

Drug policy reform in practice

Experiences with alternatives in Europe and the US

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Summary

This article provides an overview of European drug policy practices regarding harm reduction, decriminalization of consumption and possession, and more tolerant policies towards cannabis, particularly in The Netherlands and several states in the US. The discussion about drug policy is often hampered by polarized positions of a war on drugs versus legalization. This dichotomy obscures the fact that much experience has been gained regarding less repressive approaches, offering a broad panorama of guiding principles and lessons learned.

Introduction

In February 2009, the Latin American Commission on Drugs and Democracy, convened by former presidents Fernando Henrique Cardoso of Brazil, César Gaviria of Colombia and Ernesto Zedillo of Mexico, issued a report evaluating the impact of the “war on drugs” policies, framing recommendations for safer, more efficient, humane policies.¹ The report proposed a paradigm shift in strategy concerning the Latin American drug problem; a critical review of deficiencies in the prohibitionist strategy adopted by the United States; and an assessment of harm reduction achieved in the European Union.

The long-term solution for the drug problem is to drastically reduce demand in main consumer countries, the Commission argued. Treating drug users in a public health context and reducing drug consumption are preconditions for success in reducing production and eliminating drug trafficking networks. Each country must meet the responsibility of opening public debate regarding the seriousness of the problem and seek policies consistent with its history and culture. The new paradigm must shift from repression to methods that take into account national societies and cultures. Effective policies must be based on scientific knowledge rather than ideology. And all sectors of society--not only the government—must be engaged.

1. *Drogas y Democracia: Hacia un cambio de paradigma*, Comisión Latinoamericana sobre Drogas y Democracia, Febrero 2009. (http://www.drogasedemocracia.org/Arquivos/livro_espanhol_04.pdf)

To translate this paradigm shift into concrete action, the Commission proposed that Latin American countries adopt the following initiatives as a part of a global process reframing the policies for fighting illicit drug use:

1) **Change the status of addicts** from drug buyers in the illegal market to that of patients cared for by the public health system. Removing these “clients” and mounting informational and educational campaigns, might significantly reduce demand for illegal drugs, lowering their price, consequently undermining the economic foundations of the drug business.

2) **Evaluate from a public health standpoint** and on the basis of the most advanced medical science the efficacy of decriminalizing possession of cannabis for personal use. Most damage associated with cannabis use - from indiscriminate arrest and incarceration of individual consumers to the violence and corruption affecting society as a whole – is the result of current prohibitionist policies.

3) **Reduce consumption through information and prevention campaigns** aimed at and appropriate for young people, who account for the largest contingent of users. The profound reductions in tobacco consumption show the efficiency of information and prevention campaigns based on clear language and consistent arguments.

4) **Redirect repressive strategies** to the unrelenting fight against organized crime.

5) **Reframe the strategies repressing cultivation of illicit drugs.** Eradication efforts must be combined with the adoption of well-financed alternative development programs adapted to local realities in terms of viable products and their competitive access to markets.

The proposals are a useful starting point to reframe drug control policies in Latin America. In this paper we analyze some of the original guiding principles of the new paradigm put forward by the Transnational Institute (TNI) for the Commission² and expand on some of the experiences with alternative policy options in other parts of the world.

Guiding principles

The challenge in drug policy making is to find the optimal balance between protection of public health through certain controls, on the one hand, and negative consequences of repressive controls on the other. The objective is to achieve a global system that protects humanity’s well-being by controlling potentially harmful substances in a sufficiently flexible manner to respect socio-cultural differences between countries, while limiting repression meted out to users, farmers and small-scale drug traders. Policies can be guided by a list of principles:

1) Evidence-based. Changes should be based on a thorough evaluation of policies, instead of being based on ideological principles. There are already many studies available indicating

2. *The current state of drug policy debate: Trends in the last decade in the European Union and United Nations*, by Martin Jelsma (TNI), article submitted as support material for the First Meeting of the Latin American Commission on Drugs and Democracy, Rio de Janeiro, April 30, 2008. (<http://www.ungassondrugs.org/images/stories/currentstate-e.pdf>)

policy directions which work and those which do not work, constituting a body of knowledge that should be taken into account.

2) Differentiation. It is necessary to differentiate between substances and patterns of use. The health risks of cannabis consumption are not the same as those related to injecting heroin or smoking crack cocaine. There is also a significant distinction between natural plants and their concentrated derivatives; coca in its natural form can be beneficial for health, while the consumption of its alkaloid cocaine in concentrated form can lead to problems. Moreover, there is a substantial difference between recreational uses and more problematic patterns of drug use.

3) Harm reduction. A world without drugs will never exist. The ideology of 'zero tolerance' needs to be replaced by the principle of harm reduction, which presents a more pragmatic approach that favours policies capable of reducing drug-related harms as far as possible, for the consumer and for society in general. Conceptually, this principle needs to be expanded to the spheres of reducing drug-related violence and diminishing the fuelling impact of the existence of illicit economies on armed conflicts.

4) Flexibility. Socio-cultural differences need to be taken into account. The current system has been overly influenced by 'Northern' interests and cultural insensitivity. The norms that are established at global level should leave sufficient room for manoeuvre, enabling countries to adjust them to basic principles of national law, or to protect the rights of indigenous people to continue their traditional practices and customs.

5) Human rights and proportionality. Drug control should fully respect human rights, which means foremost that any sanctions should be in proportion to the crime. Punishing users for the mere fact of consumption, forced eradication against farmers who have no other form of income, heavy prison sentences against small traders or issuing the death penalty for drug offences, are all examples of disproportionality.

6) Development-oriented. Eradicate poverty and hunger, the number one Millennium Goal, has a clear priority. Drug control efforts should never lead to more poverty and hunger as now often happens with the opium bans and forced eradication. The creation of alternative livelihoods should come first.

7) Participation. When formulating policies on drugs, there should be full participation by all the main players: farmers, users, young people, health care practitioners, and local and international NGOs working closely with them. This is the only way to ensure that such policies will work, that they are rooted in practice and that they will have a positive influence on the often-difficult choices that people are facing.

Harm reduction

Harm reduction generally refers to policies and practices aimed to reduce adverse health, social and economic consequences of the use of psychoactive drugs (controlled drugs, alcohol, pharmaceutical drugs) the drug users, their families and the community without necessarily ending drug consumption. The last decade was characterized by major advances in harm reduction programs, particularly among injecting drug users, aimed at decreasing the spread of diseases like HIV/AIDS and hepatitis. According to UNAIDS, there are about 16

million injecting drug users, and around 3 million of them are infected with HIV. In 77 countries some level of needle and syringe exchange programs are running and about one million people in 63 countries are receiving substitution treatment with methadone or buprenorphine.³ There are projects of this type in every European nation, Canada and Australia, and in recent years they have been established on a wide scale in many countries in Asia, and numerous cities in the United States. Harm reduction programs have been gaining ground in some Latin America countries, notably Brazil, Argentina and Uruguay.

