminalising the substances, users or growers of the raw materials. The United States and China, the most ardent “prohibitionists”, both walked out of the 1925 International Opium Convention preparatory negotiations, because in their view sufficiently restrictive measures would not be imposed.²

Efforts by the United States to outlaw the production and nonmedical use of alcohol and drugs were viewed sceptically by traditional colonial powers, particularly France, Great Britain, Portugal and the Netherlands, all of which operated lucrative drug monopolies in overseas possessions. Not only did they control the lucrative Asian opium market, these four nations supplied the pharmaceutical market in Europe and the United States. Opium, morphine, heroin and cocaine were all widely used in medicinal preparations. The cocaine market increased exponentially during World War I when the drug was used as a local anaesthetic on hundreds of thousands of soldiers and as a means of enduring the horrors of trench warfare. For pharmaceutical companies in The Netherlands, Germany and Great Britain it was one of the

most profitable products during the war. Most of the raw material came from Dutch coca plantations in Java, at the time part of the Dutch East Indies colony, as well as some shipments originating from Peru.

Culturally, most of Europe had a perspective at odds with the Christian fundamentalism prevalent at the time in the United States. As noted in 1931 by the influential commentator Walter Lippmann, twice Pulitzer Prize winner and advisor of President Woodrow Wilson: “To the amazement of the older nations of the earth, we have...enacted new legal prohibitions against the oldest vices of man. We have achieved a body of statutory law which testifies unreservedly to our aspiration for an absolutely blameless...life on earth.”³ He pointed at the criminogenic effects of prohibition at the time, attributing the “high levels of lawlessness” to “the fact that Americans desire to do so many things which they also desire to prohibit.”

Stories about gangs and mafia expanding control over entire cities did little to inspire European policy makers at the time. “The unenforceable laws that attempted to prohibit alcohol, gambling, drugs and commercialized sex also made risks small for the host of politicians, police officers, and gangsters profiting from the newly created illegal markets. America had clearly become a land of criminal opportunity by the 1920s. ...The repeal of alcohol prohibition was a notable but rare admission in America that moral ideals are no match for human ingenuity and human nature.”⁴ The alcohol prohibition regime lasted from 1920 to 1933,⁵ the period the United States was busy trying to replicate internationally the same model for other psychoactive drugs via the League of Nations. Despite concerted efforts, the lofty aspirations to export this policy were to remain largely unfulfilled until after World War II.

After repealing alcohol prohibition in 1933, the United States continued its international drive on other drugs. As the UN World Drug Report noted, the 1936 Convention was “the first to make certain drug offences international crimes” but was only signed by 13 countries and only came into effect during World War II,

when “drug control was certainly not top priority for most countries”.⁶ Only after the war, under the United Nations system, was the necessary political atmosphere created, enabling the globalisation of the prohibitive anti-drug ideals.⁷

Having emerged from the war as the dominant political, economic and military power, the United States was in the position to shape a new control regime and apply the required muscle to impose it on other nations. As a report to the Canadian Senate sums up: “Beginning in an era of morally tainted racism and colonial trade wars, prohibition-based drug control grew to international proportions at the insistence of the United States.”⁸ The United States’ representative to the conference to negotiate the Single Convention in 1961 confirmed: “For more than half a century, the United States had been advocating the international control of narcotic drugs. On the initiative of the United States, the International Opium Commission had met at Shanghai in 1909; it had been largely responsible for the conclusion, three years later, of the first International Opium Convention, signed at The Hague.” He also “recalled that the idea of a Single Convention had been a United States initiative.”⁹

THE UN DRUG CONTROL CONVENTIONS

The 1961 UN Single Convention on Narcotic Drugs replaced the previous international agreements that had been developing piecemeal since the early years of the twentieth century, but included new provisions not contained in earlier treaties, creating a stricter zero-tolerance and more prohibitive system for control. It also extended the existing trade control systems to include the cultivation of plants from which narcotic drugs were derived, thereby placing a special burden on the traditional producing countries. The cultivation and extensive traditional use of opium poppy, coca and cannabis at that time was largely concentrated in Asia, Latin America and Africa. Traditional practice, including widespread traditional medicinal use of all three plants, was defined as “quasi-medical” practice that had to be terminated.

The UN Single Convention of 1961 established the goal to eliminate opium over a 15-year period, and coca and cannabis within 25 years. “If in those days the opium-producing countries had been as concerned about alcohol as Western countries were concerned about opium, we might have had an international convention on alcohol,” remarked the former head of the WHO Section on Addiction Producing Drugs.¹⁰

The Single Convention was established as a universal system for limiting the cultivation, production, distribution, trade, use and possession of narcotic substances strictly to medical and scientific purposes, with special attention on substances derived from plants: opium/heroin, coca/cocaine and cannabis. In the Convention’s four lists, more than a hundred substances are classified under various degrees of control. Among the most controversial classifications on the list, the coca leaf appears in List I and cannabis appears in both Lists I and IV, the latter reserved for the most dangerous substances.

The 1971 Convention on Psychotropic Substances developed in response to the diversification of drug use, introducing controls on more than a hundred “psychotropic” drugs, amphetamines, barbiturates, benzodiazepines and psychedelics, which are again distributed into four lists. Compared to the strict controls imposed on plant-based drugs, the 1971 treaty imposed a weaker control structure, due to pressure from the European and North American pharmaceutical industry during the negotiations.

