THE HISTORY AND DEVELOPMENT OF THE LEADING INTERNATIONAL DRUG CONTROL CONVENTIONS

PREPARED FOR THE SENATE SPECIAL COMMITTEE ON ILLEGAL DRUGS

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ABSTRACT

The current legal and administrative framework for international drug control is laid out in three international Conventions negotiated under the auspices of the United Nations (UN):

- the *Single Convention on Narcotic Drugs, 1961* (Single Convention) as amended by the *Protocol Amending the Single Convention on Narcotic Drugs, 1961*;
- the *Convention on Psychotropic Substances* (Psychotropics Convention); and
- the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* (Trafficking Convention).

The history of international drug control gives insight into the philosophical and practical underpinnings of the three drug Conventions. Beginning in an era of morally tainted racism and colonial trade wars, prohibition-based drug control grew to international proportions at the insistence of the United States. America and the colonial powers were confronted with the effects of drug addiction and abuse at home, but rather than address both demand – the socio-medical nature of such problems – and supply, they focused uniquely on the latter and attempted to stem the flow of drugs into their territories. In doing so, they earned political capital back home and shifted the cost and burden of drug control to predominantly Asian and Latin American developing countries with no cultural inclination or resources to take on such an intrusive task – and no economic or military power to refuse what was imposed on them. The Western control advocates' prohibition focus also stimulated the growth and development of the global illicit drug trade. And ironically, the system has had very little overall success in controlling the supply of drugs at the source. Nonetheless, supply-oriented activists largely achieved their goal of creating a prohibition-based international drug control system.

The Single Convention consolidated the system under the UN into one key narcotics control document – an instrument representing the compromises between the domestic and economic interests of predominantly Western, drug manufacturing nations. The Psychotropics Convention represented a weakening of the control structure because of the overwhelming influence of European and North American pharmaceutical interests throughout negotiations. The Trafficking Convention firmly established a system of international criminal drug control law that uses criminalization and penalization to combat global drug trafficking.

Although the three Conventions do leave member countries some leeway to craft drug control strategies shaped to their particular socio-cultural, political and economic realities, this flexibility is clearly limited by an overarching structure based on prohibition and criminalization.

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THE HISTORY AND DEVELOPMENT OF THE LEADING INTERNATIONAL DRUG CONTROL CONVENTIONS

INTRODUCTION: THE THREE CONVENTIONS

Drug[1] production and use is not new. Humans have been using psychoactive – mind-affecting – substances such as opium, cannabis, coca, betel, kava, peyote and qat for millennia, and for diverse purposes ranging from social and spiritual to medicinal and nutritional.

In contrast to this long history of varied drug use around the world by numerous cultures, international control of the production, distribution and use of drugs is relatively new – a distinctly 20th century phenomenon spurred on in part by disturbing increases in drug abuse and addiction. At many levels, today's world is a trade- and finance-based one dominated by the political and pecuniary interests of the most powerful nations. It was no different a century ago, and the birth and development of the international drug control regime is testament to that.

The current legal and administrative framework for international drug control is laid out in three international Conventions negotiated under the auspices of the United Nations:[2]

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(1) The word "drug" has different meanings in different contexts. The international drug control treaties define it in purely functional terms as the enumerated substances that come within the provisions of the agreements. These substances include narcotics (opiates, coca products, cannabis) and their derivatives, and psychotropics (an umbrella term for manufactured substances including stimulants, depressants and hallucinogens). This paper refers primarily to the substances within the purview of the international agreements; it is acknowledged, however, that the term drug can be used in a broader sense to also include "uncontrolled" substances such as alcohol, tobacco and caffeine. In this broad sense, one useful definition of a drug is: "a psychoactive substance capable of being used recreationally." (Franklin E. Zimring and Gordon Hawkins, *The Search for Rational Drug Control*, Cambridge: Cambridge University Press, 1992, p. 32-33)

(2) The full legal texts of each of the Conventions are available from the website of the United Nations Office for Drug Control and Crime Prevention (UNODCCP) at the following address: http://undcp.or.at/un_treaties_and_resolutions.html

- the *Single Convention on Narcotic Drugs, 1961*[3] (Single Convention) and the *Protocol Amending the Single Convention on Narcotic Drugs, 1961*[4] (Single Convention Protocol);
- the *Convention on Psychotropic Substances*[5] (Psychotropics Convention); and
- the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*[6] (Trafficking Convention).

The Single Convention is a consolidation of nine multilateral drug control treaties negotiated between 1912 and 1953. Apart from consolidation, the key purposes of the Convention were to reorganize the United Nations-based drug administration, and to extend the existing control system to include the raw materials for narcotics. Well over 100 narcotic drugs are controlled under the Convention; these include primarily plant-based products such as opium, opium derivatives (morphine, heroin, codeine), cannabis, coca and cocaine, but also synthetic narcotics including methadone and pethidine. The substances are categorized into four schedules, each schedule being subject to a different level of control. The Single Convention prohibits, for example, opium smoking and eating, coca leaf chewing, cannabis resin smoking, and the non-medical use of cannabis.

The Single Convention Protocol further tightens controls on the production, use and distribution of illicit narcotics. The Protocol also contains provisions on treatment and rehabilitation for drug abuse and addiction.

The Psychotropics Convention extends international control to include numerous synthetic psychotropic substances: stimulants, such as amphetamines; depressants, including barbiturates; and hallucinogens, such as mescaline and LSD (lysergic acid diethylamide).

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(3) Canadian Treaty Series 1964/30, done at New York, 30 March 1961, entered into force 13 December 1964 (cited hereafter as Single Convention). The Single Convention came into force for Canada on 13 December 1964.

(4) Canadian Treaty Series, 1976/48, done at Geneva, 25 March 1972, entered into force 8 August 1975 (cited hereafter as Single Convention Protocol). The Single Convention Protocol came into force for Canada on 4 September 1976.

(5) Canadian Treaty Series, 1988/35, done at Vienna, 21 February 1971, entered into force 16 August 1976 (cited hereafter as Psychotropics Convention). The Psychotropics Convention came into force for Canada on 9 December 1988.

(6) Canadian Treaty Series, 1990/42, done at Vienna, 20 December 1988, entered into force 11 November 1990 (cited hereafter as Trafficking Convention). The Trafficking Convention came into force for Canada on 11 November 1990.

Similar to the Single Convention, the drugs are organized into four schedules depending on their addiction and abuse potential, and their therapeutic value. The Convention sets out detailed provisions concerning the international trade of psychotropics, including measures that strictly control their export and import. Measures for the prevention of abuse and for rehabilitation are also included.

The Trafficking Convention is intended to complement the other two Conventions by attacking the illicit traffic of drugs under international control. Its key goals are improved international law enforcement cooperation and strengthened domestic criminal legislation. The Convention contains provisions on money laundering, the freezing of financial and commercial records, extradition of drug traffickers, transfer of criminal proceedings, mutual legal assistance, and strict monitoring of chemicals often used in illicit production.

Each of the treaties encourages – and often requires – that member countries put in place strong domestic penal provisions.

The nature of the Conventions flows directly from the historical context that led to them. It is helpful to be aware of some significant themes that intersperse and punctuate the history of international drug control, and the development and implementation of the three Conventions:

- *Prohibition*: The international drug control regime is based on a philosophy of prohibition – as opposed to regulation – of drug production and use for non-medical or non-scientific, i.e., illicit, purposes. The focus of the legal framework has been to attempt to control the supply of drugs at the source and to impose criminal penal sanctions on illicit drug producers, traffickers, dealers and users. Only later in the 20th century have demand-side and etiological issues such as domestic social problems, public health concerns, and user harm reduction options begun to be considered. The current control infrastructure continues to be prohibition-based.
- *Outside Interests*: The development of the international drug control system has been significantly influenced and shaped by numerous elements not directly related to drug control, including: racism, fear, economic interests, domestic and international politics, global trade, domestic protectionism, war, arms control initiatives, the Cold War, development aid, and various corporate agendas.

- *United States*: Since the start of international drug control efforts at the turn of the 20th century, the U.S. has been the key player in most multilateral negotiations. The prohibition basis derives largely from U.S. policy – the various forms, past and present, of the U.S. "war on drugs" – and the particular individuals who have represented the U.S. in international negotiations.
- *Powerful Personalities*: Certain individuals stand out in the history of international drug control. While in positions of power at opportune moments, their beliefs, morals, ambitions and single-minded determination enabled them to exert exceptional influence over the shape of the international drug control regime.