In 2003 the European Council of Ministers adopted harm reduction as the common position of the EU,⁴ It was included in the EU Drugs Strategy for 2005-2012 and the EU Action Plan on Drugs (2005-2008).⁵ The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) affirmed that "the evidence strongly supports the contention that needle and syringe exchange provision can make an important contribution to reducing HIV transmission in drug injectors. Furthermore, needle and exchange provision can be effective in engaging with populations of drug users not in contact with other services, and may provide a conduit to drug treatment and primary health care services. No convincing evidence exists that its provision negatively impacts on other prevention or drug control activities."⁶

The International Federation of Red Cross and Red Crescent Societies (IFRC) is equally succinct: *"The message is clear. It is time to be guided by the light of science, not by the darkness of ignorance and fear"*.⁷ At the UN level, basic harm reduction principles for the prevention of infectious diseases among injecting drug users have been fully endorsed by UNAIDS, the World Health Organization (WHO) and – more recently if more ambiguously – by the United Nations Office on Drugs and Crime (UNODC) and the International Narcotics Control Board (INCB), the quasi-judicial monitoring body for the implementation of the UN drug control conventions.

Harm reduction practices are rapidly expanding, even by countries with very strict anti-drug laws. China, for example, began needle exchange programs several years ago, and in 2006, it began opening a thousand methadone clinics. Countries like Iran, Pakistan and Vietnam are now openly practicing. The United States federal government has long maintained an ideological crusade against harm reduction, despite many states and cities maintaining needle exchange and opiate substitution programs. The Obama Administration shows willingness to soften the federal position, regarding future lifting of the Congressional ban on needle exchange. The ideological hard line against basic harm reduction programs is now a small minority, supported only by Russia, Japan and some African and Islamic countries, like Sudan and Saudi Arabia.

3. International Harm Reduction Association (IHRA), *The Global State of Harm Reduction 2008: Mapping the Response to Drug-Related HIV and Hepatitis C Epidemics*, May 2008.

4. *Council Recommendation of 18 June 2003 on the prevention and reduction of health-related harm associated with drug dependence* (2003/488/EC).

5. COM(2005) 45 final, Communication from the Commission to the European Parliament and the Council on a EU Drugs Action Plan (2005-2008), Brussels, February 14, 2005.

6. A European perspective on responding to blood borne infections among injecting drug users, A Short Briefing Paper, EMCDDA, Lisbon, March 2004, p. 7.

7. *Spreading the light of science: Guidelines on harm reduction related to injecting drug use*, International Federation of Red Cross and Red Crescent Societies, 2003. (http://www.ifrc.org/what/health/tools/harm_reduction.asp)

Harm reduction moves on

Along with the major increase of needle exchange and substitution programs these last five years, a few countries like The Netherlands, Germany, Switzerland, Spain, Denmark, Canada and Australia continue to experiment with more controversial harm reduction practices, like heroin prescription and drug consumption rooms for the most problematic user groups.

Supplying pharmaceutical heroin (diamorphine) to dependent users dates back to 1926 when doctors in the UK were first allowed to provide heroin on prescription. In the UK today, only a small number of users still receive heroin from their doctors, but it remains a legally sanctioned treatment for opiate dependence.⁸ Switzerland started a pilot project in 1994, through specialized centers, followed in 1998 by The Netherlands, and later Germany and Spain. Convincing evidence from evaluations of the Swiss and Dutch programs regarding reduced overdose deaths, improved health conditions of heroin users and sharply reduced rates of drug-related crime led the Danish parliament in 2008 to approve, almost unanimously, prescribing heroin to long-time heroin users with the aim to improve their health, help them avoid committing crimes and stabilize their lives. That same year, convinced by the results of their pilot programs, 68 percent of Swiss voters approved by referendum the prescription of heroin to addicts. The German parliament followed suit in 2009, making "heroin-assisted treatment" a part of their official drug policy, after seven years of pilot programs.

Drug consumption rooms are supervised facilities where drug users are allowed to consume their drugs in hygienic conditions without fear of arrest. There are about 65 consumption rooms in Switzerland, The Netherlands, Germany, Luxembourg, Spain and Norway, and two pilot projects in Australia and Canada. An EMCDDA report assesses the rationale as "drug users should, as long as they cannot or do not want to stop drug use, be enabled to survive in the hope that they may at some later stage be able to give up drug use."⁹

The INCB consistently condemns drug consumption rooms as a violation of the UN drug control conventions, as they defy the treaty obligation to limit the use of scheduled drugs exclusively to medical and scientific purposes. The INCB claims governments allowing drug consumption rooms "facilitate, aide and/or abet the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking." This attack contradicts the legal advice provided by UNODC, that "[i]t would be difficult to assert that, in establishing drug-injection rooms, it is the intent of Parties to actually incite to or induce the illicit use of drugs, or even more so, to associate with, aid, abet or facilitate the possession of drugs. ... On the contrary, it seems clear that in such cases the intention of governments is to provide healthier conditions for IV [intravenous] drug abusers, thereby reducing their risk of infection with grave transmittable diseases and, at least in some cases, reaching out to them with counseling and other therapeutic options. Albeit how insufficient this may look from a demand reduction point of view, it would still fall far from the intent of committing an offence as foreseen in the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances."¹⁰

8. Gerry V. Stimson and Nicky Metrebian, Prescribing heroin - What is the evidence?, Joseph Rowntree Foundation, London 2003. <http://www.ihra.net/Assets/1396/1/GSHRFullReport1.pdf>

9. Dagmar Hedrich, *European report on drug consumption rooms*, EMCDDA, February 2004.

10. UNDCP Legal Affairs Section, *Flexibility of treaty provisions as regards harm reduction approaches*, E/INCB/2002/W.13/SS.5, September 2002) Available at: http://idpc.info/php-bin/documents/UN_HarmReduction_EN.pdf

Harm reduction for Latin America

Harm reduction originated mainly as a response to heroin injection; hence it developed slowly in Latin America where heroin injection is a major concern only in Mexico, the sole country with an operating an opiate substitution program. Injecting drug use in Latin America is mostly cocaine, estimates ranging from 400,000 to 2 million users. Most are in Brazil, followed by Argentina, the first countries in South America to develop a harm reduction policy. Needle exchange programs exist in Brazil, Argentina, Mexico, Paraguay and Uruguay. Most drug-related health and social problems in the region are related to alcohol and to smoking cocaine (cocaine base paste and crack), for which harm reduction responses are only beginning to develop. Pilots programs in Brazil, for example, provide crack pipes (to reduce sharing of infected inhaling tools) and substitution treatment, with cannabis for crack smokers.