According to a UN staff member of the Division of Narcotic Drugs and secretary of the Technical Committee of the Plenipotentiary Conference at the time: “The most important manufacturing and exporting countries tried everything to restrict the scope of control to the minimum and weaken the control measures in such a way that they should not hinder the free international trade ... the 1971 Convention consists of two treaties: one for “street drug” hallucinogens in Schedule I and one for pharmaceuticals in Schedule II, III and IV. There are extremely strict control measures for Schedule I substances and very

Licit and illicit opium production: the example of Turkey

Turkey ratified the Single Convention in 1967, choosing not to apply for the transitional exemption extending until 1979 to phase out opium use and production. Instead, it was given the status of a “traditional opium producing country” having the right to continue production if it was managed under a state-controlled license system. During the gradual implementation of the system a substantial amount of licitly produced opium was diverted for heroin production that found its way onto the illicit United States market. Washington exerted great pressure on its NATO ally, including threats to cut off aid, resulting in Turkey banning opium cultivation in 1972.

In 1974 Turkey started opium cultivation again on a significant scale under the new strictly state-controlled license system in compliance with the Single Convention, successfully thwarting almost all leakage to the illicit market. Sources supplying the illicit markets in Europe and the United States then shifted to Pakistan and Burma (both countries having had applied for the transitional status) and Iran, later moving to Afghanistan where significant “illicit production” began and continued to expand ever since. In the United States market the bulk of what was previously sup-

plied by Turkey now came from Mexico. According to the Drug Enforcement Administration (DEA), “Mexico emerged as a prominent source of heroin to the United States in 1974, when growers stepped up production to fill the void left by the suppression of heroin supplies from Turkey in 1972.”

The DEA identified Mexico as the source of 89 percent of the heroin in the United States in 1975. “With the disruption of the Turkish-French heroin connection in recent years, more poppies have been cultivated in Mexico to meet the demand for heroin in the United States.” During the 1980s heroin from Southeast Asia became dominant in the eastern section of the country, that market share subsequently taken over by Colombian sources in the following decade. Turkey remains one of the major licit opiate producers for the pharmaceutical market, along with India, Australia, France, Spain, Hungary and some smaller producers.

Sources: GAO, *Drug Control: U.S.-Mexico Opium Poppy and Marijuana Aerial Eradication Program*, NSIAD-88-73 January 11, 1988; Comptroller General, *Opium Eradication Efforts in Mexico: Cautious Optimism Advised* (Unclassified Digest), GGD-77-6, Report to Rep. Charles S. Rangel; by Elner B. Staats, February 18, 1977.

weak ones for Schedule II and III substances and nothing for Schedule IV substances. The provisions of the 1971 Convention do not allow the monitoring of the movements of international shipments which are necessary for the prevention of their diversion.”¹¹

The scientifically questionable distinction between narcotics controlled by the 1961 Convention and so-called “psychotropics” in the 1971 Convention, was largely invented because the pharmaceutical industry resisted the idea that its products might be subject to the stringent controls of the Single Convention. Effective lobbying established a separate legal instrument. Concerted efforts to weaken the 1971 treaty provisions by the United States, United Kingdom, Canada, West Ger-

many, Switzerland, The Netherlands, Belgium, Austria and Denmark ensured that pharmaceutical interests remained relatively unharmed.¹² The 1961 and 1971 Conventions primarily aimed to end traditional uses of coca, opium and cannabis, limit their cultivation to amounts needed for medical purposes and to curb the diversion of psychoactive pharmaceutical drugs for illicit (non-medical) purposes.

The subsequent control system of the two treaties under the administrative mandate given to the International Narcotics Control Board (INCB) was also meant to guarantee that sufficient supplies would remain available for licit use. Contrary to popular belief, none of the scheduled drugs were ever made

“illegal”. The drugs were not prohibited, but their production and trade were placed under strict controls in order to limit their use to medical and scientific purposes. Exactly the same controls apply to cocaine, methadone and oxycodone, as well as many other drugs widely used in medical practice, such as diazepam (marketed as Valium and many other brand names), morphine and codeine (alkaloids extracted from the opium poppy), all controlled under these same treaties. The oft-used term “illicit drug” does not appear in the UN Conventions.

Only after the 1961 Convention control system was effectively implemented, did mass-scale illicit production begin for some of the listed substances. Until then, nonmedical use was supplied by leakage from licit production. As the 1961 Convention entered into force in December 1964, the 15-year phase-out scheme for opium ended in 1979 as did the 25-year scheme for coca and cannabis in 1989. The few countries applying that transitional provision (Pakistan, India, Burma, Bangladesh and Peru) were obliged to prohibit production for nonmedical purposes by those dates.

Licensed cultivation of cannabis for medical purposes did not exist at the time, and while licensed production of coca and opium did continue on a significant scale, the established international control system effectively ended the illicit diversion of cocaine and heroin from pharmaceutical sources. Demand for nonmedical use of cannabis, cocaine and heroin, however, exploded in the Western world during the 1970s and 1980s, with large-scale illicit production to supply that market developing in the countries where the plants had been grown traditionally. International illicit drug trafficking rapidly expanded into a multi-billion business under control of criminal groups.