This paper describes the basic 20th century history of drug control leading up to the three Conventions; it also discusses how this history influenced their negotiation and drafting, and continues to influence their interaction and implementation.(7) In doing so, the paper discusses the current flexibility and limits of the Conventions.(8)

Being aware of the history of the international drug control infrastructure assists in comprehending its deep-rooted prohibition philosophy, and the motives that created and perpetuate the system now in place. The motives in particular are not readily evident from

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(7) There are many detailed accounts of the history of drug control. See, for example, the following authoritative works: David R. Bewley-Taylor, *The United States and International Drug Control, 1909-1997*, London and New York: Pinter, 1999; Kettil Bruun, Lynn Pan and Ingemar Rexed, *The Gentlemen's Club: International Control of Drugs and Alcohol*, Chicago: University of Chicago Press, 1975; Peter D. Lowes, *The Genesis of International Narcotics Control*, Geneva: Librairie Droz, 1966; William B. McAllister, *Drug Diplomacy in the Twentieth Century*, London and New York: Routledge, 2000; David F. Musto, *The American Disease: Origins of Narcotic Control,* Third Edition, Oxford: Oxford University Press, 1999; Arnold H. Taylor, *American diplomacy and the narcotics traffic, 1900-1939: A study in international humanitarian reform*, Durham, N.C.: Duke University Press, 1969. Throughout this paper, many references are made to the works of William B. McAllister. His writings are based on extensive archival, at-the-source research (e.g., UN meetings transcripts) and provide the most up-to-date and comprehensive overview of the contextual formation of the international drug control system.

(8) This paper highlights key elements of the Conventions, but does not provide in-depth explanations of all the important articles. For more detailed descriptions of the provisions of the Conventions, see Daniel Dupras, *Canada's International Obligations Under the Leading International Conventions on the Control of Narcotic Drugs*, Ottawa: Parliamentary Research Branch, Library of Parliament, 20 October 1998. See also the following UN publications: *Commentary on the Single Convention on Narcotic Drugs, 1961*, New York: United Nations, 1973; *Commentary on the Protocol Amending the Single Convention on Narcotic Drugs, 1961*, New York: United Nations, 1976; *Commentary on the Convention on Psychotropic Substances*, New York: United Nations, 1976; and *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, New York: United Nations, 1976.

simply analyzing the text of the Conventions or their official commentaries.(9) But a review of the history fleshes out these motives and leads to a more balanced understanding of the current international drug control machinery.

THE HISTORY LEADING UP TO THE THREE CONVENTIONS: PRE-1961

Throughout the 19th century, individuals at all levels of society in Canada, the United States, Europe and Australia used opium and coca in various forms and mixtures for primarily palliative and tranquilizing purposes.(10) Medical and legal control over such drugs was minor, and knowledge of addiction and abuse was limited at best. Drug use was essentially a question of personal choice and was not regarded with social disapproval. Addiction and abuse were common, simply out of ignorance of the medical effects of the drugs. In the U.S., for example, historians have described the typical 19th century addict as female, middle class, middle aged, and white; often "housewives" and people working in the medical profession.(11)

Waves of migration from Asia to Europe, North America and Australia contributed to a marked shift in the apparent respectability of drug use. Chinese immigrant labourers in particular bore the brunt of such changing attitudes. The smoking of opium was viewed as a Chinese scourge – an enormous threat linked to immorality, criminality and general social decay – and it was largely this blatant racism that sparked the first serious domestic controls on the use of drugs, especially opium smoking by "foreigners."(12) Within this climate of racism and moral reform, international activity to control opium began in the late 19th century.

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(9) The commentaries referred to in the previous footnote are a useful tool for gaining a deeper understanding of the meaning of particular provisions, and for insight on how they are intended to be implemented.

(10) See, for example, Desmond Manderson, "Trends and Influences in the History of Australian Drug Legislation," *Journal of Drug Issues*, Vol. 22, No. 3, Summer 1992, p. 507.

(11) David T. Courtwright, *Dark Paradise: Opiate Addiction in America before 1940*, Cambridge: Harvard University Press, 1982, p. 1-8, 36-48.

(12) Mexican and Black people were also key targets as they were often associated with cannabis and cocaine use, respectively. For details on the racist aspects of drug control origins, see: Courtwright (1982); Colby Cosh, "All thanks to an hysterical lady judge," *Alberta Report*, Vol. 24, Issue 36, 18 August 1997, p. 32; P.J. Giffen, Shirley Endicott and Sylvia Lambert, *Panic and Indifference: The Politics of Canada's Drug Laws*, Ottawa: Canadian Centre on Substance Abuse, 1991, ch. 2; Timothy A. Hickman, "Drugs and Race in American Culture: Orientalism in the Turn-of-the-Century Discourse of Narcotic Addiction," *American Studies*, Vol. 41, No. 1, Spring 2000, p. 71-91; Douglas Clark Kinder, "Shutting Out the Evil: Nativism and Narcotics Control in the United States," in William O. Walker III, ed., *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park, Pennsylvania: Pennsylvania State University Press, 1992, p. 117-142; Desmond Manderson, *From Mr. Sin to Mr. Big*, Oxford: Oxford University Press, 1993; and Manderson (1992).

In China, paradoxically, rampant opium problems were seen as a symbol of unwanted Western intervention.(13) Opium use and addiction and the burgeoning opium trade were serious concerns for the Imperial Chinese government. Following the Opium Wars of 1839-1842 and 1856-1860, in which Britain defeated China, severe limitations were placed upon Chinese sovereignty through the treaties that ended the wars.(14) These restrictions prevented the Chinese government from stopping the continual flow of opium imports from India – an important source of revenue for the British colonial government in India. Meanwhile, in Britain and North America, anti-opium movements led by Christian church leaders and missionaries were growing and pressuring the British government to end the India-China opium trade. Britain justified the trade with arguments that if it were to stop, the British India market share would immediately be absorbed by other producers such as Persia (now Iran) and Turkey, and China would simply increase its domestic opium production.(15)

In 1906, a Liberal British government came to power that opposed the India-China forced opium trade, and the Chinese government simultaneously began an extensive campaign against domestic opium smoking and production. Britain agreed in 1907 to decrease Indian opium exports to China by ten per cent annually as long as China would allow independent British verification of domestic Chinese production reductions. The agreement worked better than both countries expected, until the fall of the Manchu (Ch'ing) dynasty in 1911, following which Chinese warlords began encouraging widespread opium production to build military revenue. Nonetheless, the 1907 "ten year agreement" was viewed by future prohibition advocates as the first successful opium "treaty" and it set the tone for the next 60 years of international drug control negotiations.(16)

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(13) A further paradox: "…opium was first used in the West; it was taken to China by Arab traders as a medicine, and the smoking of opium derived from tobacco smoking, another Western import, believed to have been introduced by the Portuguese to Formosa [Taiwan] and from there to the mainland of China." (Bruun *et al.* (1975), p. 9-10)

(14) Brian Inglis, *The Forbidden Game: A Social History of Drugs*, London: Hodder and Stoughton, 1975, p. 72-95; Martin Booth, *Opium: A History*, New York: St. Martin's Press, 1996, p. 134-137, 144-146.

(15) Musto (1999), p. 28-30; McAllister (2000), p. 20-24.

(16) McAllister (2000), p. 24-27.

A. The 1909 Shanghai Conference

U.S. interest in international drug control increased significantly following the Spanish-American War, which led to the U.S. acquiring the Philippines in 1898.(17) With the country came what was perceived by the American administration to be a serious problem: a government-run opium supply monopoly. Under the guidance of the newly installed Episcopal Bishop of the Philippines, Charles Henry Brent, the monopoly was suppressed, but smuggling continued and Brent convinced President Theodore Roosevelt to support the organization of an international meeting in Shanghai to address what was clearly a regional problem.(18)

In February 1909, the International Opium Commission(19) met in Shanghai with Brent as President of the meeting, but because the participants did not have the necessary plenipotentiary powers to conclude a treaty, the result was simply fact-finding and a set of non-binding recommendations (see Table I).(20) In discussing the terms of reference for the Commission, a key question was whether medically-related drug matters, such as addiction and treatment, should be considered; the proposal was defeated (by a majority of one) based on the belief that sufficient medical expertise was not represented at the meeting.(21) This set a significant precedent: most future drug meetings would be attended predominantly by diplomats and civil servants, without significant input from medical experts.

The negotiations during the Commission meetings set the stage for later conferences as the U.S., aggressively represented by Dr. Hamilton Wright, tried to convince the colonial powers to support a narrow definition of "legitimate use" of opium, whereby any non-medical or non-scientific use – according to Western medical and scientific standards – would be

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(17) Lowes (1966), p. 102.

(18) Bewley-Taylor (1999), p. 19. Bishop Brent viewed the opium issue as a moral question and use of the drug as a "social vice…a crime." (Taylor (1969), p. 37-38)

(19) The Commission consisted of all the colonial powers in the region – Britain, France, Germany, Japan, the Netherlands, Portugal and Russia – as well as China, Siam [now Thailand], Persia [now Iran], Italy and Austria-Hungary. (McAllister (2000), p. 28) See Taylor (1969), ch. 3, for details on the Commission's formation and operation.

