



Governing the Global Drug Wars

SPECIALREPORT

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Guest Editor

John Collins

IDEAS Reports Editor

Dr Nicholas Kitchen

Email: IDEAS.reports@lse.ac.uk

Creative Director

Indira Endaya

Cover photo

Michal Novotny

<http://www.michalnovotny.com/>

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➤ Re-examining the Drug Problem Through a Fresh Lens

Juan Manuel Santos, President of the Republic of Colombia

The global commitment to fight the drug problem has – without a doubt – grown stronger and more resilient during the past four decades.

Governments and international organisations, as well as the scientific and academic communities, have all worked together to understand and tackle this matter, responsible for inconceivable amounts of violence and distress throughout our countries.

Colombia has experienced progress in this fight, and historic results have been achieved. We are no longer the world's top cocaine producer, according to the latest report by the United States Office of National Drug Control Policy. Not only have we reduced crops and trafficking, but with strong determination, we have dismantled menacing drug cartels.

Decades of hard work and sacrifice have yielded significant achievements.

However, we are now witnessing, with profound concern, how this situation is drifting to neighbouring countries, along with all the pain, violence and corruption it entails, which we have endured in our country for too many years.

Therefore, we are now called upon to invest all of our power and determination towards finding new ways to increase the effectiveness of this fight if we truly wish to outwit this problem and prevent it from causing more suffering and destruction.

The Colombian Government strongly believes that the time has come to take a fresh look and we invite world leaders, scientists and experts to start an open, serious and honest debate about this war. The time has come to think outside the box.

Our invitation is to dutifully study new formulas and approaches screened through an academic, scientific and non-politicised lens, because this war has proven to be extremely challenging and oftentimes, highly frustrating.

This is a global problem that demands a global solution, and therefore a new international consensus is needed. We must all make a sustained effort at thinking about creative and innovative ways to eradicate this scourge from our societies.

We are already moving toward this reality. During the past Summit of the Americas, held in Cartagena, Colombia, thirty Presidents and Heads of State agreed – for the first time ever – to engage in discussions – led by experts – on the War on Drugs, its effectiveness and prospects.

Our hope is to witness steps of this same magnitude, or even greater ones, multiplying around the world.

This report is a valuable contribution to this healthy and necessary debate. By re-examining the international approach to the drug problem from an academic perspective, we are nourishing the discussion and setting the conditions to find a new and more efficient strategy.

Let us relentlessly search for, study, think and debate, with all our courage and determination, seeking to discover and implement bolder and smarter answers to this pressing problem. Our world needs us to step up to this challenge. Our countries trust we will. ■

➤ Executive Summary

John Collins, Guest Editor

International drug control efforts began in 1909, with the aim of eradicating the abuse of certain drugs by controlling their supply. A complex international system of enforcement grew up based on this belief in supply control. A century on, the empirical data is available and overwhelming: the system has failed. Worse, it has become increasingly clear that the human cost of pursuing many of its policies renders them unjustifiable. From mass incarceration in the United States and Asia, to the HIV/AIDS epidemic flooding Russia and the waves of violence rippling through Latin America – current global drug policies are worsening current global drug problems. This is no longer a point of controversy, but as Joseph Spillane suggests, is something which ‘no serious scholar questions’. Nevertheless, driven by a mixture of bureaucratic and ideological inertia, the international drug control system, governed through the UN and enforced by a number of core states, continues to pursue many of the same failed policies. This report asks why the system evolved in the way that it did, and explores the potential for reform.

Often, those seeking to understand the complex and opaque international drug control system look to the wording of its various conventions and governing treaties – both of which are open to wide interpretation. However, as William McAllister points out, the system evolved through complex diplomatic, bureaucratic, social and interpersonal forces. It is only through an understanding of these broader forces that we can properly explain how the system was constructed and why it continues to function in the way that it does. Building on this discussion of historical complexity, David Courtwright examines the reasons why some drugs have traditionally been the subjects of ‘war,’ while others have become deeply ingrained in the mainstream economy. This is a question expanded upon by James Mill’s survey of the questionable scientific evidence underpinning cannabis’ co-option into international controls.

As Joseph Spillane’s analysis shows, in order to better understand current international drug policies we should focus more attention on the considerable harms that these policies create. In particular he suggests that researchers should concentrate on the wealth of evidence available from the daily experience of contemporary drug addicts, which reveals the, often-harrowing impacts of the various drug wars. Paul Gootenberg analyses the interaction between international policies and shifting cocaine ‘commodity chains’ in Latin America over the last century, culminating in the current Mexican crisis. In so doing, he highlights a seemingly inherent tendency of international drug policy makers to create larger and more violent problems than their interdictionist policies resolve.

Former Swiss President Ruth Dreifuss and her colleague Diane Steber evaluate Switzerland’s interaction with the international system, highlighting the pressure exerted on states trying to pursue policies outside the traditional supply-centric paradigm. David Bewley-Taylor then examines ‘the UNGASS decade’ between 1998 and 2008, when the international community committed itself to achieving ‘a drug free world’. He argues that the consensus that characterised this period is now fracturing as nation states are more openly pursuing alternative approaches.

In the final section of this report we look towards the future of the system and highlight specific areas in need of immediate reform. Damon Barrett shows that the current system is lacking in basic human rights oversight, and as a result is permitting systematic human rights abuses. Joanne Csete focuses on the International Narcotics Control Board's (INCB) support for unscientific policies internationally and its refusal to endorse best practice public health policies, particularly around HIV/AIDS prevention. She argues that the INCB remains 'the most closed and least transparent of any entity supported by the United Nations.'

The machinery of international drug control has solidified around outdated modes of thinking and failed policies. Despite this, it has proved remarkably successful at restricting policy experimentation worldwide and encouraging the continuation of counterproductive approaches. Two steps need to be taken. First, there need to be immediate measures to incorporate basic human rights standards and improve the level of oversight within the system. This is particularly urgent in the areas of international funding decisions and the operation of the INCB. Second, an independent root and branch review of the approach to, and apparatus governing, international drug control needs to be conducted with a view to long-term structural reforms. Such a review must begin with a deep understanding of the historical forces that have shaped and continue to underpin the current policies and system. This report should serve as a starting point. ■

> Contributors

DAMON BARRETT is the Deputy Director of Harm Reduction International and the Director of the International Centre on Human Rights and Drug Policy. He was a member of the UK delegation to the UN Commission on Narcotic Drugs from 2008-2011. Damon is an Editor-in-Chief of the *International Journal on Human Rights and Drug Policy*.

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DAVID R. BEWLEY-TAYLOR, PhD, is a Senior Lecturer in the Department of Political and Cultural Studies at Swansea University. He is the author of the books: *The United States and International Drug Control, 1909-1997* (Continuum, 2001); and *International Drug Control: Consensus Fractured* (Cambridge University Press, 2012).

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DIANE STEBER BUECHLI is a lawyer and post graduate in international economics law. She works for the Swiss Federal Office of Public Health where she is responsible for questions regarding international drug policy.

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JOHN COLLINS is a PhD Candidate in the Department of International History at the London School of Economics. His research focuses on the history of international drug control. He is the Transatlantic Relations Programme Assistant at LSE IDEAS.

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DAVID T. COURTWRIGHT, PhD, is Presidential Professor in the History Department of the University of North Florida. He is the author of numerous books, including *Forces of Habit: Drugs and the Making of the Modern World* (Harvard University Press, 2001); *Dark Paradise: A History of Opiate Addiction in America* (Harvard University Press, 2001); and *Addicts Who Survived*, an expanded edition of which will be published by University of Tennessee Press later this year.

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JOANNE CSETE, PhD, is Senior Program Officer for the Open Society Foundations' Global Drug Policy Program. Previously, she was an Associate Professor of Public Health at Columbia University; the Founding Director of the HIV and Human Rights Program at Human Rights Watch; Executive Director of the Canadian HIV/AIDS Legal Network; and a senior technical advisor at UNICEF.

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RUTH DREIFUSS is the former President of Switzerland. She served as a member of the Swiss Federal Council from 1993 – 2002, during which time she was Head of the Federal Department of Home Affairs. She is a member of the Global Commission on Drug Policy and the International Commission against the Death Penalty. Ruth is Doctor *honoris causa* of the Universities of Haifa (Jerusalem) and Fribourg (Switzerland).

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PAUL GOOTENBERG is Professor of History and Sociology at Stony Brook University in New York. He is the author of *Andean Cocaine: The Making of a Global Drug* (University of North Carolina Press, 2009) and edited *Cocaine: Global Histories* (Routledge, 1999). He chairs the Drugs, Security, and Democracy fellowship program at the Social Science Research Council.

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WILLIAM B. MCALLISTER, PhD, serves as Chief of the Special Projects Division in the Office of the Historian at the United States Department of State. He is also Adjunct Associate Professor of History in the Graduate School of Foreign Service at Georgetown University. Among other publications, he is author of the book *Drug Diplomacy in the Twentieth Century, An International History* (Routledge, 2000).

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JAMES H. MILLS, PhD, is Professor of Modern History at the University of Strathclyde, and founding Director of the Centre for the Social History of Health and Healthcare, Glasgow. He is author of *Cannabis Britannica: Empire, trade and prohibition, 1800-1928* (Oxford University Press, 2005) and *Cannabis Nation: Control and Consumption in Britain, 1928-2008* (Oxford University Press, 2012).

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JOSEPH F. SPILLANE, PhD, is an Associate Professor of History at the University of Florida. He is the author of *Cocaine: From Medical Marvel to Modern Menace in the United States* (Johns Hopkins University Press, 2000) and co-edited *Federal Drug Control: The Evolution of Policy and Practice* (Haworth Press, 2004).

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➤ **Governing the
Global Drug Wars**

➤ The International Drug Control System¹

1907: Ten Year Agreement

- Britain, China and India agree trilateral framework for ending Indian opium exports to China within ten years.
- Agreement becomes model for future supply control system.

1909: Shanghai Opium Commission

- Initiated under American leadership.
- First truly international drug control meeting.
- The Great Powers examine ways to suppress international opium traffic – particularly traffic bound for China.
- Largely ends in discord but leads to 1912 Opium Convention.

1912: Opium Convention

- Beginning of international drug control system.
- States encouraged to end drug abuse. Remains vague on mechanisms to achieve this.
- Signatories must prevent shipment of opium to states which bar its entry.
- Entered into force in 1919.
- Co-opted into new League of Nations.
- United States' leadership undermined by its ambiguous relationship with League administered system.

1925: Geneva Opium Conventions

- Establish first mechanisms to enforce supply control framework.
- Permanent Central Opium Board (PCOB) created to monitor international imports and exports of narcotics.
- United States fails to secure end to all 'non-medical and scientific' drug use. Walks out of proceedings and never signs.
- Treaty gains widespread adherence over time.

1931: Conventions

- United States cooperates with UK, Germany, and other industrialised states to fashion a workable control scheme.
- First introduction of schedules into international treaties.
- Creation of system of estimates. Administered by Drug Supervisory Body (DSB).
- Formalises international distinction between licit and illicit drug trades.
- Both PCOB and DSB function as quasi-judicial bodies independent of League of Nations.

1936: Convention

- Aimed at suppressing growing illicit traffic.
- United States again fails to successfully advocate for end to all 'non-medical and scientific' drug use. Its delegates withdraw active cooperation for remainder of treaty negotiations.
- Eventually ratified only by Canada and a few other minor states. Never comes into force.

1939-40: States consider negotiating international supply control agreement. Interrupted by WWII.

¹ This overview is drawn from various sources. For a history of the international drug control system see: William B. McAllister *Drug Diplomacy in the Twentieth Century, An International History* (Routledge, 2000)

1939-1945: WWII

- Certain PCOB, DSB and League functions transfer from Geneva to Washington. Continue to function (minimally) throughout war.
- United States extracts commitments from Britain and the Netherlands to end opium monopolies in the Far East. Exceptions remain. French follow suit in 1945.

1945-6: United Nations becomes new custodian for administration of existing treaties.

- Continuity with pre-war system maintained.

1948: Convention

- Brings synthetic narcotics under international control.

1953: Opium Protocol

- Prescribes more severe limitation of agricultural production of opiates.
- Forced through by the US, France and other allies.
- Rejected by agricultural producing countries and had little hope for gaining widespread acceptance.

1961: Single Convention

- Unifies previous Conventions (except 1936) into one document.
- United States works to thwart its ratification, and instead bring 1953 Protocol into force.

1964: Single Convention enters into force. US initially refuses to ratify.

- PCOB and DSB are merged into International Narcotics Control Board (INCB). Retains a 'quasi-judicial' role.

1967: US ratifies Single Convention.

1971: Convention

- Brings Psychotropic (psychoactive) substances under international control, but in a less stringent form than applied to opioids, coca and cannabis.

1972: Protocol Amending the Single Convention

- Product of US efforts to strengthen Single Convention and INCB.
- Six decades after first Opium Convention, international system remains overwhelmingly focused on supply control issues.

1972: UN Fund for Drug Abuse Control (UNFDAC) created.

- Nominally independent but reliant on US patronage.
- Heavily supply control focused.

1988: Convention

- Primarily aimed at tackling organised crime and trafficking.
- Addresses demand issues by recommending criminalisation of personal consumption.

1998: United Nations General Assembly Special Session

- Commits states to massive reductions in drug use and supply within ten years.
- Slogan: 'A drug free world. We can do it!'

2009: UN Secretary General Ban Ki-moon claims criminalisation of injecting drug use is hampering HIV/AIDS fight. Calls for decriminalisation.

➤ Reflections On a Century of International Drug Control

William B. McAllister¹

The first widely-applicable international drug control strictures were negotiated 100 years ago. A functional bureaucratic and treaty structure has been in place for 80 years. The modern configuration of drug control conventions, international organisations, and oversight bodies attained its current shape 40 years ago. Based on my research, publications, and experience in government, this article identifies the key factors that have contributed to the creation and implementation of the international control system over the last century and offers some observations about the prospects for altering that regime.

INDIVIDUAL CONTRIBUTIONS MATTER

Given its long history it is easy to assume that the 'system' operates on a fixed trajectory, regardless of who is at the helm. Bureaucrats and politicians come and go, but the 'machine' appears to grind on with little alteration, leading many to conclude that opportunities for change or reform are extremely limited. The historical record, however, suggests otherwise. Individual contributions – both positive and negative – matter more than we often appreciate.

The negotiations of 1923-1925 defined the role of the Permanent Central Opium Board (the predecessor of today's International Narcotics Control Board); modified the operations of the Opium Advisory Committee (predecessor to today's United Nations Commission on Narcotic Drugs); and, crucially, determined how those bodies would be supported by the League of Nations secretariat (the bureaucratic structure providing the day-to-day labor that makes the international control regime a working operation). During those talks, government officials worked diligently to circumvent the power of one person. Dame Rachel Crowdy, highly accomplished, independent, and outspoken, served as head of the Opium and Social Questions section, and was the ranking woman in the League of Nations administrative hierarchy. National representatives did not want her to acquire too much power because they feared she might attempt to impose overly-strict interpretations of the emerging drug control regime's rules. The framers therefore weakened the Board's prerogatives and concocted a dual-track bureaucratic structure, creating jurisdictional lacunae and administrative rivalries that plagued the operational functionality of the control system for six decades.

¹ This paper is drawn from this author's dissertation and later book on this topic: William B. McAllister, 'A Limited Enterprise: The History of International Efforts to Control Drugs in the Twentieth Century' (PhD Dissertation, University of Virginia, 1996); William B. McAllister, *Drug Diplomacy in the Twentieth Century: An International History* (Routledge, 2000). The views expressed in this essay are the author's and do not necessarily reflect those of the US government, the US Department of State, or the current administration.

A careful reading of the record also reveals unsung heroes. For over a quarter of a century, Helen Howell Moorhead, an individual who possessed no official standing within the global drug control apparatus, played a key role in negotiations. She provided social lubrication, acted as a go-between among governmental representatives, floated policy options, and served as a backchannel communications conduit. After her death in 1950, dialogue deteriorated and opposing camps polarised, leading to unpredictable negotiations, unstable coalitions, and unsupportable treaty outcomes over the ensuing decade.

Individual ambition has also had a profound impact on the operation and direction of the system. As Moorhead declined, Leon Steinig, an administrator within the UN drug control hierarchy, attempted to redefine and expand the reach of the drug control system, in large measure to enhance his own position in service of a greater mission he hoped to promote – the regulation of fissile material and nuclear weapons. His manoeuvres, which ultimately failed, caused deep dissension within the international drug control community, severely degraded the capacity to function of the international secretariat, and resulted in his dismissal. Moreover, in the aftermath of Steinig's removal, Charles Vaillie, French representative to the United Nations Commission on Narcotic Drugs during the 1950s, took the reins long enough to force through a draconian drug control treaty that not only engendered considerable opposition, but also caused a reconsideration about the ultimate goals of the system, even among the control regime's supporters.

Even the most notable – some might say notorious – individual associated with the construction of the twentieth century drug control system, Harry Anslinger, merits nuanced consideration. As the longtime Commissioner of the US Federal Bureau of Narcotics, who also served as chief US representative at international meetings, Anslinger exerted a profound influence on the shape and operation of the global regime. Yet it is often underappreciated that his principal focus was frequently on how to protect his domestic position. Beset by near-constant threats of the reorganisation or elimination of his Bureau, Anslinger frequently used international proceedings as a way to shore up support at home.

Sometimes this meant championing a cause that he knew would not 'sell' in the international arena. At other times he used the 'demonstration effect' of refusing to cooperate (on occasion even walking out of meetings) to play to domestic audiences. Yet he also made sure his superiors knew about the Bureau's clandestine operations and cooperation with counterpart agencies in other countries, even when that activity included working with potential enemies, including Nazi Germany as late as 1941. Anslinger was also astute enough to amass the largest cache of licit drug supplies ever assembled in the late 1930s, and used this stockpile to cajole allies and neutrals during the war and to argue for the centrality of the Federal Bureau of Narcotics to the US national security apparatus that emerged in the late 1940s. Anslinger is often misidentified as a chief architect of the landmark 1961 Single Convention on Narcotic Drugs, when in fact he opposed the treaty and did all he could to prevent its coming into force. The ostensible reason he cited was that the treaty represented a retrograde movement, diminishing drug control when compared to the provisions of the 1953 Opium Protocol. Anslinger's chief concern, however, focused on language in the Single Convention that might be interpreted as weakening his longstanding argument (which was never really accurate) that *only* the continued existence of the Federal Bureau of Narcotics could fulfill the United States' international treaty obligations. The configuration of the system, including what may strike observers as its nonsensical or counterproductive aspects, is better comprehended if one understands that certain features can be traced back to personal logics.

Although one could argue that all those examples represent a long passed 'heroic age', when individuals could have a greater impact because the international regulatory rules and the global control bureaucracy was not as developed as today, I suspect we will discover that people still matter a great deal. To some extent it may be true that sphere of operations for policy entrepreneurs is somewhat more circumscribed. Nevertheless, as we approach the time when historians can access the negotiation records of the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, (which, along with the 1961 Single Convention (as amended in 1972) and

the 1971 Convention on Psychotropic Substances, serve as the three pillars of the current global drug control regime, I think it likely that they will find that the impetus for, and configuration of, that agreement will owe much to a few people who possessed both the vision and the position to advocate their preferences.

Moreover, the most important occurrence in this field (and something that I certainly did not predict) has been the promulgation of the WHO Framework Convention on Tobacco Control. Utilising non-governmental, intergovernmental, and supra-governmental channels to build support since the 1970s, this agreement came into force less than two years after its opening for signature in 2003. It represents a viable alternative to the 'traditional' treaty creation model that focuses on states as the initiators of new agreements. The Framework Convention appears to have been created by generating grassroots support for major alterations in local, national, and international drug policy (or in this instance, a lack of policy) that has challenged entrenched interests with a surprising degree of success. Studying the historical development of this approach will no doubt illuminate the contributions of individuals who were once considered marginal players in the halls of power.

INSTITUTIONAL LEGACIES PERSIST

Once an international bureaucracy is created, such as the predecessor organisations that are now known as the United Nations Office on Drugs and Crime or the United Nations Commission on Narcotic Drugs, they do not simply act as neutral conduits through which information passes. As has been noted many times before, 'where one stands depends on where one sits.' Secretariats and offices have interests, prefer certain positions or initiatives over others, and exercise significant latitude in determining how to interpret and carry out their instructions. They can act as allies of reformers, or as impediments to change.

The configuration of structures also matters. The International Narcotics Control Board (INCB), for example, acts essentially as a reactive body. It is only after states submit estimates of need and statistics of usage that the Board can determine whether there

is a risk that leakage into illicit traffic has occurred. However, at a few junctures in the history of the Board's predecessors (the Permanent Central Opium Board and the Permanent Central Narcotics Board) there was serious talk about giving the Board the much greater power to approve (or deny) imports and exports of medicinal drugs *in advance*. One can imagine how differently the international drug control regime would operate if the Board possessed the capacity to regulate supply in the licit marketplace, in essence controlling the global production and distribution of important medicines.

Bureaucracies are also hard to kill. They have built-in constituencies and budgets, and the capacity to generate political support if an existential threat materialises. Also, obviously, bureaucracies tend to do what they are created to do and not something else. Therefore, one of the reasons that those wishing to reform or liberalise drug policy often find themselves frustrated is because there are relatively few assets devoted to prevention, intervention, and treatment. In the era when these organisations were created, the overwhelming emphasis was on supply control, and hence the extant agencies are designed and staffed to accomplish that purpose. Bureaucracies can be redirected, or 'repurposed,' but doing so is often difficult because existing organs are likely to adopt new terminology without changing the fundamental focus of their mission, or because existing organisations may simply add a branch to deal with a previously unmandated function without altering their overall focus. Taken together, those extant structures exert a major influence on the trajectory of events, and it is important to consider how that power was formulated.

THE SYSTEM AS A SOCIAL CONSTRUCT

Foundational documents such as treaties and national-level promulgations that create drug control agencies are social constructs, not necessarily the rational result of judicious consideration of all relevant factors to arrive at a rational result. Individual pique, rivalries, and alliances forged for other purposes have all played important roles in creating the instruments of international drug control. Drug negotiators have been known to engage in devious parliamentary

manoeuvres to gain advantage in the midst of negotiations. Final agreements reflect power disparities and favour those participants who possess the political capital to impose their preferences. Simply reading an international protocol or a national agency's charter without understanding the historical circumstances that generated their configuration can lead to errant understandings about what an entity can do, or is designed to do.

For example, in the negotiations surrounding the 1971 Psychotropic Convention, the early versions of the draft treaty contained very different provisions than those embodied in the final agreement. Profound disagreements existed between those who wanted to forge rules similar to those applied to the 'traditional' drugs of abuse (narcotics) while others preferred a much less stringent control regime. The Single Convention also went through two drafts, dramatically different from each other, before the final draft was put before the convention in 1961. Nothing is fixed permanently: the current state of the regulatory regime can always be changed, and is – in small ways – routinely. Larger changes in the overall set of rules that govern the system are less frequent, but you can be sure that such manoeuvring is always lurking quietly, and will surface if conditions appear propitious. Treaties are also subject to considerable interpretation. As soon as the ink was dry on the 1971 Psychotropic Convention, the United Nations secretariat launched a quiet, gradual, consensual, and effective campaign to expand the scope of the protocol. Only years later did some governmental agencies and other interested parties challenge longstanding regulatory practices that are not, strictly speaking, incorporated in the treaty.

The 1961 Single Convention proved so problematic to implement that the United Nations Commission on Narcotic Drugs approved production of a Commentary that would explain and interpret its provisions. The first effort, however, proved so unsatisfactory that an entirely different second Commentary had to be prepared, which is the version that can be found on library bookshelves today. Over time most of these details are lost to observers, even those whose daily work revolves around the drug question, yet understanding the circumstances and relationships

that forged the system is important to assessing how one might go about amending it. When faced with the standard reason for maintaining status quo operations – we've always done it this way – it can be quite powerful to point out that while there may have been good reasons at one time for such practices, changed conditions warrant new approaches.