In response, the UN convened another conference to negotiate what became the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. It provided special measures against illicit cultivation, production and trafficking of drugs, the diversion of chemical precursors, as well as

agreement on mutual legal assistance, including extradition. The 1988 Convention significantly reinforced the obligation of countries to apply criminal sanctions to combat all the aspects of illicit production, possession and trafficking of drugs.

THE WAR ON DRUGS

The rapidly expanding illicit drugs trade provided the rationale for escalation to an actual war on drugs. In the United States, which was the most rapidly growing illicit drugs market, the political response was to declare war on the foreign providers rather than analyse and address the reasons for booming domestic demand. The term “War on Drugs” was first used by President Richard Nixon in 1971, identifying drug abuse as “public enemy No. 1”. Initially the main target was Mexico, from where massive amounts of cannabis were illicitly supplying the countercultural revolution in the 1960s, and by 1974 had become the main supplier of heroin for the United States market. Funded by the United States, aerial spraying of cannabis and poppy fields started in Mexico in 1976.

The military was first deployed in 1983 when Special Forces were sent to the Andes to provide counternarcotics training. A first version of the ‘narco-guerrilla’ theory was now in place, which called for a solution combining the anti-drug mission with counterinsurgency objectives in the Andean region. President Reagan subsequently issued a National Security Decision Directive (NSDD-221) in April 1986, declaring drug trafficking a “lethal” threat to the United States. The directive set in motion Operation Blast Furnace from July to November 1986, the “first publicized employment of United States Army combat forces on the sovereign soil of another country to conduct joint anti-drug efforts.”¹³ Six helicopters and 150 troops were sent to Bolivia in a failed attempt to destroy some cocaine labs, and many more military operations were to follow.

Also in 1986 the United States Congress enacted the disciplinary mechanism of drug certification. Countries that failed to fully cooperate with the anti-narcotics efforts

would face mandatory sanctions including withdrawal of most of their foreign aid along with a concomitant opposition to loans those countries sought from multilateral development banks.¹⁴ Countries decertified included Burma, Afghanistan, Colombia, Nigeria, Guatemala, Haiti, Venezuela and Mexico, although sanctions were occasionally waived for national security reasons. Many more countries appeared in at least one of the categories of the certification system.

The procedure for inclusion was highly politicised, effectively working as a compliance mechanism to coerce countries to carry out the forced eradication of a specified number of hectares; tighten drug laws and arrest quotas; accept extradition of national citizens to the United States; or to refrain from adopting less repressive policies (as was the case in Jamaica when cannabis decriminalisation appeared on the political agenda). To its considerable surprise, The Netherlands once appeared on the drug certification list of “emerging threats”, with North Korea and Cuba as the two other new threats.

The Pentagon was thrust into the front lines of the drug war with the National Defence Authorization Act for FY1989 by President George Bush Senior, making the Department of Defence the lead agency responsible for monitoring, detecting and intercepting illicit drugs transports. This decision dedicated a dramatic increase of military assets and personnel to the counterdrug effort. Funding for military drug interdiction missions nearly quadrupled between 1989 and 1993.¹⁵ At that moment in history when anti-communist rationale for maintaining high military budgets and operations abroad was questioned after the Berlin Wall came down in 1989 the Pentagon was given a significant anti-drugs role.¹⁶

According to an Air Force analyst involved in counterdrug missions, the “timing for large-scale military involvement was excellent: the Cold War was drawing to a close, freeing up large amounts of assets, but the dramatic drawdown had not yet begun.”¹⁷ In hindsight, the war on drugs can be seen as a transition between the Cold War and the War on

Terror, in terms of legitimising military operations, bases and interventions abroad. The main theatre of military anti-drugs operations was Latin America, most prominently Colombia where the United States invested six billion dollars in “Plan Colombia,” a combined counterdrug and counter-insurgency strategy, including the highly controversial policy of mass aerial herbicidal spraying of coca and poppy fields.

This was the volatile political context in which the 1988 Convention with its requirements to apply criminal sanctions was carried out, under significant pressure from the United States on the rest of the world to join it in the declared war on drugs. A curious but convenient alliance was established between the United States and Russia and China—both already in a state of transition—along with such other diverse players such as Japan and some Islamic nations, all rallying to a “common cause”. What followed was an escalation of repression and consequent excessive negative effects.

More recent attempts to initiate a similarly aggressive strategy in Afghanistan, where opium production rapidly increased since 2004, were never fully implemented, perhaps a sign that political realities were changing. The Afghan government rejected spraying from the outset, as did European allies, objecting to a “Plan Afghanistan”, fearing such a strategy would alienate a rural population heavily dependent on the opium economy. President Obama stopped pressing for an aggressive eradication effort in Afghanistan, acknowledging after a policy review that it would be ineffective as long as alternative income sources were unavailable and would only drive Afghan farmers into the hands of the Taliban.

