Room, R. (2015) The UN drug conventions: Evidence on effects and impact. In: ElGuebaly, N., Carrà, G. & Galanter, M., eds., *Textbook of Addiction Treatment: International Perspectives*, pp. 1377-1385 Milan, Heidelberg, New York, Dordrecht & London: Springer.

The UN Drug Conventions: Evidence on Effects and Impact

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Abstract

The 3 international drug treaties cover many psychoactive substances ("drugs"), although not tobacco (now under a separate treaty) or alcohol. They include a penal regime to enforce the limitation of use to medical or scientific purposes, a trade regime concerning drugs for medical use, and a planning scheme to ensure adequate supplies of medical opiates. The system, initiated in 1912, had shifted its main focus by the 1988 treaty to combating the illicit markets which accompany a prohibitory system. The place of the drug treaties in the United Nations system, and the bodies which compose the system are briefly characterised. Nearly every country has signed each treaty, though often with reservations. The option this involves of denouncing and reacceding with reservations has now been successfully used by Bolivia concerning coca leaves. The system has assured access to pain medication in most high-income countries, but not in much of the world, where the system's emphasis on law enforcement has often indirectly but effectively cut off supplies. In terms of controlling legal medical markets, the system has had mixed success. But the system has mostly failed in cutting off the illicit drug trade. In a system which has been committed to a prohibitory approach, there are recent signs of change, particularly in the Americas, which are briefly discussed.

Introduction

The United Nations drug control system is organized around three international treaties: the Single Convention on Narcotic Drugs of 1961, as amended by a Protocol of 1972; the Convention on Psychotropic Substances of 1971; and the UN Convention against Trafficking in Narcotic Drugs and Psychotropic Substances of 1988. Their texts, and the official commentaries on them, are conveniently available online: https://www.unodc.org/unodc/treaties/index.html

The treaties, of course, do not cover the whole range of psychoactive substances. There is a separate treaty on tobacco, the Framework Convention on Tobacco Control of 2003, negotiated under the auspices of the World Health Organization, and an International Convention against Doping in Sport (many of the substances covered by it are psychoactive), adopted in 2005 under the auspices of UNESCO. Notably absent from the list of substances under international control is alcohol, although it was actually the subject of the first international drug treaty, controlling "trade spirits" in colonial Africa, negotiated in 1889 but now in abeyance (Bruun et al., 1975). The 2012

WHO Expert Committee on Drug Dependence briefly discussed whether alcohol would qualify for listing under the UN drug conventions, and referred this for consideration at a future Expert Committee meeting (WHO, 2012:16).

From the perspective of the inherent harmfulness of different psychoactive substances (e.g., Nutt et al., 2010), what is included and what excluded in the three "drug treaties" is not easily defensible except as reflecting the vagaries of history. But despite the ongoing convergence in scientific thinking about psychoactive substances (Courtwright, 2005), it is still true that discussions of international drug control which take account of the whole range of drugs and their regulation are rare (for an exception, see Braithwaite & Drahos, 2000).

In this chapter, however, attention remains focused on the three UN drug treaties. We consider the intended functions of the treaties, the institutional arrangements for their implementation, and what evidence is available on effects and impact of the system. As this is written at a moment when change in the system seems increasingly possible, a brief discussion of potential future developments is also included.

Main Text

Intended Functions of the Treaties

The treaties have three main functions: as a penal regime to enforce limitation of use of scheduled substances to medical or scientific purposes; as a specialized trade treaty controlling international trade in psychoactive substances for medical use; and as a central planning scheme to ensure adequate supplies particularly of opiates for medical use.

A Penal Regime to Enforce Drug Prohibition

The Single Convention, as its name conveys, replaced an array of treaties and protocols which had accumulated since the first opium treaty, the Hague Convention of 1912. But the Single Convention went well beyond what was in the previous treaties, signaling a change in the system's orientation (Carstairs, 2005). Whereas the prime concern of the previous treaties had been with regulating international trade in plant-derived drugs (opiates, cocaine and cannabis), the 1961 Convention introduced requirements that possession and delivery, along with a wide variety of market-related actions concerning the drugs covered, be criminalized under a country's domestic laws (Bewley-Taylor and Jelsma, 2012). What had been a system concerned primarily with controlling international movement of drugs became a system committed to enforcing prohibitions on nonmedical use of the drugs, with each country's criminal laws as means of enforcement. The international prohibition system as it now exists can thus be said to have begun with the 1961 treaty.