BUREAUCRATIC POLITICS AND THE ABSENCE OF DEMAND ISSUES

The international drug control regime, and to a considerable extent the national-level bodies charged with drug-related policy, are not necessarily primarily focused on helping current drug abusers or preventing new cases of drug dependence. It is actually quite remarkable, when one examines carefully the discourses that surround the formation and implementation of the system over the past century, how often drug diplomatists talked about everything but the phenomenon of drug abuse. During the 1920s, medical officials associated with the League of Nations Health Committee (the predecessor of today's World Health Organization) made the perfectly sensible suggestion that formulating some sort of generally-agreed definition of drug abuse would be a good idea. Nobody objected in principle, but very quickly the political representatives that populated the League's Opium Advisory Committee (predecessor to today's United Nations Commission on Narcotic Drugs) and the pharmaceutical industry representatives who frequented the meetings, eschewed that question in favour of renderings of the problem that focused on raw tonnage of opiates being traded around the world. The definition of the concept 'drug' itself, was reduced to simply listing the drugs to be controlled in each treaty. It took many decades, really until the later 1960s, before authorities engaged in more sophisticated attempts to define basic concepts such as 'drug' and 'abuse.'

That lacuna did not occur because early drug-control officials were incompetent, but rather because the regulatory system quickly became dominated by those concerned with issues such as promoting the sales of what we now call the 'ethical' drug industry; eliminating manufacturers producing in illicit ways from

competing in the licit market; providing exceptions to maintain military stockpiles; promoting research and development; taking account of religious sensibilities; making allowances for 'backward' regions of the world that would have no medicinals whatsoever without recourse to drugs considered inappropriate in a western setting; and not interfering with imperial revenues in those colonies that maintained state-run opium monopolies. Although those interests changed somewhat over time, it was, again, only with the advent of the 1971 Psychotropic Convention that an international treaty specifically enjoined states to take measures to prevent drug abuse from occurring in the first instance.

Of course, the entire system is built around the concept of supply *control*, not, it should be emphasised, the oft-used 'prohibition'. No drugs are absolutely proscribed by the international treaties (although Schedule IV of the Single Convention enumerates a short list of substances that governments have the option to ban); the Schedules of Control take account of the fact that even highly regulated substances such as cocaine and LSD retain some medical utility or research value. What is often misunderstood about the international regime was that its early framers were interested in balance. They did not want to limit supplies of necessary medicinals to an extent that would drive up the price, especially since the rules were solidified just as the world slipped into the Great Depression, and pharmaceutical sales represented one of the few potential bright spots in the global economy.

A rudimentary elucidation of economics illuminates the key point: if the control system were so finely-regulated that the final order for licit medicines in any given year were filled by emptying the final vial off the last shelf of the only supplier with stock remaining, then the price would rise to unaffordable levels. Therefore, a conundrum is built into the system: the goal is to manufacture enough useful substances to supply medical need at a reasonable price, while preventing the excess capacity necessary to hold the price down from being diverted into illicit traffic. That part of the system has actually worked rather well. There is little diversion from licit channels into illicit traffic; many now campaign for fewer fetters to be placed on pain-management options for patients, but the cost of

the analgesics themselves is not a significant factor in the debate. In sum, it is precisely because the original design of the system was as devoted to cost-effective access as to limiting illicit supplies that demand-side issues were shunted to the background, in hopes of reducing the matter to a 'simple' police problem.

THE ROLE OF INSTITUTIONAL GATEKEEPERS

It follows, then, that much of the story of international drug control is about gatekeeping. Who decides what qualifies as a drug, and what level of control is appropriate for a given substance? How can those decisions be changed? Which actors in the system have entrenched interests in the status quo sufficient to block reform, and which have both the capacity and will to advocate revision? Whilst an understanding of the history of the construction of the system can provide answers to those questions, the main issue is to understand that such 'pressure points' exist. Those wishing to engender change would do well to carefully consider where to direct their efforts. In recent decades, the explosion of international non-governmental organisations, a general opening up of foreign affairs issues beyond what one might call the traditional 'foreign ministry portfolio,' and the ease with which the internet can be used to generate publicity for a cause, have all multiplied the points of entry would-be reformers might utilise.

For many issues that combine social, economic, medical, ethical, and other factors into a complicated matrix, reform has historically been engendered when change advocates seize the moral high ground. In the case of the drug question, it is important to account for conditions at the time the regime was created. The principal concerns were a rampant epidemic of drug abuse that appeared to contribute substantially to the collapsing Chinese Empire; the fear of 'contagion' (that drug abuse might spread to other countries and enter mainstream society); and the fact that several major colonial powers purveyed opiates to their poorest subjects by operating state-run monopolies that added revenue to imperial coffers. Given that rather unsightly scenario, reformers attacked the opium monopolies as immoral and counterproductive, positioned China as a victim deserving of help, and warned against the moral and practical perils of burgeoning drug abuse.

Many parties opposed reform, presenting arguments that remain familiar today: if we disengage from the trade some competitor (perhaps less scrupulous) will simply take over and reap the profits; people will always acquire illicit substances if they wish to have them, so better to keep the traffic above board in order to regulate it; curbing the trade will reduce tax revenues, requiring additional proceeds from other sources; free enterprise and market forces should be allowed to operate without undue fetters. Yet by 1912, the reformers' arguments had grasped the initiative away from those in favour of the status quo. A long rearguard action ensued, but in retrospect it is clear that the reform movement would eventually overthrow the old system, largely because of its superior rhetorical position in the public sphere. We are seeing much the same phenomenon today. As those who wish to institute new types of reform marshal their arguments, they highlight the damage that the 'drug war' does to the environment, note human rights abuses, emphasise the advantages of harm reduction strategies, and cite the importance of pain management and other considerations that the current system deprivileges. If the historical record is any indicator, that strategy is likely, over time, to alter or perhaps even overturn, the values that undergird the current regime.

CONCLUSION

What lessons can be drawn from this history? One observation is that, with rare exceptions, problems cannot be solved, but only managed. There is, however, a great difference between managing problems well and managing them poorly. In the realm of Great Power politics, that is the difference between peace and war. In the realm of drug policy, one can imagine rather better outcomes than those that currently maintain, if not necessarily perfect solutions. There will always be a dramatic tension between the poles of complete prohibition and totally unfettered access (neither of which exist in the real world anyway), causing gatekeepers to incline in one direction or the other. And even when one does resolve a significant international or national problem, it's human nature not to notice.

For example, in late 1972 American officials, after much negotiation, successfully concluded talks with the Cuban government that ended the longstanding issue of the hijacking of US airliners. By early 1973 the number of incidents dropped precipitously, and State Department officers were justifiably proud of their success. But the archival records indicate that they felt unappreciated, because nobody really noticed. When the problem went away, policymakers and the media moved on to the next hot-button issue. So, even in the best of circumstances (and this is not meant to be discouraging but simply realistic), one cannot necessarily expect a lot of credit for a job well done.

So how might one define success in the complicated world of drug policy? One option worth considering is to set realistic use and abuse targets and then adjust policy to maintain them. Imagine for example, that a particular country suffered a ten percent heroin addiction rate among its population. A goal could be set to reduce that figure to, say, five percent. Programmes could be implemented to achieve the target rate, and then to maintain the 'floor' percentage so that it did not rise. In addition, once the target rate was met, some funding would be shifted to deal with the inevitable problems created by the remaining addicts. Similar 'floor' percentages could be set for other drugs in the same manner. This scenario assumes that there is an irreducible minimum use/abuse rate for any given drug in any given society, eschewing the 'zero tolerance' standard, not necessarily because it is not laudable, but because it is unrealistic by all historical standards of human behaviour.

Various other criteria – for example harm reduction statistics, human rights standards, environmental improvements and crime prevention – could be factored in to the calculations. This approach strikes me as technically achievable. We have the capacity to measure key criteria with sufficient accuracy, especially with regard to medium-term and long-term trends, and to make judgments about progress toward a goal. This strategy also seems to me to be bureaucratically feasible. Government agencies that know what they are supposed to achieve, utilising measurable outcomes (the current buzzword on the other side of the Atlantic is 'metrics') can produce quite satisfactory results. This idea should even be politically feasible,

at least potentially, if sufficient groundwork were laid to persuade key constituencies to consider a major change in the goals and operation of the system. I cannot pretend that this suggestion is not without its own problems, but it strikes me as at least having the virtue of moving the issue off the infertile ground of absolutes, be they drug-free utopias or libertarian nirvanas.

In closing, again at the risk of stating the obvious, it should be remembered that Rome wasn't built in a day. It took a long time to construct the current international drug control regime, and alternative paths that would have produced something other than the current system were real possibilities at various junctures in the past. Nothing is fixed in place permanently, but nor is it likely that a major reconfiguration might be achieved in short order. Like many other issues that touch on multiples facets of the human experience, some combination of education, advocacy, and the biblical quality of 'longsuffering', are the elements most likely to effect change over time. ■

➤ A Short History of Drug Policy or Why We Make War on Some Drugs but not on Others

David T. Courtwright

Overseas trade and European expansion in the sixteenth, seventeenth, and eighteenth centuries turned psychoactive drugs, including spirituous alcohol and tobacco, into global products. From the beginning, the commerce provoked controversy. Doctors argued about the indications, dosages, and risks of imported drugs. When use spread beyond medicine, the state became involved. Some rulers resorted to mutilation and execution to enforce prohibitions, especially against tobacco smoking. None succeeded in stamping out the novel vice or in suppressing the cultivation of tobacco, which quickly became a global crop. 'Mankind has found too few comforts,' wrote historian V.G. Kiernan, 'to let itself be robbed of them.'

Governments therefore changed course. By the late seventeenth century most European rulers treated tobacco and other drugs as lucrative commodities and sources of revenue. They created a system of legal commerce in which officials concerned themselves with collecting excise taxes and customs duties or, alternatively, setting up monopoly systems to fill the state's coffers. Lawbreakers were more likely to forfeit smuggled cargoes than their lives. Governments did impose some regulations, such as banning smoking in combustible buildings or forbidding the sale of spirits to Indian tribes. Backwoods traders mostly ignored the latter injunction. Little in the eighteenth century functioned as actual prohibition.

One partial exception was opium in China. In 1729 the Yongzheng Emperor banned the import of opium for *madak*, a disreputable opium-tobacco mixture smoked in the southeastern provinces. Medicinal opium imports remained legal, an early statutory illustration of the common moral distinction between therapeutic and recreational uses. By the end of the eighteenth century, however, the Qing government had outlawed all forms of the opium trade. Foreign merchants and local pirates defied the ban by smuggling opium of Indian and Middle Eastern origin. In 1839 Qing attempts to end the traffic catalyzed an 'opium war' with the British that lasted until 1842. China's defeat in this war and a second conflict in 1856-1858 legalised and expanded the Indian opium trade. Annual imports rose from six million pounds of opium in 1839 to 15 million in 1879. By then Chinese farmers were producing an additional 32 million pounds domestically to feed the growing national demand.

ADDICTION AND INDUSTRIALISED VICE

Historians still debate the extent and significance of opium use and addiction in Qing China. What is clear is that consumption was rising faster than population, and that this was broadly true of psychoactive commodities in the late eighteenth and early nineteenth centuries. General improvements in agriculture, plantation management, and manufacturing increased supply and reduced prices, including those of spirituous liquors. America's Trans-Appalachian West, where farmers converted surplus grain into

1 Victor G. Kiernan, *Tobacco: A History* (London: Hutchinson Radius, 1991), 23.

easier-to-transport whiskey, became a vast regional still. The amount of whiskey shipped through Louisville – amounting to 250,000 gallons in 1810 – rose to 2,250,000 gallons by 1822. A gallon retailed for 25 cents at a time when the lowliest agricultural labourer earned a dollar a day.

Increasingly, medical authorities saw excessive spirits drinking as the primary cause of addiction to alcohol. 'Intemperance,' as it was then known, was a progressive disease whose chief manifestation was the loss of control over drinking and whose sole remedy was abstinence from alcoholic beverages. The sociologist Harry Levine dated this 'discovery of addiction' to the period between 1785 and 1835.² Levine argued that the leading figure was Benjamin Rush, the Edinburgh-trained American physician who pulled together the key strands of the addiction concept and gave it its modern form, much as Charles Darwin would later do with evolution. While other scholars have challenged Rush's priority, Levine's basic insights – that alcohol addiction was central to temperance ideology, that temperance was one of the nineteenth century's most popular and influential reform movements, and that temperance shaped attitudes toward the regulation of drugs other than alcohol – have endured. Absent the idea of addiction, the whole system of controlling drug supply that has developed over the last two centuries would make little moral or practical sense.

The temperance movement was initially strongest in Protestant, spirits-drinking countries in North America and Europe. However, during the nineteenth century it became part of – in many ways, the foundation of – a larger anti-vice movement that was international in character and attracted personalities as diverse as Frances Willard and Mohandas Gandhi. From the 1870s to the 1930s – the heyday of anti-vice activism – reformers launched campaigns to abolish prostitution and trafficking in women; to combat venereal disease; to suppress obscenity; and to discourage, restrict, or prohibit the non-medical use of alcohol and drugs.

Though often caricatured as meddling puritans (as some were), it is important to remember that the reformers confronted a social and economic landscape in which vice was becoming more conspicuous, more commercialised, and more dangerous. Drug innovations – the isolation of alkaloids; the invention of hypodermic syringes; flue-cured Bright tobacco in cigarettes; beverages and patent medicines fortified with stimulants and narcotics; and new synthetic or semi-synthetic drugs such as heroin – were married to new techniques of mass production, promotion, and distribution. The speed and gross tonnage of steamships doubled between the 1850s and the 1890s, simplifying global expansion for distillers and tobacco and drug manufacturers. The upshot was that more people could consume more potent drugs more easily, cheaply, and quickly, increasing the likelihood of addiction, poisoning, accidents, disorder and crime in the imperial homelands and in the colonies.

The same held for other vices. Steamships and trains carried western women as well as western drugs, which helps to explain why the white slavery controversy erupted in the three decades before World War I, during years of rapid globalisation and rural-to-urban migration. The development of steam and rotary presses facilitated the production of pornographic literature, formerly an expensive luxury good. Photography, another nineteenth-century invention, was quickly adapted to pornographic purposes. The Victorian campaigns against obscenity were, wrote historian Andrea Friedman, a 'defensive' reaction to 'the flood of sexual commerce' that reformers believed 'threatened the nation's future.'³

² Harry G. Levine, 'The Discovery of Addiction: Changing Conceptions of Habitual Drunkenness in America,' *Journal of Studies on Alcohol* 39 (1978): 143-174.

³ Andrea Friedman, *Prurient Interests: Gender, Democracy, and Obscenity in New York City, 1909-1945* (New York: Columbia University Press, 2000), 18.

ANTI-VICE ACTIVISM

The word 'defensive' goes to the heart of the matter. Reformers fought back against the spread of what they took to be personally ruinous and socially destructive vices. The liquor traffic remained the key target, tied as it was to domestic abuse, crime, corruption, pauperism, insanity, prostitution, venereal disease, industrial accidents, military unpreparedness and defective offspring. Medical authorities thought the abuse of alcohol and other drugs caused 'degeneration,' heritable neurological damage that assumed protean forms. The drunkard's child might be an opium addict, his grandchild an epileptic, his great-grandchild a congenital idiot. But the end was always the same, personal ruin and racial decline. Caleb Saleeby, a prominent English eugenicist, argued that alcoholics should be prevented from procreating. So did the Nazis. When they came to power in Germany, they made chronic alcoholism one of their legal bases for sterilisation.

Admittedly, the motives for anti-vice activism went beyond concerns of public health, safety, and security. Ethnic, racial, and class prejudices were on display in the Australian and American campaigns to outlaw opium smoking, a vice associated with Chinese immigrant labourers. Henry Ford, an ardent dry, detected the fingerprints of international Jewish conspiracy in the liquor trade. Adolph Hitler saw them in prostitution and white slavery, and claimed that sexual vice in the Leopoldstadt district of Vienna contributed to his antisemitic awakening. Protestant clergy and missionaries, lacking scapegoats other than their own countrymen and governments, attacked the India-China opium trade and the Philippine opium monopoly that the Americans inherited from the Spanish. Though their motivation may have been religious, their tactics were often secular and innovative. Reverend Wilbur Crafts, who successfully lobbied to phase out the Philippine monopoly, perfected an early version of the blast fax, pre-printing 2,000 telegraphic protests for signature by influential men. Crafts, who lectured in twenty-nine countries and authored a book a year, was as indefatigable as St. Paul and as determined to war against the flesh. He fought to ban not only non-medical use of alcohol and narcotics, but screen vamps, close dancing, Sunday sports, and cigarettes.

Yet when he died in 1922, Crafts was an anachronism. Though religious reformers still figured in anti-vice campaigns, they had become less prominent over time. Instead, secular concerns about public health, social costs, and national security increasingly dominated the debates over vice control. Russian temperance efforts got a boost from the military disasters of 1904-1905, widely attributed to inebriety in the ranks. Vodka, not Japan, had inflicted Russia's humiliating defeat. World War I intensified such anxieties and prompted a global wave of reform. The 1914 emergency decree against absinthe sales in France; the 1916 drug regulations in Britain; prohibition of distilling in wartime Russia and other countries; the closure of brothels near American army bases; anti-venereal-disease propaganda everywhere – all of these measures were predicated on the social and strategic burdens of vice, which nations at war could ill afford.

THE THREE AXES OF POLICY

Modern drug policy, then, was born in an era of international anti-vice activism, an activism whose rationale became noticeably more secular over time. It was also a progressive rationale, a manifestation of the determination, in historian Daniel Rodgers's words, 'to hold certain elements out of the market's processes, indeed to roll back those parts of the market whose social costs had proved too high.'⁴

But roll back how? Reformers did not necessarily favour prohibition, or favour it across all categories of vice. Charles Henry Brent, the Ontario-born Episcopal missionary bishop who led early diplomatic efforts to restrict the global traffic in narcotics, opposed American-style alcohol prohibition. Many temperance advocates favoured, not a ban on alcoholic beverages, but fixed-profit municipal monopolies that limited sales to adults

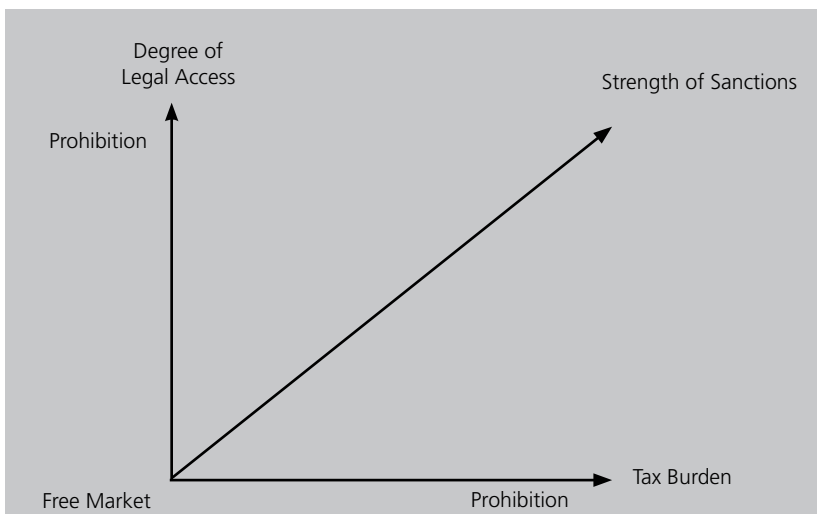
4 Daniel T. Rodgers, *Atlantic Crossings: Social Politics in a Progressive Age* (Cambridge: Harvard University Press, 1998), 29-30.

who drank in moderation. The monopolies would deny profits to the liquor Hydra and, in the Fabian version, enable governments to fund educational and recreational projects to give the working class alternatives to drink. Soft power, as we might say today, worked better than hard.

Narcotic regulation provoked its own disagreements. The international treaties of 1912, 1925, and 1931 and related enforcement statutes created a global control system intended to limit narcotic production to estimated medical needs and to minimise diversion and non-medical use. Rudimentary at first, the system gradually became more efficient and comprehensive; it enjoyed widespread support among both economic progressives and social conservatives throughout the 1920s and 1930s. Yet no consensus emerged on the question of maintenance: whether (and for how long) addicts might receive a legal supply of narcotics. The British opted for a liberal maintenance policy. The French, with a different conception of citizenship and greater anxieties about national morale, forbade maintenance and dispatched addicts to prison. So did the Americans, although during the 1930s the federal government built two large narcotic hospitals which admitted patients on a voluntary as well as an involuntary basis. Officially, the Japanese government also provided treatment for addicts in occupied China. In fact, its policy was hypocritical. Japanese officials vigorously suppressed opium trafficking in the home islands, but tolerated it under a facade of reform in their Manchukuo colony. They did so in part because they viewed opium as a drug of racially inferior Chinese losers.

The simplest way to map these variations, and to track the policy choices of reformers past and present, is with a graph of three axes [See Figure 1]. The Y axis represents the degree of regulation. It runs from universal access for substances like tea and coffee, to adult access for tobacco, to restricted adult access for alcohol (no drinks for drunks), to prescription controls for licit drugs, to prohibition for illicit drugs. The X axis describes taxation, from nothing, to modest imposts, to heavy taxes, to taxes so heavy that they amount to prohibition. The Z axis describes the penalties for violating the rules governing sales or taxation. These range from nothing, to reprimands, to fines and imprisonment, to hanging. The origin point for the three axes – no regulations, no taxes, no sanctions – is the free market.

Figure 1: The Three Axes of Drug Policy



Policy debates are arguments over what position particular drugs (or, more broadly, vices) should occupy in this scheme. For example, critics of federal marijuana policy in the United States would move cannabis down the axis of regulation, from prohibition to prescription, or further still to over-the-counter adult sales. They also favour moving cannabis down the sanctions axis by reducing or eliminating criminal penalties for possessing small amounts. And they often argue that cannabis, when legal, should be situated well up the scale of taxation, both to provide revenue and to offset treatment and other costs that may arise from more widespread use and addiction.

THE DOUBLE STANDARD

The three policy axes imply a calculation about risk. The more dangerous and addictive a substance, the more compelling is the case for strict regulation, taxation, and/or sanctions. But this raises an obvious question. Why, for much of the last century, were alcohol and tobacco, the two drugs that indisputably caused the most mischief and addiction, underregulated, undertaxed, and undersanctioned relative to drugs upon which governments periodically declared war? The question is often posed rhetorically, to indict needlessly or inconsistently strict illicit-drug policies. But here let me take it literally. What caused this psychoactive double standard, a double standard made the more striking by temperance's formative role in the western crusades against drugs and vice?

The most basic answer is that the alcohol and tobacco industries were, like the investment banks of our own era, too big to fail. Indeed, an 1895 Royal Commission concluded that in Canada the alcohol industry's assets were worth more than those of the Dominion's chartered banks. Governments made sure to take their cut. Vodka may have demoralised the Imperial Russian Army, but it also paid for it. Everywhere workers found jobs, from coopering barrels to rolling the cigars commonly sold in bars. In France, one in every eight persons derived income from the alcohol industry in the early twentieth century. Property, taxes, and jobs gave alcohol and tobacco manufacturers, wholesalers and retailers great political influence.

They did not hesitate to use it, or to supplement it with bribes and gifts, to incline politicians and journalists to their interests.