An aggressive drug control strategy in Afghanistan, including military interdiction operations, forced eradication and possibly aerial spraying, now seems to be promoted most vigorously by the Russian Federation.¹⁸ Obama’s newly appointed Director of the Office of National Drug Control Policy, Gil Kerlikowske, told the press he wanted to abandon the term “war on drugs” altogether,

Decriminalisation – Depenalisation – Legalisation - Regulation

There is much confusion in the literature and public debate about the terms *decriminalisation*, *depenalisation*, *legalisation* and *regulation*. Universally accepted definitions do not exist and interpretations frequently vary even within the same language. In the most common English usage decriminalisation is the elimination of a conduct or activity from the sphere of criminal law, while depenalisation is simply the relaxation of the penal sanction provided for by law. The term decriminalisation is most commonly used in reference to offences related to drug consumption and usually manifested by the imposition of sanctions of a different kind (administrative) or the abolition of all sanctions; other (non-criminal) laws can then regulate the conduct or activity that has been decriminalised. Depenalisation can refer to consumption-

related offences (which may be dealt with through referral schemes or alternative sanctions for drug users) but also to small-scale trading, generally indicating elimination or reduction of custodial penalties, although the conduct or activity remains a criminal offence. Confusingly, in Spanish, depenalisation often refers to what in English is most often called decriminalisation. Legalisation is the removal from the sphere of criminal law of all drug-related offences: use, possession, cultivation, production, trading, and so on. Regulation refers to a strictly controlled legal market, in which administrative rather than criminal law regulates production, distribution and price (by taxation); and limits availability and access, using models developed for pharmaceutical drugs, alcohol and tobacco.

saying the bellicose analogy was counter-productive.¹⁹

DE-ESCALATION

Some of the consequences resulting from the escalation of the last two decades were a nearly worldwide rapid increase in the prison population; human rights violations; restricted access to essential medicines; criminalisation of users creating obstacles for health care, including strategies for HIV/AIDS prevention. Opting for decriminalisation and harm reduction, states began what would become a widespread “soft defection” from the zero-tolerance repressive model. Europe, Canada and Australia, all reluctant to join the war on drugs, were the first to change policy, more recently followed by several Latin American countries.

States signatory to the 1988 Convention are obligated to “adopt such measures as may be necessary to establish as criminal offences under its domestic law” (art.3, §1) production, sale, transport and distribution for non-medical purposes of the substances included in the schedules of the 1961 and 1971 Conventions. Penal sanctions should also apply to the “cultivation of opium poppy, coca bush or cannabis plants for the purpose of the pro-

duction of narcotic drugs”. The text establishes a difference between the intent to traffic and personal consumption, stating that “the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption” should also be classified as a criminal offence, but “subject to the constitutional principles and the basic concepts of its legal system” (art.3, §2).

Especially in the United States, Russia and China, mass imprisonment for drug offences has been practiced, but the majority of European, Latin American and Asian countries have also seen a major increase in their drug-related prison populations.²⁰ The penitentiary crisis and concurrent failure to reduce the illegal drug market have prompted various legislative reforms regarding depenalisation and decriminalisation (see text box on terminology).

In many countries, personal consumption is not, in itself, an offence. The UN conventions do not oblige any penalty (criminal or administrative) to be imposed for consumption per se, as is clearly stated in the official Commentary to the 1988 Convention: “It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug

Decriminalisation in the Czech Republic

As in all communist countries, the former Czechoslovakia's laws were very repressive. The first major post-communist reform of its drug laws was completed as early as 1990. Among other legislative changes that were seen as a return to democratic and humanistic values, along with capital punishment, penalties for simple possession of illegal drugs were abolished.

But before the end of the decade, unsubstantiated claims were appearing in the media about how the new Czech Republic had become a centre for international drug trafficking. Stories circulated about dealers hanging around in front of schools. Allegations were circulating that the country was obligated to "re-criminalise" simple possession, as part of its commitments for entry into the European Union.

In 1997 a proposal was submitted to parliament re-introducing criminal penalties for drug users in possession of any amount of illegal drugs. Under this pressure, the government submitted its own more moderate proposal introducing criminalization of possession, but only for amounts that were "bigger than small", which was passed in April 1998. The law was subsequently vetoed by President Vaclav Havel. Parliament overturned the veto and the amended law went into effect on January 1, 1999. Following these turbulent events, the National Drug Commission proposed that the government fund a scientific study to evaluate the impact of the new amendments.

The researchers were asked to address five hypotheses: "After the introduction of the penalty for possession of illegal drugs: (1) availability of illegal drugs will decrease; (2) the number of (prevalence of) current drug users will decrease; or at least (3) the incidence of new users will decrease; (4) there will be no increase in the negative health consequences related to illegal drugs; and (5) social costs will not increase."

The study concluded that implementing a penalty for possession of illicit drugs for personal use did not meet any of the tested objectives and presented an unjustifiable (economical) expense for the police and the courts. The definition of "small," "bigger than small," and "bigger" amounts was not resolved until 2010. The thresholds adopted qualify the Czech Republic as one of the most liberal in the world regarding possession of drugs for personal use. Possession of up to 15 grams of cannabis, 1.5 grams of heroin, 1 of gram cocaine, 2 grams of methamphetamine, or 5 ecstasy pills, is decriminalised.

Possession of quantities not exceeding these thresholds can result in a misdemeanour charge, but in practice only results in a police warning.