(20) Table I sets out the chronology and relevant dates of all the key international drug control agreements. The key provisions of most of the international agreements concluded prior to the three Conventions are available in: United States, *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971,* Washington, D.C.: Bureau of Narcotics & Dangerous Drugs, 1972.

(21) Bruun *et al*. (1975), p. 11; Lowes (1966), p. 187-188.

TABLE I: Multilateral Agreements on Narcotics and Psychotropic Substances

Date and Place Signed	Title of Agreement	Date of Entry into Force
26 February 1909 Shanghai, China	Final Resolutions of the International Opium Commission [1]	Not Applicable
23 January 1912 The Hague, Netherlands	International Opium Convention	11 February 1915 / 28 June 1919 [2]
11 February 1925 Geneva, Switzerland	Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium	28 July 1926
19 February 1925 Geneva, Switzerland	International Opium Convention	25 September 1928
13 July 1931 Geneva, Switzerland	Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs [3]	9 July 1933
27 November 1931 Bangkok, Thailand	Agreement for the Control of Opium Smoking in the Far East	22 April 1937
26 June 1936 Geneva, Switzerland	Convention for the Suppression of the Illicit Traffic in Dangerous Drugs	26 October 1939
11 December 1946 Lake Success, New York, USA	Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936	11 December 1946
19 November 1948 Paris, France	Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946	1 December 1949
23 June 1953 New York, USA	Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium	8 March 1963
30 March 1961 New York, USA	Single Convention on Narcotic Drugs, 1961	13 December 1964
21 February 1971 Vienna, Austria	Convention on Psychotropic Substances	16 August 1976
25 March 1972 Geneva, Switzerland	Protocol amending the Single Convention on Narcotic Drugs, 1961	8 August 1975
20 December 1988 Vienna, Austria	United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances	11 November 1990

[1] This is the only document in the Table that is not an enforceable multilateral treaty. It is included because it marks the beginning of substantial international cooperation on the control of drugs.
[2] China, the Netherlands, and the U.S. put the Convention into force among themselves in 1915 (they were joined later that year by Honduras and Norway). Only when the Convention was made part of the Versailles Treaty in 1919 did it come into force globally.
[3] As amended by the Protocol signed at Lake Success, New York, on 11 December 1946.

(Sources: Canadian Treaty Series; Kettil Bruun, Lynn Pan and Ingemar Rexed, *The Gentlemen's Club: International Control of Drugs and Alcohol*, Chicago: University of Chicago Press, 1975; United States, *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971*, Washington, D.C.: Bureau of Narcotics & Dangerous Drugs, 1972.)

considered illicit. The colonial powers argued for the legitimacy of a more lenient "quasi-medical" use. In the final wording of Resolution 3, the Commission concluded "that the use of opium in any form otherwise than for medical purposes is *held* by *almost* every participating country to be a matter for prohibition *or for careful regulation*; and that each country in the administration of its system or regulation purports to be aiming, as opportunity offers, at progressively increasing stringency" (emphasis as in original).

The Commission was far from truly "international." The focus was on Chinese opium problems – five of the nine resolutions mention China by name – and the U.S. and Britain dominated discussions. The U.S. was pushing for prohibition and felt China needed assistance with its domestic opium problems. Britain worked to protect its lucrative Indian opium trade, arguing that curbing such trade would be useless until China brought its domestic production under control.(22)

It is noteworthy that underlying the hard-line stance of the U.S. delegation at the Shanghai meeting were key domestic political and economic goals that would also flavour later negotiations. It was assumed that if other countries controlled their own production and export of opium, the U.S. would not be burdened with the task, because the poppy and the coca leaf had never been grown in appreciable quantities in North America. Furthermore, international action urging countries to take drastic internal measures provided ammunition for Brent and Wright who were pressuring the U.S. government to develop stringent domestic drug control laws.(23)

B. The 1912 Hague International Opium Convention

At the Shanghai meeting, the Americans had proposed a future conference to draft an international drug control treaty that would include the Shanghai resolutions in an expanded and more stringent form. This proposal was contested by the other countries and went nowhere. In the following years, however, the U.S. lobbied continually and forcefully around the world for a new conference. Addressing the opium problem directly, publicly and internationally was a way for the U.S. to achieve its domestic control objectives, to put an end to the profitable drug

(22) Walker III, William O., *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954*, Chapel Hill, N.C.: University of North Carolina Press, 1991, p. 16-17; Lowes (1966), p. 152-153.

(23) Musto (1999), p. 36-37.

trade dominated by the colonial powers, and to curry favour with the Chinese and thereby hopefully improve Sino-American economic relations.[24]

Eventually, 12 countries agreed to meet at the Hague on 1 December 1911 to draft a treaty.[25] Again, the meeting was presided over by Brent, and Wright led the U.S. delegation. Most states had insisted on amendments to the U.S. draft agenda, which focused on stringent control of opium production, manufacture and distribution in Asia. For example, Britain insisted that manufactured drugs – such as morphine, heroin, and cocaine – be considered. This was an attempt to dilute the opium agenda and deflect attention from Indian opium production; Britain also hoped that a fair treaty would create a level playing field for British pharmaceutical companies to compete with the dominant German synthetic drug industry.[26]

Chapters I and II of the1912 *International Opium Convention*[27] (1912 Hague Convention) dealt with raw and prepared opium. For example, Article 1 required parties to "enact effective laws or regulations for the control of the production and distribution of raw opium" unless such laws were already in place. The Convention also further recognized the U.S.-initiated principle of restricting opium use to medical and scientific purposes. Chapter IV was aimed at reducing drug trafficking in China.

Chapter III focused on licensing, manufacturing and distribution controls on synthetic drugs, but Germany ensured that the provisions were weak and vague. Article 10 allowed countries to simply use their "best endeavours" to implement these controls. Furthermore, Germany refused to sign the treaty until it was agreed that all countries would have to ratify[28] the Convention before it came into force. This was an effective tactic for delaying control measures as it took almost a decade before all countries ratified – Germany did so only

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(24) William B. McAllister, "Conflicts of Interest in the International Drug Control System," in William O. Walker III, ed., *Drug Control Policy: Essays in Historical and Comparative Perspective*, University Park, Pennsylvania: Pennsylvania State University Press, 1992, p. 145.

(25) They were: Britain, China, France, Germany, Italy, Japan, the Netherlands, Persia [now Iran], Portugal, Russia, Siam [now Thailand], and the United States.

(26) McAllister (2000), p. 32-33; Bruun *et al.* (1975), p. 11-12.

(27) Done 23 January 1912, in force 28 June 1919. See Taylor (1969), ch. 4, for details on the negotiations and final document.

(28) Ratification being the process by which each country enacts domestic implementation legislation – unless the internal laws already fulfil the new international obligations – and thereby consents to the treaty's application within its territory.

because the 1919 Versailles Treaty ending World War I required such ratification as a condition of peace.(29)

The 1912 Hague Convention assisted Wright in his push for domestic U.S. legislation: he argued that a federal law was necessary for the U.S. to fulfil its obligations under the Convention. In 1916, the U.S. Supreme Court found that this was not so, but by then the *Harrison Narcotics Act of 1914* had become the first federal drug control law in the United States; it would remain a pillar of U.S. drug policy for the coming decades.(30)

The creation of the League of Nations in 1919 following World War I presented the international community with a centralized body for the administration of drug control. In 1920, the League created the "Advisory Committee on the Traffic in Opium and other Dangerous Drugs" – commonly known as the Opium Advisory Committee (OAC), the precursor to the United Nations (UN) Commission on Narcotic Drugs. The League Health Committee – forerunner of the UN World Health Organization – was also formed. Administration of the 1912 Hague Convention had originally been the responsibility of the Netherlands, but was transferred to the Opium Control Board (OCB) created by the OAC. Enforcement of the Convention was weak as the countries on the OCB profited most from the drug trade.(31)

The League began to consider demand-side, socio-medical issues such as why individuals use drugs, what constitutes drug abuse, and what social factors affect abuse. But prohibition and supply-side issues soon took precedence once again as preparations began for new, again U.S.-initiated, treaty talks in the mid-1920s. In general, the international regime has tended to separate the study of drug-related medical and social problems – including etiological questions – from those of drug control.(32)

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(29) McAllister (2000), p. 36-37; Bruun *et al.* (1975), p. 12; Lowes (1966), p. 182-186.

(30) Musto (1999), p. 59-63. Because the U.S. Constitution did not allow a direct federal role in the criminalization of drug use, Wright designed the Harrison Act as a tax statute – physicians, pharmacists, wholesalers and retailers had to get a tax stamp to distribute drugs – and it was enforced by the Treasury Department. Thus, use was limited by restricting access. (McAllister (2000), p. 35)

(31) McAllister (1992), p. 145-146.

(32) McAllister (2000), p. 46-50; Lowes (1966), p. 188.