National alcohol prohibition in the United States between 1920 and 1933 seems, at first glance, to violate this rule. But the Volstead Act, which permitted possession and consumption of alcoholic beverages, medical prescriptions, sacramental use, and limited home production, was a heavily compromised form of prohibition. The Eighteenth Amendment's ban on 'intoxicating liquors,' which the Volstead Act also defined, was possible only because of unusual circumstances. These included a new income tax that lessened federal dependence on alcohol excises; the Great War and its spawn of national prohibition experiments; intensified nativism against Germans, who were associated with brewing; relentless single-issue pressure by the Anti-Saloon League; and 'rotten

Figure 2: Wartime Tobacco Advertisement



Source: University of Minnesota Libraries, Manuscripts Division. <http://special.lib.umn.edu/manuscripts/>

boroughs' that enabled dry voters in the Protestant countryside to trump wet voters in fast-growing urban and immigrant districts. A fluke of timing and gerrymandering, the amendment did not survive the Great Depression. The desperate need for the jobs and revenue that brewers could provide finished off national prohibition, already undermined by lawlessness, bribery, and bootlegging violence. The world took note. Anti-prohibitionists in Europe and the African colonies, where the liquor trade remained a contentious issue, seized on the bad American example, as amplified and broadcast by Hollywood movies.

In contrast to alcohol, Western governments had less of a financial stake in the narcotic traffic. The volume of India-China opium trade was already diminishing when the British agreed, in 1907, to phase it out. While viticulture, brewing, and distilling were concentrated in Western Europe and North America, most opium and coca crops came from poorer and less influential regions. Manufacturing was another story. Western drug companies did a brisk business in cocaine and morphine, and the powerful German pharmaceutical industry was reluctant to go along with the international controls proposed in the 1912 Hague Opium Convention. Defeat in World War I, however, forced Germany (and its opium-growing ally, Turkey) to accept export controls, supervised by the new League of Nations. Though Hitler later took Germany out of the League, his government quietly cooperated with international drug-control authorities.

As it happened, Hitler also despised tobacco and shunned alcohol after a humiliating adolescent episode when he became drunk at a graduation party, tore up his diploma, and used it as toilet paper. But Hitler's abstemiousness was unusual among leaders of great powers in the mid-twentieth century. Nothing in the personal habits of Stalin, Roosevelt, Churchill, and Mao suggests sympathy for alcohol or tobacco prohibition. Churchill, in particular, has entered history, cigar in one hand and glass in the other, as a Promethean alcoholic whose feats rationalised the excesses of lesser mortals. Mao did repress narcotic trafficking and addiction after he came to power in 1949. But the ensuing drug vacuum was quickly filled by cigarettes, an already popular drug product that Mao himself habitually used, along with barbiturates. With the final, post-revolutionary triumph of the cigarette, the history of smoking in China came full circle, from tobacco in the seventeenth century, to madak in the eighteenth, to refined opium in the nineteenth, and back to tobacco in the twentieth.

I do not mean to imply that drug policy in China or elsewhere was simply a matter of follow the leader. The habits and prejudices of elites mattered, but so did those of ordinary people. The more widespread and socially integrated a drug was, the more difficult it was to prohibit, or to keep prohibited after wartime crises had passed. Conversely, the more marginal and subculturally identified a drug was, the easier it was to prohibit and to keep prohibited.

Custom protected usage. Alcohol had deep cultural roots in most societies, and tobacco had managed to put down roots everywhere in the four centuries since the Columbian Exchange. It is true that cigarettes remained controversial in the early twentieth century, thanks to their insalubrious reputation and low-life associations. Henry Ford denounced the cigarette as 'the little white slaver,' a phrase with overtones of sexual trafficking and promiscuity as well as nicotine addiction.⁵ But, when Ford hurled his epithet in 1914, cigarettes were on the brink of rapid mainstream expansion. The war proved a boon to smoking, particularly to the potent, convenient cigarette. Field commanders approved. A boost to morale, tobacco did not intoxicate like alcohol and narcotics, nor incapacitate by spreading disease, as did prostitutes. 'Our boys want smokes' posters and newspapers advised. Patriotic citizens and relief organisations chipped in to augment the quartermasters' supplies. [See Figure 2]

Advertisers did their bit after the war, mounting a masterful campaign to equate the cigarette with modernity and to bring women into the cigarette fold. Movies, peer influence, and a second world war did the rest. By the 1950s cigarettes were ubiquitous. Americans, who smoked more than a billion daily, stood atop the

⁵ Henry Ford, *The Case Against the Little White Slaver* (Detroit: H. Ford, 1914).

consumption table. It was however, a fictional Briton of cosmopolitan ambit who came to personify the alcohol-tobacco double standard. James Bond, who made his debut in 1953, smoked and drank nonstop through thirteen of Ian Fleming's books, until their similarly inclined author died in 1964, at the age of fifty-six.

Fleming, who had worked himself up to seventy cigarettes a day by his late thirties, spent his last days battling heart disease and 'staring from his bedroom window at the sea in total misery.'⁶ Therein lay smoking's rub. By 1964 it was also clear that, despite the tobacco industry's best efforts to muddy the medical waters, cigarettes and other tobacco products hastened the onset of lethal diseases, including cancers of the respiratory system.

The relentlessly mounting evidence of tobacco-related disease, soon shown to apply to those who breathed environmental tobacco smoke as well as smokers themselves, increased pressure against the industry, particularly in developed nations. Starting in the 1960s, policy began inching up the regulatory axis, as governments mandated warning labels, advertising restrictions, and bans on indoor smoking in public buildings, restaurants, and bars. Even the cafés of Paris and Buenos Aires eventually succumbed. Tobacco taxes also moved up, stimulating cigarette counterfeiting and smuggling. Globalised mafiosi shipped cigarettes, along with illicit drugs, prostitutes, and weapons, along a vast criminal highway that ran from western Europe through the Balkans and central Asia to the edge of China. Undeterred, public health authorities and diplomats pursued cooperative efforts to curb tobacco consumption and marketing, notably through the 2003 Framework Convention on Tobacco Control. Today, international tobacco control is roughly where international narcotic control was a century ago: still at a rudimentary stage, but with enlightened opinion pushing toward further regulation.

The same cannot be said of alcohol control, domestic or international. Drunks assuredly pose a threat to third parties, which is why most governments have long enforced laws about driving or operating machinery under the influence. But the evidence about personal health effects is mixed. If you have a drinking problem, the economist Harold Winter points out, you are more likely to suffer hypertension, Parkinson's disease, colds, diabetes, osteoporosis, depression, pancreatic cancer, macular degeneration, gallstones, dementia, and a host of other illnesses. Except that, by 'drinking problem,' Winter means not drinking at all. Remarkably, moderate drinkers' risk of death from all causes is roughly 25 percent less than that of abstainers. From a health point of view, the optimal policy would be to foster moderate drinking and to punish excessive and binge drinking, which do undermine health and safety.⁷ This conundrum, together with alcohol's continued commercial importance (not least in the global tourism industry, where drink doubles as social lubricant and profit centre), complicates policy, discourages regulatory or tax shifts toward prohibition, and softens the propaganda line. Quit smoking, we are told. Shun illegal drugs. But drink responsibly.

My shorthand for the current state of affairs is that the double-double standard has become the single-double standard. By that I mean that the legal and cultural privileging of two dangerous drugs, alcohol and tobacco, common in the mid-twentieth century, has given way to the privileging of one dangerous drug, alcohol. Even James Bond has been reformed. After 1973, when Roger Moore took over the role from Sean Connery, the film actors who portrayed Bond greatly curtailed his smoking, especially of cigarettes. The vodka martinis, shaken not stirred, remained close to hand.

6 Andrew Lycett, *Ian Fleming: The Man Behind James Bond* (Atlanta: Turner Publishing, 1995), 172, 384 (quotation).

7 Harold Winter, *The Economics of Excess: Addiction, Indulgence, and Social Policy* (Stanford: Stanford University Press, 2011), 62-64.

CONCLUSION

Alcohol's recent history demonstrates one of the principal shortcomings of the international drug-control system: its occasional and embarrassing failures to match regulations, taxes, and sanctions to the actual dangers posed by different psychoactive substances. However, this fact alone warrants neither pessimism nor cynicism. Domestic laws and international treaties cover hundreds of psychoactive drugs and precursor chemicals. The scheduling and control measures for the vast majority of these substances remain uncontroversial. Except for doctrinaire libertarians, no one really wants a free market in secobarbital. And while cultural inertia, prejudice, and vested interests still distort policy for some drugs, they have not precluded incremental reforms based on new scientific data and cost-benefit studies. Reformers marshalled both types of evidence in the campaigns to down-schedule and decriminalise cannabis. They did likewise in the campaigns to further restrict and stigmatise tobacco use – to my mind the most convincing demonstration of the control system's capacity for reasoned change.

If such adjustments have occurred with frustrating slowness, and despite entrenched opposition, that is the nature of the *longue durée*. After all, it took three centuries after the globalisation of drug use for the control system to assume its modern institutional form. It may take another three centuries for it to become fully rational in public-health terms. But even if it never achieves that goal – what regulatory system does? – we can see in history both the necessity of drug control and the demonstration of its fundamentally progressive character. ■

➤ Science, Diplomacy and Cannabis: The Evidence Base and the International Drugs Regulatory System, 1924-1961¹

James H. Mills

No government should take unilateral measures without considering the impact of its actions and ultimately the consequences for an entire system that took governments almost a century to establish.

In 2003 David Blunkett, then Home Secretary, sought to reclassify cannabis, thus ensuring that those caught in possession of it in the UK could not be arrested. His action was immediately condemned by Philip Emafo, who used the quote above to criticise it. At the time Emafo was President of the International Narcotics Control Board (INCB) of the United Nations, and the most senior drugs official in the world. At the heart of Emafo's rebuke to Blunkett was history.

This paper begins to answer the question raised by Emafo's response, namely, was he right to be confident that history supported his case? In other words, was it safe to assume that the century of regulatory action on cannabis had been one of sensible decisions made for sound reasons that had resulted in a coherent and well thought-out approach to controlling the drug, a history that no wise government could contemplate improving upon? Discussion here will focus on one aspect of the evidence-base – the scientific data that was deployed at key moments in the integration of cannabis into the international drugs regulatory system – in order to understand what sort of information lay behind the expansion of the range of drugs incorporated into it throughout the twentieth-century.

THE SECOND GENEVA OPIUM CONFERENCE AND CANNABIS

Cannabis made its entry into the international drugs regulatory system in 1925, in the Geneva Opium Convention of that year. The full context for this is explored elsewhere,² but in summary the Egyptian delegation took the initiative to include cannabis into the agenda that had initially been designed simply to deal with opium, opiates and cocaine. Few other delegations had much information to hand about cannabis, and some impressively forceful rhetoric on the part of the Egyptian representatives seems to have been enough to convince most of the case against the drug. The dramatic announcements on the mental health implications of cannabis use in Egypt had a considerable impact, as the country's chief delegate, Mohammed El Guindy, was able to support these with statistics. In his opening speech on the subject he claimed that 'illicit use of hashish is the principal cause of most of the cases of insanity occurring in Egypt... generally speaking, the proportion of cases of insanity caused by the use of hashish varies from 30 to 60 percent of the total number occurring in Egypt'. Similar evidence was included

¹ This paper draws on research funded by the ESRC (RES-000-27-0018), and the Wellcome Trust (WT085432/Z).

² James H. Mills, *Cannabis Britannica: Empire, Trade, and Prohibition 1800-1928* (Oxford University Press, 2003), 152-87.

in the official 'Memorandum with reference to hashish as it concerns Egypt' that was submitted by the delegation in support of El Guindy's speeches. However, this time the figure was even more alarming, claiming that 'about 70 percent of insane people in lunatic asylums in Egypt are hashish eaters or smokers.'³

Throughout the Egyptian campaign, this was the only material produced that might be considered 'medical' or 'scientific' evidence. It could be argued that, if the figures were reliable, this was all the evidence necessary. However, this also raises the question of where the statistics came from and how compelling they were. Their origins lie in the Egyptian Lunacy Department. This had been the personal fiefdom of an Englishman for over a quarter of a century. John Warnock was appointed by the Public Health Department in Cairo in 1895, at a time when Egypt was an established part of the British Empire. He had been working in the British asylum system for almost a decade by this time, and was seen as the ideal man to reform the Abbasiya Asylum. He remained at the task until 1923, during which time he expanded the existing institution, built a new hospital, drafted laws on mental illness in Egypt, and created a whole new Department dedicated to Lunacy within the colonial Ministry of the Interior. By the time he retired, almost two and a half thousand Egyptians were being treated at any one time within the units of the Lunacy Department.

Warnock seems to have developed little attachment to the place that was to be his home for such a large part of his life. He admitted that he did not study written Arabic and that he found it 'impossible to learn all the tongues necessary to converse with all the patients and their friends' and his grasp of the vernacular was such that he could only 'make [his] wants known and give orders'. The country exhausted him, and by 1916 he had to take a long leave from the stress of work in Egypt, which had been exacerbated by the presence of shell-shocked soldiers from the African campaigns of World War I. He contemptuously dismissed Egyptian political ambitions after the war, and noted that 'self-determination was proving to be an infectious mental disorder'.⁴ Yet despite this apparent lack of sympathy with the society around him, he felt sure that he could locate the chief cause of insanity in the Egyptian population. This was the use of cannabis.

His first year at the asylum was a particularly trying period. He arrived in February 1895 and noted the following difficulties:

*Besides the almost complete lack of funds, my total ignorance of Arabic, and the total ignorance of patients and staff of any language but Arabic, prevented my doing anything for some time. I was unable even to tell the servant to shut the door or to ask a patient his name. I had no interpreter. However, after some time I found a patient who could write English and for a while he was employed in translating Arabic letters etc. until it was discovered that he interpolated numerous mis-statements founded on his delusions. In those days an English or French-speaking clerk was not available. For a time I could only look on and guess at what was going on in most matters.*⁵

Yet despite the range of difficulties in gathering accurate details about patients, which included problems of translation, deliberate mis-information, communicating with staff, and a reliance on guess work, Warnock claimed that he was able to produce an authoritative account of the causes of mental illness in the asylum within ten months of his arrival. This was reported as 'The Cairo Asylum: Dr Warnock on Hasheesh Insanity by TS Clouston MD Edinburgh', published in the *Journal of Mental Science* in 1896. This was a summary of Warnock's observations of the asylum statistics that his hospital had generated in the period from his arrival at the hospital in February to the end of 1895. Warnock's statistics were central to Clouston's argument and after noting such numbers as 'in 41 percent of all his male patients hashish alone or combined with alcohol caused the disease' he concluded that 'I have no doubt that in quite a number of cases there hashish

3 Egyptian Proposal for Inclusion of Hashish, 12th December 1924, PRO HO 144/6073.

4 John Warnock, 'Twenty-Eight Years' Lunacy Experience in Egypt (1895-1923),' *Journal of Mental Science*, 70 (1924): 233-61.

5 Thomas S. Clouston, 'The Cairo Asylum: Dr. Warnock on Hasheesh Insanity,' *Journal of Mental Science*, 42 (1896): 793-4.

is the chief if not the only cause of the mental disease'. He went on to note the clinical features of this 'Hasheesh Insanity' that included 'an elated, reckless state, in which optical hallucinations and delusions that devils possess the subject frequently exist' or even 'terrifying hallucinations, fear of neighbours, outrageous conduct, continual restlessness and talking, sleeplessness, exhaustion, marked incoherence and complete absorption in insane ideas'. The statistics, and the exotic location, seem to have been enough to convince TS Clouston, who exclaimed 'such are the latest words in regard to hashish and its insanity.'⁶

Despite Warnock's frank admissions that he had very little idea of what was going on upon his arrival in Egypt – and indeed had no reliable means of remedying this situation beyond hazarding a few guesses of his own and trying to interpret the lunatic translations of his delusional clerk – it seems that he was happy to jump to conclusions about the cause of illness among a large proportion of his patients within twelve months of his taking up the post. He may well have read an earlier report on Egyptian mental illness, which he had certainly seen by the end of his career and mentioned in his 1924 article, which argued that 'with the men the attack of insanity was attributed in nearly all cases to one of three causes, the use of hashish, some disappointment or grief, and religious excitement. Of these, the first is by far the most frequent.'⁷ Whatever was the case, these were conclusions that he stuck to. In 1903 he published a lengthy account of his observations at the asylum. Again, he relied on numerical evidence to make his point: 'in Egypt, statistics are available since the year 1895. During the six years 1896-1901 out of 2564 male cases of insanity admitted to the Egyptian Asylum at Cairo, 689 were attributed to the abuse of hashish, i.e. nearly 27 percent'. He quoted statistics from India to make the comparison: 'between 1882 and 1892 Indian hemp caused 25 to 35 percent of the insanity in Bengal asylums' even though the reliability of these numbers had been challenged by the Indian Hemp Drugs Commission itself. He was at pains to refute the conclusions of the IHDC and emphasised that 'my experience does not confirm the Indian Commission's belief that cannabis indica only sometimes causes insanity. In Egypt it frequently causes insanity'. He was keen to stress that his statistics were entirely dependable. He did this by claiming that each patient counted as a sufferer of hashish insanity was correctly diagnosed. He did not believe police reports of hashish use nor did he give much credence to relatives of the patient. Indeed, he did not believe the patients themselves noting that 'excited protests and denials of the habit are known by experience to indicate a hardened hashish smoker'. Instead he relied on his own intuition and repeated questioning of the patients until a confession was obtained.

Quite how reliable this method was of establishing that a case was one of cannabis use is worth considering. In 1895 he stated that he thought that one of the key symptoms of weak mindedness caused by hashish insanity was that 'they deny the use of hashish'. He made it clear in 1903 that 'as the mental state of the patient improves he is again questioned about hashish and before discharge he is invited to give full details of his habit'. It seems then that procedures in Warnock's hospital encouraged inmates to confess to use of cannabis preparations, as the final hurdle before release was another interrogation on the subject of cannabis use by a doctor who admitted that he could consider a denial of the habit as a symptom of problems of mental illness.

In fact, his conclusions themselves were more wide-ranging than they had a right to be. Based on his experience of cases at the asylum that he believed to be caused by cannabis use, he made sweeping observations such as 'the use of cannabis indica in Egypt seems to have graver mental and social results than in India and is responsible for a large amount of insanity and crime in this country'. However, he also admitted that 'as to whether excessive use of hemp drugs is commoner here than in India I can give no opinion, but many thousands use it daily here' and indeed went further in noting that while 'many thousands smoke hashish only a comparatively few suffer from grave toxic symptoms'.⁸ In other words, he made broad generalisations

6 Ibid.

7 A. R. Urquhart and William S. Tuke, 'Two Visits to the Cairo Asylum, 1877 and 1878,' *Journal of Mental Science* 25 (1879-80): 43-53.

8 John Warnock, 'Insanity from Hasheesh,' *Journal of Medical Science* 49 (1903): 96-110.

about cannabis use and cannabis users that were meant to apply to all users, in all of Egypt, despite the fact that he saw only a small proportion of them at the hospitals. The issue of whether this was a representative proportion of the cannabis users in the country never seems to have troubled him, and he broadened his conclusions drawn from the troubled individuals at the asylum to apply to thousands of ordinary Egyptians that took hashish and yet never became subjects of his scrutiny. In short, his method of establishing that an individual at his hospital was a cannabis user was suspect, and the conclusions that he drew about cannabis use in general were based simply on the small sample of all of Egypt's many users that had ended up in his hospital. Much as in India in the nineteenth century, the habits indulged in by much of the local population were condemned by colonial doctors who had no idea what was going on outside of the walls of the hospital, and to whom it never occurred that a small band of lunatics could in no way be considered a representative sample on which to base observations about wider society.⁹ It was in these circumstances that the scientific evidence was generated that secured the passage of cannabis into the international drugs regulatory system for the first time.

THE WHO AND THE SINGLE CONVENTION ON NARCOTIC DRUGS, 1961

Cannabis remained an uneasy presence in the international drugs regulatory system for the next three decades. Often ignored in deliberations at the League of Nations and later the United Nations, when it did figure in discussions it divided opinions and caused confusion to those unfamiliar with it. As such, it came as some relief to the Secretariat of the United Nations Commission on Narcotic Drugs when in 1952 the World Health Organization's Expert Committee on Habit Forming Drugs issued a clear statement on the issue of whether substances made from the plant served any useful purpose. The Committee was of the opinion that cannabis preparations were practically obsolete, and that, so far as it was concerned, there was no justification for the medical use of cannabis preparations.¹⁰

With a stroke of the pen a range of substances that had featured in the medical systems of societies in Africa, Asia and elsewhere for centuries, together with the allopathic preparations of the plant that had been developed since the nineteenth century, were declared useless. The United Nations Secretariat readily adopted the statement, which was to eventually find itself enshrined in the 1961 Single Convention on Narcotic Drugs, the centrepiece of the international drugs regulatory system of the period.

The evidence for the WHO position can be found in its statement on 'The Physical and Mental Effects of Cannabis', which was presented to the Commission on Narcotic Drugs in 1955. It was authored by Pablo Osvaldo Wolff, who had served as Secretary of the Expert Committee on Addiction Producing Drugs of the WHO. It was damning in its revelations and in its tone, and drew on over fifty publications and scientific papers to support its argument. Among these publications were those by John Warnock discussed above. Many of the papers had been considered by the League of Nations Sub-Committee on Cannabis, which had patiently collected data on the plant and preparations of it for five years between 1935 and 1940 only to fail to reach any clear or definitive conclusions because of its growing awareness of the complexity of the issues.

Wolff made it clear that he had succeeded in reaching clear conclusions where predecessors had failed because he had no time for those who would 'minimise the importance of smoking marihuana'. The report scarcely dwelt on physical effects: 'among cannabis smokers diseases of the respiratory tract are frequent, bilharsiasis and circulatory as well as alimentary diseases become refractory etc.' It was with its mental effects that the author was most concerned. Wolff ranged widely across the work of others and lifted their observations on

⁹ James H. Mills, *Cannabis Britannica: Empire, Trade, and Prohibition 1800-1928* (Oxford University Press, 2003), 93-123.

¹⁰ World Health Organization, *Third session of the World Health Organization Expert Committee on Drugs Liable to Produce Addiction* (Geneva, 1952), http://www.unodc.org/unodc/en/data-and-analysis/bulletin/bulletin_1952-01-01-01_3_page008.html.

varied conditions such as 'transitory intoxication', 'mania from hashish', 'acute psychosis associated with the withdrawal of cannabis indica from addicts' or 'a certain link between chronic cannabis consumption and the atypical schizophrenic picture'.

Wolff referred to the evidence of his own research in seeking to convince delegates at the UN that these medical conditions were not simply risks for individual consumers but rather were threats to society at large, and it is this which catches the eye. He turned to 'clippings from newspapers from South American countries which suffer particularly from the consequences of marihuana abuse, and which the writer has been collecting for years'. Clearly conscious of how tenuous this looked, he was forced to admit that these were 'somewhat sensational' in character, but he made a point of insisting that the recurrence of such stories, as well as the police statements referred to within them 'show that there must be much truth in them'. Having done this, he selected the most startling of the stories; 'Four youths, the youngest 16 years old, robbed and murdered a filling station attendant. The defence admitted that they were so strongly under the influence of marihuana that they did not know what they were doing. The jury refused to accept this as a defence and found them all guilty of murder in the first degree'. Despite acknowledging the weakness of such evidence he left colleagues in no doubt about the 'criminogenic influence of the cannabis resin' and he concluded that 'cannabis constitutes a dangerous drug from every point of view, whether physical, mental, social or criminological'.¹¹

Mr Yates of the Secretariat commended Wolff's report to the Commission as he felt that it 'embodied not only a statement of the facts, but also a number of critical evaluations'.¹² The Chair of the Commission, the French representative Charles Vaillie, and Harry Anslinger were careful to publicly record their appreciation of Wolff's efforts. Interestingly, an earlier book by Wolff that had used the same material was used as evidence in a British murder trial in 1952 where it was dismissed by a British doctor who concluded, after being read passages from it, that 'I have a personal lack of confidence in some of the material produced on the other side of the Atlantic'. There were no such qualms at the Commission on Narcotic Drugs, where it was agreed that his account should be forwarded to its parent body, the UN's Economic and Social Council.¹³

CONCLUSION

The intention behind this paper is not to argue that the science behind the incorporation of cannabis into the international drugs regulatory system was flawed and therefore the current position of preparations of the plant in the world's list of banned drugs is wrong. Cannabis is a complex substance that pharmacologists and medical scientists are continuing to grapple with and which promises to defy easy generalisations for the purposes of policy for some time to come. Rather, it has sought to understand the place of knowledge and evidence in the evolution of the international drugs regulatory system, particularly as it expanded beyond opium from the 1920s onwards. This article has further suggested that at important moments of this history related to cannabis the evidence that was presented, and indeed accepted as justifying action, was questionable in origin and readily endorsed with little scrutiny.