Source: Zabransky, T., Mravcik, V., Gajdosikova, H. & Miovska, M., *Impact Analysis Project of New Drugs Legislation, Summary Final Report*, Secretariat of the National Drug Commission, Office of the Czech Government, October 2001.

consumption as such to be established as a punishable offence".²¹ There are more and more countries in which possession of a quantity of drugs for personal use is decriminalised, no longer a priority for law enforcement or subject to reduced sentences.²²

These changes in the law or its enforcement practice have an immediate positive effect on the overburdened penal system and overcrowding in prisons. The most thoroughly documented case is that of decriminalisation in Portugal in 2001. The prison density

(prisoners per 100 places) fell from 119 in 2001 to 101.5 in 2005, practically solving the problem of overcrowding in just a few years.

Several evaluations have been undertaken to assess the impact, the most recent one, in 2010, again "disconfirms the hypothesis that decriminalisation necessarily leads to increases in the most harmful forms of drug use. While small increases in drug use were reported among Portuguese adults, the regional context of this trend suggests that they were not produced solely by the 2001 deci-

minalisation. We would argue that they are less important than the major reductions seen in opiate-related deaths and infections, as well as reductions in young people's drug use. The Portuguese evidence suggests that combining the removal of criminal penalties with the use of alternative therapeutic responses to dependent drug users offers several advantages. It can reduce the burden of drug law enforcement on the criminal justice system, while also reducing problematic drug use."²³ Another good example of decriminalisation of possession for personal use is that of the Czech Republic (see text box).

The Red Cross argues in a recent advocacy paper, that "from a humanitarian perspective, repressive laws that imprison and harass drug users merely serve to drive them away from health and social support services. This not only violates humanitarian principles and human rights legislation, but makes providing HIV prevention, treatment, care and support all but impossible and exposes the general population to more harm. Changing policies and reforming the justice system are central to harm reduction."

The paper calls "for the decriminalisation of drug users, as well as access to due legal process and health services for those who use drugs both within and outside detention centres."²⁴ In an earlier report the Red Cross had already concluded: "The message is clear. It is time to be guided by the light of science, not by the darkness of ignorance and fear."²⁵

Anand Grover, the UN Special Rapporteur on the "right of everyone to the highest attainable standard of physical and mental health", calls in his recent report for a "human rights-based approach to drug control". He states that "this excessively punitive regime has not achieved its stated public health goals, and has resulted in countless human rights violations." He recommends countries "decriminalize or depenalize possession and use of drugs" and "repeal or substantially reform laws and policies inhibiting the delivery of essential health services to drug users, and review law enforcement initiatives around drug control to ensure compliance with human rights obligations."

Referring to the preamble of the 1961 Single Convention which identified the primary goal as promoting the "health and welfare of mankind", Grover writes: "Widespread implementation of interventions that reduce harms associated with drug use — harm-reduction initiatives — and of decriminalization of certain laws governing drug control would improve the health and welfare of people who use drugs and the general population demonstrably." He proposes the "creation of an alternative drug regulatory framework in the long term, based on a model such as the Framework Convention on Tobacco Control."²⁶ The WHO tobacco convention, in force since 2005, could provide an example of a control model for psychoactive substances outside the realm of criminal law.²⁷

CANNABIS POLICY CHANGES

De-escalation has occurred in many places in the case of cannabis, the psychoactive substance after alcohol and tobacco with the highest mass consumption, an estimated 200 million people worldwide. The percentage of recreational users who develop problematic patterns of consumption is very small. Various countries have introduced more tolerant policies in relation to cannabis consumption, despite it being classified in the same category as heroin in the UN treaties.

Deviation in practice has subsequently taken different forms. Many countries have simply reduced the priority of chasing cannabis users. In others like Switzerland, Belgium, Luxembourg, Spain, Portugal, Ireland, the Czech Republic, as well as thirteen states in the United States and several in Australia, there have been changes in the law to decriminalise the possession of small quantities of cannabis. In practice, in the majority of European countries, infringements involving up to 30 grams of cannabis are rarely prosecuted or only incur administrative sanctions. But at least three models have developed that go beyond decriminalisation of cannabis possession for personal use: the Dutch, California and Spanish models.

In The Netherlands, use of drugs is not an offence and possession up to 5 grams of can-

Cannabis and the 1961 UN Single Convention

During the negotiations about the Single Convention there was an attempt to make cannabis and its resin the only substances prohibited on the premise that there was “no justification for their medical use”, according to a memo from the WHO. The WHO Expert Committee however remained of the opinion that the “prohibition or restriction of the medical use of cannabis should continue to be recommended by the international organs concerned, but should not be mandatory.”²⁸

The draft on the table at the Single Convention conference included a special section under the heading “prohibition of cannabis” but strong opposition from several sides prevented its adoption. The Dutch delegate cautioned that a “possible danger was that the international instruments might go beyond what was necessary in the field of international co-operation for the protection of public health. A basic principle should be that the national authorities were responsible for preventing the abuse of drugs and for deciding whether a certain drug should be placed under stricter control, or even totally prohibited.” India objected partly because it opposed banning the widespread use of bhang made

from cannabis leaves with a low THC content. Others pointed out the use of cannabis in some pharmaceutical preparations as well as in traditional medicine, further remarking that it could not be excluded that future research would reveal more medicinal benefits.²⁹

Several compromises were reached. In a rare deviation from the zero-tolerance principle, the leaves and seeds were explicitly omitted from the definition of “cannabis”, now only referring to the “flowering or fruiting tops of the cannabis plant”. Hence the traditional use of bhang in India could continue. The reference to “prohibition of cannabis” was deleted, but cannabis was now included in Schedule I and in the strictest Schedule IV. With regard to the latter, the Single Convention stipulates that any signatory “shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only”.³⁰

nabis was decriminalised, and classified a petty offence or misdemeanour. Also a *de facto* decriminalisation of buying and selling of amounts for personal use was enacted, enabling the establishment of “coffeeshops”, although these activities are still not allowed *de jure*. The expediency principle, a discretionary option in Dutch penal law, is exercised, allowing authorities to refrain from prosecuting. The cultivation of up to five plants per person for personal use is tolerated as well.