But there is no Latin American application of the harm reduction concept, adapted to the main drug-related problems in the region. The paradigm shift from zero tolerance to harm reduction has brought much progress elsewhere, regarding better treatment options, less stigmatization of drug users, prevention of disease and reduction of crime. But the model cannot simply be transposed to Latin America where a similar paradigm shift should include harm reduction for smoking/inhaling (as opposed to injecting) and a focus on stimulants (as opposed to opiates). The availability of milder stimulants on the market, for example, might prevent certain recreational user groups from starting to use cocaine. The Bolivian proposal to make natural coca products legally available could well have advantages in this respect. Testing coca substitution treatment for cocaine dependence is worth consideration. Harm reduction should apply to social harms as well, reducing levels of drug-related violence, a major concern in Latin America.

Decriminalization & depenalization

The prison population throughout most of the world has exploded these last twenty years, partly due to the tightening of anti-drug laws, under the influence of the 1988 Convention. The Convention makes it mandatory for the signatory countries to *“adopt such measures as may be necessary to establish as criminal offences under its domestic law”* (art. 3, §1) all the activities related to the production, sale, transport, distribution, etc. of the substances included in the most restricted lists of the 1961 and 1971 conventions. Criminalization also applies to the *“cultivation of opium poppy, coca bush or cannabis plants for the purpose of the production of narcotic drugs”*. The text distinguishes between the intent to traffic and personal consumption, stating that the latter should also be considered a criminal offence, but *“subject to the constitutional principles and the basic concepts of [the state’s] legal system”* (art. 3, §2).

Parties to the Convention could – but are not obliged to – adopt stricter measures than those mandated, such as the criminalization of use. Nevertheless, there is no obligation to do so. In the US, Russia and China, massive imprisonment is practiced, and the majority of European and Latin American countries have also seen a major increase. The resultant prison crisis and lack of positive impact have prompted various depenalisation and decriminalization reforms.

There is much confusion about the precise meaning and the distinction regarding the two terms. A universally accepted definition does not exist and interpretations vary in different

languages. We use the definition most frequent in the English literature and proposed by the EMCDDA: *decriminalization* meaning removal of a conduct or activity from the sphere of criminal law; *depenalisation* signifying merely a relaxation of the penal sanction exacted by law. Decriminalization usually applies to offences related to drug consumption and may be reflected either by the imposition of sanctions of a different kind (administrative) or the abolition of all sanctions; other (noncriminal) laws can then regulate the conduct or activity that has been decriminalized. Depenalisation usually comprises personal consumption as well as small-scale trading and generally signifies the elimination or reduction of custodial penalties, while the conduct or activity still remains a criminal offence. The term *legalization* would refer to the removal from the sphere of criminal law of all drug-related offences: use, possession, cultivation, production, trading, etc.

In many countries, personal consumption is not an offence. The UN conventions do not oblige any penalty (penal or administrative) to be imposed for consumption *per se*, as is clearly stated in the official Commentary to the 1988 Convention: "It will be noted that, as with the 1961 and 1971 Conventions, paragraph 2 does not require drug consumption as such to be established as a punishable offence".¹¹ The Commentary suggests determining a strategy regarding the range of offences relating to personal use, similar to that practiced by many states, in which such offences are distinguished from those of a more serious nature by a threshold in terms, for example, of weight.¹² There are some countries in which possession of a quantity of drugs for personal use is completely decriminalized, and there are many where this is no longer a priority for law enforcement, or where sentences have been reduced. These changes in the law or jurisprudence can have a positive effect on the overburdened penal system and prison overcrowding.

In 2003 the EU set sentencing guidelines for trafficking offences but not for personal use. An attempt to find a common definition to distinguish between possession for consumption and intent to traffic failed: "[T]he notion of unified thresholds was ultimately dismissed as unworkable due to the fact that many countries use the distinction between possession and trafficking to enable them to de-penalize low-level offences."¹³ Thus, enormous differences continue to exist within the EU. Spain, Italy, Portugal and Luxembourg, for example, do not consider possession of drugs for personal use a punishable offence. In The Netherlands, Germany and the Czech Republic, possession for personal use remains unlawful, but guidelines are established for police, public prosecutors and courts to avoid imposing any punishment, including fines, if the amount is insignificant or for personal consumption. Other countries impose administrative sanctions and only very few countries (Sweden, Latvia, Cyprus) exercise the option to impose prison sentences for possession of small amounts.

Legally, what constitutes an amount for personal use differs widely and has been the subject of debate, revision and controversy. In the last decade at least seven EU countries (Belgium, Germany, Greece, Italy, Netherlands, Portugal and Finland) have redefined limits for non-prosecution of individuals caught with drugs that appear to be for personal use. In

11. E/CN.7/590. *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, given in Vienna on 20 December 1988, New York: United Nations, 1998, ISBN 92-1-148106-6, for 3.95, p. 82.

12. Commentary, op. cit., p. 83.

13. Charlotte Walsh, *On the threshold: How relevant should quantity be in determining intent to supply?*, *International Journal of Drug Policy* 19 (2008) 479–485.

2000 Portugal, in decriminalizing consumption and possession of all drug, adopted the norm of “the quantity required for an average individual consumption during a period of 10 days.” Indications are given for what constitutes an average daily dose, for example 2.5 grams for cannabis or 0.2 grams for cocaine. “These thresholds are presumptive as opposed to be determinative; however, so long as there is no additional evidence implicating the drug user in more serious offences, drug possession is decriminalized, dealt with as an administrative violation, as opposed to being prosecuted as a criminal offence.”¹⁴ The Cato Institute recently concluded that “judged by virtually every metric, the Portuguese decriminalization framework has been a resounding success. Within this success lie self-evident lessons that should guide drug policy debates around the world.”¹⁵

Other EU jurisdictions define thresholds in terms of a specific amount in grams or units. In Austria the limit of the “serious offence” (punishable by prison) is 15 grams of cocaine and 3 grams of heroin, while “small amounts” are defined as 1.5 grams of cocaine, 1 gram of ATS and 0.5 grams of heroin. In Finland, by comparison, the law refers to 1 gram of heroin or 1.5 grams of cocaine, although in practice, the lower limit for a prison sentence is 10 grams of ATS, 40 ecstasy pills, 4 grams of cocaine and 2 grams of heroin. All EU countries offer legal or judicial distinction to graduate the severity of the offence. An increasing trend is to divert drug users from the penal system (treatment instead of punishment). This principle requires determining whether people should be assisted or imprisoned by drawing a line between users and traders. More easily said than done. Inaccurate distinction may distort the principle of the law: a low threshold separating personal use and traffic might result in users being imprisoned as traffickers, whereas a high threshold could allow dealers to continue working with little interference. According to the EMCDDA, the real emphasis in the EU “seems to be on the intent rather than the amount possessed... The great majority chooses to mention some sort of “small” quantity in the law or guidelines, but leaves it to prosecutorial or judicial discretion, with knowledge of all of the surrounding circumstances, to determine the true intention behind the offence. No country definitively uses the quantity to determine who is a user or a trafficker.”¹⁶

In 2005 a debate was triggered in the UK over re-establishing thresholds “on the quantity of a controlled drug found in a person’s possession above which a court will presume that it was held with intent to supply others.”¹⁷ The originally proposed quantities were considerably higher than those found in most other jurisdictions that had struggled with this question, especially for cannabis, the proposed threshold set at 500 grams for herb (marihuana) and 112 grams for resin (hash), but also for amphetamines (14 g) and heroin or cocaine (7 g). After a media furor and a consultation process, the government initially considered lowering the proposed amounts (down to 5 g for cannabis, 2 g for heroin/cocaine), but ultimately decided to abandon the whole endeavor, concluding it too difficult to establishing universally applicable and appropriate amounts.