What does this mean for those contemplating the wider history of the evolution of the international drugs regulatory system and considering its possible futures? The episodes recounted above draw attention back to the evidence base that has been deployed in the past for all key decisions regarding not just cannabis but the wider schedule of drugs. If the material gathered in support of including preparations of cannabis into the international drugs regulatory system was so slight, it raises the question of how far it was the case that

11 The Physical and Mental Effects of Cannabis, Additional Study, 17th March 1955, BL, WHO/APD/56, p. 32.

12 Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Sixth Meeting 20th April 1955, BL, UN, E/CN.7/SR 266, p. 14.

13 Commission on Narcotic Drugs Tenth Session Summary of the Two Hundred and Sixty-Seventh Meeting 21st April 1955, BL, UN, E/CN.7/SR 267, p. 4.

controls were imposed on other drugs on similarly flimsy evidence. Historians such as Frank Dikotter and Yangwen Zheng have begun to answer this question with their re-examination of the assumptions made about the Chinese market for opium in the nineteenth-century that lay behind the origins of the international drugs regulatory system. They have argued that these assumptions were based on misrepresentations and misunderstandings of the cultures of consumption and political agendas in China in that period.¹⁴ It remains to be seen just how far the evidence behind other aspects of the establishment and development of the international drugs regulatory system stands up to scrutiny.

If nothing else, this weak evidence base should act as a brake on politicians and officials like Philip Emafo, who seek to use the longevity of the system in order to defend it, on the assumption that its history is a rational and well-founded one. If the system is not founded upon a sound evidence base and a rational assessment of it then what has driven it? Others, like William McAllister and David Courtwright, are better placed to give a full answer, but it is certainly the case, regarding cannabis at least, that political and diplomatic ambiguities, personal and moral prejudices, and bureaucratic forces have been important factors. For those thinking about the future of the system it is important to acknowledge this, and also to realise that most of those political agendas, moral positions and bureaucratic drivers are now long gone, distant memories from an age of European imperialism, World War, racial hierarchies and discredited values.

If those addressing contemporary problems want to tackle drugs and their consumption in a fresh way then the lesson from the past is to reject it. Put aside the status quo as something that is tainted by the confusion and connivance of previous generations rather than formed by their wisdom, and start with a blank sheet of paper and an honest declaration of interests. Even if what emerges from such a process resembles what is in place today, at least it will have been arrived at through a fully-informed and transparent process, rather than warped by the flows of world history. ■

¹⁴ Zheng Yangwen, *The Social Life of Opium in China* (Cambridge University Press, 2005); Frank Dikotter, *Narcotic Culture: A History of Drugs in China* (University of Chicago Press, 2004).

➤ Historians and Harm: Toward a More Thoughtful Appraisal of Policy Consequences

Joseph F. Spillane

With the modern war on drugs now more than a century old, it had become commonplace to frame control policies in martial terms. National governments have declared war on drugs, on traffickers, and on consumers themselves, all in the name of defending the health, stability, and security of the state. There are, undeniably, certain drug-specific harms which derive from use but, just as certainly, state policy has generated its own universe of drug-related harms, on both the micro (individual) and macro (community) levels. Put more directly, the front lines of the drug war are littered with casualties.

This simple observation – that drug control regimes produce harms which are extrinsic to drug consumption itself – is a staple of contemporary drug policy analysis. No serious scholar questions that the drug war generates enormous social harms, ranging from the disruptions produced by punishment, to the health consequences of increasing the social exclusion of drug users. Over the last quarter-century, a rapidly growing harm reduction movement has challenged drug prohibition regimes to consider the consequences of policy choices, and to seek ways to minimise the social costs of the drug war.

It may seem odd, in light of all this attention to harm and harm reduction, that historians have not yet fully joined the public conversation. To be sure, historians as a group appear to be deeply sympathetic to the aims and assumptions of harm reduction. But these are primarily associations of political interest. To date, historians' affinity for harm reduction policies has produced relatively few systematic efforts at documenting the history of harm. If the war on drugs were an actual war (indeed, one might consider it to be so), historians have, to date, produced many fine monographs on the origins of the war, and taken us into the war-rooms of the generals to consider grand strategy, but have produced few details on the combatants themselves, and the many who have fallen on the fields of combat.

This is not simply a gap in documentation; a failure to erect the appropriate monuments commemorating the human cost of war. Rather, the comparative inattention of historians has left us with an inadequate sense of the historicity of drug war-related harm. Far from being a static and predictable consequence of drug prohibition, harm just may be the most dynamic aspect of drugs history. Harm is always contingent, the product of the complex interplay between law, policy, economics, and culture. This essay briefly reviews the reasons for historians' inattention to harm, and considers the ways in which that history can be unearthed and made both comprehensible and useful.

THE HISTORY OF THE DRUG WAR: WORSE THAN WE KNOW?

The thin historical documentation of drug war harms is a product of nothing more complex than the fact that scholarly attention and interest have long been directed elsewhere. Of the greatest significance has been the historical interest in policy enactment, rather than implementation. To be fair, there have been good reasons for the time and attention spent on the moments of policy enactment – when historian David Musto produced his pioneering work, *The American Disease*, forty years ago, few remembered just why it was that national governments had embraced varieties of prohibitionist policies in the early twentieth century. Small wonder then, that Musto's work was subtitled, 'Origins of Narcotic Control.'¹

As Musto made clear, his work was begun at a time when competing origin narratives were being wielded by contemporary critics and supporters of the drug war. For critics, the birth of the drug war was the story of prohibitionist legislation enacted for spurious reasons that had nothing to do with public health or well-being. For supporters, prohibitionist laws were well-timed interventions aimed at minimising the deleterious consequences of a psychoactive free market. Neither side in the debate over origins seemed particularly interested in implementation. Drug hawks casually assumed that the unrestrained drug use of a legal market was thereafter curtailed; while the critics' equally casual assumption was that a fairly predictable (and therefore empirically uninteresting) set of consequences befell users. To the extent that historians like Musto – to say nothing of a parallel and vast scholarship regarding national experiments with alcohol prohibition in the United States and elsewhere – were committed to untangling the question of origins, the actual waging of war remained largely unexplored.

The interest in law's origins has hardly abated since the first appearance of Musto's work. Indeed, numerous historical accounts continue to explore the process by which drugs are sorted by law into categories – most broadly, to use Richard DeGrandpre's terminology, into angels and demons.² Once again, there are valid reasons for this attention. Licit and illicit are categories made possible only through law, and their juxtaposition allows us to better understand the law's sorting mechanisms. Unfortunately, much of this work continues to treat important categories of behaviour, from consumption patterns to day-to-day policing, as derivative of these legal categories.

Recently, a number of historical studies have redirected attention from the origins of prohibition toward the origins and development of the addiction concept. This work has cast a welcome new light on some important and poorly-understood questions: out of what social and cultural material has the addiction concept emerged? How did the idea of addiction support the rise of prohibitionist regimes? Once again, historians are responding to dominant political debates. The rise of addiction science has been the most striking development of the late twentieth and early twenty-first centuries, and historians have found themselves pulled into the debate between contemporary champions and critics of a neuroscientific model of addiction as an ontologically distinct disorder.

The addiction concept is an important element in the shaping of state policy, but it does not go particularly far in advancing our understandings of life during wartime. Studies of the addiction concept are particularly concerned with the *idea* of addiction, and even more particularly with the written texts that form the basis of public discussion. And they have made a persuasive case that these texts did help to provide broad justification for the policy regimes that followed. But these texts cannot – and, in fairness, historians readily concede that they do not – offer much in the way of documenting the lived experience of the men and women who ultimately became the subjects of these addiction frameworks and of drug prohibition itself.

¹ David F. Musto, *The American Disease: Origins of Narcotic Control*, (New Haven: Yale University Press, 1999).

² Richard DeGrandpre, *The Cult of Pharmacology: How America Became the World's Most Troubled Drug Culture*, (Durham: Duke University Press, 2006).

The objects of drug control remain today as they have ever been, as marginal within the field of history as they were socially marginal within their own lifetimes. Our sympathy cannot substitute for understanding. Historians must give a richer and more empirically detailed account of lived experience. Above all, we must produce a more robust account of harm, not only to build battlefield memorials to the fallen, but to deepen our own understanding of the conduct and cost of war. When these accounts begin to emerge, we may well find what contemporary military historians have found – stories more deeply troubling and disturbing than we ever fully imagined.

LOCATING HARM: THE CHALLENGE FOR HISTORIANS

If drug historians can be said to have followed the lead of contemporary politics, it may also be said that this was often where the archives most readily allowed them to go. We know a great deal, though perhaps still not enough, about the national and international political and policy debates surrounding drug control. Likewise, we have medical, pharmacological, and scientific texts in great abundance from at least the late nineteenth century forward. The challenge for historians interested in harm is to locate the drug users themselves.

One useful approach, for contemporary history, would be to go out from the archives and start collecting oral histories. One of the most important studies of harm ever published, *Addicts Who Survived*, was simply an edited volume of oral histories from elderly methadone patients in New York City.³ Collected more than thirty years ago by David Courtwright and Don Des Jarlais, the interviews captured stories of scoring, hustling, hooking, dealing, working, creating, and being busted (to use the book's chapter titles). These survivors' tales took the general notion of a prohibitionist regime, and gave it a whole new level of detail and specificity, with real insights into the impact of police tactics, the search for openings within the world of legitimate medical supply, and the challenge of maintaining supportive social networks in an otherwise hostile environment.

Not a single oral history project of this kind has been attempted since, representing a shocking loss of historical experience for subsequent generations of scholars. Just why is hard to say. Oral history itself has obvious temporal boundaries and, although far better integrated into the academic mainstream, still represents something of a minor subspecialty in the field. Perhaps, to the extent that the ranks of oral historians include many inspired by the task of recovering the lived experience of the socially marginal situated within attractive social and political movements (from labour activism to civil rights), the lives of addicts, prisoners, and the like hold less appeal. The few projects which have been undertaken to date have typically been initiated and carried out by social scientists or by activist groups, which for historians at least raises the hopeful possibility for future dynamic interdisciplinary collaborations.

In the absence of oral histories, the most attractive strategy for historians might be to focus on the responders, those stationed at the front lines on behalf of, or at least in some relation to, prohibitionist regimes. What sort of responding institutions appear to have the most direct connection to the extrinsic harms of the drug war? Clearly the criminal justice system must figure prominently in any account. From police surveillance to institutional commitment, criminal justice represents a series of highly discretionary decision-points, any one of which could have profoundly life-altering consequences – and which, at a certain scale, could change entire communities. Likewise, the existing record of public health and treatment interventions may offer a much needed window into patterns of health and disease among drug users, as well as helping to gauge the impact of these interventions.

³ David T. Courtwright, Herman Joseph, and Don Des Jarlais. *Addicts Who Survived: An Oral History of Narcotic Use in America, 1923–1965*, (Knoxville: University of Tennessee Press, 1989).

Attending to the front lines requires re-directing our gaze away from the generals of the drug war. Consider the Federal Bureau of Narcotics and its chief, Harry Anslinger. For more than three decades in the United States, Anslinger and the FBN helped define the nature of public discourse on drugs and public policy, and their work has been extraordinarily well documented. But it was the city drug squads whose day-to-day activities were of the greatest interest to drug sellers and users. Scale alone can tell part of the story – in 1953, for example, the FBN made 234 drug arrests in Chicago, while the Chicago Police Department made 4,100. Of course, a full accounting of law enforcement practice would have to be about more than scale – it would include an extensive discussion of police corruption, use of force, interrogation practices, and patterns of systematic racial and gender bias.

Institutional histories also have a bias toward generals and grand strategy. Again, drawing on the mid-twentieth century United States, the Lexington Narcotic Hospital (in Lexington, Kentucky) was the largest single source – at times, the only source – of publicly funded treatment. Lexington was also home to the Addiction Research Center, one of the world's great centres of scientific addiction research. It is useful to remember, however, that Lexington served only a small fraction of the American addict population. In any one year, the Manhattan criminal courts alone would have sentenced about the same number of addicts to local or state-level institutional confinement as Lexington would have received from around the country.

Like a flash of lightning briefly illuminating a darkened landscape, occasionally a single life history reveals the impacts of the drug war in operation. The life history of the pseudonymous Janet Clark, published in 1961 as *The Fantastic Lodge*, is both a powerful rendering of the terrible harms of drug control efforts, and a helpful mapping of wartime experience.⁴ Historians have made good use of the parts of the narrative relevant to their interests – *Addicts Who Survived* excerpted an extended passage on Lexington, while historian Nancy Campbell skilfully demonstrated Janet's place in the sociological construction of gender and addiction at mid-century – but no one has tried to deploy this account as a guide to tracking harm. That is unfortunate, for *The Fantastic Lodge* offers some powerful insights: how policing efforts disrupted the social networks of urban addicts, leaving them vulnerable and with reduced social support; how police, eager to penetrate illicit markets, exploited users for their value as informants and buyers; and the truly harrowing experience of addicts sent to local jails for short periods of time, over and over again. By the time Janet died, alone and unnoticed, in an Illinois mental hospital, she had borne the brunt of nearly every kind of official state intervention. None of this reduces Janet to a mere victim – *The Fantastic Lodge* is also a rich account of agency and resilience – but it does show the way in which specific interventions by the state generated specific harms. There are very few accounts like Janet's. But for her encounter with sociologist Howard Becker, nearly all of her life would have been unrecorded and largely forgotten by now. But it is possible for historians to use Janet's account as a guide, offering hints and suggestions as to where one might look to find her peers across time and place.

BUILDING CONCEPTUAL MODELS

As challenging as it will be for historians to unearth the evidence required to establish an empirical account of drug war-related harms, all of that effort will be wasted unless there are meaningful interpretive frameworks in place to help make sense of the evidence. Here, there is good reason to be optimistic, for recent scholarship, both historical and social scientific, provides a solid conceptual foundation for comprehending the hidden histories of harm. Taken together, this recent work may be reducible to a series of four principles that can guide future work.

⁴ Helen MacGill Hughes, ed., *The Fantastic Lodge: The Autobiography of a Girl Drug Addict*, (Boston: Houghton Mifflin, 1961).

The first of these principles is that the nation-state may well be a conceptual obstacle to producing fully developed histories of harm. The principle is not absolute, for the field is still generating very useful national and comparative studies, such as Howard Padwa's *Social Poison: The Culture and Politics of Opiate Control in Britain and France*.⁵ But Padwa's own work relies on evidence that suggests that the idea of 'British' and 'French' policy regimes obscure some salient divisions within national structures of governance, and the extent to which local circumstances could alter national policy plans and directions. Broad invocations of authorities and regimes cannot substitute for specifying the shape of particular administrative structures.

The second essential principle is that historians must begin to examine drug policy at a more refined level than prohibition. Years ago, David Courtwright reminded historians that drug policy could be tracked on three axes: regulatory categories, taxation, and sanctions. The idea of prohibition is a fairly generic stand-in term for the complex of legal rules surrounding the production, distribution, and possession of drugs. Following this idea, historians could offer more robust considerations of legal restrictions on access to syringes, limitations on pain relief and palliative care, or the use by police of non-drug charges (or informal harassment) to control drug users' behaviour.

Beyond more detailed considerations of policy, historians might also follow a third principle: that the history of harm must also be a history of inaction and silence. Why have addicts in different times and places been largely invisible? And what are the costs of this invisibility? While it is entirely appropriate, for example, to consider the coercive aspects and social control functions of public health surveillance and intervention, it is also worth considering the impact of neglect and indifference as well. In a sense, we need a history of failure, and accounts of why states have been unable or unwilling to provide the kinds of support or positive interventions that might have made a positive difference at the level of individual or community.

The fourth principle is perhaps the most critical: harm exists at the intersection of state action with individual and community vulnerability. Historians are certainly aware, for example, that certain communities have received disproportionate policing attention (though even this remains far less well documented than it should be), but have given less consideration to how policing impacts community organisation and health. Greater attention to basic concepts like social capital and social networks may reveal patterns of resilience and adaptation, but also reveal disruptions caused by the war on drugs. In some ways, the fourth principle becomes the key to a story of harm that is truly historically specific and contingent, where broadly similar legal regimes can produce dramatically different effects that are not simply a function of prohibitionist discourse.

To briefly illustrate these principles, consider a single episode from the city of New Orleans. On October 31, 1932, Charity Hospital in New Orleans admitted a comatose man, diagnosed with malaria and thought by hospital officials to be a drug addict. The patient deserted the hospital after being revived, and was readmitted two days later, again in a coma. He died the following day. Over the course of the next five months, five more Charity Hospital patients, all injecting drug users, died of malaria. Over the course of the following year, a total of forty-eight injecting drug users were admitted to Charity Hospital with diagnoses of malaria, ten of which died.

So what is to be made of this episode? In a broad sense, of course, it highlights the historical vulnerability of injecting drug-users to blood-borne diseases, including hepatitis, tetanus, and endocarditis. But there is some interesting historical specificity here. The largest peak of new cases came following a decision by the New Orleans police to begin interpreting the state law against unauthorised possession of a syringe to include medicine droppers and hypodermic needles. In response, drug users reported, an injection outfit would be planted in a single location, to which users could come to inject. Moreover, the mortality rate for

⁵ Howard Padwa, *Social Poison: The Culture and Politics of Opiate Control in Britain and France, 1821-1926*, (Baltimore: Johns Hopkins University Press, 2012).

drug-users with malaria in this New Orleans context was fifteen times higher than for malaria cases in the state as a whole. Specific harms derived from the local police decision to reinterpret a state law regarding syringes, coupled with poor access to health care, compounded by users' fear of exposing themselves to public surveillance of any kind. These are tragic stories, repeated many times over – but in different ways – in the history of the drug war.

CONCLUSION

Martial rhetoric is a hardy perennial of drug control. One can go back a century or more and still find advocates of doing battle and waging war. What must be remembered is that, as with any war, there are a few constants, but many variations as well. The intensity, scope, and scale of combat are choices that may be made, and these all impact the harms produced. Harm reduction advocates have focused on minimising these harms for at least a quarter of a century now, and more recently have been joined by human rights groups for whom the drug war's consequences raise fundamental concerns over human health, welfare, and freedom. Historians must engage these conversations, not with general expressions of solidarity, but by using the tools of our profession to highlight the historical specificity of drug war harms.

We must be prepared, in showing variety and contingency within the prohibitionist framework, to acknowledge that this is a story simultaneously liberating and cautionary. Liberating, in the sense that we can more readily see that choices are possible, that drug war harms may be reduced. At the same time, there is a cautionary aspect to this story as well, for it makes abundantly clear that there is no single direction in which the drug war may move, no inherent tendency either toward or away from progress. Consequently, there is no reason to believe that human rights abuses committed in the name of drug control will necessarily improve. Indeed, the more we understand how deeply embedded drug war behaviours are in specific structural, political, and cultural contexts, the more we see just how much of a challenge it will be to uproot them. ■

➤ Cocaine's 'Blowback' North: A Commodity Chain Pre-History of the Mexican Drug Crisis¹

Paul Gootenberg

Behind the sensational headlines, national security panic, and grim statistics from six years of horrific drug violence along the Mexican-US border, lies a blowback-strewn history of US drug policy entanglements across the hemisphere. Here, rather than probe the system's capacity or incapacity for reform, I analyse the shifting historical 'commodity chains' of drugs that helped, along with misbegotten policy, to prompt the ongoing crisis with Mexico.

Under rising American pressures, cocaine – once a minuscule benign legal trade in a distant corner of the Andes – became an illicit drug by the 1950s. This fuelled the dramatic rise of the Colombian 'cartels' of the 1980s. By the mid-1990s, further US pressures pushed the drug's profitable wholesaling north to Mexico – the prelude to today's showdown between drug-lords and the Mexican state. Half of world usage of recreational cocaine is still in the United States, where outlays for this expensive drug make up half of the \$80 billion or so spent annually on illegal drugs. Given the staggering historical growth in the drug's supply (which grew ten-fold during the 1980s boom), it is hardly surprising that cocaine's retail price has plummeted almost continuously since the 1970s, as smugglers outwit the rising costs of interdiction and from competition sparked by prohibition's risk premium. The outbreak of the Mexican drug war in 2007 provided the only respite from this trend. This dramatic price fall is the exact opposite of the DEA's chief stated aim of driving drug prices up and out of the range of casual users or addicts at home.

FROM LEGAL TO ILLICIT TRADES

The Andean cocaine boom of the late-twentieth century was founded on the vestiges of a legal economy of cocaine, which bequeathed the techniques and first illicit networks.² Cocaine production, mainly for anaesthesia and other medicinal uses, passed through two phases: first its construction as an export commodity (1885-1910); and second, its steep contraction from 1910-48, due to Asian colonial competition, shrinking medicinal usage, and the impact of initial US and League of Nations drives to restrict 'narcotics.' In a dramatic turn, after 1905 the United States – the drug's avid booster – became its militant global foe, and early US drug authorities preached universal drug eradication at its origins. But until the 1940s, despite rising informal sway in the Andean region, the United States was not able to convince or cajole producer nations of the evils of cocaine. The Peruvian industry, which entailed the processing of coca leaf into crude cocaine, *Pasta Básica de Cocaína* (PBC), shrank to an east-central Andean hub in the Huánuco region near the Upper Huallaga valley.

¹ Note: Many versions of this paper circulate, this one first edited by Fred Rosen for the Spring 2011 LASA Forum. My Ph D student Froylán Enciso helped on Mexico issues.

² This draws from my book: *Andean Cocaine: The Making of a Global Drug* (Chapel Hill: University of North Carolina Press, 2008).

This precursor drug culture had three legacies. First, legal cocaine was a largely peaceful enterprise, save for mild local plantation labour coercion. Secondly, legal cocaine economies like Peru's did not spawn border-crossing contraband networks – even if the recreational pleasures of 'coke' were widely appreciated. A multi-polar cocaine world prevailed between 1910 and 1945, when some nations like the United States banned and dried up non-medicinal cocaine use, and others openly made or tolerated the drug. This diversity of regimes did not spawn incentives for a black market nor violent competition. Third, this shriveled and antiquated business survived as the basis of regional life in remote Huánuco, which after World War II became the world's last bastion of cocaine-making lore.

Following the war, when the United States emerged as the uncontested power in world drug affairs, its eradication ideals magnified through new UN drug agencies such as the Commission on Narcotic Drugs (CND). Helped by a wave of compliant Cold War regimes in Latin America, the Federal Bureau of Narcotics (FBN) and the State Department were finally to achieve their long-standing goal of criminalising cocaine (and on paper, even the Andean coca leaf) – in Peru by 1948 and Bolivia by 1961.

The immediate effect of cocaine's total criminalisation – and a secret FBN campaign against Andean cocaine launched in 1947 – was the birth and dispersion of an *illicit* circuit of cocaine. Geographically, cocaine trafficking was a grass-roots movement, in which modest 'chemists', smugglers, and club-owners linked up from diverse social worlds to establish a web of new drug scenes and way-stations across South America and the Caribbean. It was not the work of cartels or the international mafia. By the early 1960s, these ever-more elusive and experienced smugglers were joined by a hardy new social class of peasants entrenched in illicit coca growing. Highland *campesinos*, marginalised during the US-sponsored 'development decade' of the 1960s, began migrating *en masse* to lowland Bolivia and Peru, lured by the mirage of Amazonian road and modernisation projects. Combining a smuggling class with a class of peasant suppliers resulted in cocaine's uncontained expansion in the decades ahead.