C. The 1925 Geneva Opium Conventions

Although the U.S. had chosen not to join the League of Nations, American influence in international drug control matters did not wane. Worried by the 1912 Hague Convention's limited effect on the smuggling of opium and, increasingly, manufactured drugs in East Asia, the U.S. pressured the League to convene a new conference – the League feared that if it did not comply, the U.S. might act independently.(33)

Between November 1924 and February 1925, two back-to-back conferences were held and two separate treaties concluded. The first Geneva Convention(34) focused on opium-producing nations; signatories were permitted to sell opium only through government-run monopolies and were required to end the trade completely within 15 years.

The second Geneva Convention, the *International Opium Convention*(35) (1925 Geneva Convention), was intended to impose global controls over a wider range of drugs, including, for the first time, cannabis – described as "Indian hemp" in Article 11 of the Convention. Articles 21-23 required Parties to provide annual statistics on: drug stocks and consumption; the production of raw opium and coca; and the manufacture and distribution of heroin, morphine and cocaine. Chapter VI replaced the OCB with an eight-person Permanent Central Opium Board (PCOB).(36) Chapter V of the second Convention set up a PCOB-monitored import certification system to control the international drug trade by limiting the amount that each country could legally import.

While the 1912 Hague Convention had focused on domestic controls, the Geneva Conventions were an attempt to improve transnational control. The U.S. had proposed strict adherence to the principle of only medical and scientific legitimate drug use, and stringent controls over the production of drugs at the source. When these proposals were flatly refused at the second conference, the U.S. delegation walked out of the conference and never signed the treaties. As well, the Chinese delegation withdrew because no agreement could be reached on

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(33) McAllister (2000), p. 50-51.

(34) *Agreement concerning the Manufacture of, Internal Trade in, and Use of Prepared Opium*, done 11 February 1925, in force 28 July 1926. See Taylor (1969), ch. 7, for details on the negotiations and final document.

(35) Done 19 February 1925, in force 25 September 1928. See Taylor (1969), ch. 7, for details on the negotiations and final document.

(36) Intended to be more impartial and politically disinterested, the PCOB has remained extremely political to this day (it still exists). Since inception, its membership has continually included a British, U.S. and French representative. (McAllister (2000), p. 83)

the suppression of opium smoking.[37] Instead, both countries continued to focus on enforcement of the 1912 Hague Convention.

Despite a growing prohibition-based control regime, the drug problem only seemed to get worse; William B. McAllister has summed up the international context at the end of the 1920s:

> In addition to continued overproduction of opium inside China, statistical returns indicated that Chinese imports of manufactured drugs had skyrocketed. The European colonial powers continued to tolerate (and profit from) opium smoking through government monopolies. As western European governments pressured pharmaceutical companies to conform to more stringent control standards, unscrupulous operators moved to states that had not ratified the [Geneva] International Opium Convention. Traffickers became more sophisticated in their operations, colluding with political and/or military brokers to avoid prosecution. Drug abusers and their suppliers acted as inventively as the diplomats and bureaucrats; those wishing to circumvent the system altered their routes of acquisition to fit the new pattern.[38]

D. The 1931 Geneva Narcotics Manufacturing and Distribution Limitation Convention / 1931 Bangkok Opium Smoking Agreement

The import control system put in place by the 1925 Geneva Convention was only partially effective because drugs were simply transhipped through non-signatory countries. In 1931, the League of Nations convened a further conference in Geneva to place limits on the manufacture of cocaine, heroin and morphine, and to control their distribution. The result of the conference was the *Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*[39] (1931 Limitation Convention).

Beginning in 1931, Canada shifted from being essentially reactive to international drug control efforts and began playing an active role in supporting U.S. efforts to expand control at the source. Colonel Charles Henry Ludovic Sharman was named Chief of the Narcotics Division – part of the Canadian Department of Pensions and National Health – and was the principal developer of Canadian domestic and international drug policy until the 1960s. Canada,

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(37) Bruun *et al*. (1975), p. 14.

(38) McAllister (2000), p. 86.

(39) Done 13 July 1931, in force 9 July 1933. See Taylor (1969), ch. 9, for details on the negotiations and final document.

through Sharman, was highly involved in the 1931 Limitation Convention negotiation process.(40)

A new player also emerged on the U.S. delegation: Harry J. Anslinger, first Commissioner of the newly created Federal Bureau of Narcotics – he would hold this position for 33 years. Utterly devoted to prohibition and the control of drug supplies at the source, Anslinger is widely recognized as having had one of the more powerful impacts on the development of U.S. drug policy, and, by extension, international drug control into the early 1970s.(41)

The centrepiece of the 1931 Limitation Convention was the manufacturing limitation system set out in Chapters II and III. Parties were required to provide the PCOB with estimates of their national drug requirements – for domestic medical and scientific purposes – and based on these estimates the PCOB would calculate manufacturing limits for each signatory. A Drug Supervisory Body (DSB) was created to administer the system. Article 26 significantly decreased the effectiveness of the Convention: States did not assume any responsibilities under the Convention for their colonies. Article 15 required states to set up a national drug control "special administration," somewhat modelled on the U.S. domestic control apparatus.(42)

The Convention came into force quickly because various countries and the League of Nations thought it could provide a useful model for arms control negotiations. The League even prepared a report explaining how the principles set out in the 1925 Geneva Convention and the Limitation Convention could be applied to disarmament issues.(43)

In late 1931, a further conference was held in Bangkok to address opium smoking in the Far East. The treaty(44) produced was weak, primarily because the U.S. attended only as an observer and the European colonial powers were unwilling to implement effective controls on opium use while there was significant opium overproduction and trafficking. The fact that the U.S. strategy of absolute prohibition had made little impact on opium trafficking and use in the

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(40) Giffen *et al*. (2000), p. 483.

(41) See, for example, McAllister (2000), p. 89-90; Bewley-Taylor (1999), p. 102-164; Bruun *et al.* (1975), p. 137-141; Inglis (1975), p. 181-190. See also, Harry J. Anslinger and Will Oursler, "The War against the Murderers," in William O. Walker III, ed., *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict*, Wilmington, Delaware: Scholarly Resources Inc., 1996.

(42) Anslinger would use this provision continually in the future as a way of protecting his position and the U.S. Federal Bureau of Narcotics from being altered through reorganization. (McAllister (2000), p. 98, 108-109)

(43) *Ibid.*, p. 110-111.

(44) *Agreement for the Control of Opium Smoking in the Far East*, done 27 November 1931, in force 22 April 1937. See Taylor (1969), ch. 10, for details on negotiations and final document.

Philippines did not assist the U.S. in pushing for the elimination of poppy cultivation. The key effect of the Bangkok conference was that it convinced the U.S. a firmer approach was needed to combat raw material production and illicit drug trafficking.(45)

E. The 1936 Geneva Trafficking Convention

Based on initiatives of the International Police Commission – forerunner of the International Criminal Police Organization (INTERPOL) – negotiations had begun in 1930 to develop a treaty to stem the illicit drug traffic and harshly punish traffickers through criminal sanctions.(46)

In 1936, the *Convention for the Suppression of the Illicit Traffic in Dangerous Drugs*(47) (1936 Trafficking Convention) was concluded in Geneva. The U.S., led by Anslinger, had attempted to include in the treaty the criminalization of all activities – cultivation, production, manufacture and distribution – related to the use of opium, coca (and its derivatives) and cannabis for non-medical and non-scientific purposes. Many countries opposed this and the focus remained on illicit trafficking.(48) Article 2 of the Convention called upon signatory countries to use their national criminal law systems to "severely" punish, "particularly by imprisonment or other penalties of deprivation of liberty," acts directly related to drug trafficking.

The U.S. refused to sign the final version because it considered the Convention too weak, especially in relation to extradition, extraterritoriality and the confiscation of trafficking profits. The U.S. was also worried that if it signed, it might have to weaken its domestic criminal control system already in place in order to comply with the Convention. In effect, the Convention never gained widespread acceptance as most countries interested in targeting traffickers concluded their own bilateral treaties.(49)

Despite its minimal overall effect, the 1936 Trafficking Convention represented a turning point: all the previous treaties had dealt primarily with the regulation of "legitimate"

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(45) Taylor (1969), p. 275-279; McAllister (2000), p. 106.

(46) Taylor (1969), p. 288-298.

(47) Done 26 June 1936, in force 26 October 1939. See Taylor (1969), ch. 10, for details on negotiations and final document.

(48) Taylor (1969), p. 293-295.

(49) *Ibid.*, p. 296-297; McAllister (2000), p. 123.

drug activities, whereas the 1936 Trafficking Convention now made such activities an international crime subject to penal sanctions.