14. Charlotte Walsh, op. cit.

15. Glenn Greenwald, *Drug decriminalisation in Portugal: lessons for creating fair and successful drug policies*, Cato Institute 2009.

16. *Illicit drug use in the EU: legislative approaches*, EMCDDA thematic papers, Lisbon 2005, ISBN 92-9168-215-2.

17. Thresholds Drugs Act 2005, Home Office Crime Reduction and Community Safety Group (<http://drugs.homeoffice.gov.uk/publication-search/reducing-supply/thresholds-response/thresholds-drugs-act-05>)

Decriminalization & depenalisation in Latin America

A clear example of setting unrealistically low quantity thresholds is Mexico's decriminalization law of April 2009. The quantities set for personal use in this 'narcomenudeo' decree are 5 grams of cannabis, 2 g of opium, and very low figures of 0.5 g cocaine, 0.05 g of heroin, and 0.04 g of methamphetamine or ecstasy. In comparison, in Paraguay, for example, quantities of 2 grams are used for cocaine and heroin. In 2008 a judge in Sao Paulo absolved a person arrested in possession of 7 grams of cocaine because it was not sufficiently proven it was not meant for personal consumption. If threshold quantities are introduced, they should be evidence-based (what are in reality average purchases made for personal consumption) and in the prosecution process they should only be used as indicative rather than determinative.

Such thresholds can be useful as a guideline to absolve users from prosecution when caught with small quantities. In the case of larger quantities the prosecution should be responsible to prove intent before anyone can be convicted of trafficking charges. As a legislative principle, room for maneuver must be left to the judge to take into account other indications (how many offences, social conditions, circumstances of arrest, etc.) for deciding penalty levels when the minimum dosage quantity is exceeded. The Latin American Commission on Drugs and Democracy supports decriminalization and a distinction between users and traders, but does not specify how to translate that into legislative reforms. The risk is the type of minimal reforms as implemented in Mexico, which have a positive symbolic value, helpful to de-stigmatize drug users and protect some from incarceration, but may have detrimental effects for a significant group of users that are improperly categorized as traffickers.

The Mexican "narcomenudeo" decree also sets thresholds for low-level drug dealing, defined by quantities up to 1000 times the dosage for personal use, in combination with a depenalisation. While it is essential to distinguish clearly between street dealers and big traffickers, courier-level smuggling (someone caught at the airport who swallowed more than 500 grams of cocaine or 50 grams of heroin) is still treated as large-scale trafficking with the highest penalty category. In 2008 Ecuador issued a "pardon for mules", singling out a specific group of prisoners as victims of indiscriminate and disproportionate legislation. More than 3000 offenders arrested with a maximum quantity of two kilograms of any drug, who had no prior conviction under the drug law, and who had completed ten percent of their sentence or a minimum of one year, were released from prison. Much of the policy debate focuses on consumption-related offences, while the prison crisis is largely due to the absence of better distinctions between petty trade, dealing related to financing personal use, and trafficking by organized crime. A new paradigm is needed at this level, and other Latin American countries as well as Europe can learn from the example given by Ecuador.

Decriminalization of cannabis

In the case of cannabis, the illegal substance with the highest mass consumption – an estimated 170 million people worldwide, according to the World Drug Report – the percentage of recreational users who develop problematic consumption patterns is very small. Because the Latin American Commission on Drugs and Democracy proposed decriminalizing the possession of cannabis for personal use, we will look into this issue more closely.

Since its inclusion under the strictest controls in the 1961 Single Convention on Narcotic Drugs there has been debate on the wisdom of that decision. Cannabis has been included not only in Schedule I, but also in Schedule IV, requiring the most stringent control measures because those substances are considered particularly dangerous by virtue of their harmful characteristics, risks of abuse and limited therapeutic value. Among these substances are heroin and cannabis but not cocaine, which is only listed in Schedule I. The Convention suggests applying the most stringent control system to cannabis, yet leaves countries some flexibility in their interpretation of the *necessity* of such control. Parties to the Convention may adopt any additional control measures regarded as necessary, including full prohibition, of the drugs listed in Schedule IV. Countries must judge the *opportunity* and *necessity* of applying the convention norms. Conventions are not *self-executing* and in the transposition of the international standard into national law, countries are allowed discretion. Nevertheless, states should interpret treaties in good faith and in the light of their object and purpose, according to Article 31 of the 1969 Vienna Convention on the Law of Treaties.¹⁸

The inclusion of cannabis was a mistake, many have argued, based on the erroneous scientific and medical information generally available when the treaty was drafted. In 2006, the UNODC recognized that “much of the early material on cannabis is now considered inaccurate, and that a series of studies in a range of countries have exonerated cannabis of many of the charges leveled against it.”¹⁹ It noted that “medical use of the active ingredients, if not the plant itself, is championed by respected professionals.” Hence the UNODC acknowledged that the scientific base for putting cannabis in Schedule IV had been incorrect. The report also demonstrated that supply reduction is impossible given the potential to grow the plant anywhere, and that past efforts to control availability had failed.

Following the cultural upheaval and the youth counterculture of the late 1960s cannabis control regimes came under scrutiny, particularly in Western societies. In the 1970s, several public inquiries and commissions²⁰ looked into the matter and most essentially concluded that many of the harms connected to cannabis use were exaggerated, that the effects of the criminalization were potentially excessive and the measures even counterproductive, and that lawmakers should drastically reduce or eliminate criminal penalties for personal use of cannabis. However, in most countries, with the notable exception of The Netherlands, these recommendations did not result in substantive policy reform.²¹

18. Danilo Ballotta, Henri Bergeron and Brendan Hughes, ‘Cannabis control in Europe’, in: A cannabis reader: global issues and local experiences, EMCDDA monographs, Nr. 8, Lisbon, June 2008 (http://www.emcdda.europa.eu/attachements.cfm/att_53377_EN_emcdda-cannabis-mon-vol1-ch7-web.pdf)

19. *World Drug Report 2006*, United Nations office on Drugs and Crime, p. 156 (<http://www.unodc.org/unodc/en/data-and-analysis/WDR-2006.html>)

20. Such as the Advisory Committee on Drugs Dependence (Britain, 1969), the Baan and Hulsman Commissions in the Netherlands (1970 and 1971), the Commission of Inquiry into the Non-medical Use of Drugs (Canada, 1973), the National Commission on Marihuana and Drug Abuse – known as the Shafer Commission after its chairman, Raymond P. Shafer – in the US (1972 and 1973), the Senate Social Committee on Social Welfare (Australia, 1977).