Cold War politics stamped the emergence of cocaine.³ The illicit drug was born in 1948-49 in the Huallaga of eastern Peru, as the rightist pro-US military regime of General Manuel Odría cracked down on the country's last factories, jailing manufacturers (branded as subversives) and sending others into clandestine outlets. The jungle processing technique that passed into illicit hands was 'crude cocaine', which peasants easily adopted with cheap developmental chemicals like kerosene and cement. By the early 1950s, smugglers ferried PBC out to refiners of powder cocaine (HC1) along two main transshipment chains: a Caribbean passage via Havana (a regional hub of mobsters lured by dollars and corruption), and northern Chile, where Valparaíso clans moved coke up the west coast via Panamanian and Mexican hideouts. Meanwhile, the US-backed cocaine crackdown in Peru, coupled with the lack of authority and US sway in revolutionary Bolivia, meant that PBC swiftly spread to this latter country. Bolivia thus became the drug's key incubation site during the 1950s, in dozens of small and scattered 'labs.' By the early 1960s, coke was found throughout the hemisphere, with thriving scenes and routes across Argentina and Brazil, and new users in US cities like New York. Two Cold War events consolidated cocaine's presence. First, Fidel Castro's 1959 revolution in Cuba meant the expulsion of Havana's traffickers, who took their skills and connections with them to South America, Mexico, and Miami. These exiles formed the first professional cocaine trafficking class. Secondly, US efforts to gain control over the shaky Revolutionary Nationalist Movement (MNR) in Bolivia led by 1961 to a joint anti-narcotics campaign there (and a conservative military shift by 1964). This drove thousands of peasants into dynamic remote coca frontiers in lowland Chapare, Santa Cruz, and Beni.

3 Paul Gootenberg, 'The 'Pre-Colombian' Era of Drug Trafficking in the Americas: Cocaine, 1947-1965,' *The Americas* 64/2 (2007): 133-76.

Meanwhile, the United States, whose authorities quietly worried about their inability to halt the new drug, supported a slew of secret hemispheric policing summits, visiting UN drug missions, and INTERPOL raids. All such repressive measures further dispersed the drug and hardened its new smugglers. By the late 1960s, however, the rise of US-backed 'bureaucratic authoritarian' military regimes in nations including Brazil and Argentina drove long-distance cocaine routing through one site: the continent's one viable democracy, Chile. Here, the break-up of the 1950s clans created many competing exporters linked to ample supplies of Bolivian, and once again, Peruvian coca paste.

RISE AND DEMISE OF COLOMBIAN CARTELS, 1973-95

Before the 1970s, Colombia played no systematic role in South American cocaine trades, though the country had a tradition of entrepreneurs, regional smugglers, marijuana exports from the Caribbean coast, and a legacy of everyday violence from the 1950s. Cocaine's politics-driven shift to Colombians came during the Nixon era (1969-74).

Two more Cold War events propelled cocaine's geographic presence to the north. The first, related to Nixon's anti-communism policies, was General Augusto Pinochet's September 1973 military coup in Chile. By 1970 some low-level Colombians served as mules for Chileans. Pinochet, to win favour with Washington and the newly-formed DEA, launched campaign in late 1973 against Chilean traffickers, most of whom were quickly jailed or expelled. The impact was to swiftly push routing of peasant coca-paste from the Huallaga and Bolivia north, via the Amazonian border-town of Leticia, to Colombia. Pioneering Medellín smugglers like Pablo Escobar and the Ochoa brothers restructured the trade and dramatically expanded its scale and reach. The second political event was Nixon's 1969 declaration of 'war' against drugs, aimed primarily against marijuana (i.e., America's 1960s anti-war youth culture) and heroin (feared among Vietnam vets and as a scapegoat for the 'black' crime wave sweeping US cities).⁴ Crackdowns on these drugs – the 1970s' Operation Intercept sweeps of the Mexican border, and the squeeze against the French Connection heroin pipeline - made a perfect market opening for Andean cocaine. This hit 1970s American culture as a glamorous and pricey 'soft-drug.' Cocaine was easier, safer, and lucrative to conceal, and weed suppliers from Colombia to Mexico quickly switched product lines.

Much has been said about the Colombian 'cartels', an official misnomer for such robust regional and family market enterprises. Once propelled to Colombia, cocaine thrived in places like Medellín, the nation's declining entrepreneurial city.⁵ *Empresarios* like Escobar, Ochoa, and Carlos Ledher took advantage of Caribbean island-hopping wholesale transport routes, Colombian workers in places like Miami and Queens, and the 1970s lag in DEA attention, which deemed cocaine a rich man's vice. By 1975, the Colombian trade passed the four tonne mark and by 1980 some 100 tonnes of cocaine entered the United States. Exporters concentrated in three regional groups: Medellín, Central (Bogotá), and Cali (del Valle) – the latter a bustling new city near the Pacific port of Buenaventura, promoted by clans like the Rodríguez-Orejuela and Herreras. However until the early 1990s, Medellín, under Escobar's charismatic lead, handled some 80 percent of the trade, mostly from coca paste made in Peru's Huallaga.

By the mid-1980s, cocaine had some twenty-two million American users. Sliding prices and racially-tagged discount markets (such as 'crack'), together with the drug's growing aura of violence, transformed cocaine into the top target of American drug warriors. Under Republicans Reagan and Bush senior, this extended drug hysteria around cocaine led to a sharp militarisation of the overseas campaign against the Andean coca bush.

⁴ Michael Massing, *The Fix* (New York City: Simon and Schuster, 1998) claims Nixon's policies were 'working.' I would argue that they worked in the long term to spawn the latter US cocaine boom.

⁵ Mary Roldán, 'Cocaine and the 'miracle' of modernity in Medellín, in Paul Gootenberg (ed.), *Cocaine: Global Histories*, (New York: Routledge, 1999), 165-78.

Reliable state allies were difficult to find in the tolerant regimes of Peru, Colombia, and Bolivia (especially infamous during García Meza's 'narco-regime' in the early 1980s). The 1980s escalation of hemispheric interdiction measures in Peru (direct military aid, Huallaga adviser bases); in Bolivia (Operation Blast Furnace, US-trained UMOPAR forces); Colombia (the late 1980s forced extradition pact), and Panama (climaxing in the 1989 invasion to oust ex-ally Manuel Noriega); failed to slow cocaine. Just the opposite: US pressures led to enhanced trafficker concealment and business expertise; to a doubling of Amazonian coca between 1982 and 1986 (as crop insurance against captured lots); and a nosedive in the drug's wholesale price from \$60,000 to \$15,000 per kilo across the decade.

As competition and monetary stakes rose to millions per shipment, Colombians drew on strategic violence, in contrast to the precursor trades. Colombians deployed *sicario* hitmen against remnant Cuban rivals, and early 1980s Miami was beset by gang turf battles among motley 'cocaine cowboys'. In Colombia itself, force remained a defensive impunity tool against the police and informers, though bribes usually sufficed. The business-like trafficker class at first sought broader legitimacy: running for office (Escobar was briefly an Alternativa Liberal senator), financing elections, offering strategic truces or fiscal support to the state and local good works. But a mix of US pressure and Colombian anxieties about narco 'infiltration' of the state led to a political breakdown in the mid-1980s. After 1984, the impunity of drug traffickers faded (starting with Justice Minister Lara Bonilla's political ouster of Escobar), and traffickers retaliated with a barrage of symbolic and real attacks against the state: terror bombings, kidnappings, and assassinations of judges, candidates, and journalists, including the audacious killing of Lara Bonilla himself. Colombia, already awash in political violence (including a rising tide of guerrillas and paramilitaries), became the world murder capital.⁶ Between 1980 and 1990, Medellín homicides spiked from 730 to 5,300 yearly, anticipating the contemporary tragedy of Mexico's Ciudad Juárez.

If any lesson exists for Mexico today, it is that the early 1990s war against Colombia's Medellín cartel did not really work. It mainly shifted cocaine's centre of gravity from that besieged city to rivals in Cali, and many observers read the campaign as a tacit alliance between the Colombian state and Cali's low-key dealers against the riskier Escobar. As shown by criminologist Michael Kenney, US intervention in 1990s Colombia ultimately led to more effective drug trafficking organisations.⁷ Colombia now hosts some 600 camouflaged export webs, so-called cellular 'boutique' *cartelitos*, which have diversified with global sales strategies (to Brazil, Africa, and Europe), branched into complementary drugs, and gone high-tech with counter-intelligence and genetically-altered coca.

Two other repressive measures shifted cocaine's trajectory. First, during the early to mid-1980s, the DEA and FBI became alarmed by the visible intensity of trafficking, money laundering, and gang violence in Dade County – the main entry-point for Colombian cocaine – and focused interdiction on Florida's south coast. The military-style Joint Florida Task Force and offensives like 'Operation Swordfish' centralised more than 2,000 agents headed by then Vice-President Bush. By the late 1980s, Colombians were actively retreating from the Caribbean corridor. A 1992 bust of their major courier was the last straw for Cali exporters, who turned to alternative transshipment via Panama, Central America, and soon through northern Mexico, brokered by the Honduran Juan Matta Ballesteros.⁸ Caribbean drugs trickled only through Haiti, the closest 'failed state' to US borders (particularly after the ousting of Aristide), and handled by the Duvalier-era military. The 1980s' inroads against Florida's Colombian cocaine powered a blowback thrust to nascent Mexican drug-lords.

6 Robin Kirk, *More Terrible Than Death* (New York City: Public Affairs Books, 2003).

7 Michael Kenney, *From Pablo to Osama: Trafficking and Terrorist Networks, Government Bureaucracies, and Competitive Adaptations* (University Park: Penn State University Press, 2007).

8 Ron Chepesiuk, *Drug Lords: The Rise and Fall of the Cali Cartel* (Preston: Milo Books, 2003); Stan Zimmerman, *A History of Smuggling in Florida* (Stroud: The History Press, 2006), chapter 8.

The second shift of the late 1990s came with pyrrhic successes against peasants and middlemen in eastern Peru and Bolivia resulting in coca's move to Colombia. During the mid-1990s, US pressures on compliant regimes finally led to visible reductions in Andean coca. In Peru, the authoritarian Fujimori regime, alarmed by the lucrative alliance of *Sendero Luminoso* guerrillas with harassed Huallaga *cocaleros*, embraced militarist suppression, including a shoot-down policy that cut cocaine's air bridge to Colombia. In Bolivia, the US-funded Plan Dignidad finally slashed coca paste exports, leaving in its wake, however, the militant peasant movement that would propel, as political blowback, the coca nationalist Evo Morales to the presidency in 2005. Yet these temporary victories simply drove coca cropping to Colombia, a country with scant native coca tradition, thus concentrating a thriving vertically integrated agro-industrial cocaine industry in Colombia by the late 1990s.

MEXICAN OPPORTUNITIES SEIZED, 1985-2000

Since the mid-1990s, the hottest profit site of cocaine's trail to the United States has snaked a thousand kilometres north: to the US borderlands of Mexico, adjacent to the American market. This was the prequel to the post-2007 Mexican drug war. Drug smuggling activities in border-towns like Tijuana, Nogales, and Juárez date to the early twentieth century: first patent drugs, alcohol, later opiates and then marijuana. By the 1970s, the city of Culiacán, Sinaloa, was the storied capital of Mexican drug trades, and *narcotraficantes* still originate in northern rustic under-classes, if aligned and tutored under decades of Institutional Revolutionary Party (PRI) rule along with regional businessmen and politicians. By 1989, a third of cocaine bound for the US market entered via Mexico; by 1992, that figure reached half, and by the late 1990s, 75-85 percent.⁹ In the mid-1990s, income generated by drug exports in Mexico, led by this cocaine surge, ranged from \$10 billion (according to US officials) to \$30 billion (Mexican figures). This dwarfed the income generated from Mexico's largest legal commodity export, oil (\$7.4 billion).

This move to Mexico was blowback from the clampdown on the 1980s Medellín cartel through interdiction against Florida air and sea corridors. Cali took the lead, soon traversing Central America looking for partnerships with Pacific Mexican traffickers, who fenced goods across the border on a fee per kilo basis. Tough-minded Mexicans, like Sinaloa's pioneer Félix Gallardo, soon won leverage against the beleaguered Colombians by implementing new mechanisms, such as shares in kind payments, which increased profits by five to tenfold, as did tapping Chicano gangs as retailers in the United States. By the early 1990s, according to the DEA, the Sinaloan cartel exceeded Medellín's peak of revenues, and after 2000, moved to fully outflank Colombians, with direct purchases from faraway peasants in Peru's Huallaga and sale outlets in such places as Argentina. Other forces magnified cocaine's role: Mexico's 1980s 'lost decade' of economic meltdown, the long death-throws of the original PRI, the transformation of frontier towns like Juárez and Tijuana into sprawling metropolises, and the boom of border commerce with the 1994 NAFTA treaty.

Exposed in the 1985 'Camarena affair', in which the killing of a DEA agent exposed official complicity in the trade, Sinaloan smugglers dispersed, splintering into a series of regional 'cartels' now fueled by cocaine super-profits. This geographic proliferation of drug organisations crossed the north from Sinaloa to bases in Tijuana, Juárez, and Matamoros and Reynosa in the east, and transit points everywhere.¹⁰ As in Colombia, successive anti-drug sweeps since 1970 worked to strengthen innovative firms, insofar as they weeded out weaker and less efficient operators and favoured a protective vertical business structure. The transition to the Juárez cartel (founded by real estate moguls and federal police) began in the mid-1980s with Pablo Acosta's cocaine transshipment base in Ojinaga, Chihuahua, which ferried cargo planes to and from Colombia. This was soon amplified by Amado Carrillo Fuentes, who later became Mexico's richest and most iconic trafficker of the 1990s Salinas era.

⁹ Luis Astorga, *Mitología del 'narcotraficante' en México* (Mexico: Plaza y Valdés, 1995); Peter Andreas, *Border Games* (Ithaca: Cornell University Press, 2nd Edition, 2009), chapter 4.

¹⁰ Froylán Enciso helped untangle cartel geographies; we also co-edited: 'Mexico's Drug Crisis: Alternative Perspectives,' *NACLA Reports* 44/3 (May-June 2011); Howard Campbell, *Drug War Zone: Frontline Dispatches from El Paso and Juárez* (Austin: University of Texas Press, 2009).

As in Colombia and Medellín vs. Cali in the 1990s, Juárez groups exploited the government's post-1985 drive against the Sinaloans, moving to the top of the Mexican trafficking pyramid. Félix Gallardo dispersed men throughout the northwest, until he was jailed in 1989, and rival organisations grew out of regional partners who evolved or split from Sinaloa, such as Tijuana's Arellano-Félix brothers. The Matamoros or 'Gulf' cartel gained ground as the Mexican state escalated the conflict and later targeted Juárez. In a stunning case of blowback, Gulf forces recruited the 'Zetas' – ruthless former members of an elite US-trained anti-drug squad, who have branched out since 2003 on their own across Mexico.

By the 1990s, the spectacular billions in cocaine money unveiled and undermined the Mexican state's traditional political collusion with regional drug traders. Dating to the aftermath of the 1910 Revolution, this compact consolidated after 1940 into a profit-sharing management of violence and rivalries between the state and the Sinaloan mafia. After the rigged 1988 elections, the United States revised its support of Mexico's authoritarian order to include drug suppression, as well as new trade openings. The neoliberal regime of Carlos Salinas de Gortari (1988-94) embodied the contradictions of drug politics. On the one hand, Salinas, seeking to refurbish Mexico's image for NAFTA, assumed an active national role in US-led drug wars, creating inter-agency policing institutions based on the model of the US DEA. Mexico's Attorney General office (the PGR) became a professional anti-drug bureaucracy. The focus also hardened on the US side of the border, militarised as an official 'High-Intensity Drug Trafficking Region' during the 1990s South-West Border Initiative. Gone were the easy days of patrolling the cocaine-strewn Florida straits.¹¹

On the other hand, most Mexican 'drug control' was a pretence, undercut by the involvement of Salinas' high appointees and family in the burgeoning trades and drug-related political assassinations. Cocaine interdiction and its evasion multiplied opportunities for work and profit. Total trafficker bribes rose from \$1.5-3.2 million in 1983 to some \$460 million in 1993, larger than the entire PGR budget, and thousands of federal agents jumped into oiling the drug trades. Cocaine's destabilisation became public during the next 1994-2000 Zedillo *sexenio*, when (breaking with Mexican custom) the new president openly condemned his predecessor's corruption. Epitomising this exposure, in 1997, was the discovery (as US intelligence and training moulded the Mexican drug war) that the military chief of Mexico's 'DEA', General Gutiérrez Rebollo, was in fact collaborating with the Juárez cartel, an incident sampled in the Hollywood drama *Traffic*. The blowback of the long American war against cocaine, begun in the 1940s, had come home to roost.

CONCLUSION

The Mexican drug war, declared by National Action Party (PAN) President Felipe Calderón in 2007, is repeating, with more than 60,000 killings so far, Colombia's bloodletting of the 1980-90s. The PRI, with copious US aid, will likely continue the fighting in the north. Institutionalised as Plan Colombia after 2000, that earlier intervention did not dent the global cocaine trades, but merely shifted and diversified illicit drugs more menacingly and murderously close to 'home.' There is little or no historical memory of such previous US hemispheric failures at prohibitionist drug control. Indeed, the Colombian experience since the 1990s is often officially touted as a 'successful' security model for Mexico today. As cocaine commodity chains, under pressure, are poised once again for dramatic geographic shifts – to transshipment via faltering states like Honduras, with coca sourcing boomeranging back to eastern Peru, and with consumption expanding to globalised sites in Brazil, the UK, and China – we should recognise this deep history of blowback-driven failures. Many leaders in Latin America, at least, are beginning to see the pattern. ■

11 Andreas, *Border Games*, 55-7.

➤ Swiss Drug Policy in International Context – Fought, Ignored, Admired

Diane Steber Buechli and Ruth Dreifuss

Geographically situated in the centre of Europe, Switzerland is known for its many languages in the smallest of spaces; chocolate, watches and mountains – many of its products are export hits. In the 1980s, a less praiseworthy addition attracted attention: the image of open drug scenes. The resulting federal drug policy with its four pillars is well-known – but how did the international environment react to the Swiss Government's policies and how did the country in turn deal with these reactions? The following article addresses these issues and seeks to portray how much perseverance and resistance was displayed on both sides, and perhaps to answer the question 'does persistence beat resistance?'

THE DEVELOPMENT OF INTERNATIONAL DRUG POLICY UNDER THE AEGIS OF THE UN

Nine international agreements on drug control were concluded between 1912 and 1953. In 1961, these instruments were combined into the *Single Convention on Narcotic Drugs*. In the early 1970s, a 1972 Protocol amending the *Single Convention* and the 1971 *Convention on Psychotropic Substances* were concluded. The former instrument primarily served to strengthen control mechanisms and set out the strategy for the destruction of illegal plantations; the latter instrument expanded the list of illegal substances.

Throughout the 1970s, the policy focus remained predominantly on the supply side, but the growing demand for drugs increasingly alarmed the authorities in developed countries. Several of these countries gained their first experiences with opiate replacement therapies as pragmatic, medical, alternatives. Nevertheless, the international community generally responded to these developments with a renewed strengthening of prohibitionist instruments. Thus the *1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* adopted the criminalisation of the possession and consumption of drugs for personal use as a fundamental principle of control.

The corpus of these treaties formed the basis for both the regulation of the legal use of these controlled substances and the fight against their illegal production, traffic and consumption. Taken together, the conventions formed a body of international law, applied by individual member states.

The system is overseen by three UN bodies:

- **The Commission on Narcotic Drugs (CND)**
Founded in 1946, CND is the central UN drug policy-making body. It determines in particular the strategic goals of the UNODC and monitors their implementation.
- **The International Narcotics Control Board (INCB)**
Established by the 1961 Convention, the INCB monitors the cultivation, traffic and use of narcotic substances worldwide to ensure that these activities are confined to legal purposes. The INCB publishes an annual report of its work and the worldwide situation on drugs. In order to assess this and facilitate dialogue on national drug policy, it regularly sends delegations to individual member states.
- **The United Nations Office on Drugs and Crime (UNODC)**
UNODC is an institution of the UN Secretariat and coordinates all drug-related activities of the UN.

SWITZERLAND'S INTEGRATION INTO THE INTERNATIONAL DRUG CONTROL SYSTEM

Switzerland ratified the 1961 Single Convention in 1968 with little public debate and quickly revised its own controlled substances legislation to meet its new obligations. The message of the Swiss Federal Council to Parliament concluded with the observation that the Swiss pharmaceutical industry would gain the advantage of being able to buy opiates in virtually all countries. This was a big improvement on the 'closed list' of producers pushed by the United States and its allies in the 1953 Opium Protocol.

The Swiss acceded more reluctantly and in a more gradual manner to the Convention of 1971 and the Protocol of 1972. It wasn't until 1994 that the two Instruments were submitted to the Swiss Parliament

for ratification. Pressure on Switzerland had been steadily increasing as it had turned into a hub for drug trafficking as well as a base for money laundering by criminal organisations. However, opposition from the pharmaceutical industry had to be overcome. This opposition was largely in response to the proposed regulation and control of psychotropic substances and precursor chemicals, like traditional narcotic drugs, by the federal state. The industry's main interest was in obtaining the necessary substances for research and production of medicaments. They feared that the proposed controls created impediments to this. Furthermore, there was an increasing national awareness of the medical, social and security implications of drug consumption. Switzerland became torn between two undesirable alternatives: the loss of sovereignty over its national drug policy or the exploitation of legal grey areas for crime. Only after the foundation for a strong four-pillar policy had been laid did Switzerland join these two international agreements in 1996.

The ratification of the 1988 Convention was even more widely debated. The issue at stake had less to do with drug trafficking and money laundering offences that were already covered by domestic law. Rather, the criminalisation of both consumption and possession of illicit drugs for personal use, including cannabis, was at the core of a dispute between two equally strong camps – which launched two opposing popular initiatives. In the summer of 1993, 'Youth without Drugs' submitted an initiative demanding strict criminalisation. Towards the end of 1994, the 'Droleg' initiative followed, proposing the decriminalisation of drug use, and for it to instead be regulated by the state.

The Federal Council of Switzerland suggested a delay in any debate on ratifying the 1988 Convention until a referendum on the initiatives had been held. Ratification without proviso would have been the natural consequence of the adoption of the 'Youth without Drugs' initiative, whereas the acceptance of 'Droleg' not only would have meant no further accessions to international conventions, but in addition the exit from all

previous ones. The Federal Council and Parliament recommended that citizens reject both initiatives and therefore support the formulation of a middle ground in the form of the four-pillar policy. In 1997 and 1998, after two very animated voting campaigns which helped increase public awareness on the issue, both initiatives were rejected by a margin of 71 and 74 percent respectively.

These results paved the way for Switzerland to join the 1988 Convention. However, it did so with the caveat that drug consumption would not be a criminal offence. This caveat aimed to ensure the continuation of its established drug policy, but also leave open the potential for further development of legislation, particularly around the production, traffic and sale of cannabis products. By 2005 Switzerland had been fully integrated into the international drug control system. Its relationship with the system, however, remains ambiguous. On the one hand, it complies with its obligations in the fight against organised crime. On the other hand it continues to build on the national four-pillar policy, in which interventions such as low-threshold methadone treatment, the prescription of heroin, harm reduction measures such as syringe exchange programmes, drug injection rooms, and quality testing of illicit substances all occupy a central position. Because of this tension between Switzerland and system, the country has been scrutinised by the UN drug policy bodies for many years.

CONTROLLED HEROIN PRESCRIPTION

Switzerland was visited by the International Narcotics Control Board (INCB) in both 1994 and 1995. This quick succession of visits was justified on two grounds. First, because Switzerland had still not ratified the Agreements of 1971 and 1988. Second because of the ongoing early experiments in controlled heroin prescription. These experiments were initially evaluated very critically by the INCB.¹ In its 1994 report, the INCB called for their assessment by a panel of independent experts drawn from the WHO. Switzerland welcomed this proposal as an addition to the monitoring by its own national research teams.