The 1971 treaty greatly expanded the scope of the system by including a wide range of synthetic substances, many of them with pharmaceutical uses. The market controls in the 1971 treaty are weaker than those in the 1961 treaty, reflecting the powerful influence of the pharmaceutical industry on the treaty negotiations (McAllister, 1991). The requirement concerning criminalization under domestic law is more simply stated than in the 1961 treaty, requiring penalization of "any action contrary to a law or regulation adopted in pursuance of its obligations under this Convention".

But since the Convention requires a medical prescription to authorize use of a covered drug, any possession or use without a prescription should be criminalized.

The 1988 treaty, as its name reveals, represented a further shift in the system's focus, with more attention focused on combatting the illicit markets which had emerged as a byproduct of the prohibition system, including for the first time controls on precursor chemicals used in the preparation of controlled drugs. But, in an effort to eliminate any remaining ambiguity, it also included a further provision on criminalization at the level of the individual drug user: that a signatory country should "establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption".

The system of treaties inaugurated by the 1961 convention, then, has as a main goal the elimination or at least suppression of any nonmedical use of drugs, aiming to eliminate illicit markets in drugs by a five-pronged approach: (1) particularly for drugs covered by the 1961 treaty, by restriction of the supply of the drugs, limiting production to the estimated medical need for the drugs; (2) by a system of export and import permits, restricting legitimate trade in the drugs in accordance with a receiving country's wishes; (3) by requiring that most substances covered by the treaties be in a prescription system, as a way of confining availability to medical control and use; (4) by criminalising production, sale and other market activities outside those permitted for drugs for medical use; and (5) by criminalising users for purchase or possession of drugs other than for medical purposes.

A Trading and Marketing Control Regime

The treaties also set up a trading and marketing regime, a special kind of trade treaty which aims more to structure and direct international trade, rather than the more usual main aim of trade treaties -- to facilitate trade. Requiring that an import permit be issued by the receiving country before drugs can be shipped to it means that a country can control and indeed cut off the legal supply of a drug to its residents.

Although the drug treaty system was established before the formation of the current system of international trade treaties, it has served an informal function of protecting the substances under its jurisdiction from any trade disputes seeking to open up markets for controlled drugs. This contrasts with the situation for alcohol and tobacco (O'Brien, 2013; Baumberg & Anderson, 2008; Shaffer et al., 2005)

A Central Planning Scheme to Supply Medical Needs

Particularly through the 1961 treaty and its predecessors, and particularly for opiates, the international system is intended to ensure that supplies of opium-derived drugs for medical use are available globally. Each signatory country is supposed to send to the International Narcotics Control Board (INCB) annual data on medical use of opioids and estimates of requirements for the next year. There is a system of permits for countries to grow opium to meet the demand from the medicinal market (around 2010, nearly half the legal supply was grown in Tasmania). Particularly with respect to opium, the aim is a globally-controlled system of cultivation, manufacture and supply which will ensure that medical needs everywhere for opioid medications are met.

Institutional Arrangements for Implementation of the Treaties

In the United Nations system, the drug treaties come under the jurisdiction of the UN's Economic and Social Council (ECOSOC), which serves as the final deciding body for issues such as the scheduling of drugs under the treaties, and determines whether a conference should be called to consider amendments to the treaties. The political body governing the drug system is the Commission on Narcotic Drugs, with 53 member states elected by ECOSOC, but with proceedings open to attendance by other UN member states. The CND meets annually for several days in March in Vienna, in proceedings including plenary sessions, a Committee of the Whole for the discussion of proposed resolution, and committee meetings. Each year the CND adopts resolutions following discussions which are often lengthy, since its decisions are customarily made by consensus.

The administrative body for the system is the UN Office on Drugs and Crime, which has responsibility also for the two UN crime treaties (on transnational organized crime and against corruption). UNODC has a limited "regular budget" as part of the UN system, and relies for 90% of its funding on "voluntary contributions", mainly from governments. Since these contributions are usually earmarked for specific projects, donor countries have a large say in determining the directions of the UNODC's work. In 2012, UNODC had about 500 employees, spread around the world – a smaller number than the US Drug Enforcement Agency had posted outside the U.S. (Room & Reuter, 2012).