F. World War II

In the late 1930s, the Opium Advisory Committee (OAC) of the League of Nations began to question the emphasis of the international drug control regime on prohibition and law enforcement. Some countries proposed dealing with abuse through public health approaches, including psychological treatment, dispensary clinics and educational programs. Promoting the U.S. belief that addicts could only be cured through institutionalization, Anslinger, supported by Sharman, was able to block all OAC efforts to consider socio-etiological approaches to drug problems. Instead, at Anslinger's insistence, the focus remained on developing a new treaty to impose prohibition and supply control globally.(50)

Ironically, in anticipation of war, many countries (in particular the U.S.) built up stockpiles of opium and opium products intended for medical purposes.(51) World War II put further development of the international drug control apparatus on hold.

G. The 1946 Lake Success Protocol

Following the War, the drug control bodies and functions of the League of Nations were folded into the newly formed United Nations.(52) The UN Economic and Social Council (ECOSOC) took over primary responsibility through its Commission on Narcotic Drugs (CND), which replaced the OAC. Under the CND, the Division of Narcotic Drugs (DND) was charged with the preparatory work for conferences. The PCOB and the DSB continued under the CND in their respective roles of compiling statistics for national estimates and administering previous treaties. Canada's Sharman became the first Chair of the CND and he also held a seat on the DSB.

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(50) McAllister (2000), p. 126-127.

(51) The possibility of war accentuated the hypocrisy and opportunistic nature of the U.S. prohibitionist position. By 1939, Anslinger "was simultaneously pursuing a League-sponsored treaty to curtail agricultural production in far-off lands, a regional agreement that would allow him to commence poppy cultivation at home, and a global acquisition program that amassed the world's largest cache of licit opium yet assembled." (McAllister (2000), p. 133)

(52) See Bewley-Taylor (1999), p. 54-59; Bruun *et al.* (1975), p. 54-65.

All of these changes in responsibility and organization meant amendments were required to all the existing international drug control treaties. Such amendments were concluded in a Protocol[53] signed at Lake Success, New York, on 11 December 1946.

H. The 1948 Paris Protocol

Anslinger and Sharman campaigned heavily to ensure that the CND would report directly to ECOSOC as an independent organization. They were afraid that if the main drug control apparatus was a larger health or social issues organization – such as the World Health Organization (WHO) or the United Nations Educational, Scientific and Cultural Organization (UNESCO) – etiology and treatment issues might take precedence over the prohibition focus. In particular, they wished to ensure that governments would be represented by enforcement officials, as opposed to physicians or others with sociology and public health backgrounds. Furthermore, the USSR showed interest in considering the social factors underlying drug abuse – for the Western powers to have agreed with the Soviet Union would have undermined their unwavering Cold War stance against Moscow and communism.[54]

Although control remained principally with ECOSOC, the World Health Organization (WHO) – in particular its Drug Dependence Expert Committee – became responsible for deciding what substances should be placed under control.[55] This authority was given to the WHO in an international Protocol[56] signed in Paris in 1948. Article 1 stated that if the WHO found a drug to be "capable of producing addiction or of conversion into a product capable of producing addiction," it would decide how to classify it within the international drug control structure. The Protocol also brought under international control specific synthetic opiates not covered by previous treaties.

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(53) *Protocol amending the Agreements, Conventions and Protocols on Narcotic Drugs concluded at The Hague on 23 January 1912, at Geneva on 11 February 1925 and 19 February 1925 and 13 July 1931, at Bangkok on 27 November 1931, and at Geneva on 26 June 1936*, done 11 December 1946, in force 1 December 1946. See Bewley-Taylor (1999), p. 54-59, for details on the negotiations and final document.

(54) McAllister (2000), p. 153-154, 159-162.

(55) Bruun *et al.* (1975), p. 70.

(56) *Protocol Bringing under International Control Drugs outside the Scope of the Convention of 13 July 1931 for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs, as amended by the Protocol signed at Lake Success, New York, on 11 December 1946*, done 19 November 1948, in force 1 December 1949. See Bewley-Taylor (1999), p. 66-67, for details on the negotiations and final document.

I. The 1953 New York Opium Protocol

By the late 1940s, it became clear that the large number of international drug treaties, with their differing types and levels of control, had become confusing and unwieldy. Anslinger, Sharman and their allies had the CND recommend to ECOSOC the idea of consolidating all existing treaties into one document – it would also be an opportunity to bring in more stringent prohibition-based controls.(57) This plan was sidelined for a decade when the Director of the DND, Leon Steinig, proposed the creation of an "International Opium Monopoly" to attempt to end the illicit trade and guarantee wholesale licit opium supply.

Throughout the 1950s, Cold War tensions pushed Anslinger to rebuild the U.S. stockpile of opium and opium derivatives, often by making large purchases from Iran through U.S. pharmaceutical companies. Many European countries were also stockpiling. The multinational pharmaceutical companies in these countries and the U.S. feared that a monopoly as proposed by Steinig would be restrictive and lead to higher prices. Anslinger and Sharman along with the British, Dutch and French killed the monopoly discussions in the CND. The French representative to the CND, Charles Vaille, suggested a new opium protocol as an interim solution until the treaties could be consolidated. A plenipotentiary conference was approved by ECOSOC, and Anslinger seized the new protocol initiative as an opportunity to impose strict global controls on opium production.(58)

The Protocol(59) (1953 Opium Protocol) was finalized in New York in 1953, and bluntly stated in Article 2 that Parties were required to "limit the use of opium exclusively to medical and scientific needs." Various provisions were included to control the cultivation of the poppy as well as the production and distribution of opium. Article 6 restricted opium production to seven states: Parties could only import or export opium produced in one of these countries.(60) The 1953 Opium Protocol comprised the most stringent international drug control provisions yet,

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(57) ECOSOC approved the recommendation in two resolutions: 159 II D (VII) of 3 August 1948, and 246 D (IX) of 6 July 1949. See also McAllister (2000), p. 172; Bewley-Taylor (1999), p. 137.

(58) McAllister (2000), p. 172-179.

(59) *Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of, Opium*, done 23 June 1953, in force 8 March 1963. See Bewley-Taylor (1999), p. 92-95, for details on the negotiations and final document.

(60) The seven producing countries were: Bulgaria, Greece, India, Iran, Turkey, the USSR and Yugoslavia.

but never gained the support Anslinger had hoped for. It did not receive sufficient ratifications to bring it into force until 1963, and by then it had been overtaken and terminated by the 1961 Single Convention.

THE CONTEXT, NEGOTIATIONS AND OUTCOMES OF THE THREE CONVENTIONS

A. Single Convention on Narcotic Drugs, 1961

The Single Convention has played a central formative role in the creation of the modern prohibitionist international drug control system. It is a continuation and expansion of the legal infrastructure developed between 1909 and 1953.

The process of consolidation of the existing international drug control treaties into one instrument began in 1948, but it was 1961 before a workable third draft was ready to be presented for discussion at a plenipotentiary conference.(61) The conference began on 24 January 1961 in New York and was attended by 73 countries, each "with an agenda based on its own domestic priorities."(62)

William B. McAllister has divided the states attending the conference into five distinct categories, according to their drug control stance and objectives:

- *Organic states group*: As producers of the organic raw materials for most of the global drug supply, these countries had been the traditional focus of international drug control efforts. They were open to socio-cultural organic drug use, having lived with it for centuries. While India, Turkey, Pakistan and Burma took the lead role, the group also included the coca-producing states of Indonesia and the Andean region of South America, the opium- and cannabis-producing countries of South and Southeast Asia, and the cannabis-producing states in the Horn of Africa. They favoured weak controls because existing restrictions on production and export had directly affected large portions of their domestic population and industry. They supported national control efforts based on local conditions and were wary of

(61) As one of the Canadian delegates to the CND, Robert Curran, a Department of National Health and Welfare official, played the most significant role in shaping a document that would be acceptable by all countries as a starting point for negotiations. (McAllister (2000), p. 205) For a discussion of this third draft, see Leland M. Goodrich, "New Trends in Narcotics Control," *International Conciliation*, No. 530, November 1960.

(62) McAllister (1992), p. 148.

strong international control bodies under the UN. Although essentially powerless to confront the prohibition philosophy, they effectively forced compromise in negotiations by working together to dilute the treaty language with exceptions, loopholes and deferrals. They also sought development aid to compensate for losses caused by strict controls.