The overall results of the experiments were positive and published by their research teams in 1997. These were, however, only briefly discussed in the subsequent INCB Report which read: 'It [the Swiss Government] claimed that, for a limited number of addicts who could not be reached by other means, the medical distribution of heroin, accompanied by health and social support services, led to some positive results.' Drawing its own conclusions, the INCB Report cautioned against a continuation of the experiments or their international expansion and questioned whether the 'limited positive results claimed by the Swiss Government' were not, in fact, the result of some other intervening factor.²

In 1998, the previous year's rejection of the 'Youth without Drugs' initiative was not commented on by the INCB, even though the initiative's demand for a strict drug prohibition policy would have ended Switzerland's controlled heroin distribution. However, the 1998 Federal Decree for the controlled distribution of heroin and its support in the 1999 Referendum were met with continued scepticism by the INCB.

In 1999, the independently researched WHO report on the Swiss heroin prescription trials between 1994 and 1996 was published. This proved much more critical than the 1997 evaluation by the Swiss researchers. Methodological concerns were raised, and it was pointed out that it was not conclusive whether the positive effects on health and social integration were due to the prescription of heroin or the overall circumstances of care. It was also noted that the discrepancies between the effects of different prescribed opiates could not be determined accurately. It was therefore not clear whether heroin treatment offered better results than other substitution therapies. Ultimately, Switzerland's 'unique social and political characteristics' were highlighted and it was concluded that the results of these trials could be generalised only to a limited extent.

1 International Narcotics Control Board, *Annual Report for 1995*, para 384.

2 International Narcotics Control Board, *Annual Report for 1997*, paras 367-368.

The Ministry of Health issued a statement welcoming the report of the panel of experts and accepted its findings. However, it also made clear that the demanded scientific standards relating to methodology were not fully realisable under the circumstances. The Ministry stressed that the experiments were not designed to determine whether the improvements in health and social status of the participants resulted from the heroin prescription itself or its surrounding circumstances. The INCB responded to the findings of the expert commission with a press release and a statement in its subsequent annual report. In both publications, only the negative results were recorded, and the unchanged negative position of the INCB towards heroin prescription was emphasised.

In 2000 Switzerland was again visited by an INCB mission. The resulting comments in the INCB Report corresponded with previous trends: the positive effects of Swiss drug policy were supposedly unclear and controlled heroin prescription would have to be further tested for negative side effects. As before, it was pointed out that the Swiss results were not readily transferable to other countries. Moreover, the INCB stressed its concern that the Swiss experiment could inspire other countries, including non-European ones, to adopt similar programs.

DRUG CONSUMPTION ROOMS

To counteract the problem of increasing HIV-infections among intravenous drug users, the first syringe-exchange programmes were introduced in Bern in 1985. These were gradually expanded nationwide and into selected prisons. Although this innovation was also scrutinised by the INCB, it could not be considered a violation of the international drug conventions. The introduction of the first accredited injection room in Bern in 1986, followed by another in Zürich in 1987, was a different matter. The international reactions to these consumption rooms (which were subsequently introduced in other cities) were similar to the reactions to the heroin prescription programme. The INCB took the standpoint that the consumption rooms went against international conventions, and hyperbolically described them as 'drug injection rooms that maintain and facilitate drug abuse under supposedly hygienic conditions.'³ Switzerland responded to this accusation with a legal opinion of its own that arrived at a different conclusion, but this was largely ignored by the INCB.

CANNABIS

Cannabis consumption has increased significantly in Switzerland since the 1970s. However, the issue was for a long time overshadowed in public discourse by concerns surrounding hard drugs. From the mid-1990s, cannabis cultivation and its trade rose significantly in Switzerland; many so-called 'hemp shops' were established. In 2000, a verdict by the federal court closed this legal loophole relating to cannabis, determining that Swiss hemp above certain THC levels would now fall under the Narcotics Act. However, this decision had little practical impact.

In the course of the 1990s Swiss policy on cannabis drew the world's attention when a decriminalisation plan began to crystallise. This plan was initially widely misunderstood by the international community. In particular, the planned decriminalisation of consumption was often mistakenly equated with the full legalisation of its cultivation, traffic and consumption. Consequently neighbouring states, in particular, worried about its effect on their own drug scenes. Therefore Switzerland made it a high priority to keep neighbouring countries informed about its drug policy and up to date with new developments. This took place in bi- and

³ International Narcotics Control Board, *Annual Report for 2000*, para 504.

tri-national meetings, as well as on a regional level following a request for discussions by Germany's federal state Baden-Wuerttemberg. During these meetings, perceptions of Swiss drug policy could be exchanged and partly revised, and the ideas behind it articulated more clearly, with many concerns being eliminated.

Unsurprisingly, the INCB was critical of this planned decriminalisation as part of the revision of the Narcotics Act. Again, the INCB claimed that such measures, among other things, violated the 1961 Single Convention. Switzerland commissioned a number of legal opinions on this issue, all of which came to the conclusion that no violation of the Convention had taken place. The INCB nevertheless stuck to its initial position without attempting to justify the rejection of the Swiss legal opinions. Nevertheless, the plan was rejected in 2004 by the Swiss Council and a crackdown on the cultivation of cannabis is now being conducted. At present, discussions about various administrative sanctions with regard to cannabis are underway in Parliament.

OTHER INTERNATIONAL RESPONSES TO SWISS DRUG POLICY

The Swiss Government's new approaches to drug policy were by no means ignored. The Federal Office of Public Health organised several dozen visitor programmes, so that delegations from around the world could get a first-hand impression. The wide publication of the scientifically monitored experiments provoked further strong interest. In general, there were often two opposing positions. One rejected the experiments on ideological grounds and advocated no assistance in any form with substance abuse as a matter of principle. The other accepted the experiments out of pragmatic concerns, including the reduction of death rates and HIV transmissions, improvements of the situation for sufferers and other general positive evaluations. Ambros Uchtenhagen summed up succinctly that 'in drug policy, a clash exists between those who approach the issue from a scientific perspective and those who stick to their ideological convictions.'⁴

Motivated by what Uchtenhagen termed 'ideologischer Prinzipientreue,' the repressive nature of the UN drug policy paradigm has been sharply criticised by the international scientific community. In the *International Journal of Drug Policy*, several scientists spoke out against the 2000 UNDCP World Drug Report. A detailed review accused the Report of a distorted and biased reproduction of data and concluded that 'the document cannot be considered of value in terms of providing an analysis of comprehensive information in a scientifically rigorous and neutral manner. The kinds of data manipulation noted here have been noted by others regarding how drug data are distorted to support particular drug policies.'⁵ In the same issue, it was recorded that fatal heroin overdoses decreased starkly thanks to Switzerland's drug policy.

The scientific community's reactions to the Swiss experiments have been broadly positive. The results of the heroin prescription programme have been used to argue for its introduction in other countries. For instance a 2005 publication of the Swiss Ministry of Health, which offered an overview of the results to date, observed that 'the Netherlands has been in admiration of the Swiss, and at the same time jealous.'⁶ In addition, the cooperation of different stakeholders was praised: 'One could almost consider it a 'blueprint' for the pragmatic collaboration between science, therapy options, police, criminal prosecution as well as politics.'⁷

Within the Group Pompidou, of which Switzerland has been a member since 1985, substance abuse and illicit trade with narcotics are increasingly analysed from a multidisciplinary perspective. The Swiss experiences were initially met with doubts, but became more and more accepted as a positive contribution to the mitigation of the problem. Today, discussion is increasingly taking place within the EU where a consensus

4 'In der Suchtpolitikstreiten auf wissenschaftlicher Evidenz bauende Tendenzen mit ideologischer Prinzipientreue,' AmbrosUchtenhagen, 'Suchtpolitik und Suchtarbeit im internationalen Spannungsfeld,' *Abhängigkeiten* 12 (2006): 66.

5 Carla Rossi, 'A critical reading of the World Drug Report,' *International Journal of Drug Policy* 13(2002): 225–235.

6 Frederick Polak, 'Invited Comment: Shortcomings of Heroin Prescription Research,' in *Heroin-assisted Treatment. Work in Progress*, ed. Margaret Rihs-Middel et al. (Bern: Hans Huber, 2005), 91.

7 Michael Krausz, 'Heroingestützte Behandlung – Basisversorgung oder Ultima ratio im internationalen Vergleich,' *Abhängigkeiten* 13(2007): 54–65.

for the medicalisation of substance abuse is slowly forming. Similarly, voices were raised in the UN, which wanted to give priority the social dimensions and health concerns of drug related issues. In 1998, a special meeting on drugs of the UN General Assembly took place, where Switzerland publicly advocated its four pillar strategy. 10 years later UNAIDS and the WHO, as well as the Global Fund to Fight Aids, Tuberculosis and Malaria, became important actors in this field. The UN is currently seeking to develop a more coherent international policy, which takes all aspects of drug related problems into account.

CONCLUSION

The Swiss positions on harm reduction policy at a European level, for instance within the Pompidou Group, helped convince other European partners despite some initial scepticism. By the end of the 1990s they had been adopted by a majority of European countries, despite being rejected by individual states such as Italy and Sweden, which continue to pursue forceful and repressive drug policies. At the global level, however, the strategy backed by Switzerland and a majority of European countries could not persuade the UN bodies charged with the implementation of the International Conventions.

Nevertheless, the questioning of a one-sided prohibitionist drug policy and the normalisation of harm-minimisation policies and related therapeutic measures are beginning to be accepted worldwide: replacement therapies and syringe exchange programmes are commonplace; heroin is available on prescription in five countries; consumption rooms are established in seven countries and cannabis consumption is de-penalised, de-criminalised or either *de facto* or *de jure* legalised in almost thirty countries. Moreover, in a number of national and subnational jurisdictions around the world, the use of cannabis products for medical purposes is government-controlled. As noted in the forthcoming book by David Bewley-Taylor, 'soft defection' from the straitjacket of international conventions is increasing in frequency.⁸ The search for a bottom-up consensus, in which health, social integration and the security of the population will be placed a priority, is underway. ■

8 David R. Bewley-Taylor, *International Drug Control: Consensus Fractured* (Cambridge University Press, 2012).

➤ The Contemporary International Drug Control System: A History of the UNGASS Decade

David R. Bewley-Taylor

In March 2009, representatives from more than 130 countries met in Vienna, the home of the UN bodies dealing with the 'world drug problem.' Delegates were concluding a year-long review of the progress made by the international drug control system against the goals set by the UN General Assembly Special Session (UNGASS) more than a decade earlier. At that 1998 session in New York member states had agreed on a Political Declaration, under the quixotic slogan 'A Drug Free World. We Can Do It!' This committed them to eliminating, or at least massively reducing the illicit production of coca, cannabis and opium, as well as achieving large scale demand reduction by 2008.

In 2009, after six gruelling months of negotiation, the meeting also announced a new Political Declaration and Action Plan. These soft law instruments, like their predecessors eleven years earlier, would heavily influence the direction of international control efforts for the next decade or so. During the general debate, a number of states pointed out that the UNGASS goals had not been met and lamented shortcomings within the draft Declaration. However, the approval of the final documents, which closely resembled those from the UNGASS, signalled an ostensible acceptance of the structure and ethos of the UN multilateral drug control system; a system built upon the doctrine of prohibition.

As dramatic events at the meeting were to emphasise, however, not all states were equally enthusiastic in their support for punitive prohibition. Indeed, in the years between 1998 and 2009 (the UNGASS decade), the UN drug control system experienced an increase in internal tensions, as well as a subtle form of transformation.

THE INTERNATIONAL DRUG CONTROL SYSTEM: STRUCTURES AND DYNAMICS

The contemporary system – or global drug prohibition regime – is constructed upon a suite of UN treaties.¹ Dating back to 1912, these treaties aimed to eliminate the non-scientific and non-medical production, supply, and use of narcotic and psychotropic drugs. The treaty-based system developed on the basis of two interconnected tenets: the belief that the best way to reduce problems caused by illicit drug use is to minimise the scale of the illicit drug market; and that this can be achieved through a reliance on prohibition-oriented supply-side measures.

Like most UN treaty-based regimes, a number of organisational actors oversee its various aspects. Key among these is the Commission on Narcotic Drugs (CND), which is the central policy-making body. The CND consists of 53 member states, and is assisted by the World Health Organization (WHO) and the International Narcotics Control Board (INCB or the Board). The Board is the self-described 'independent

¹ Ethan A. Nadelmann, 'Global Prohibition Regimes: The Evolution of Norms in International Society,' *International Organization* 44 (1990): 479–526.

and quasi-judicial' control organ for the implementation of the treaties. It assesses worldwide scientific and medical requirements for scheduled substances and monitors compliance with the relevant conventions. Both the CND and the INCB rely on the United Nations Office on Drugs and Crime (UNODC) – the UN agency responsible for coordinating drug control activities – for administrative and technical support.

Within this framework, textual ambiguity and subjective legal interpretation allow certain leeway in formulating national policies. Yet flexibility is limited. Consequently, while there has long been variation in national policies – a spectrum ranging from quasi-legal coffee shops in the Netherlands to zero-tolerance policing elsewhere – the regime greatly restricts national freedom of action. For example, no member state can create a regulated cannabis market for recreational use and still remain within treaty boundaries. Moreover, the conventions generate a powerful 'background prohibitionist expectancy' on nations regarding personal drug use.²

Although it is ultimately a multilateral construct, the shape and operation of the current treaty system is very much a result of American endeavour. The prohibitionist norm at the heart of the regime owes much to the successful internationalisation of the United States' domestic approach – namely, that the recreational use of certain substances is morally wrong. Furthermore, the near universal levels adherence to the regime cannot be divorced from Washington's support. States obviously perceive benefits from regime membership. Yet a combination of the UN's benevolent image and US suasion, both at the annual sessions of the CND and through unilateral mechanisms such as certification, have helped ensure nations become Parties to the conventions and not deviate from their prohibitive ethos thereafter. Costs, both in terms of national reputation and good relations, particularly with respect to economic ties with Washington, are important considerations. As one study noted in 1975,

[w]hen a 'superpower' exhibits [a high degree of involvement] there is unlikely to be much resistance or unresponsiveness on the part of countries appealed to for support, unless such support is contrary to national interests. Generally speaking, co-operation with the US in drug control matters does not conflict in any significant way with the interests of other... countries and is therefore readily provided.³

While the end of the Cold War significantly altered the international landscape, the dynamic described above remained clearly identifiable into the late 1990s and first decade of the twenty-first century. However, the change of geopolitical terrain in the late 1980s and early 1990s triggered a widespread reconsideration of national interest. In the US, the immediate post-Cold War era saw a complex debate about the 'very point and purpose of American internationalism.'⁴ Elsewhere, the loss of the dominating meta-narrative of one concept war (i.e. the war against communism), allowed for an increasingly widespread reconsideration of an alternative – the 'war on drugs.' Ironically, the end of the Cold War also included revised cost-benefit calculations in many (particularly European) states, where for various reasons the issue of illicit drug use gained traction on the domestic policy agendas.

With the growth, complexity, and multi-faceted nature of illicit drug issues, it became evident to an increasing number of countries that the benefits of a flexible interpretation of the conventions outweighed the costs of deviating from the regime's normative expectancy. In this respect, support for the zero-tolerance US federal approach, and by association for the punitive international prohibition approach, was increasingly regarded as contrary to national interest. As pragmatic domestic concerns came to the fore, fewer governments were

2 Charles D. Kaplan, 'The Uneasy Consensus: Prohibitionist and Experimentalist Expectancies behind the International Narcotics Control System,' *Tijdschrift Voor Criminologie* 26 (1984): 105.

3 Kjetil Bruun, Lynn Pan and Ingemar Rexed, *The Gentlemen's Club: International Control of Drugs and Alcohol* (Chicago and London: University of Chicago Press, 1975), 142.

4 John Dumbrell, 'America in the 1990s: Searching for a Purpose,' in *US Foreign Policy*, ed. Michael Cox and Doug Stokes (Oxford University Press, 2008), 89.

content to formulate policy through an American, morally inspired, conceptual lens. This shift in focus took place in relation to both a more efficient use of finite law enforcement resources, as well as a public health context surrounding injecting drug use and the spread of HIV/AIDS. This coincided with a realignment of the international environment after the collapse of the Berlin Wall.

It was these concerns that became important drivers for the behaviour of some states and the growing systemic tensions that were to characterise the UNGASS decade. Increasingly dissatisfied with the punitive approach promoted by the conventions, a significant number of regime members engaged in a process of 'soft defection.'⁵ Rather than quitting the regime, these states deviated from its prohibitive norm, and exploited plasticity within the treaties, while technically remaining within their legal boundaries. Since norms are crucial to the essential character of a regime, such a process of normative attrition represented a form of regime transformation. Crucially, however, in this case transformation involved regime weakening and changes from *within*, rather than a more substantive change of the regime.

REGIME WEAKENING: HARM REDUCTION

A key part of this weakening process during the UNGASS decade took place over the issues of 'harm reduction.' These are 'programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.'⁶ The term here is used to refer to specific health-oriented interventions designed to reduce harms associated with injecting drug use.

Increasing engagement with harm reduction at the national and EU levels produced a significant and often heated debate within the conference rooms in Vienna. Indeed, while gaining approval from increasing numbers of states, its acceptance of continued illicit drug use provoked hostile reactions from other regime members (particularly the US), as well as from parts of the drug control apparatus – both of which favoured a more rigid and prohibitionist interpretation of the conventions. The increasing tensions were visible during both country and regional statements and debates around CND resolutions.

In the years following 1998, the issue of harm reduction oscillated on and off the Commission's agenda, according to its place within national policy debates. Nonetheless, statements from individual states favouring the approach became bolder, and eventually so did the position of the EU in the later years of the decade. This was particularly evident in 2005, during a thematic debate on HIV/AIDS. Countering such emboldened behaviour, statements from the US and other prohibitionist-oriented states, including Japan, the Russian Federation, and (somewhat incongruously) Sweden, also became more pronounced.

For example, at the 2003 mid-point review of UNGASS goals, the head of the US delegation stated that 'we must resist calls for lenient drug consumption policies... [we] know that these policies fail to sustain our important efforts as represented by the international narcotics conventions.'⁷ This was soon echoed by the INCB, and at times also by the UNODC's Executive Director, Antonio Maria Costa. The Board was particularly hostile to drug consumption rooms. This was despite legal advice from the UNODC's predecessor (the UNDCP) that they could operate comfortably within the regime's legal boundaries.⁸ It was, however, the debates around CND policy positions relating to HIV/AIDS that revealed the true intensity of disagreement on harm reduction.

5 David R. Bewley-Taylor, *International Drug Control: Consensus Fractured* (Cambridge University Press, 2012), 20.

6 IHRA Briefing (2010), *What is Harm Reduction? A Position Statement from the International Harm Reduction Association*, www.ihra.net/files/2010/08/10/Briefing_What_is_HR_English.pdf.

7 Phillip S. Smith, 'Vienna: UN Reaffirms Prohibitionist Path. Cracks Appear in the Consensus as Clamour for Change Grows,' *DRCNet*, 25/4/2003, <http://stophthedrugwar.org/chronicle-old/284/vienna2003.shtml>.

8 Legal Affairs Section, UNDCP, *Flexibility of the Treaty Provisions as Regards Harm Reduction Approaches*, 30/9/2002, UN Doc No E/CN/2002/W.13/SS.5, <http://www.tni.org/sites/www.tni.org/archives/drugsreform-docs/un300902.pdf>.

The Commission fosters a consensus-based environment, resulting in resolutions and declarations that are typically bland and oftentimes disguise the intensity of negotiations. Between 1998 and 2009, the CND agreed on six resolutions concerning drug use and HIV/AIDS, and which consequently involved the issue of harm reduction. Introduced by a range of nations, including Australia, Brazil and the Netherlands, the original versions often contained the term 'harm reduction' and explicit references to needle exchange. As a result of opposition from the US and other states, however, this language was removed. The critics fear was that, while non-binding, its inclusion within resolutions would legitimise and encourage the approach.

Over the years the negotiations involved deadlocks, filibustering, heated side discussions, extended sessions and, on at least one occasion, tears before home time. On many occasions judicious use of the phrase 'reducing the adverse health and social consequences of drug abuse', as agreed in the 1998 Political Declaration, eventually secured agreement, but as the decade wore on it was becoming clearer that there were deepening cracks within the so-called Vienna consensus.⁹ Debates over harm reduction also did much to highlight the increasing tensions between the drug regime and the UN's broader position on human rights. This was particularly the case in relation to the Board, as it became increasingly out of step with other UN bodies interacting with the drug issue, for example UNAIDS and the UN Development Programme, but also with the basic human rights principles of the UN system. However, that the UNGASS decade only saw one CND resolution dealing with human rights, itself fiercely debated, underscored the fact that not all states believed human rights had a place in discussions on drug policy.

The fragile façade of consensus within the CND was finally broken at the High Level Segment (HLS) of the Commission's 2009 meeting, which intended to conclude the review of the UNGASS Decade and to agree the new Political Declaration and Action Plan. Echoing its 1998 predecessor, the document reaffirms the regime's prohibitionist goals, to 'actively promote a society free of drug abuse.'¹⁰ However, not all member states were content with the Declaration. With a delivery that brought the conference room to a standstill, the German Ambassador addressed the delegates. He slowly listed twenty-six, predominantly European states (IS 26), that wished to add an Interpretative Statement to the already agreed Declaration.¹¹ Having failed to secure the inclusion, or even a clarifying footnote referring to harm reduction within the document, the Statement declared that they

will interpret the term 'related support services' used in the Political Declaration and Action Plan as including measures which a number of states, international organisations and non-governmental organisations, call harm reduction measures.'

This unprecedented step was a public demonstration of the fact that any remaining consensus among regime members on how to approach problematic drug use had been shattered.

The introduction of the Interpretative Statement by the IS-26 was undoubtedly one of the more noteworthy events of the UNGASS decade. It also revealed much about the nature of the system in 2009. As was to be expected, it was not well received by prohibitionist states – the United States and the increasingly important Russian Federation, in particular. To this group, it further undermined the essential tenets of treaty system. However, it is important to note that despite widespread engagement with a range of harm reduction measures, only twenty-six states signed the Statement. This number represented about one third of States pursuing syringe exchange programmes. While perhaps to some extent a result of a frantic negotiating environment, this disconnect represented a pragmatic calculation of costs. Although not even challenging the normative

⁹ Martin Jelsma and Pien Metaal, *Cracks in the Vienna Consensus: The UN Drug Control Debate*, (Washington: Washington Office on Latin America, 2004).

¹⁰ Commission on Narcotic Drugs, *Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem* (New York: United Nations, 2009), 7.

¹¹ Australia, Bolivia, Bulgaria, Croatia, Cyprus, Estonia, Finland, Georgia, Germany, Greece, Hungary, Latvia, Liechtenstein, Lithuania, Luxembourg, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Saint Lucia, Slovenia, Spain, Switzerland, and the UK.

fabric of the regime, only twenty-six states felt it important enough to expend political capital on. To the rest of the members, the costs – either reputational or in terms of relations with Washington – exceeded the benefits. Moreover, it is likely that a degree of free riding was at play, with some harm reduction oriented states content to allow others to move the issue forward.

REGIME WEAKENING: CANNABIS

The consideration of specific national interests is also central to understanding UNGASS Decade debates around another key area of contention – cannabis. After a period of relative policy stability during the 1990s, the UNGASS decade saw increasing numbers of states apply alternative measures to criminal prosecution for personal drug possession. Within this context cannabis unsurprisingly became a significant point of CND discussion between 1998 and 2009. There was an increasing level of soft defection among regime members with respect to the issues of ‘decriminalisation’, ‘depenalisation’, and especially with medical marijuana schemes. In quantitative terms, the number of cannabis-specific resolutions at the Commission was comparable to that relating to drug use and HIV/AIDS. However, the forceful and proactive support for harm reduction by some nations within the CND was not apparent for cannabis. On the contrary, delegates from soft-defecting states generally found themselves fighting a rearguard action. Interventions within debates and negotiations on the text of resolutions were often reactions to attacks on perceived leniency from prohibition-oriented nations. Rather than actively seeking to legitimise national level policy choices, the priority was to defend them. In many ways then, the cannabis issue created a reversal in roles to those witnessed during discussions of harm reduction and HIV/AIDS.