The International Narcotics Control Board (INCB) is a board consisting of 13 individual members elected by ECOSOC, 3 of them from a list of 5 nominated by the World Health Organization. They are supposed to serve as independent experts, not as representatives of any state; a unit within the UNODC serves as the INCB's secretariat. In addition to technical duties such as running the international market for opiate medications, the INCB has regarded itself as the "guardian of the treaties", issuing an annual detailed global report on the state of compliance as the INCB defines it (Bewley-Taylor & Trace, 2006).

The World Health Organization also has responsibilities under the 1961 and 1971 treaties for providing scientific and medical expertise, particularly concerning the classification and scheduling of psychoactive substances under the Conventions. According to the 1971 Convention, its assessments "shall be determinative as to medical and scientific matters". These responsibilities are primarily assigned to the Expert Committee on Drug Dependence, which is supposed to be constituted every two years for a process involving first pre-review and then two years later a detailed review concerning classification of particular substances. However, due WHO's limited resources, the Committee did not meet between 2006 and 2012. Recognising that the present scheduling of many substances had not been re-examined in the light of scientific and other developments for many years, the most recent Expert Committee supported a proposal for each scheduled substance to be re-reviewed every 20 years. In an Annex to the Committee's report it was also pointed out that the language of the Conventions does not map easily onto current scientific language concerning drugs (WHO, 2012:16, 23-35).

Over a number of years, the drug treaty system and the WHO drifted apart. A signal of this has been the CND's rejection in recent years of WHO recommendations on scheduling (Babor et al., 2010:213-214). Another signal of the division has been over the place of harm reduction in the

treatment of drug problems. In public health in general, the reduction of harm is a central commitment and strategy, and as the global public health agency WHO was necessarily committed to its promotion. However, prior to 2009 the US had insisted that the concept and term "harm reduction" not be used in the work of the international treaty agencies. After 2009, relationships between UNODC and WHO have been revitalized, including joint work on treatment guidelines (Room & Reuter, 2012).

What Can Be Said About the Effects and Impact of the System?

One measure of the success of the system is its near-universality, in terms of formal adherence to the treaties. Each year's INCB report notes with some pride the tally of countries which are signed up to each treaty. The desire for universality triumphed in the case of Bolivia's recent denunciation and reaccession to the 1961 treaty, despite disapproval by the INCB and other guardians of the system. Bolivia took this route to add a reservation to the treaty which would then allow Bolivians to chew coca leaves without contravening Bolivia's treaty commitments. Thwarted in an attempt to make this change by international consensus, Bolivia denounced (announced its withdrawal from) the treaty, proposing to reaccede with a reservation concerning coca-chewing if the reservation was accepted (Room, 2012a). If one-third of countries acceding to the treaty had objected, Bolivia's reaccession would not have gone into effect. It is a mark of the system's commitment to universality that there were only a few objections, despite considerable displeasure expressed by the INCB and others about Bolivia's reservation.

A second measure is in terms of its success in ensuring access to pain medication. For developed countries, this is not generally a problem. But the WHO has estimated that 80% of the world's population lacks adequate access to effective pain medication (WHO, 2007). Part of the problem, of course, is a lack of resources to procure or supply the medication. But another part is the indirect result of the treaty system. In consequence of the system's emphasis on law enforcement, decisions on importation of controlled drugs are often in the hands of police, who may choose to restrict or stop imports in order to impede diversion of the medicine to illicit markets. Reflecting concern about this, the most recent WHO Expert Committee decided that ketamine, a cheap and relatively safe anaesthetic widely used in poor countries, should not be brought under the treaties. "Concerns were raised that if ketamine were placed under international control, this would adversely impact its availability and accessibility. This in turn would limit access to essential and emergency surgery, which would constitute a public-health crisis in countries where no affordable alternative anaesthetic is available. On this basis, the Expert Committee decided that bringing ketamine under international control is not appropriate." (WHO, 2012:9). Reflecting a greater priority still being placed on prohibition of nonmedical use than on the availability of needed medications, many national delegations and three regional groupings expressed concerns or regret about the WHO decision at the May 2013 meeting of the CND (IDPC, 2013:11).