Despite open sales to adults in the coffee-shops, the levels of consumption of cannabis are similar to those of the neighbouring countries like Germany and Belgium, and much lower than in the United Kingdom, France or Spain.³¹ Problems persist at the “back door”, where the coffeeshop owner has to obtain his supply, which remains an illegal activity subject to law enforcement. Suppliers can still be prosecuted for transporting can-

nabis to the shops and coffeeshop owners can be arrested for buying inventory, despite being allowed to sell it.

From a legal perspective, the situation is viewed as an imperfect “solution” evolving from the pragmatic attitude that solving half the problem was better than none at all. In 2000 a parliamentary majority voted to regulate the back door by allowing the cultivation of cannabis in a closed system, hence decriminalising production of cannabis to be sold in the coffee shops. The government refused to enact the legislation, arguing that regulation would be problematic and would meet with strong international opposition. In 2005 a second initiative proposed to experiment regulating supply of cannabis to coffeeshops. The government asked for legal advice, which concluded that cultivating cannabis for other than medical or scientific purposes was banned both under UN conventions and Euro-

pean Union law. Following the opinion that the experiment would not “comply with the spirit of existing treaties,”³² the initiative failed.

In the United States there is a remarkable diversity of policies at state and local levels. Currently, 13 states have decriminalised use or possession of cannabis, and 16 states have recognised medical use of cannabis, with some states opting for both policies. Due to legislative and voter initiatives, the panorama of state and local control policies is constantly changing, generally toward more lenient control regimes.

In 1996, voters in California passed Proposition 215, the Compassionate Use Act, exempting medical use of cannabis from criminal penalties. It does not legalise cannabis, but changes how patients and their primary caregivers are treated by the court system. California’s law allow for individuals to “possess, cultivate and transport” cannabis as long as it is used for medical purposes with a doctor’s approval. In spite of strong federal opposition, medical marijuana dispensaries and cannabis buyers’ clubs emerged to provide cannabis to those with legitimate medical need, varying from clients suffering from serious illnesses such as cancer, AIDS, epilepsy and multiple sclerosis, to less clearly defined ailments like anxiety, sleeplessness, attention deficit disorder and assorted pains.

This “California model” has grown into something close to *de facto* legalization, not dissimilar to the Dutch situation. Today there are more than 200,000 Californians with a doctor’s letter entitling them to purchase cannabis and hundreds of dispensaries selling it.³³ As in The Netherlands, an attempt was made to take the step towards a legally regulated cannabis market via referendum in November 2010. Voters decided 54 to 46 per cent against Proposition 19. A second attempt has been announced for the 2012 ballot, and given that support for cannabis regulation has been steadily growing, the proposition’s success should not be discounted.³⁴

A third and inventive model, largely unnoticed beyond its borders, developed in Spain.³⁵ Cannabis consumer associations, or “cannabis clubs” practicing collective culti-

vation for its members were established. The arrangement makes use of the Spanish decriminalisation based on a ruling of the Supreme Court in 1974. Felipe Gonzalez’s Social Democrat government in 1982 formally decriminalised the possession of drugs for personal use, while establishing a penal distinction between “more harmful drugs,” such as heroin and cocaine, and those that “cause less health harm,” such as cannabis. The result was a two-tiered system of law enforcement that treated cannabis trafficking as a less serious offense.³⁶ Concomitantly this also created a permissive climate for cultivating cannabis plants for personal consumption, leaving the maximum quantity unspecified.

Cannabis clubs started in 2001, in Barcelona and particularly in the Basque country, where five such associations started collectively cultivating on a plantation where each member owned a number of plants that were cared for by the association, with members having the right to collect their part of the harvest for personal consumption up to a maximum of about 350 grams per member per year (with some variation from one association to another). Formally, no trade or sale of cannabis (which is prohibited) occurs. The association is only paid by its members for tending their plants. This model is potentially applicable in other countries where possession including cultivation for personal use has been decriminalised.