Moreover, attacks from certain member states were often closely related to the criticisms of soft defection emanating from the UN’s drug control apparatus. Both the INCB and UNODC, played an important role in shaping and in some instances steering, even stifling, debate on the issue within the CND.

For example, although the Dutch coffee shop system had long been the focus of the Board’s disapproval, the UNGASS decade saw it widen the scope of its ire in response to a growth in tolerant policies elsewhere. Criticism came in the form of a diligent producer versus ‘lenient’ consumer state narrative. From this perspective, traditional consumer states deviating from a punitive approach to the possession of cannabis for personal use were set against producer states that were portrayed as trying their best, within the spirit and the letter of the treaties, to suppress the illicit trade. Admittedly a view with some validity, this gained traction with countries like the US, Sweden and Japan, who opposed the liberalising trend on ideological grounds, as well as with North African and Gulf States, some of which were more functional in their outlooks and hoped to secure funding for cannabis control efforts.

Interestingly, while the CND’s consensus environment worked against soft-defecting states in relation to resolutions on HIV/AIDS, it also worked in favour of regime members favouring tolerant cannabis policies. All seven resolutions on cannabis adopted during the UNGASS decade were introduced by prohibitionist-oriented nations with the intention of tightening control. However, states including Portugal, Spain, Italy, Canada and the Netherlands were successful in ‘flattening’ the language and removing mention of the criminalisation of cannabis use for non-medical purposes. The goal of several resolutions, this would have significantly expanded the scope of the treaties and gone beyond the requirements of the 1988 convention which does not specifically oblige Parties to criminalise drug use.

BOLIVIA AND THE COCA LEAF: INCB HOSTILITY AND THE LIMITS OF SOFT DEFECTION

The INCB's position on both harm reduction and cannabis revealed an increasingly antagonistic attitude towards interpretations of the treaties that it regarded as, if not illegitimate, then at the very least in conflict with their spirit. However, it was the issue of coca that truly exposed the extent of the Board's willingness to defend the regime rather than seek to diffuse growing tensions within it. The coca issue also revealed the limitations of soft defection and that, while dissatisfied some aspects of the conventions, many states remained reluctant to support moves that would go beyond the process of regime weakening.

In what is now regarded by many analysts as an historical error, the coca leaf is included in schedule I of the Single Convention, alongside drugs such as heroin and cocaine. This is despite the ancient and socially-ingrained place of coca chewing and coca tea-drinking within many Andean countries. The Convention bans coca chewing but initially allowed countries a temporary exemption under article 49 to phase out the practice within twenty-five years. With the Convention coming into force in 1964, this deadline expired in 1989. The ongoing practice of coca chewing led the Board to examine the issue and suggest that states move to resolve the discrepancy in the 1990s. This occurred in light of inconsistencies between articles in the Single Convention and the 1988 Convention, regarding traditional licit uses of drugs. With scientific studies on the health implications of coca chewing disappearing without trace within the UN system in the late 1990s, the Board's position began to alter. During the UNGASS decade it became reluctant to highlight the tensions surrounding coca or to encourage the CND and WHO to resolve the matter. Instead, the Board became increasingly critical of coca policy in a number of Andean states, escalating its condemnation of both traditional uses as well as of the industrialisation of coca products.

Within this context, the INCB expressed particular concern over Bolivia's desire to remove the confusion over the legitimacy of ongoing domestic coca chewing and adjust coca-related provisions within the Single Convention. For the officials in La Paz, an amendment

of article 49 to remove references to the transitional period was a serious but necessary step. Unlike other states that on other occasions had been able to reduce various costs associated with regime membership via soft defection, article 49 of the Convention provides no wiggle room where coca chewing is concerned. Bolivia's unprecedented move consequently differed to the soft defections over harm reduction and cannabis since it would have gone beyond regime weakening and represented a change, albeit ostensibly relatively minor, of the regime itself. Bolivian coca policies and laws had been under review since the 2005 election of President Evo Morales, a former coca farmers' leader and himself a coca chewer. Morales raised the profile of the issue, resulting in the unusual appearance of a head of state at the CND on a number of occasions. The INCB quickly adopted a combative and oppositional stance within its annual report and through statements by its President. Despite pressure from the Board, which was further bolstered by opposition from the US, Morales himself used the platform of the HLS to formally announce that Bolivia would begin the necessary legal steps to end the prohibition of traditional uses of coca. He did so despite Bolivia's inclusion on the list of states to be considered for de-certification in 2008. After many twists and turns, this was to lead to the most significant challenge to the UN drug control regime since its inception in 1961.

CONCLUSION

How then do we sum up the UNGASS decade? It was certainly a period of regime transformation. But rather than a widespread and anterior challenge to the treaty system, this took on the form of a subtle change within the regime whereby a growing number of Parties deviated from the prohibitive norm at its core. In terms of national interest, most states were reluctant to expend political capital and thus incur the various costs associated with working towards a more substantive change of the regime. The resultant process of regime weakening played out in a number of ways at the Commission. Some states were willing to work for the legitimisation of harm reduction via inclusion of the principle, if not the term, in CND resolutions and ultimately fight for addition of the phrase itself to the official record through the Interpretative Statement at the HLS. Conversely, some of the same states kept a low profile for domestic cannabis policies, but fought to ensure their policy space was defended from prohibition-oriented states and some parts of the UN drug control apparatus – particularly the increasingly belligerent INCB.

The closing years of decade, however, also demonstrated that not all states were able to pursue revised national interests through a process of soft defection. For its own very specific set of reasons, Bolivia became the first Party to move for an amendment of any of the treaties and initiate a formal change of the regime. This triggered a hostile response from a range of countries. Indeed, beyond the very public rebukes from the Board, concerted opposition in 2010-11 from a US led 'Group of Friends' of the conventions, including some from the IS-26, blocked attempts to amend the Single Convention. This left Bolivia with no other option than to withdraw from the treaty and to re-accede, with a reservation on coca – an unprecedented process that remains ongoing. It also revealed that, having achieved their aims in relation to harm reduction, many states from the IS-26 had no interest in further rocking the boat for an issue with no obvious benefit to them – a decision no doubt influenced to some extent by Washington's stance on the issue.

That said, more recent events in Latin America suggest that Bolivia may not be alone in moving beyond the practice of soft defection that characterised the UNGASS decade. Escalating levels of drug-related violence within the region has resulted in a reassessment of current policies at the highest levels. This has involved a commitment to discuss all options, including regulated markets. More specifically, in June 2012 President José Mujica of Uruguay announced his intention to establish a government monopoly to control cannabis for recreational use, a policy option that is forbidden under the current treaty framework. Perhaps, then, we are witnessing the beginnings of a more direct challenge to the regime and a point of debate that will become increasingly prominent within the CND in the years leading to the next high-level review of 2019. ■

➤ Reflections on Human Rights and International Drug Control

Damon Barrett

Less than a year after the September 11th 2001 attacks, the Committee of Ministers of the Council of Europe adopted guidelines on human rights and the fight against terrorism. The issue had already been under United Nations (UN) consideration, and by 2005 a Special Procedure had been put in place, with a recurring focus on human rights and terrorism at the UN Human Rights Council. In 2011, a set of guiding principles on business and human rights were submitted to the Council by John Ruggie, the Special Rapporteur on the issue. Over time, various thematic debates, declarations and guidelines have developed on issues such as indigenous peoples, children, women, climate change, poverty and HIV, among many others. However one might view their relative quality and impact, the application of human rights to these issues is appropriate. Furthermore, the recognition at the international level of the human rights risks associated with areas like business enterprise or counter-terrorism is essential.

However, a century after the genesis of a worldwide fight against drug addiction and illicit trafficking, no such thematic guidelines or mechanisms exist today. Human rights in international drug control have instead traditionally been absent, and are viewed as a nuisance by many governments and UN agencies. At the same time widespread – and, in some cases, systematic – human rights abuses in its pursuit have been well documented.¹ Human rights abuses related to drug control are not merely a matter for individual nation states. Instead, the international control system itself, by its aims and current operation, makes such abuses more likely. In particular, the system consciously avoids addressing important but controversial issues in order to preserve the appearance of international consensus. As such, it is appropriate to categorise human rights abuses related to drug control as systemic at the international level. Even as national efforts to end abuses and ensure accountability must be ramped up, there must also be a simultaneous and urgent effort to address the institutional weaknesses and normative gaps in the international drug control regime itself.

INDICATORS OF RISK AND SYSTEMIC ABUSE

The 1961 Single Convention describes drugs as a ‘danger of incalculable gravity’ and an ‘evil’ that the international community has a ‘duty to combat.’² However, despite this moralistic underpinning, human rights abuses resulting from drug law enforcement are now widely documented. Consider the following four cases.

¹ For an overview see *Count the Costs: 50 Years of the War on Drugs*, ‘Undermining Human Rights,’ <http://www.countthecosts.org/seven-costs/undermining-human-rights>.

² ‘Preamble,’ *Single Convention on Narcotic Drugs*, 1961.

'Javier', an eleven year old boy from Guaviare in Colombia, describes his experiences of the aerial fumigation of illicit coca plantations:

My family farmed coca and food crops... Where we're from, the people don't get any help... People even die of starvation out there. And that's why they grow coca. It's the only way to earn a living... The planes often sprayed our community. People would get very sad when they saw the fumigation planes. You see the planes coming – four or five of them – from far away with a black cloud of spray behind them. They say they are trying to kill the coca, but they kill everything... The fumigation planes sprayed our coca and food crops. All of our crops died. Sometimes even farm animals died as well. After the fumigation, we'd go days without eating. Once the fumigation spray hit my little brother and me... I got sick and had to be taken to the hospital. I got a terrible rash that itched a lot and burned in the sun... Two years ago, after the last round of fumigation, we couldn't take it anymore and we were forced to flee. The farm was abandoned. My parents separated and they put me into an orphanage run by a Catholic priest. I miss my family terribly. When I said goodbye to my mom and dad, I couldn't stop crying.³

In June 2012 a 23 year-old woman, Tran Ha Duy, was sentenced to death in Vietnam for carrying four kilos of methamphetamine into the country from Qatar. She and her 21 year-old sister, who received twenty years imprisonment, had been involved with foreign traffickers as couriers in order to earn money they said they required for 'their daily needs'. According to prosecutors, this was about \$500 - \$1000 per trip. Duy had originally been sentenced to life in prison for what she had done, but the Vietnamese Government successfully appealed and she was sentenced to death.⁴

Mario was 21 when he was arrested in Jakarta for purchasing a small amount of shabu (amphetamine). On July 13, 2009, he was found guilty of possession and sentenced to one year and four months imprisonment and given a fine of IDR 2 million (about \$220). The fine was too large for his family, who had been surviving by collecting scrap plastic and on Mario's now nonexistent income as a motorcycle taxi driver. Due to his inability to pay, Mario's sentence was increased to eighteen months. The family's tiny income was subsequently spent on visits to see him, as well as on constant bribes to access the prison, and to keep Mario healthy within his heavily overcrowded confines.⁵

A 13 year-old schoolgirl in the US, Savana Redding, was strip-searched following a tip from another student that she had ibuprofen on her person. Two female school officials searched her, enforcing the school's anti-drug policies. '[T]hey asked me to pull out my bra and move it from side to side', Savana said. 'They made me open my legs and pull out my underwear.' No drugs were found.⁶

Why recount these particular cases? After all, one could mention the tens of thousands displaced by aerial fumigation in Colombia; the thousands executed for drug offences; the hundreds of thousands in abusive drug detention centres; the millions incarcerated for minor drug offences; the millions living with HIV and millions more denied access to prevention and treatment services; or the tens of thousands killed in drug related violence. Yet these real stories accomplish two main goals. First, they provide a human face for the statistics. Second they highlight an inherent contradiction in current drug control efforts. All represent examples of 'successful' control efforts – crops eradicated; traffickers and buyers punished; and school searches to identify students who may be using drugs. Yet, all also represent clear indicators of human rights risk.

³ Quote in: Jess Hunter-Bowman, 'Real life on the frontlines of Colombia's drug war' in *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People*, ed. Damon Barrett (IDEbate Press, 2011), <http://www.childrenofthedrugwar.org/>.

⁴ Le Quang, 'Vietnamese student given death penalty for drug smuggling,' *ThanhNien News*, June 20th, 2012, <http://www.thanhniennews.com/index/pages/20120620-vietnamese-students-sentenced-to-death-for-drug-smuggling.aspx>.

⁵ Asmin Fransiska, Ricky Gunawan and Ajeng Larasati 'Between Diego and Mario: Children of the drug war in Indonesia' in Damon Barrett (ed.), *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People*, (IDEbate Press, 2011), <http://www.childrenofthedrugwar.org/>.

⁶ Adam Liptak, 'Strip-Search of Girl Tests Limit of School Policy,' *New York Times*, 23 March 2009, http://www.nytimes.com/2009/03/24/us/24savana.html?_r=0.

Health; prosecution; extradition; policing; restrictions and bans on certain cultural, religious and indigenous practices; and the eradication of crops. Each case reflects some aspect of international obligations under the UN drug conventions. These require states to adopt a predominantly enforcement-led response to health and development problems. States parties to the 1961 and 1988 Conventions have to eradicate illicit crops like those grown by Javier's family. States parties have to arrest and prosecute traffickers or couriers like Tran Ha Duy. They are expected to criminalise buyers like Mario, and they are expected to work to prevent drug use among young people like Savana Redding.

Meanwhile, the institutions of the UN drug control system are heavily dysfunctional and fail to expose inherent problems with international efforts. Instead, they expend enormous effort on achieving and maintaining consensus – an unwritten 'spirit of Vienna' precludes the UN Commission on Narcotic Drugs (CND) from voting on anything but whether new substances are brought under international control – and protecting the 'integrity' of the drug control regime itself. Both aspects prevent open and honest debate about problems at international or national levels. In this context, it is worth revisiting an analysis by the UN Office on Drugs and Crime (UNODC) from 2008.⁷ It identified a number of 'unintended negative consequences' of drug control, including:

- **The creation of the criminal market for drugs**

The criminal market for drugs has reached substantial macro-economic proportions. This is the by-product of a supply-focused international system that incentivises illicit production and traffic through inflated criminal market prices. With this comes corruption, destabilisation and violence. These criminal market externalities, coupled with State efforts to repress them, generate large-scale human rights abuses.

- **Policy displacement from health to law enforcement**

Policy displacement from health to law enforcement is a consequence of the creation of a criminal market and subsequent attempts to repress it. As a result, less money and less political attention is spent on public health, while more is spent on responding to trafficking, violence and crime – an ironic departure from the stated aim of the Single Convention to promote the 'health and welfare of mankind.'⁸

- **Geographic displacement (the balloon effect)**

Geographic displacement is an inevitable consequence of supply reduction efforts. As production in one place is diminished, it appears elsewhere in order to meet the same demand. This 'balloon effect' then serves to displace the crime, violence and destabilisation to new geographic areas and communities. This then serves to justify a further expansion of law enforcement efforts and budgets.

- **The stigmatisation and marginalisation of people who use drugs**

Finally, the UNODC notes that people who use drugs have been pushed to the margins of society and tainted with a moral stigma. In one of his final reports to the Human Rights Council, Manfred Nowak, then Special Rapporteur on Torture, noted the various 'exceptional circumstances' or 'unique situations' used by government officials to explain acts amounting to torture and cruel, inhuman and degrading treatment. Among them was the threat posed by drugs.⁹ Faced with such perceived threats, history shows us that human rights abuses are more likely, particularly against stigmatised or marginalised groups. People who use drugs have been marginalised and stigmatised through laws and

⁷ 'Making Drug Control 'Fit for Purpose': Building on the UNGASS Decade,' UN Doc No E/CN.7/2008/CRP.17, 7/3/2008.

⁸ 'Preamble,' Single Convention, 1961.

⁹ UN Doc No A/HRC/13/39/Add.5, para 44.

policies, but also through their social association with the drug threat. Other communities have also been marginalised by drug control efforts. Farming communities in producer nations, for example, and ethnic minorities in consumer nations, have both suffered heavily under the various drug wars.

What has been created is an international system of human rights risk. So long as human rights abuses are carried out in pursuit of drug control or human rights situations deteriorate because of the regime, and so long as such problems are camouflaged by the desire for consensus and to protect the integrity of that regime, these abuses and human rights concerns are appropriately categorised as systemic at the international level.

ADDRESSING INSTITUTIONAL AND NORMATIVE WEAKNESSES IN THE DRUG CONTROL REGIME

The General Assembly continually reasserts in its annual omnibus resolution that 'countering the world's drug problem' must be carried out in full conformity with the UN Charter and fundamental human rights norms.¹⁰ The question, then, is what does this require of specific branches of the international system?

The UN drug conventions

These must not be read in a vacuum from international human rights law. While there is nothing about the treaties themselves that requires abusive measures, their many articles do closely relate to various human rights concerns, and there is nothing within them to temper excesses. Instead, each treaty allows States parties to adopt 'more strict or severe measures' than those explicitly codified. Indeed, the official commentary to the Single Convention includes the death penalty as an example of a possible 'severe' approach.¹¹ This may have been the case, legally speaking, when it was originally written in the 1960s, but it is now well out of date. Two specific steps could be taken to rectify this incongruence:

First, a full review of the terms of the drug conventions should be undertaken with the aim of incorporating and applying over fifty years of human rights jurisprudence. To be clear: this is not about amending the conventions. Instead, it is about clarifying their interpretation and application given today's international legal landscape. Consider two of the above examples:

In the Savana Redding case the Juvenile Law Center argued that strip-searching the 13 year-old girl violated international norms of dignity and respect. Further, the majority of the US Supreme Court found that searching Savana violated her rights under the Fourth Amendment of the US Constitution.¹² A child rights analysis under the Convention on the Rights of the Child (CRC) would likely yield a similar finding. But while this case was fairly clear, what about the many other issues relating to children and young people, such as the widespread use of random school drug testing?¹³ These questions remain unclear.

Javier's case is also instructive. Article 14(2) of the 1988 Convention Against Illicit Traffic contains the only explicit mention of human rights in the UN drug conventions, and it relates to crop eradication. So what would an eradication programme that respects human rights look like? What, for example, is the role for free prior and informed consent of indigenous peoples in the Andean region?¹⁴ Again these questions remain

¹⁰ See, for example, GA Res 63/197, March 6th 2009, para 1; GA Res 64/192, March 30th 2010, para 2.

¹¹ Commentary on the Single Convention on Narcotic Drugs, 1961, pp. 449–450, para 2.

¹² Supreme Court of the United States, Stafford Unified School District#1, et al., *Petitioners v. April Redding*, Respondent (2009) 557 US. No.08-479.

¹³ See Adam Fletcher, 'Random School Drug Testing: A case study in doing more harm than good' in Damon Barrett (ed.), *Children of the Drug War: Perspectives on the Impact of Drug Policies on Young People*, (IDEbate Press, 2011).

¹⁴ See Damon Barrett, 'Bolivia's concurrent drug control and other international legal commitments' International Centre on Human Rights and Drug Policy, 1/7/2011, <http://www.druglawreform.info/en/issues/unscheduling-the-coca-leaf/item/2604-bolivia-s-concurrent-drug-control-and-other-international-legal-commitments>.

unanswered – although it should be noted that the phrase ‘appropriate measures’ is used in article 14(2) and mirrored in article 33 of the CRC(itself relating to drugs).¹⁵ What these cases suggest is that there is a clear need to develop normative guidance on what are appropriate drug control measures in terms of human rights.

As a result, the second step to be taken in order to eliminate regime incongruence should be the creation of a set of basic normative guidelines on human rights and drug control. These should set the baseline for determining what measures may be deemed appropriate in pursuit of States parties’ obligations under the drug conventions. It should also form the basis of an annual debate at the UN CND.

The International Narcotics Control Board (INCB)

Joanne Csete’s paper deals with the INCB in detail, and I associate myself fully with her views. For now it is sufficient for me to note that, as the quasi-judicial monitoring mechanism for the drug conventions, it is incumbent on the Board to properly apply human rights law to its deliberations and advice to states. The above review should facilitate this, though it requires institutional will from the Board – given that it is an independent mechanism. The fact that this will is lacking (along with an acceptable understanding of international law) was evident in 2012 when the INCB President refused even to condemn torture (or ‘any atrocity’) in the name of drug control, citing a lack of mandate within the drug conventions.¹⁶

The Commission on Narcotic Drugs (CND)

The CND’s first session was in 1946, but it was not until 2008 that it finally adopted a resolution on human rights. Yet this resolution avoided specifics and merely asked the UN Office on Drugs and Crime to incorporate human rights into its work. Further, during the drafting process it was heavily watered-down, conspicuously removing any reference to the newly adopted indigenous people’s declaration; the moratorium on the death penalty; and the Human Rights Council, or its Special procedures. During the debates (of which I was a part as a civil society member of the UK delegation) China claimed that it was ‘ridiculous’ to require the CND to operate in line with human rights law, while Japan challenged whether the Universal Declaration was part of international law at all.

Since then, human rights safeguards have become easier to insert, as much as a result of the change of administration in the US as with the development of ‘agreed language.’ Under the George W. Bush administration, reference to human rights would routinely be blocked by the US delegation. This no longer happens to such an extent, resulting in more rights language being agreed upon. One reason why a state like the US can exert such influence (above that afforded by its traditional superpower role at the UN) is the fact that the CND almost never votes.¹⁷ This in effect affords each state a veto if it wishes to dig in its heels on an issue. To prevent this, most resolutions are watered down to the lowest common denominator – with some killed off outright. What this ‘spirit of Vienna’ generates is an ongoing appearance of international consensus when there are, in fact, clear and growing tensions.¹⁸

This appearance is further bolstered by poor civil society engagement at the CND. While it has improved somewhat over recent years, it still remains poor, especially when compared with other UN forums. In 2011 a resolution was brought forward on improving civil society participation in line with ECOSOC resolution 1993/31 (which sets out the relevant procedures). Initially, it was vigorously opposed by China and later by

¹⁵ Damon Barrett and Philip Veerman, *A Commentary on the UN Convention on the Rights of the Child: Article 33, Protection from Narcotic Drugs and Psychotropic Substances* (Leiden: Brill/Martinus Nijhoff, 2012).

¹⁶ For a transcript and audio recording see <http://www.ihra.net/contents/1196>.

¹⁷ Except to decide on whether to include a new substance under international control.

¹⁸ See David Bewley-Taylor, *International drug control: Consensus Fractured* (Cambridge University Press, 2012).

Germany, after it had been watered down so as to be – in the German view – retrograde. It was eventually approved, although much changed from its original form. In the 2012 session, the first official civil society hearing was held. Nevertheless, matters worsened when NGOs were censored in their attempts to criticise both the Executive Director of UNODC (for his lack of leadership on HIV), and the INCB (for the quality of its legal reasoning).¹⁹ It is clear that processes for meaningful civil society participation must be put in place. However, it is also clear that some national delegations would prefer to curtail civil society engagement with the system.

These reforms have been suggested many times before, as has a new Special Procedure on human rights and drug control.²⁰ But given the already stretched workload of the Human Rights Council, the CND may be a more appropriate forum for this issue. Just as Special Procedures were developed by the former Commission on Human Rights, there is nothing procedurally barring the CND (also a Functional Commission) from instituting its own mechanism. It could also submit an annual report to the Human Rights Council's March session, which would coincide with the annual CND session in the same month. Its mandate could, in turn, be based on the basic guidelines suggested above and form part of an annual thematic segment on human rights. This would demand that human rights issues are brought to the fore at the CND. As straightforward as this may sound, however, there is clear opposition to instituting this mechanism in Vienna. Some delegations simply retain the view that human rights are 'Geneva business.'