- *Manufacturing states group*: This group included primarily Western industrialized nations, with the key players being the U.S., Britain, Canada, Switzerland, the Netherlands, West Germany and Japan. Having no modern cultural affinity for organic drug use and being faced with the effects of drug abuse among their citizenry, they advocated very stringent controls on the production of organic raw materials and on illicit trafficking. As the principal manufacturers of synthetic psychotropics, and backed by a determined industry lobby, they forcefully opposed undue restrictions on medical research or the production and distribution of manufactured drugs. The group favoured strong supranational control bodies as long as they would continue to exercise *de facto* control over such bodies. Their strategy was essentially to "shift as much of the regulatory burden as possible to the raw-material-producing states while retaining as much of their own freedom as possible."
- *Strict control group*: These were essentially non-producing and non-manufacturing states with no direct economic stake in the drug trade. The key actors were France, Sweden, Brazil and Nationalist China. Most of the states in this group were culturally opposed to drug use and suffered from abuse problems. They favoured restricting drug use exclusively to medical and scientific purposes and were willing to sacrifice a degree of national sovereignty to guarantee the effectiveness of supranational control bodies. They were forced to moderate their demands in order to assure the widest possible agreement.
- *Weak control group*: This group was led by the Soviet Union and often included its allies in Europe, Asia and Africa. They considered drug control a purely internal issue and were adamantly against any intrusion on national sovereignty, such as independent inspections. With little interest in the drug trade and minimal domestic abuse problems, they were opposed to giving any supranational organ excessive power, especially over internal decision-making.
- *Neutral group*: This was a diverse group including most of the African countries, Central America, sub-Andean South America, Luxembourg and the Vatican. They had no strong interest in the issue apart from being guaranteed access to sufficient drug supplies. Some voted with political blocs, others were willing to trade votes, and others were truly neutral and could go either way on the control issue depending on the persuasive power of the

arguments presented. In general, they supported compromise toward maximum agreement.(63)

The result of all these competing interests was a document that symbolized compromise: the Single Convention clearly upheld and expanded existing controls and in its breadth was the most prohibitionist document yet concluded, but it was not as stringent as it might have been. Onerous aspects of the 1953 Opium Protocol were not included, such as the provision restricting opium production to the seven enumerated countries. Sharman no longer negotiated for Canada, and Anslinger had played a minor role in the conference due to conflicts with the U.S. State Department. The State Department was content with the Convention because U.S. influence was guaranteed within the UN supervisory bodies and the prohibitive framework had been broadened to include tight controls over coca and cannabis. As the Single Convention had been a U.S.-initiated idea, to have backed down on it would have lost the U.S. respect at the UN and given the impression of weakness in the face of the Soviet Union during a tense Cold War period.(64)

The principal foundations of the previous treaties remained in place in the Single Convention.(65) Parties were still required to submit estimates of their drug requirements and statistical returns on the production, manufacture, use, consumption, import, export, and stock build-up of drugs.(66) The import certification system created by the 1925 Geneva Convention continued, and Parties were required to licence all manufacturers, traders and distributors – all transactions involving drugs had to be documented.(67) The Single Convention built on the trend of requiring Parties to develop increasingly punitive domestic criminal legislation. Subject to their constitutional limitations, Parties were to adopt distinct criminal offences, punishable preferably by imprisonment, for each of the following drug-related activities in contravention of

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(63) *Ibid.*, p. 148-151. See also Bewley-Taylor (1999), p. 141-143.

(64) Anslinger was extremely disappointed with the Single Convention because he believed the opium control provisions were not strong enough (e.g., Article 25 still allowed any country to produce up to five tons of opium annually, albeit subject to strict control measures). He tried to derail the Convention by lobbying countries for sufficient ratifications to bring the 1953 Opium Protocol into force first. He was unsuccessful and his influence waned subsequently. (Bewley-Taylor (1999), p. 136-161)

(65) Only the 1936 Trafficking Convention remained in force on its own and was not included in the consolidation. This was because agreement could not be reached on which provisions to include in the Single Convention. (McAllister (2000), p. 207-208) Article 35 of the Single Convention simply encouraged cooperation between countries to combat illicit trafficking.

(66) Single Convention, Arts. 19, 20.

(67) *Ibid.*, Arts. 21, 29-32.

the Convention: cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, delivery on any terms whatsoever, brokerage, dispatch, dispatch in transit, transport, importation and exportation.(68) Furthermore, the granting of extradition was considered "desireable."(69)

The Convention classified substances within four schedules according to levels of control. Schedules I and IV were the most stringent and covered primarily raw organic materials (opium, coca, cannabis) and their derivatives, such as heroin and cocaine. Schedules II and III were more lenient and contained primarily codeine-based manufactured drugs. At the U.S.'s insistence, cannabis was placed under the strictest control regime in the Convention: Schedule IV. This regime included drugs such as heroin, for which any medical use was considered "obsolete" by the WHO. The argument for placing cannabis in this category was that it was widely abused. The WHO later found that cannabis could have medical applications after all, but the structure was already in place and no international action has since been taken to alter this anomaly. As Kettil Bruun, Lynn Pan and Ingemar Rexed have documented, this inertia is largely due to the "unwillingness of the UN bodies involved to entertain changes likely to involve a departure from the basis of the current operations of the drug control system."(70)

The Single Convention pleased the U.S. by extending control to include cultivation of the opium poppy, coca bush and cannabis plant, though not nearly as forcefully as Anslinger had negotiated under the 1953 Opium Protocol.(71) Articles 23 and 24 of the Convention set up national opium monopolies and put very strict limitations on the international trade in opium.

Article 49 of the Convention required Parties to completely abolish, over a maximum period of 25 years from the coming into force of the Convention, all quasi-medical use of opium,(72) opium smoking, coca leaf chewing, and non-medical cannabis use. All production and manufacture of these drugs was also to be abolished within the same time periods. Only Parties for which such uses were "traditional" could take advantage of the delayed implementation; for others, prohibition was immediate. As the maximum time period ended in

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(68) *Ibid.*, Art. 36.

(69) *Ibid.*, Art. 36(2).

(70) Bruun *et al.* (1975), p. 200-203.

(71) Single Convention, Arts. 22-28.

(72) The time limit was 15 years for quasi-medical opium use.

1989, these practices are today fully prohibited and the drugs may be used only for domestically regulated medical and scientific purposes.

Apart from consolidating the previous treaties and expanding control provisions, the Single Convention also streamlined the UN drug-related supervisory bodies. The PCOB and the DSB were combined into a newly created organ, the International Narcotics Control Board (INCB), designed to monitor application of the Convention and to administer the system of estimates and statistical returns submitted annually by Parties.(73) It would consist of eleven members, three nominated by the WHO and eight by Parties to the Convention and UN members. Proof of the manufacturing lobby's effectiveness in negotiations was indicated by the prerequisite knowledge required for WHO nominees: "medical, pharmacological or pharmaceutical experience."(74) The INCB was given a weak embargo power enabling it to recommend that Parties stop the international trade of drugs with any Party state not complying with the provisions of the Convention.(75)

The prohibition focus of the Convention was emphasized by the minimal attention paid to drug abuse problems. Only Article 38 touched on the social, demand side of the drug problem by requiring Parties to "give special attention to the provision of facilities for the medical treatment, care and rehabilitation of drug addicts." Furthermore, it was considered "desireable" that Parties "establish adequate facilities for the effective treatment of drug addicts," but only if the country had "a serious problem of drug addiction and its economic resources [would] permit." The minor recognition of demand/harm reduction approaches, such as prevention through education, has been one of the key criticisms of the Single Convention, and international drug control treaties in general.(76)

The Single Convention effectively consolidated several decades worth of assorted drug control machinery into one key document administered by one principal body – the United Nations.

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(73) Single Convention, Arts. 5, 9-16.

(74) *Ibid.*, Art. 9(1)(a).

(75) *Ibid.*, Art. 14(2).

(76) See, for example, *Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961*, Toronto: Addiction Research Foundation, 1983, p. 10-11; recommendations 4, 5, 15, 19, 20.

B. Convention on Psychotropic Substances

In the 1960s, following the signing of the Single Convention, drug use and abuse exploded around the world, most notably in developed Western nations.(77) The increase was especially noticeable in the pervasive use and availability of synthetic, psychotropic substances created since World War II, such as amphetamines, barbiturates, and LSD. Certain substances became essentially consumer goods, resulting in many people becoming addicted. Most of these drugs were not subject to international control, and because national systems of regulation differed widely, trafficking and smuggling flourished.(78)

Throughout the 1960s, the CND and the WHO debated the issue of control of psychotropic drugs at regular meetings and made various recommendations to member states concerning the national control of particular substances, including stimulants, sedatives and LSD. In January 1970, the CND discussed a draft treaty prepared by the UN Division of Narcotic Drugs on the international control of psychotropic drugs. Following some modifications by the CND, this document became the basis for negotiations at the plenipotentiary conference convened in Vienna on 11 July 1971 – the conference that resulted in the Psychotropics Convention.(79)

The 1961 Single Convention had been used as a template for the draft Psychotropics Convention, and many of the former's features are found in the latter: CND/INCB administrative authority, schedules distinguishing levels of control for different drugs, mandatory transaction documentation and licencing, an import/export control system, illicit trafficking and penal provisions. Although a light reading may reveal little difference between the two Conventions, they are extremely different. The Psychotropics Convention imposes significantly weaker controls. The reason for this becomes evident when the positions of the negotiating stakeholders are revealed and selected parts of the two treaties are carefully

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(77) See, for example, Vladimir Kuševic, "Drug Abuse Control and International Treaties," *Journal of Drug Issues*, Vol. 7, No. 1, Winter 1977, p. 35-53. See also McAllister (2000), p. 218-220; Musto (1999), ch. 11; McAllister (1992), p. 153-162; Bruun *et al.* (1975), ch. 16; Inglis (1975), ch. 13.