21. *Cannabis Policy: Moving Beyond Stalemate*, Global Cannabis Commission Report, Beckley Foundation, September 2008, (http://www.beckleyfoundation.org/pdf/BF_Cannabis_Commission_Report.pdf). For a summary, see: *An Overview of Cannabis Policy: Moving Beyond Stalemate*, Beckley Foundation, Briefing 17, October 2008 (http://www.beckleyfoundation.org/pdf/BFDPP_Briefing17_Cannabis_Oct08_EN.pdf)

The main policy developments in the 1970s were either to tighten a punitive 'zero tolerance' position or to exploit the leeway in or circumvent the limited framework of the conventions. At the international level the prohibitionist approach prevailed, resulting in the criminalization of cannabis in the 1988 Convention. Article 3 was included to limit the leeway the 1961 Single Convention provided for national variations. Parties were now required to criminalize possession and cultivation for personal use unless it would be contrary to the constitutional principles and basic concepts of their legal system.

The tightening of the international regime was partly a reaction to the reform in cannabis control policies in several countries, in particular The Netherlands and some US jurisdictions in the 1970s. Given the stalemate at the international level to change or reform the UN drug control conventions, but strengthened by the support for a more lenient approach by official government commissions or inquiries, these alternative control regimes were implemented within the limits set by international drug control requirements. Hard-line parties to the conventions and the INCB argued some clearly surpassed those limits.

The 1988 Convention still left room for maneuver within a general prohibitionist policy framework. This has resulted in a myriad of alternative control regimes depending on national or local circumstances and political opportunity, often determined by national legal principles and traditions. In its report *Cannabis Policy: Moving Beyond Stalemate*, the Global Cannabis Commission of the Beckley Foundation describes a wide divergence of alternative cannabis control regimes that have emerged. The report provides a typology of the existing cannabis control models implemented at national and sub-national levels that have departed from the standard approach of full prohibition. The alternative regimes are characterized by considerable differences, complicated by differences between *de jure* and *de facto* reforms.

The report identifies four alternative control regime categories. The definitions on decriminalization and depenalisation by the Global Cannabis Commission slightly differ from the ones used by the EMCDDA. The first regime, prohibition with cautioning or diversion (depenalisation), exists in varying degrees in France, Australia, Canada, Britain, and several US states. The second category, prohibition with civil penalties (decriminalization), exists in Belgium, Italy, the Czech Republic, Portugal, Denmark and Australia. The third, partial prohibition (including *de facto* legalization, e.g. prohibition with an expediency principle, and *de jure* legalization), exists in The Netherlands, Germany, Austria, Spain, several US states, Switzerland and India.

A fourth category, medical marijuana control, is seen as a special case and mainly exists in North America and some countries in Europe. Medical use differs from the other models that concern recreational use. The original rationale for the prohibition of cannabis was that it had no current accepted medical use. Although the research is only in its infancy, recent scientific insights do indicate medical benefits, such as reducing nausea induced by chemotherapy, stimulating appetite in AIDS patients, and reducing intraocular pressure caused by glaucoma. According to the Commentary on the 1961 Single Convention, "medical purposes" does not necessarily have exactly the same meaning at all times under

all circumstances. Its interpretation must depend on the stage of medical science at the particular time in question.²²

The report concludes that despite methodological flaws in research and pitfalls of cross-country comparisons “there does not appear to have been any large increase in cannabis use in countries that have maintained the *de jure* illegality of cannabis but implemented reforms which, either at a national or subnational level, have reduced the penalties to civil or administrative sanctions.” It is also apparent from a number of studies that, “at least as long as the illegality of cannabis is maintained, the laws and sanctions which apply seem to have, at most, a relatively modest impact on rates of cannabis use.” The alternative regimes have reduced, but not eliminated, some of the social impacts of prohibition on individuals and appear to reduce the costs to the criminal justice system. None of the regimes, including full prohibition, have significantly reduced the scale of the market. Trends in consumption appear to be more influenced by poorly understood transnational social, cultural and economic factors than cannabis control laws.

It is important to note, the report adds, that these benefits can be undercut by police practices that increase the number of users who are penalized or enforce the law in a discriminatory way. Another matter is the production of cannabis, which is subject to stricter provisions in the Conventions. The main aim of the various regimes has been to lessen the burden of criminal sanctions on possession and use, and in some places on cultivation for one’s own use. Even in the most far-reaching alternative regimes, there is no explicit legalization of cultivation, production or distribution of cannabis, which would violate provisions of the international conventions.

The Netherlands

Dutch coffee shops, where consumers can buy a limited amount of cannabis without interference of law enforcement, play a symbolic role as a paradigm of liberal cannabis policies. However, the phenomenon is often poorly understood. Contrary to what is commonly believed, possession of cannabis in The Netherlands is a statutory offence (use is not prohibited) and as such, according to the government, The Netherlands complies with the Conventions. The INCB, however, consider coffee shops are not in compliance with the drug control treaties.²³ In its annual report for 1997 it even said that Dutch policy “*might be described as indirect incitement.*”²⁴

Dutch policy is a *de facto* decriminalization of possession, buying and selling of amounts for personal use of cannabis, although *de jure* those activities are not allowed. The cultivation of up to five plants per person for personal use is tolerated as well. Despite open sale, the levels of consumption of cannabis are similar to those of the neighboring countries like Germany and Belgium, and much lower than in the UK, France or Spain.²⁵

22. Commentary on the 1961 Single Convention on Narcotic Drugs, United Nations, New York, 1973, Commentary on Article 4, 12.

23. See for instance: *Report of the International Narcotics Control Board for 1997*, United Nations, New York 1998, par. 28; and *Report of the International Narcotics Control Board for 2001*, United Nations, New York 2002, par. 553. In other reports the INCB stated that “buying, stocking and selling cannabis products for non-medical use does not conform with the provisions of the 1961 Convention.” (1996 and 2001 annual reports).