According to the principal Basque protagonist of the model, “this type of associative collective plantations fits perfectly within existing legislation, without needing any legal reform, since the collective cultivation for personal use is not only widespread, but, in general, remains unpunished. In addition, it allows people who, for want of means or time or because of health problems, cannot cultivate themselves to delegate to the association the agricultural tasks and can thus avoid having to resort to the black market. If our model became generalised, the amount of money absorbed now by the illicit market would be reduced substantially, public resources spent now on repressive tasks would diminish and state tax collection would increase”.³⁷

CONVENTION REFORM ON THE AGENDA

The three models are testing the limits of the international legal drug control framework. Going further, as Proposition 19 intended, would be difficult to justify under the existing treaties. The debate about regulation of the cannabis market, however, is moving forward and the question seems to be when rather than if countries will decide to take that step. Which nations will be the first to risk criticism and possible censure and how many would follow in their footsteps? Arguments in favour of regulation have gained strength:

(1) It is clear by now that the cannabis market will not disappear and that law enforcement has not contributed in any way to diminish its availability and use, but has changed certain patterns in the market, notably further decentralising production. The volume of illicit international trafficking has diminished because a great deal is now cultivated locally for domestic markets, making it even more impossible to control. In general, sources for cocaine and heroin remain geographically concentrated and international smuggling routes can be tracked and sometimes intercepted. Nonetheless interdiction has only rarely and temporarily created shortages on the illicit market, but in the case of cannabis that option is no longer feasible. Cannabis can be grown anywhere, especially using indoor techniques. There is simply no way law enforcement will ever be able to suppress it.

(2) A number of recent efforts to develop a rational scale of harms of drugs have all confirmed that although cannabis is not harmless and problematic use patterns can develop, those harms and risks are less critical than those associated with alcohol or tobacco.³⁸ There are no clear scientific reasons to maintain the current stringent classification of cannabis. Legally speaking, the WHO Expert Committee mandated under the 1961 and 1971 Conventions to advise on scheduling decisions must first give its authoritative opinion on the matter before the treaty status of cannabis can be revised. As yet no country has dared to formally request a WHO review, fearing the political fallout.

(3) Given its sheer volume and large number of consumers, cannabis represents a significant share of the global illicit market and thus an important funding source for criminal groups and corruption. The drug-related explosion of violence in Mexico and the continuing violence in the favelas in Brazil has led to more public support for cannabis regulation in both countries, as one of the potential means to reduce levels of drug-related violence.

(4) In the current financial crisis countries are scrutinising public expenditure in all fields. Regulating the cannabis market would achieve significant savings on cannabis-related expenditure by law enforcement and the criminal justice system, and would generate substantial revenue through taxation.

(5) Experimentation with the different models described above has demonstrated that more lenient approaches do not lead to major increases in levels of consumption. The risks regarding implementing legal regulation of production and distribution are therefore low.

Creating the legal space for cannabis regulation may be the most pressing argument to consider changing the Conventions. But there are several other good reasons to argue the need to put the difficult issue of treaty change on the international agenda. To begin with, cannabis is not the only substance, the classification of which is questionable.

The other obvious case is the coca leaf, placed under the same controls as cocaine in Schedule I of the 1961 Convention. Compared to how other plants containing psychoactive alkaloids (such as ephedra or khat) are classified, coca is unnecessarily strictly controlled, an issue rightfully challenged by the Bolivian government today. The zero-tolerance attitude led to the suppression of markets of natural milder drugs, in the case of coca condemning a millennia-old indigenous tradition. In a relatively short time the illicit market became dominated by the more lucrative concentrated and more harmful derivatives.

The 1971 Convention added to the confusion by introducing the dubious category of “psychotropic” drugs, which included opioids such as buprenorphine and pentazocine, but also the active ingredient THC of cannabis

(scheduled in the 1961 Convention) and the active ingredient cathinone of the khat plant — which has never been scheduled. While the 1961 Convention included the precursors of the narcotic drugs, precursors and plants were excluded from the 1971 Convention. Some of those appeared later in the Lists of the 1988 Convention, like ephedrine, an alkaloid present in the not-scheduled ephedra plant, used as a precursor for methamphetamine controlled under the 1971 Convention. In the course of the politicised negotiations around the three treaties, all logic was abandoned. Plagued with inconsistencies, the scheduling system attached to the treaties must be brought back into coherence with a scientific rationale for scaling potential harms.

Moreover, the landscape of the global drugs market has undergone major changes that the current system is struggling to deal with. New “legal highs” appear on the market almost every day, some of them closely similar in effect to the traditional drugs, with the internet providing new distribution channels difficult to control. Another visible trend is the increased misuse of pharmaceutical drugs. In the United States drug-related deaths, overdoses and emergency hospital visits related to pharmaceutical opioids such as oxycodone have already surpassed those for heroin.

A major disparity is emerging, where in many countries strict drug control legislation has impeded access to and availability of essential medicines such as morphine, methadone or ephedrine, in other countries pharmaceutical painkillers are generating the most problematic patterns of nonmedical drug use, replacing heroin. And most recently, a new generation of so-called performance- or cognition-enhancing drugs is further blurring the distinction between recreational use and self-medication, and how that relates to the (non-defined) medical use of drugs as permitted under the treaties. While publicly an image persists about a supposed clear difference between illicit and licit markets, in reality those dividing lines have largely disappeared and most of the market is decidedly grey.

The continuing ambiguity regarding interpretation of certain treaty provisions, often

leads to tensions around the legality of decriminalisation and harm reduction practices. The International Narcotics Control Board (INCB), for example, views drug consumption rooms as in violation of the conventions, arguing that the facilities do not comply with the treaty obligation to limit the use of scheduled drugs exclusively to medical and scientific purposes. Governments introducing these services are attacked by the INCB for facilitating or abetting the commission of crimes involving illicit possession and use of drugs.