(78) The U.S. attempted to regulate psychotropics through the Bureau of Drug Abuse Control created by the *Drug Abuse Control Act of 1965*. This Act also shifted the constitutional basis for drug control from the taxing power to interstate and commerce powers – a change that led to the demise of Anslinger's Federal Bureau of Narcotics and the birth of the Bureau of Narcotics and Dangerous Drugs (BNDD) under the federal Justice Department. (Musto (1999), p. 239-240)

(79) Kuševic (1975), p. 38.

compared.(80) The overwhelming influence of the multinational pharmaceutical industry on the Psychotropics Convention was particularly noticeable.(81)

In contrast to McAllister's five discernible Single Convention negotiating groups described above, at the Vienna conference the countries divided into two distinct groups with conflicting positions. One group included mostly developed nations with powerful pharmaceutical industries and active psychotropics markets – essentially the "manufacturing group." The other group consisted of developing states, supported by socialist countries, with few or no psychotropic manufacturing facilities – predominantly the "organic group." At these 1971 negotiations, however, the positions of the two groups were *entirely reversed*. The manufacturing group adopted the traditional arguments of the organic group: weak controls, national as opposed to international controls, national sovereignty taking precedence over a strong supranational UN body. The justification for these positions was that strict controls would be difficult to carry out and would cause financial loss. The organic group, on the other hand, pushed hard for strict controls similar to those they had been forced to accept under the Single Convention.(82)

Beginning with a comparison of the Preambles of the two Conventions is appropriate and revealing. Although the Preamble is not legally binding, it is intended to provide an overview of the spirit of the instrument. In the Single Convention, addiction to narcotic drugs is described as "a serious evil for the individual…fraught with social and economic danger to mankind." It is recognized, however, that "the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes." By contrast, the Psychotropics Convention makes no mention of the "serious evil" of "addiction," but rather notes "with

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(80) McAllister (1992), p. 154-162; Kuševic (1975), p. 38-41. McAllister's comparison is highly detailed and recommended; Kuševic adds useful context and insight. See also, S.K. Chatterjee, *A Guide to the International Drugs Conventions*, London: Commonwealth Secretariat, 1988, p. 15-33, for a more technical and rudimentary comparison of the two Conventions.

(81) The key author of the preparatory draft, Arthur Lande, had ended his career with the UN not long before the Vienna conference. He attended the conference as the representative of the U.S. Pharmaceutical Manufacturer's Association, one of many industry-related observers. Another example of blatant corporate influence involved a group of six small Latin American countries. They uncharacteristically supported weakening the treaty and were collectively represented by a Swiss man who spoke poor Spanish and was not a government official, diplomat, or technical drug expert. He worked for the European pharmaceutical giant, Hoffmann-LaRoche. (McAllister (2000), p. 232; Kuševic (1975), p. 39)

(82) McAllister (1992), p. 154; Kuševic (1975), p. 39.

concern the public health and social problems resulting from the abuse of certain psychotropic substances." As well, it is recognized that "the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted." The general tone of the Psychotropics Convention Preamble is less harsh, and it is implied that "abuse of certain," not all, psychotropics, is not as serious a problem as "addiction to narcotic drugs" in general.

The approach to organizing the drugs into schedules with varying levels of control also differed between the two Conventions. In the 1961 Single Convention negotiations, when the placement of a drug in a particular schedule was disputed, that drug almost always ended up in a schedule the organic group disagreed with – for example, the placement of cannabis in Schedule IV. The assumption acted upon by the manufacturing group in forcing such placements was that narcotic drugs should be considered hazardous unless and until proven not to be. This reasoning did not apply, however, when U.S. economic interests were at stake: in 1971, the U.S. delegation argued forcefully and often successfully that organic raw materials should be in the strictest schedules, while their manufactured derivatives should go in the weaker schedules.(83)

The Psychotropics Convention also contains four schedules of control, although their nature and organization is substantively different from those of the Single Convention. For example, the most stringent schedule in the Single Convention is Schedule IV,(84) which is equivalent to Schedule I(85) in the Psychotropics Convention. In both cases, the drugs included are only available for limited use by authorized persons in government-operated medical/scientific institutions and their manufacture, import and export are strictly controlled. The weakest schedule in the Psychotropics Convention is Schedule IV, which contains tranquilizers. Certain manufacturing states tried to eliminate Schedule IV by arguing that such drugs were sufficiently regulated by national controls, rendering international control unnecessary. Schedule IV remained in the end, albeit with a much smaller number of drugs in it, but the underlying assumption used in 1961 regarding placement had been completely reversed,

(83) McAllister (1992), p. 157-158.

(84) Which contains cannabis and heroin, for example.

(85) Which includes hallucinogens, such as LSD.

in particular by the U.S.: "unless there was substantial proof that a substance was harmful, it should remain uncontrolled."[86]

Another key difference between the two Conventions is highlighted through a close comparison of the schedules. Previous drug control treaties, including the Single Convention, always included not just the base substances, but also extended control to include their salts, esters, ethers and isomers, i.e., their derivatives. However, derivatives were *completely absent* from the schedules of the Psychotropic Convention. The effect of this is that every substance that is to come within the treaty regime must be explicitly mentioned. In practical terms, it is impossible to do this as new derivatives are constantly being created, and they comprise 95 per cent of the substances created by pharmaceutical firms. A general inclusion of derivatives would have meant that new substances would be automatically included. It seems that the omission was the result of a deal made between political representatives when the technical experts were not present – the derivatives had to be sacrificed in order for the manufacturing states to agree to sign the treaty.[87]

The system of estimates set out in Article 19 of the Single Convention requires Parties to report annually to the INCB how much of a particular substance controlled under the treaty they will need for the next year. This system is one of the pillars of the international drug control regime and dates back to the second Geneva conference, which led to the 1925 *International Opium Convention*. It was *completely excluded* in the Psychotropics Convention. As McAllister has pointed out, "[t]his omission was clearly in the interests of the manufacturing states, because without estimates of need it is impossible to calculate whether more of a substance than can legitimately be put to use is being fabricated."[88] This allowed multinationals to manufacture unlimited quantities of psychotropic substances without being constrained by annual limits on production based on licit need.

These omissions – derivatives and estimates – were largely corrected during the 1970s and 1980s by the DND and the INCB through quiet recourse to customary international law. The DND and INCB asked Parties to submit psychotropics information and statistics not required by the Convention. The initial positive responses from various organic group states were then used to convince others to follow. Similarly, the CND and WHO simply announced

(86) McAllister (1992), p. 158.

(87) McAllister (2000), p. 233.

(88) McAllister (1992), p. 157.

that derivatives would fall within the schedules. Some governments complied and others were eventually forced by international pressure to follow.(89)

Article 3 of the Single Convention gives the WHO the key role in determining whether, based upon a medical/scientific analysis, a new drug should be added to a schedule and thus placed under international control. The WHO's recommendation is presented to the CND, which makes the final decision. However, any Party may appeal the CND's decision to ECOSOC within 90 days. The ECOSOC decision is final. While a decision is being appealed, the CND may still require Parties to place control measures on the substance in question.

Under the Psychotropics Convention, the WHO continues to make control recommendations based upon medical and scientific criteria. However, Article 2(5) explicitly directs the CND to bear in mind "the economic, social, legal, administrative and other factors it may consider relevant" in coming to its decision. Furthermore, Article 17(2) states that the CND's decision is subject to approval by a two-thirds majority of CND members.(90) The CND decision may still be appealed to ECOSOC, although Parties have up to 180 days to bring the appeal. As well, the ECOSOC decision is not necessarily final – there is the possibility of continual appeals. Finally, while a decision is being appealed, Article 2(7) allows a Party to take "exceptional action" and exempt itself from certain control measures the CND may have ordered for the substance in question pending the outcome of the appeal. The cumulative effect of all of these additions to the Psychotropics Convention is that it can be much harder for the WHO to bring a new psychotropic drug within the control system than to add a new narcotic drug to the Single Convention.

The criteria for placing a new drug under control also differ between the two Conventions. According to Article 3 of the Single Convention, a narcotic drug will come within the control regime if it is "liable to similar abuse and productive of similar ill effects as the drugs" in the relevant schedule. The criteria required under Article 2(4) of the Psychotropics Convention are significantly and substantively more stringent. The WHO must find:

(89) McAllister (2000), p. 241.