24. *Report of the International Narcotics Control Board for 1997*, United Nations, New York 1998, par. 28

25. *2007 Annual report on the state of the drugs problem in Europe*, EMCDDA, Lisbon 2008, www.emcdda.europa.eu

Possession, production and sale of cannabis had been criminalized in 1953, at a time when the substance was unknown to the general population.²⁶ When cannabis became popular during the 1960s, the cannabis retail market was predominantly underground. At first, cannabis use was dealt with severely by law enforcement authorities. Eventually police began to tolerate “house dealers” in youth centers. The change was based on social and public health concerns, in particular the separation of markets of soft (cannabis) and hard drugs (heroin, cocaine etc.) that represented an “unacceptable” risk.²⁷

The reform coincided with the rapid spread of heroin from 1972 onward and doubts about the social and health risks of cannabis. In 1971, the Hulsman Commission advised the government to decriminalize the use and possession of small amounts of cannabis. The production and distribution of cannabis were to be reduced from felony to misdemeanor offences. A year later, in 1972, the Baan Commission was more cautious. It recommended that a period be set for experimentation using the expediency principle, a discretionary option in Dutch penal law, allowing authorities to refrain from prosecution. The Netherlands explicitly made that clear in the reservation it made upon signature and acceptance of the 1988 Convention that would have limited its discretionary powers.²⁸

The control regime developed ‘bottom up’, through local initiatives, subsequently endorsed by municipalities, eventually formalized by law and in the national guidelines. A revision of the Opium Act in 1976 introduced statutory decriminalization for cannabis. Use was no longer an offence and possession up to 30 grams became a petty offence or misdemeanor, while possession of more than 30 grams remained a criminal offence.

Large-scale prosecution of cannabis offences was considered contrary to the public interest, stigmatizing many young people and socially isolating them. Since 1979, the regime is governed through official national guidelines by the public prosecution office. Retail sale of cannabis is tolerated, provided outlets meet the so-called AHOJ-G criteria which were adopted from local examples and introduced nationally in 1991: no overt advertising (A); no hard drugs (H); no nuisance or disturbance (O, *overlast in Dutch*); no underage visitors (J, for *jongeren*); and no large quantities sold (G, for *grote hoeveelheden*). The prosecution office assigned the “lowest judicial priority” to investigation and prosecution of possession for personal use. The guidelines gave significant discretion to municipalities on how to implement them.

When the government decided to decriminalize cannabis and to tolerate the retail sale, they did not foresee the coffee shop phenomenon, which the authorities never intended to exist. Commercial coffee shops replaced the house dealers in youth centers, and the number of shops increased rapidly during the 1980s, creating uncontrollable situations in which the guidelines were regularly ignored. There was some violence, increased theft,

26. Dirk Korf, “An open front door: the coffee shop phenomenon in the Netherlands”, in: A cannabis reader: global issues and local experiences, EMCDDA monographs, Nr. 8, Lisbon, June 2008 (http://www.emcdda.europa.eu/attachements.cfm/att_53372_EN_emcdda-cannabis-mon-vol1-ch9-web.pdf)

27. Marcel de Kort, “The Dutch Cannabis Debate, 1968-1976.” *The Journal of Drug Issues*, 1994; 24(3): pp. 417-427. (<http://www.drugpolicy.org/library/dekort2.cfm#n17>)

28. See: United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988: Treaty adherence as of 13 July 2007 (http://www.unodc.org/pdf/treaty_adherence_convention_1988.pdf)

and sale of hard drugs. In reaction, resistance grew in the most affected neighborhoods along with a loss of support for the control model.²⁹

Consensus about the model began to crumble when the Christian Democrats, who had co-established the policy, withdrew their support. After criticism from neighboring countries France and Germany guidelines were tightened in 1996 to uphold the model. The sale of up to 30 grams was reduced to 5 grams per transaction and a ceiling of an in-house stock 500 grams of cannabis was introduced. In addition, the minimum age for entrance to the shops was increased from 16 to 18. The government provided new legal instruments for municipalities to diminish the number of coffee shops, including the option to bar them. Currently, 66 per cent of the 443 municipalities have a “zero policy”, allowing them to close down already existing coffee shops even if they do not violate the AHOJ-G criteria.³⁰ Municipalities may also impose additional rules on coffee shops to avoid public disturbance.

Over the years enforcement of the criteria by special police intervention teams became stricter, new laws and regulations were introduced to phase out coffee shops in municipalities that wished to do so, or if the rules were not respected. Restrictions on coffee shops in the proximity of schools and licenses for owners were also introduced. The number of coffee shops steeply declined from a peak of about 1,500 to 813 in 2000, and down to 702 in 2007.³¹

The Dutch made the transition from “zero tolerance” to *de facto* legalization, at least at the “front door” of the coffee shop, where the sale of cannabis to users is tolerated. Problems persist at the “back door”, where the coffee shop owner has to obtain his supply, which remains illegal and is subject to law enforcement. Suppliers can still be prosecuted for transporting cannabis to the shops. Coffee shop owners can be arrested buying their inventory, even though they are allowed to sell it. “It’s a crazy situation,” says a coffee shop owner. “Every day I’m obliged to commit crimes because I have to stock up illegally. But at the same time I pay taxes on the sales.”³²

Law enforcement focuses on large-scale dealers. Until the mid-1980s most cannabis used in The Netherlands was imported cannabis resin. Due to a crack down on import and improvement in cultivation techniques, domestically grown herbal cannabis, *nederwiet*, became more popular. Criminal organizations have since taken over a large part of the cannabis industry and according to the police at least 80 percent of what is grown in The Netherlands is exported every year with a value of more than two billion euros.³³

The link between demand and supply remains a major policy challenge, and the “back door problem” is increasingly jeopardizing the system as a whole. The paradoxical situation of prohibition of supply and regulation of demand are at a crossroads. In 2000 a parliamentary majority voted to regulate the back door by allowing the cultivation of cannabis in a closed system, hence decriminalizing production of cannabis to be sold in the coffee shops.

29. Hans T. van der Veen, *Regulation in Spite of Prohibition: The Control of Cannabis Distribution in Amsterdam*, Cultural Critique, Winter 2009.

30. B. Bieleman, A. Beelen, R. Nijkamp, E. de Bie, *Coffeeshops in Nederland 2007*, WODC/Intraval, June 2008 (English summary available at http://english.wodc.nl/images/1581_%20summary_tcm45-148900.pdf)

31. *Coffeeshops in Nederland 2007*, op. cit.

32. *Cannabis Cafes Get Nudge to Fringes of a Dutch City*, The New York Times, August 20, 2006

33. *Police to crack down on cannabis export*, NRC Handelsblad, October 20, 2008

(http://www.nrc.nl/international/Features/article2030745.ece/Police_to_crack_down_on_cannabis_export)

Growers would be allowed to produce for the shops on an exclusive basis, which in turn would be only allowed to sell cannabis produced by these growers.³⁴ The government refused to enact the legislation, arguing that regulation would be problematic and would meet with strong international opposition.

In 2005 a second initiative proposed to experiment regulating supply of cannabis to coffee shops. The government asked for legal advice, which concluded that cultivating cannabis for other than medical or scientific purposes was banned both under UN conventions and European Union law. Following the opinion that the experiment would not “comply with the spirit of existing treaties,”³⁵ the initiative failed.

Regulation of supply remained a concern. In the fall of 2008, at a “cannabis summit” around 30 mayors of the main Dutch municipalities again asked for a “monitored pilot scheme” to assess if licensing growers could reduce cannabis supply-related crime. The Labor Party announced in May 2009 a plan to allow five legal cannabis plantations, modeled on the legal medical cannabis cultivation that is supervised by the Ministry of Health. An evaluation of all aspects of Dutch drug policy will take place in 2009-2010, which should also decide on the future of the coffee shops.