Regarding legality, this treaty interpretation is in contradiction to the position of UNODC, that, “It would be difficult to assert that, in establishing drug-injection rooms, it is the intent of Parties to actually incite to or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs. ... On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for [intravenous] drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counselling and other therapeutic options. Albeit how insufficient this may look from a demand reduction point of view, it would still fall far from the intent of committing an offence as foreseen in the 1988 Convention.”

Addressing several other arguments that some treaty articles might not allow harm reduction programmes, the same legal advice document from UNODC, referring to the HIV/AIDS crisis, states: “It could even be argued that the drug control treaties, as they stand, have been rendered out of synch with reality, since at the time they came into force they could not have possibly foreseen these new threats.”³⁹

CONCLUSION

In 2012, the world will commemorate a century of international drug control. The International Opium Convention was signed on 23 January 1912 in The Hague by the United States, China, France, Germany, Italy, Japan, the Netherlands, Persia (Iran), Portugal, Russia, Siam (Thailand), Nicaragua, the

United Kingdom and the British overseas territories (including British India). Out of legitimate concerns about drug-related problems and with the laudable aim to protect the welfare of mankind. Over time the control system degenerated into a war on users, farmers and petty traders. The excessive negative consequences and negligible effectiveness have now been broadly acknowledged and a process of de-escalation is in full motion in many places.

Guiding principles in that process are respect for human rights, harm reduction, decriminalisation, proportionality of sentences, a developmental approach to illicit cultivation, and an evidence-based return to rationality. The current treaty system is plagued with inconsistencies, its ambiguities an obstacle to policy improvements, and sooner than later the current set of drug control conventions need to be revised. Inevitably the ongoing reform process will collide with the zero-tolerance nature of the UN conventions and with a number of their outdated articles. As was said in the first UN *World Drug Report* in 1997: “Laws – and even the international Conventions – are not written in stone; they can be changed when the democratic will of nations so wishes it.”⁴⁰

What the world needs is a group of countries willing to declare that the current treaty framework is no longer fit for purpose. A small group of countries initiated the development of an international drug control system a century ago. In 2012 another small group of countries could initiate its needed reform and design the outlines of a new legal framework for the next century, based on the many lessons learned over the past hundred years.

NOTES

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GLOBAL COMMISSION ON DRUG POLICY



The purpose of **The Global Commission on Drug Policy** is to stimulate an informed, science-based discussion about humane and effective ways to reduce the harm caused by drugs to people and societies. There is a growing perception that the 'war on drugs' approach has failed. Eradication of production and criminalization of consumption did not reduce drug traffic and drug use. In many countries the harm caused by drug prohibition in terms of corruption, violence and violation of human rights largely exceeds the harm caused by drugs.

The Global Commission on Drug Policy will build on the successful experience of the **Latin American Commission on Drugs and Democracy** convened by former presidents Cardoso of Brazil, Gaviria of Colombia and Zedillo of Mexico. Persuaded that the association between drug trade, violence and corruption was a threat to democracy in Latin America, the Commission reviewed the 'war on drugs' policies and opened a public debate about an issue that is surrounded by fear and misinformation.

In February 2009 of the Commission's published its statement, **Drugs and Democracy: Toward a Paradigm Shift**. The statement received wide coverage in the media and the ensuing debate led to positive drug policy changes in Mexico and Argentina. Change is imminent in Brazil. In many countries repressive policies remain firmly in place. Hence the need for a constructive debate about viable alternatives, both at the national and international level.

Goals

- » review the basic assumption, effectiveness and consequences of the 'war on drugs' approach
- » evaluate the risks and benefits of different national responses to the drug problem
- » develop actionable, evidence-based recommendations for constructive legal and drug policy reform

Background Papers (available at <http://www.globalcommissionondrugs.org/Documents.aspx>)

- » *Demand Reduction and Harm Reduction*, by Dr Alex Wodak AM
- » *Drug Policy, Criminal Justice and Mass Imprisonment*, by Bryan Stevenson
- » *Assessing Supply-Side Policy and Practice: Eradication and Alternative Development*, by David Mansfield
- » *The Development of International Drug Control*, by Martin Jelsma
- » *Drug Policy: Lessons Learned and Options for the Future*, by Mike Trace
- » *The Drug Trade: The Politicization of Criminals and the Criminalization of Politicians*, by Moisés Naím

TNI Drug Law Reform Project

The project aims to promote more humane, balanced, and effective drug laws. Decades of repressive drug policies have not reduced the scale of drug markets and have led instead to human rights violations, a crisis in the judicial and penitentiary systems, the consolidation of organized crime, and the marginalization of vulnerable drug users, drug couriers and growers of illicit crops. The project aims to stimulate the debate around legislative reforms by highlighting good practices and lessons learned in areas such as decriminalization, proportionality of sentences, specific harm reduction measures, alternatives to incarceration, and scheduling criteria for different substances. It also aims to encourage a constructive dialogue amongst policy makers, multi-lateral agencies and civil society.



Transnational Institute (TNI)

De Wittenstraat 25
1052 AK Amsterdam
The Netherlands

Tel: -31-20-6626608

Fax: -31-20-6757176

E-mail: drugs@tni.org

www.tni.org/drugs

www.druglawreform.info