A third measure is in terms of success in controlling legal markets. Here the system can show some success, among mixed results. The pre-Single Convention system succeeded (aided by the Depression) in substantially reducing world consumption of opium in the years prior to World War II. The current system, however, has not impeded the substantial rise in recent years in prescribed use of opioids in north America, which accounts for the lion's share of global use of prescribed opioids. In general, the conclusion of Bruun and colleagues (1975) remains true: the system's successes tend

to occur where "it has been the conduct of professions and private enterprise which has been influenced". Large firms and state-licensed professionals have something to gain from cooperation with a control system, and with such levers of influence drug control systems have had some successes, for instance, in getting chemical industries to control chemical precursors, and in changing doctors' prescribing patterns when drugs, such as the barbiturates, prove to be more dangerous than was thought. The lack of any trade disputes about drugs under the system's control, in an era when free-market ideology has been dominant, might also be regarded as an unheralded success for the system.

A fourth measure, of course, is the system's degree of success in eliminating or at least reducing illicit trade, markets and use. Here the overall result must be viewed as a failure. In 1998, the UN system set a 10-year goal of "eliminating or significantly reducing the illicit cultivation of coca bush, the cannabis plant, and the opium poppy by the year 2008". This goal remained as distant at the end of the period as it had been at the beginning (Reuter et al., 2009).

Signs and Directions of Change

The failure of the international drug prohibition system in terms of its most public goal, of eliminating or minimizing illicit markets, has been apparent for some decades. At national and subnational levels, there have been initiatives and experiments since the 1960s in moving in other directions, although these initiatives have been greatly hampered by the perceived necessity of operating within the constraints of the international system. Thus even the Dutch "coffee shop" system for quasi-legal retail sale of cannabis, the most far-reaching attempt to move from an illicit to a regulated market, was handicapped by the "back door" problem – that cannabis which was sold under license at the front door had come in the back door illegally, since no way could be found to reconcile a legal wholesale supply with national obligations under the treaty (Korf, 2008).

But there are signs of change in the early 2010s, particularly in the Americas. A diverse array of Latin American countries have shown a growing impatience with the status quo, and have been willing to push against the longstanding "Washington consensus" for the status quo on drug policies. First several retired Latin American presidents, and then some sitting presidents, have expressed the need for new directions. The motivations have been diverse. In Mexico and Central America, the primary issue has been the carnage in their populations from a "war on drugs" aimed at cutting off the supply to the insatiable demand from northern neighbours. In Bolivia, as mentioned, legalization of the folk custom of coca-leaf chewing has been a main concern. In countries like Uruguay, efforts to create a regulated legal cannabis market are aimed primarily at removing a main source of criminalization of young people. With a report from the Organization of American States (OAS) exploring alternative scenarios for the future (OAS, 2013), these impulses at national levels have now taken a collective form in the region's intergovernmental agency.

At least as important have been the changes in the U.S. In November 2012, votes on popular initiatives for regulated cannabis markets in Colorado and Washington began concrete processes of change likely to have lasting effects, no matter how the US federal government eventually reacts. At about the same time, trends in opinion polls among US adults for the first time showed a popular majority for legalizing cannabis (Walsh, 2013). Changes in the legal status of cannabis do not, of

course, deal with the drug problem as a whole. But, since three-quarters of the illicit drug users in the world use only cannabis, in numeric terms dealing with cannabis will have a large effect.

The direction and extent of any changes are still unclear. The OAS report lays out some alternative scenarios for the future. Other recent reports have laid out options for change in the treaties, and have discussed more and less likely scenarios (Room, 2012b), including a potential Framework Convention on Cannabis which might supersede the handling of cannabis in the Single Convention (Room et al., 2010). But, at least in the short run, it is more likely that changes will be piecemeal and country-specific, rather than at the system level – whether involving changes made within the rules of the system, as in the case of Bolivia, or beyond the rules, as with cannabis buyers' clubs in Spain and other parts of Europe (Jelsma, 2011) and the Colorado and Washington initiatives.

Acknowledgment

Dave Bewley-Taylor and Ambros Uchtenhagen are thanked for their suggestions and prompts, but are not of course responsible for the results.

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