United States

In the US, the cradle of drug prohibition, policies on cannabis are in fact much more diverse than one might think. Different approaches have created a curious dichotomy. At the federal level there is a strict policy of enforcing prohibition legislation, while there is a remarkable diversity of policies at the state and local level. Currently, 13 states have decriminalized use or possession of cannabis, and 13 states have recognized medical use of cannabis.³⁶ Some states fall into both categories, and in total 20 states now have different policies that conflict with the federal one of absolute prohibition. Due to legislative and voter initiatives the panorama of state and local control policies is constantly changing, generally towards more lenient control regimes.

While the US successfully exported its prohibitionist policy to the rest of the world, the federal government has had significant difficulty in maintaining its policy domestically. The dichotomy began when the Nixon administration introduced the Controlled Substances Act in 1970 and initiated the so-called war on drugs. The law designated cannabis as a Schedule I drug. However, Nixon also appointed the National Commission on Marihuana and Drug Abuse to study cannabis use in the US. The Commission favored ending cannabis prohibition and adopting other methods, recommending a social control policy seeking to discourage marihuana use, while concentrating primarily on the prevention of heavy use.³⁷

34. *Regulation of cannabis in The Netherlands and Europe*, Netherlands Drug Policy Foundation, August, 2001 (<http://www.drugsbeleid.nl/nederlands/reguleringeng.htm>)

35. T.M.C. Asser Instituut voor Internationaal Recht en Europees Recht, *Experimenteren met het Gedogen van de Teelt van Cannabis ten Behoeve van de Bevoorrading van Coffeeshops – Internationaal rechtelijke en Europees rechtelijke aspecten*, December 2005

36. For an overview see *13 Legal Medical Marijuana States* at ProCon.org (<http://medicalmarijuana.procon.org/viewresource.asp?resourceID=881>)

37. *Marihuana: A Signal of Misunderstanding*, The Report of the National Commission on Marihuana and Drug Abuse, March, 1972, (<http://www.druglibrary.org/schaffer/library/studies/nc/ncmenu.htm>)

The Commission's recommendations were: (1) possession of marijuana for personal use should no longer be an offence, but marijuana possessed in public would remain subject to summary seizure and forfeiture; and (2) casual distribution of small amounts of marijuana for no remuneration, or insignificant remuneration not involving profit, would no longer be an offence. While presenting the findings to Congress in 1972, the commission's chairman recommended the decriminalization of small amounts of amounts, saying, "the criminal law is too harsh a tool to apply to personal possession even in the effort to discourage use."

Nixon dismissed the Commission's findings. Nevertheless, the report had a considerable impact on the diverging trends on cannabis in the US. In 1973 Oregon became the first state to decriminalize cannabis. Possession of one ounce (28.45 grams) or less became punishable only by a \$500 to \$1,000 fine; stricter punishments continued to exist for sale or cultivation. California followed in 1975, making possession under one ounce for nonmedical use punishable by a \$100 fine; stricter punishments existed for amounts exceeding an ounce, possession on school grounds, subsequent violations, sale or cultivation. The Alaska Supreme Court ruled in 1975 that possession of amounts up to one ounce for personal use was legal under the state constitution and its privacy protections.

Other states followed with widely varying decriminalization or depenalisation policies. Measures include fines, drug education, or drug treatment instead of incarceration and/or criminal charges for possession of small amounts of cannabis, or assigning the lowest priority for law enforcement to various cannabis offences. At the federal level these reforms are considered contradictory to the 1970 Controlled Substances Act. The intransigence of the federal government has made cannabis policy a battleground for activists, voters, local and state legislators and in the final instance, the courts.

In 1996, voters in California passed Proposition 215, the Compassionate Use Act, exempting medical use of cannabis from criminal penalties. It does not legalize cannabis, but changes how patients and their primary caregivers are treated by the court system. California's law allows for individuals to "possess, cultivate and transport" cannabis as long as it is used for medical purposes with a doctor's prescription. Patients can claim exemption from the law, but the burden of proof is largely on the patient.³⁸

The contradictory federal and state policies led to what has been called a "low-level civil war". The Drugs Enforcement Administration (DEA) raided and closed down medicinal cannabis clubs and dispensaries, prosecuted suppliers, threatened doctors who recommended cannabis, and successfully battled co-ops and patients in cases that reached the Supreme Court. In 2001, the Court ruled that federal drug laws do not permit an exception for medical cannabis and rejected the medical necessity defense to crimes enacted under the 1970 Controlled Substances Act.³⁹ In June 2005, the Supreme Court ruled that Congress may ban the use of cannabis even where states approve its use for medicinal purposes.⁴⁰ The Californian Attorney General called the raids "punitive expeditions" that were an affront to the will of California's electorate.⁴¹

38. *Proposition 215 and You*, Californians for Medical Rights, November 12, 1996 (<http://www.drugpolicy.org/library/cmrguide.cfm>)

39. *United States v. Oakland Cannabis Buyers' Coop*

40. *Gonzales v. Raich* (previously *Ashcroft v. Raich*), 545 U.S. 1 (2005)

41. *Pot Luck*, The American Prospect, October 23, 2002 (http://www.prospect.org/cs/articles?article=pot_luck); *Pot Raids Spur Calls to Quit Working With DEA*, Los Angeles Times, November 21, 2002

Nevertheless, medical marijuana dispensaries and cannabis buyers' clubs emerged to provide cannabis to those with legitimate medical need. A stable gray market has emerged in California – as in The Netherlands, regarding coffee shops – through trial and error. Cannabis entrepreneurs can avoid trouble by following such rules as: don't advertise, don't sell to minors, and don't open more than two stores. Cannabis is now available as a medical treatment in California to almost anyone who tells a willing physician he would feel less discomfort if he smoked.⁴² An owner of a dispensary estimated that 40 percent of clients suffer from serious illnesses such as cancer, AIDS, glaucoma, epilepsy and multiple sclerosis. The rest claim to have less clearly defined ailments like anxiety, sleeplessness, attention deficit disorder, and assorted pains.⁴³

Despite substantial differences across counties and cities, the "Californian model" has grown into something close to *de facto* legalization, despite the large legal gray area.⁴⁴ There are more than 200,000 Californians with a medical letter from a doctor entitling them to purchase cannabis, and hundreds of dispensaries selling it. Vending machines distributing marijuana now operate in California. The computerized machines can only be used by people who have been prescribed the drug for health reasons. Patients provide a prescription, are fingerprinted and photographed.⁴⁵ Cannabis sold through the dispensaries is only a small fraction of the total California cannabis market, but it is reported that the wholesale price of cannabis has fallen by half since the legalization of medical marijuana.⁴⁶

Under the Obama Administration, the current situation will probably remain ambiguous. The President has honored his campaign pledge to stop DEA raids on medical marijuana dispensaries, but he does not seem eager to act upon his 2004 assessment when he was running for the Senate when he said, "we need to rethink and decriminalize our marijuana laws."