DONORS AND THE UN OFFICE ON DRUGS AND CRIME

Currently, human rights criteria rarely influence international funding decisions or programming around drug enforcement, even at the UN. Take the case of Tran Ha Duy, set out above. For years European donors, the US and the UN have been providing Vietnam with money and technical assistance to increase its capacity to catch traffickers and couriers like Tran Ha Duy and her sister. The vast majority of couriers caught are sentenced to death, despite the fact that they are essentially low-level players in the illicit trade. But Vietnam is not unique. Governments have also provided Iran with millions of dollars for drug enforcement, often through UNODC, even as Iran's execution rates have skyrocketed with over one thousand executions in the last two years. Frequently, these executions are carried out without basic due process. On its website, UNODC notes its success in helping catch 61 traffickers in Iran. Harm Reduction International requested information on the whereabouts and sentences of those arrested. To date, UNODC has not responded. Consequently, Human Rights Watch and Harm Reduction International recently called for drug enforcement aid to Iran to be frozen.²¹

Border liaison offices (BLOs) have been built with international funding and UN assistance along Chinese borders to improve interdiction capacity. The Government of Burma recently announced at a UN sponsored meeting that it had extradited 128 people to China via these projects. All may face the death penalty. When asked as to the whereabouts of those it had helped to extradite, the UNODC said that it did not have that information.²² What the Chinese and Iranian cases indicate, therefore, is an absence of systematic human rights safeguards and monitoring of international funding and assistance – including at the UN itself. This represents a basic lack of accountability. Furthermore, these normative, institutional and legal gaps at the international level then feed through into programmes, funding and operational outcomes on various drug control projects worldwide.

19 For an overview see <http://www.drugfoundation.org.nz/content/no-way-behave>.

20 For example, Tom Obokata 'Illicit cycle of narcotic from a human rights perspective', *Netherlands Quarterly of Human Rights* 25 (2007): 159-187.

21 'Iran: Donors Should Reassess Anti-Drug Funding,' Human Rights Watch, 21/8/2012, <http://www.hrw.org/news/2012/08/21/iran-donors-should-reassess-anti-drug-funding>.

22 Damon Barrett, Patrick Gallahue and Roxanne Saucier, *Partners in Crime: International Findings for Drug Control and Gross Violations of Human Rights* (Harm Reduction International, 2012).

In 2011 UNODC developed internal human rights guidelines, largely in response to the above concerns.²³ These are quite far reaching, but much now hinges on how they are implemented. For example, how can UNODC continue to work with Iran on drug enforcement when executions continue at such a pace? More broadly, however, the following steps are required. First, all donors and implementation agencies should support the development of human rights and drug control guidelines as described above. Second, they should audit current project and funding for compliance with those guidelines and, they should take action on gaps and concerns raised. Finally, they should implement a transparent system of human rights impact assessments for future projects.²⁴

CONCLUSION

In her judgment on the Savana Redding case for the Ninth Circuit Court of Appeals, Judge Kim McLane Wardlaw wrote that:

It does not require a constitutional scholar to conclude that a nude search of a 13-year-old child is an invasion of constitutional rights of some magnitude. More than that it is a violation of any known principle of human dignity.

A similar rebuke could be made of a wide array of the practices conducted in the pursuit of international drug control. This article has presented a snapshot of the range of human rights issues involved, the scale of the problem, and the institutional weaknesses in the international regime. The regime, in its current form, is not only out-dated, but by its very aims and operation exacerbates the risk of human rights abuses. Its current institutional set-up further prevents abuses from being properly addressed, and instead works to hinder open and critical debate. I have suggested some avenues for addressing this situation from the top down. But real change in this sector should also come from the bottom up. When effective activism and advocacy to address abuses on the ground can be reinforced by the kind of normative and institutional reforms described, we may perhaps then begin to craft a system in which human rights issues are taken seriously. ■

²³ UNODC Guidance Note, *UNODC and the Promotion and Protection of Human Rights*, (Vienna: 2012), http://www.unodc.org/documents/justice-and-prison-reform/HR_paper_UNODC.pdf.

²⁴ Harm Reduction International has developed a model tool which can be adapted to suit the needs of the relevant donor or agency.

➤ Overhauling Oversight: Human Rights at the INCB

Joanne Csete

Reform of the UN drug conventions, however desirable it may be, is probably not imminent. Governments are likely to have to live with the conventions as they are for some time. As with any legislation, the conventions come to life in the way they are interpreted and implemented. As other papers in this report have shown, there is room for varied interpretations of fundamental provisions of the drug conventions.¹

The global arbiter of interpretation and implementation of the conventions is the International Narcotics Control Board (INCB). The INCB was established by the 1961 Single Convention with the mandate ‘to limit the cultivation, production manufacture and use of drugs to an adequate amount required for medical and scientific purposes, to ensure their availability for such purposes, and to prevent illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs.’² The INCB characterises itself as a ‘quasi-judicial’ body – a word not used in the conventions – and highlights its independence as well as that of its members.³

The drug policy reform movement in the world today does not always speak with one voice, but there is a strong consensus among many of its proponents that a goal of reform is drug policy better grounded in human rights norms as well as in the science and ethics of public health. These principles emerge from a large body of evidence suggesting that people who use drugs in many countries face systematic human rights abuse, including police abuse, and that states frequently do not give adequate priority to ensuring health services for people who use drugs. In his paper in this report, Damon Barrett makes the case that the drug conventions cannot be regarded as isolated from other international law, including human rights law. Similarly, the conventions cannot be seen to be divorced from accepted norms of public health and medical ethics. They are concerned with what is, after all, an important and neglected public health issue. The health concerns of the conventions are explicit in that they commit states to providing services to ensure ‘the early identification, treatment, education, after-care, rehabilitation and social reintegration of persons with drug dependence, as well as services designed to prevent illicit drug use.’⁴

This paper explores two key questions: (1) If the INCB were doing its job with an eye toward ensuring that drug control efforts are grounded in – or at least do not undermine – human rights and public health, what might be some features of its work that are not now present? (2) What would it take to achieve such a change?

1 For example, see William McAllister’s contribution to this report.

2 Single Convention on Narcotic Drugs, 1961, Art. 9.4 and Art. 12.5

3 See www.incb.org

4 For example, Single Convention, 1961, Art. 38

RIGHTS AND HEALTH WITH A FOCUS ON TREATMENT FOR DRUG DEPENDENCE

As noted above, the centre of the INCB's mandate is ensuring that adequate quantities of controlled substances are available for 'scientific and medical uses'. Among the most important of these uses is treatment of drug dependence itself, notably the use of opium-derived substances such as methadone and buprenorphine to treat opiate addiction. Given its treaty-mandated status, the INCB should be the world's most important promoter and protector of this use of controlled opioids. Unfortunately, this is far from the reality.

The World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the UN Office on Drugs and Crime (UNODC) have clearly stated that so-called substitution or maintenance therapy with methadone or buprenorphine (sometimes also called medication-assisted therapy or MAT) is well supported by decades of research.⁵ MAT is an essential element of HIV control because the medicines in question are delivered orally, thus enabling patients to avoid the harms of injection. MAT helps to stabilise people's lives, reduce crime, and enable patients to adhere to other therapies including HIV treatment. The UN position paper emphasises that continuous administration of MAT over an indefinite period is clinically indicated for some patients, and that 'weaning' MAT patients off these medicines just for the sake of abstinence is unsound.

The INCB seems to disregard these internationally accepted norms. In its annual reports, which represent virtually the only public record of its work, the Board has often sounded the alarm over fast-growing HIV epidemics linked to drug use, but has generally refused to recognise MAT as an important HIV prevention tool, as the technical UN bodies have done. Its most recent annual report, released in March 2012, for example, includes this observation:

With regard to the existing methadone substitution programmes that are being conducted in Mauritius, the Board invites the Government to increase the provision of psychosocial support and to find ways of guiding drug abusers towards reducing their drug intake so that they may eventually stop abusing drugs.⁶

The characterisation of methadone treatment as 'abusing drugs' undermines this essential therapy in a way that is exactly contrary to the mandate of the INCB.

The INCB regularly states its concern that methadone and buprenorphine (another opioid used to treat drug dependence) are likely to be diverted to illicit markets. However, it largely ignores the many examples of countries that have reliable systems of security and control for these essential medicines. Based on its annual reports and technical reports, the INCB has done nothing to urge Russia, which bans methadone, to lift that ban, or to urge countries with very limited availability to methadone therapy to expand it. INCB members, who serve as experts in their personal capacities, have in recent years included persons who have denounced methadone maintenance therapy as little better than heroin addiction or have suggested that only non-medication-assisted therapies are acceptable under the drug conventions. These views are in direct conflict both with the unanimous Declaration of Commitment on HIV/AIDS of the UN General Assembly in 2001 and with position papers of WHO, UNAIDS and UNODC recommending opiate maintenance therapy as a central element of HIV prevention.

⁵ World Health Organization, UN Office on Drugs and Crime, and Joint UN Programme on HIV/AIDS. WHO/UNODC/UNAIDS position paper, *Substitution Maintenance Therapy in the Management of Opioid Dependence and HIV/AIDS Prevention*, (Geneva: United Nations, 2004), http://whqlibdoc.who.int/unids/2004/9241591153_eng.pdf.

⁶ International Narcotics Control Board, *Annual report of the International Narcotics Control Board for 2011*, (Vienna: 2012), paragraph 106, At: <http://www.incb.org/incb/en/annual-report-2011.html>.

More recently, the INCB refused to join UNODC, WHO, UNAIDS and many other UN bodies in denouncing compulsory drug ‘treatment’ facilities that exist in a number of countries.⁷ The INCB chairman, Dr Hamid Ghodse, said at the 2012 session of the Commission on Narcotic Drugs that the INCB could not denounce such practices because it was not mandated to make such pronouncements by the terms of the drug conventions and rather had to maintain a rigorous neutrality in such matters. Ghodse also asserted that human rights is not the concern of the INCB or of the drug conventions. In the case of compulsory ‘treatment’ centres, the INCB in its report for the year 2011 effectively endorsed such centres when it encouraged the government of Vietnam – which runs one of the biggest networks of ‘treatment’ detention centres in the world – to reinforce its existing drug-control institutions.⁸

Even apart from abusive practices in treatment of drug dependence, it would be helpful if the INCB would prioritise in its work countries where health services for people who use drugs are compromised because of moral judgments and stigma they face as well as misunderstanding of the nature of drug dependence. Drug dependence affects many millions of people in the world but, compared to other health concerns, treatment to address it is particularly inaccessible to those who need it,⁹ good-quality services are rarely a national priority, and the WHO and UNODC have only recently tried to suggest minimum standards for its provision. In many countries good-quality treatment for drug addiction is completely unaffordable for those who need it. Though people who inject drugs are rightly regarded as a high-risk group for HIV, in many countries they are systematically excluded from treatment for HIV. This is in spite of evidence that they adhere to HIV treatment regimens as well as other patients do.

If the INCB were doing the job of overseeing adherence to the drug conventions in their fullness, these concerns would have high priority. Instead, the Board’s concern for treating drug dependence, and other health services for people who use drugs, seems consistently overshadowed by a scientifically unjustified bias in favour of abstinence at all costs and by support for harsh policing.

RIGHTS AND LAW ENFORCEMENT

Law enforcement practices have an enormous influence on the ability of people who use drugs to be safe and healthy and to have access to health and social services. People who use drugs are easy prey for police who need to fill arrest quotas. Police in many settings are known to target drug treatment facilities and needle exchange services to fill quotas, thus discouraging people from seeking those services. Once people who live with drug dependence are in custody, police can easily use their addiction as an instrument of coercion. Police crackdowns may lead people to inject in hidden locations where they are far from services should they experience overdose or vascular injury, and paraphernalia laws may force them to hide and share needles unsafely. In many places, seeking health services may force people who use drugs to be registered with the police even if they are otherwise not charged with a crime. The undermining influence of all of these factors on health and rights of people who use drugs has been documented in many countries in all regions of the world.

If the INCB saw its mandate in a way that included health and human rights on a par – or even anywhere on the radar screen – with law enforcement, it could be a very important voice for encouraging police and judicial practices that would protect people’s right to health services and to conditions in which they can protect themselves from deadly illness. Instead, the Board has a long history of praising countries for repressive practices that undermine access to health services and violate people’s rights.

7 UNAIDS, World Health Organization, UNICEF et al. (2012), *Joint Statement: Compulsory Drug Detention and Rehabilitation Centres*, http://www.who.int/hiv/mediacentre/joint_statement_20120308.pdf.

8 *Ibid.*, paragraph 117.

9 Philip S. Wang et al., (2007), ‘Use of Mental Health Services for Anxiety, Mood and Substance Disorders in 17 Countries in the WHO World Mental Health Surveys,’ *Lancet* (370): 841-850.

An extreme example was the INCB's reaction to a major drug crackdown in Thailand in 2003. During this more than 2500 persons were gunned down by the state, execution-style, in the name of the 'war on drugs' even though many were later found to have little to do with drugs or to be very minor offenders. Visiting the country a few months later, the INCB noted that the action had decreased amphetamine use in the country, not commenting on the horrific cost of this result. It congratulated the government for investigating the killings at a time when civil society organisations around the world as well as some UN officials protested that the government was blocking all independent investigations.¹⁰ In 2005, when the European Commission and many human rights organisations were criticising Bulgaria for passing one of the world's most draconian drug laws by which even minor offenses could draw prison sentences of over 10 years, the INCB congratulated the country on its political commitment to addressing drug abuse.

The INCB seems to have no trouble accepting governments' justifications of repressive policing as necessary to ensure the greater collective good of public security. But the 'quasi-judicial' INCB cannot be above international law on this point. The international human rights regime recognises that there are times when the rights of individuals must be limited for the sake of public security, but the UN has established standards for judging whether countries abuse the 'public security' or 'public emergency' defence. Those standards, known as the Siracusa principles,¹¹ set out minimum conditions that states should observe when they abrogate human rights in the name of security or for emergency purposes. These principles assert that limitations of human rights in emergencies must, among other things:

- Respond to a pressing public or social need, i.e. a legitimate emergency;
- Be pursued within the limits of an emergency that is publicly declared;
- Pursue a legitimate aim and be proportionate to that aim;
- Not be arbitrary or unreasonable;
- Be consistent with national law;
- Constitute the least restrictive means possible for achieving the purpose of the limitation;
- Include complaint mechanisms and adequate remedies for those whose rights are violated; and
- Not interfere with the democratic functioning of society.

The principles include this caution:

National security may be invoked to justify measures limiting certain rights only when they are taken to protect the existence of the national or its territorial integrity or political independence against force or threat of force... The systematic violation of human rights undermines true national security and may jeopardise international peace and security. A state responsible for such violation shall not invoke national security as a justification for measures aimed at suppressing opposition to such violation or at perpetrating repressive practices against its population.¹²

One may question whether drug control should ever constitute an emergency of the kind envisioned by the Siracusa principles. But even if it does, it is incumbent on the body that oversees state practice of drug control to call upon internationally agreed standards to rein in the most abusive practices.

The INCB's unconstrained praise of repressive practices only fuels the strong temptation that countries face to use 'drug war' approaches to justify measures that may be disproportionately harsh. There is also ample evidence from many countries to suggest that drug control measures are sometimes applied in a discriminatory

¹⁰ Joanne Csete and Daniel Wolfe, *Closed to reason: the International Narcotics Control Board and HIV/AIDS* (Toronto: Canadian HIV/AIDS Legal Network/Open Society Institute, 2007), <http://www.aidslaw.ca/publications/publicationsdocEN.php?ref=672>

¹¹ Economic and Social Council of the United Nations (ECOSOC), 1984, *Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights*, UN Doc No E/CN.4/1984/4.

¹² *Ibid.*, paragraphs 29, 32.

way against racial or ethnic minority populations. This phenomenon is extensively documented in the United States with respect to drug arrests and incarceration of people of African and Hispanic origin. In many European countries, people of African, Caribbean, Asian and Roma origin are over-represented among persons searched, arrested and incarcerated for drug offenses. Countries may hide behind popular drug wars in pursuing racist measures that would not be as politically acceptable. Even if the measures taken in these cases are seen by society and political leaders to respond to a public emergency, the discrimination inherent in these measures raises questions about their appropriateness. The INCB does not have a record of concerning itself with these violations of basic rights.

PARTICIPATION OF CIVIL SOCIETY

In recent decades the United Nations has opened its procedures significantly to civil society participation. Virtually all major United Nations events and summits accommodate NGO forums of various kinds, and many invite NGO participation in the form of speaking slots to accredited delegates, permission to distribute publications, and space for NGO networking. The Joint United Nations Programme on HIV/AIDS (UNAIDS) includes civil society representatives on its governing body, though not as voting members. Even the UN Security Council, historically one of the UN's most secretive bodies, has opened up its proceedings. There is an officially established NGO Working Group that relates to the Security Council and is involved in regular meetings and briefings often through the vehicle of the rotating Council president.¹³

UNAIDS and its predecessor the WHO Global Programme on AIDS have been leaders in emphasising the importance of meaningful participation of people affected by HIV in UN processes concerning the epidemic. While practices are not always perfect, the principle is repeatedly articulated and explicitly includes meaningful participation of sex workers, LGBT persons, people who use drugs, and people living with HIV. UNAIDS asserts that meaningful participation of drug users, for example, in programs and policies that affect them is the only way to ensure that government responses take account of the reality of conditions in the lives of marginalised persons.

The INCB has also noted the importance of involving civil society in drug control efforts. In its 2012 report covering the year 2011, for example, it notes:

*Governments must ensure the provision of drug abuse prevention services, especially in communities experiencing social disintegration. All stakeholders – schools, community groups, parents and state and voluntary agencies – should be involved in the design and implementation of interventions aimed at achieving this goal.*¹⁴

In the same report, the Board notes that the involvement of civil society in drug control programs is crucial 'to empower the communities and promote a culture of aspiration rather than one of marginalisation.'¹⁵

In spite of such observations, the INCB remains perhaps the most closed and least transparent of any entity supported by the United Nations. There are no minutes or public reports on the deliberations of the INCB. The INCB's proceedings are closed not only to NGOs but also to member states. The country visits – on which it bases its annual reports – generally do not include meetings with civil society organisations, people who use drugs, or others affected by drug control measures. In recent years, the INCB president has met with NGOs

¹³ Security Council Report, 2007, *Security Council transparency, legitimacy and effectiveness: effort to reform Council working methods, 1993-2007*, http://www.securitycouncilreport.org/site/c.gKWLeMTIsG/b.3506555/k.DA5E/Special_Research_ReportbrSecurity_Council_Transparency_Legitimacy_and_Effectivenessbr18_October_2007_No_3.htm.

¹⁴ International Narcotics Control Board, *Annual report of the International Narcotics Control Board for 2011*, (Vienna: 2012), paragraph 50a, At: <http://www.incb.org/incb/en/annual-report-2011.html>.

¹⁵ *Ibid.*, paragraph 50d.

in one session at the annual meeting of the UN Commission on Narcotic Drugs. When questioned about the closed nature of the Board at these sessions, INCB officials have repeatedly cited security concerns and the need for confidentiality associated with sensitive drug control measures. Can it be impossible, however, for the INCB to engage with civil society if the Security Council can do so with the delicate and potentially explosive issues that it considers?

In this regard, the INCB undermines its own mission. Drug control measures, like HIV control measures, are more effective and sustainable if they are designed and implemented based on the reality of affected communities. The exclusion of civil society and of member states from its deliberations encloses the INCB in the bubble of its own reality and isolates it from voices that could help guide and improve its work. It is also completely contrary to the spirit of transparency, accountability and participation that the UN professes as a working principle.

CONCLUSIONS AND RECOMMENDATIONS

The international drug conventions' achievement of their stated goal of contributing to human health and well-being would be more likely if the conventions were implemented with attention to human rights standards and with the participation of civil society. Widely accepted human rights standards for health services and health service delivery are very pertinent to drug treatment and rehabilitation and should be built into oversight of the state adherence to the conventions. Attention to human rights standards – including the right of people who use drugs to participate meaningfully in decisions related to services meant for them and the right to mechanisms of redress when rights are violated – should be part of the obligations that states take on when they ratify the drug conventions.

There is an urgent need for the INCB as the body overseeing compliance with the conventions to take human rights seriously regarding state commitments to services for people who use drugs and the ready tendency of states to limit human rights in the name of drug control. For this to happen, a number of things must change:

- The proceedings of the INCB should be opened up to both member states and civil society organisations, as the meetings of other United Nations-supported entities are. Regular interaction with human rights organisations and member states concerned about human rights would be beneficial.
- Rules for the composition of the INCB should be amended to require that the body include reputable human rights experts among its members or that it include ex officio an expert or experts from the office of the UN High Commissioner for Human Rights. International law expertise has usually been lacking in this body of experts, though international law is at the heart of the group's mandate.
- At the very least, the INCB should make a serious effort to work into its activities the human rights guidelines recently published by UNODC.¹⁶ This guidance underscores the importance to drug control efforts of ensuring that policing and provision of health and social services to people who use drugs be conducted explicitly so as to protect and promote human rights.

It would be refreshing to read an annual report of the INCB in which the Board refrains from heaping praise on countries for repressive policies and rather encourages countries to ensure that health services for people who use drugs are humane and affordable, and drug-control strategies are rights-limiting only when there is truly no less invasive alternative. Human rights norms can help make this happen, but not if they are summarily dismissed by a body that should play a central role in espousing rights-based strategies and actions. ■

¹⁶ UN Office on Drugs and Crime, *UNODC and the promotion and protection of human rights* (Vienna, 2012), http://www.unodc.org/documents/justice-and-prison-reform/HR_paper_UNODC.pdf.



The economic and political position of Europe in the world is changing, particularly its relationships with China and the United States. The Eurozone crisis represents a strategic opportunity for Europe to rethink itself and become a more powerful united force.

The report, *Europe in an Asian Century*, explores how China looms large in Europe's recovery from the crisis and is increasingly interested in Europe's future for economic and wider strategic reasons. And as the US increasingly focuses on Asia, Europe is impelled to carve a role for itself beyond the old certainties of the transatlantic relationship. Europe therefore has a pivotal strategic opportunity to capitalise on these shifts in global power to lay claim to the same key status as China and the US. However, the UK's obstructionism will prevent Europe from achieving this.

As the world continues to experience the fallout from the 2008 financial crisis, it is increasingly turning towards China. The outsourced 'workshop of the world' has become the world's great hope for growth, and the source of the capital the West's indebted economies so desperately need. Simultaneously, and in the United States in particular, commentators and policymakers have increasingly voiced concerns that the economic clout of a communist superpower might pose a threat to the liberal world order. These contradictory impulses – China as opportunity and China as threat – demonstrate one clear truth, exhibited in the Obama administration's much-trailed 'Asian pivot': that China is important.



It is in this context that this report attempts to provide a systematic assessment of the economic bases of China's foreign policy and the challenges the country faces as it makes the transition from rising power to superpower. In doing so, it is informed by a central question, of to what extent China's remarkable growth has given rise to a geoeconomic strategy for China's future.



The events of the Arab Spring were an inevitable surprise. In a region where political oppression and economic under-development were most keenly felt among a demographic bubble of well-educated youth, the classic conditions for revolution were met. However, few could have predicted the spark that would ignite a wave of protest across the region. The final outcome of the protests across the region is still uncertain, but more than a year on, events have settled into patterns sufficiently to allow an interim assessment of their success.

This report finds little evidence to suggest that future historians will rank the events of 2011 with those of 1848, or 1989. Simply too few of the fundamentals of social, economic and political organisation in the Arab world have been successfully contested by the protests. As 2011's Spring turns into 2012's summer, the answer to the question of whether there has been a power shift in the Middle East, is a decisive 'not yet'.



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