Conclusions

The examples of The Netherlands and California show that alternative cannabis control regimes are possible within the generally prohibitive UN framework. Due to the much more restricted provisions in the UN conventions regarding the cultivation and supply of cannabis these models result in a substantial gray legal area, leaving cultivation and supply in the domain of criminal organizations. Hence the Dutch paradox of *de facto* legalization of cannabis use without provisions for regulated legal supply. The Californian model addresses that ambiguity to some extent, regulating supply for a limited number of users in need of medical cannabis, but does not address the situation of the far larger number of recreational users – despite the obvious diversion of medical cannabis for recreational purposes.

(<http://articles.latimes.com/p/2002/nov/21/local/me-pot21>)

42. In *Calif., Medical Marijuana Laws Are Moving Pot Into Mainstream*, The Washington Post, April 11, 2009

43. *Dr. Kush: How Medical Marijuana Is Transforming The Pot Industry*, The New Yorker, July 28, 2008 (http://www.newyorker.com/reporting/2008/07/28/080728fa_fact_samuels)

44. *Dr. Kush*, op. cit.

45. Marijuana vending machines in US, *BBC News*, January 28, 2008 (<http://news.bbc.co.uk/2/hi/americas/7212778.stm>); Pot vending machines take root in Los Angeles, *Associated Press*, January 30, 2008 (<http://www.msnbc.msn.com/id/22910820/>)

46. *Dr. Kush*, op. cit.

Latitude within the UN Convention seems to have been tested to its limits by some countries. The INCB, watchdog of the UN convention, believes alternative control regimes already violate the provisions. It reminded governments that there are mechanisms within the Convention to change "*the scope of control of narcotic drugs, by adding a drug to a schedule, deleting a drug from a schedule or transferring a drug from one schedule to another.*"⁴⁷

With regard to the liberalization cannabis policies, the INCB addressed an alarming paradox of particular relevance to Latin America, noting that "*it is disturbing that, while many developing countries have been devoting resources to the eradication of cannabis and to fighting illicit trafficking in the drug, certain developed countries have, at the same time, decided to tolerate the cultivation of, trade in and abuse of cannabis.*"⁴⁸ The INCB certainly has a valid point, and one just needs to look at the border between Mexico and the US where those two worlds meet to see the tragic consequences: the alarming death toll due to the competition of drug trafficking organizations for drug routes and the ill-conceived counter-measures by the Mexican government. The violence is fuelled by the demand from the US and the virtually unlimited supply of weapons due to the lenient gun control regime that is at odds with international standards.

On the issue of harm reduction the limits of the conventions have been reached as well. Although the INCB now reluctantly accepts some harm reduction measures such as needle exchange and opiate substitution treatment, it considers other harm reduction measures (including coffee shops and drug consumption rooms) not to be in conformity with the conventions and serving primarily as a form of social control.⁴⁹ Addressing coffee shops, the INCB seems to widen the concept of harm reduction from negative health consequences of drug use to the much wider arena of negative social consequences of the international drug control system. But the Board rejects any such consideration, judging that addressing social problems in this manner is not in conformity with the treaty obligations. That is of particular relevance for Latin America, where negative social impacts such as drug-related violence of gangs and drug trafficking organizations and the overcrowding of prisons leading to inhumane conditions are just as relevant as negative health impacts.

A revision of the UN drug control treaties

The UN drug control conventions have handicapped the search for policy improvements and are plagued with inconsistencies:

1) It is necessary to resolve the conflict between the conventions and certain harm reduction practices like the drug consumption rooms. The urgent need to halt the HIV/AIDS epidemic is sufficient justification to stop hampering effective responses with rules established half a century ago – before this danger to worldwide public health existed. In an unpublished confidential memorandum prepared on request of the INCB in 2002, legal experts of the UNODC concluded: "*It could even be argued that the drug control treaties, as they stand, have been rendered out of synch with reality, since at the time they came into force they could not have possibly foreseen these new threats.*"⁵⁰

47. *Report of the International Narcotics Control Board for 2001*, United Nations, New York 2002, par. 227.

48. *Idem*, par. 226.

49. *Report of the International Narcotics Control Board for 2008*, United Nations, New York 2009, par. 29.

50. E/INCB/2002/W.13/SS.5, *Flexibility of treaty provisions as regards harm reduction approaches*, prepared by the Legal Affairs Section of the UNDCP for the 75th session of the INCB, September 30, 2002. <http://www.tni.org/drugsreform-docs/un300902.pdf>

2) Obligatory penal sanction for possession, sale and cultivation (including small amounts for personal use or for the subsistence of a family) is an obstacle to finding a better balance between protection and repression. Flexibility is needed to confront drug-related violence and the crisis in the prison system, and to view gradual reduction of illicit cultivation as part of conflict resolution and prevention and respect for human rights.

3) Countries wishing to experiment with legal regulation of the cannabis market (using the WHO Framework Convention on Tobacco Control as an example), should be allowed to. Countries believing total prohibition of cannabis is the best way to protect public health can continue with their current policies, just as some Islamic countries continue to ban alcohol.

4) A solution is urgently needed regarding the coca leaf that will compensate for the injustice stemming from the condescension denying the value of ancient Andean culture. Coca leaves must be removed from the Schedule I of the Single Convention of 1961 along with the obligation to abolish chewing and other uses of coca in its natural form.

After 50 years, it is time to modernize the system and establish a coherent Single Convention to replace the three existing treaties. If a better balance between protection and repression is to be established legislators will have to shed the political fear that paralyzes them. The conventions are not sacred, but must be seen as outdated instruments, full of inconsistencies. As stated in the first UN *World Drug Report* back in 1997: *“Laws – and even the International Conventions – are not written in stone. They can be changed when the democratic will of the nations so wishes it”*.

The Executive Director of UNODC, Antonio Maria Costa, affirmed *“there is indeed a spirit of reform in the air, to make the conventions fit for purpose and adapt them to the reality on the ground that is considerably different to the time they were drafted. With the multilateral machinery to adapt the conventions already available, all we need is: first, a renewed commitment to the principles of multilateralism and shared responsibility; second, a commitment to base our reform on empirical evidence and not ideology; and thirdly, to put in place concrete actions that support the above, going beyond mere rhetoric and pronouncement”*.⁵¹

The year 2012, a century after the approval of the first international treaty on drug control, The Hague Opium Convention of 1912, would be a symbolic and opportune time to do it.

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51. E/CN.7/2008/CRP.17, *“Making drug control ‘fit for purpose’: Building on the UNGASS decade”*, Report by the Executive Director of the United Nations Office on Drugs and Crime, as a contribution to the review of the twentieth Special Session of the General Assembly, March 7, 2008.