(90) The U.S. tried to increase this majority to three-fourths. (*Ibid.*, p. 161)

(a) that the substance has the capacity to produce
  (i) (1) a state of dependence, and
    (2) central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood, or
  (ii) similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and
(b) that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control.

Taking the lead for the manufacturing group on this point, the U.S. and Britain were the most adamant about including such highly restrictive criteria.(91)

In terms of addressing the demand side of drug problems, the Psychotropics Convention is far ahead of the Single Convention's hollow Article 38 described above. Article 20 of the 1971 treaty is somewhat of a milestone as it introduced the concepts of public education and abuse prevention into the international drug control legal infrastructure. In particular, Parties are to "take all practical measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, after-care, rehabilitation and social reintegration of the persons involved, and shall coordinate their efforts to these ends." Promoting the training of personnel to carry out these tasks is a requirement "as far as possible," and encouraging the study and public awareness of etiological issues related to abuse is also endorsed. Although the provisions leave considerable room for countries to avoid taking measures, they are a definite improvement over the Single Convention.

The penal provisions laid out in Article 22 of the Psychotropics Convention allow states to use treatment, education, after-care, rehabilitation and social reintegration instead of just conviction or punishment in dealing with abusers who commit offences under the Convention. While the acknowledgement of treatment and rehabilitation is an improvement over previous strictly penal provisions, it is intended to be used primarily in addition to, rather than as an alternative to, imprisonment.(92)

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(91) *Ibid.*, p. 159.

(92) United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, p. 353-354.

The overall outcome of the 1971 negotiations was a treaty that was significantly weaker than the Single Convention. Furthermore, any possibility of revisiting the provisions of the Psychotropics Convention was not realistic in the early 1970s as a new chapter in the U.S. "war on drugs" was beginning.(93)

C. Protocol Amending the Single Convention on Narcotic Drugs, 1961

In the early 1970s, U.S. President Richard Nixon officially declared "war on drugs" in response to the massive drug abuse in the U.S. and the social damage it was causing – the effects of this announcement were global.(94)

In 1971, as part of the Nixon administration's international anti-narcotics campaign, U.S. officials suggested creating a government-funded, UN-administered anti-drug abuse fund.(95) The United Nations Fund for Drug Abuse Control (UNFDAC) was created in 1971 and initiated with a $2 million donation from the U.S., although other governments were reluctant to contribute because of the motives behind the U.S.-based Fund. This reluctance was well founded as UNFDAC essentially became a U.S. tool. The emphasis was put on law enforcement and crop substitution – rather than abuse and demand-oriented strategies. Money went primarily to projects in which U.S. allies were involved and which focused on countries where the U.S. had been unable to stop opium production.(96)

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(93) The U.S.-initiated "war on drugs" is considered to have begun with the federal *Harrison Narcotics Act of 1914* and has continued ever since at varying levels of intensity. The most recent supporters of the "war" include President Nixon in the late 1960s and early 1970s, President Ronald Reagan in the 1980s, President George Bush in the late 1980s and early 1990s, President Bill Clinton in the 1990s, and now President George W. Bush. The literature on the "war on drugs" is voluminous. See, for example, Steven R. Belenko, ed., *Drugs and Drug Policy in America: A Documentary History*, Westport, Connecticut: Greenwood Press, 2000; H. Richard Friman, *NarcoDiplomacy: Exporting the U.S. War on Drugs*, Ithaca, NY: Cornell University Press, 1996; James A. Inciardi, *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy*, Palo Alto, California: Mayfield Publishing Company, 1986; Kenneth J. Meier, *The Politics of Sin: Drugs, Alcohol and Public Policy*, Armonk, New York: M.E. Sharpe, 1994; Musto (1999); William O. Walker III, *Drug Control in the Americas*, revised edition, Albuquerque, New Mexico: University of New Mexico Press, 1989; and Steven Wisotsky, *Beyond the War on Drugs: Overcoming a Failed Public Policy*, Buffalo, New York: Prometheus Books, 1990.

(94) Musto (1999), p. 248-259; Bruun *et al.* (1975), ch. 10.

(95) The U.S. campaign included massive international funding for crop substitution, technical assistance to improve administration and law enforcement, anti-trafficking initiatives, and coordination of educational programs. Many developing countries were, however, averse to receiving U.S. money with clear strings attached. The fund was seen by the U.S. to be a way around such reluctance. (McAllister (2000), p. 236-237)

(96) *Ibid.*, p. 238.

The Fund also received serious criticism for having been overcome by inefficient aspects of the UN bureaucratic machinery: "A large proportion of the money allocated to the Fund's various programs is in fact spent on supporting an ever-expanding bureaucracy to administer the programs. Indeed many of the Programs appear to serve no purpose other than to provide occupation for the enlarged secretariats."(97) It was also argued that the UNFDAC should be transferred from the drug bodies under ECOSOC to the United Nations Development Program – a body better able to assess the development and aid needs of recipient countries.(98)

Another key initiative commenced by the Nixon administration was to strengthen the Single Convention. Forceful U.S. lobbying led to a UN plenipotentiary conference being convened in March 1972 to amend the Convention.(99) The result of the conference was the Single Convention Protocol. The main goal of the amendments was to expand the role of the INCB in the control of licit and illicit opium production and in illicit drug trafficking in general. The U.S. intended to revive aspects of the 1953 Opium Protocol by attempting to reduce licit opium production. However, in 1972, licit production was just meeting licit demand, and few countries were willing to risk a global shortage of opium for medical use.(100) Thus, the U.S. proposals were significantly diluted.

The backbone of the Single Convention Protocol consists of provisions enhancing the powers of the INCB, especially in relation to illicit trafficking. In Article 2 of the Single Convention, the definition of the INCB's functions now includes an explicit reference to the prevention of "illicit cultivation, production and manufacture of, and illicit trafficking in and use of, drugs." Article 35 encourages Parties to supply the INCB and the CND with information on the illicit drug activity in their territory; as well, the INCB is empowered to advise Parties on their efforts to reduce their illicit drug trade. When Parties conclude extradition treaties among each other, such agreements are now deemed to automatically include the drug-related offences, including trafficking, set out in the Single Convention.(101) In Article 22(2) of the Psychotropics

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(97) Bruun *et al.* (1975), p. 281.

(98) *Ibid.*, p. 282; Kuševic (1975), p. 51.

(99) American ambassadors were specifically chosen for the purpose of travelling to Party countries to convince them to support the amendments proposed by the U.S. The conference was largely acknowledged to be a support tool for Nixon to use in the upcoming Presidential elections. (Kuševic (1975), p. 47)

(100) Kuševic (1975), p. 48. Kuševic argues that it would have been more useful to attempt to reduce *diversion* from licit demand into the illicit market.

(101) Single Convention, Art. 36, as amended by the Single Convention Protocol, Art. 14.

Convention, it is simply "desireable" that such offences in relation to psychotropic substances be made extraditable between Parties.

The Protocol amended the abuse prevention provisions of the Single Convention so they now mirror those in Article 20 of the Psychotropics Convention.(102) The amended Single Convention also echoes the Psychotropics Convention by now allowing countries to use "treatment, education, after-care, rehabilitation and social reintegration" either as an alternative to or in addition to conviction or punishment.(103)

Although not as stringent as originally intended by the U.S., the Single Convention Protocol continued the prohibitive tradition of the international drug control regime – especially against opium – and stepped up the increasingly intense war on illicit trafficking.

D. Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

Numerous national and regional drug control initiatives took off in the 1970s and 1980s.(104) In Europe, the Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs – commonly known as the "Pompidou Group" – was created and facilitated drug-related discussions between the countries. As well, the Heads of National Law Enforcement Agencies (HONLEA) met regionally – in Asia and the Pacific in the 1970s and spreading to Africa, Latin America and Europe in the 1980s – to improve police and customs drug enforcement cooperation. INTERPOL expanded its operations and became "an important clearinghouse for information and a sponsor of local, regional, and global drug enforcement meetings."(105)

Amid such developments, concerns arose within the UN and among its main control-oriented members that the anti-trafficking efforts of the international drug control system were compromised by the fact that certain nations were not Parties to the Conventions and/or did

(102) *Ibid.*, Art. 38, as amended by the Single Convention Protocol, Art. 15.

(103) *Ibid.*, Art. 36, as amended by the Single Convention Protocol, Art. 14.

(104) In the U.S., the war on drugs lost some momentum in the 1970s during the terms of Presidents Gerald Ford and Jimmy Carter. Eleven U.S. states decriminalized aspects of marijuana regulation and were supported by such mainstream organizations as the American Medical Association, the American Bar Association, the American Public Health Association, and the National Council of Churches. President Ronald Reagan reversed this trend in the early 1980s. (Wisotsky (1990), p. xviii)

(105) McAllister (2000), p. 242-243.

not have domestic law enforcement systems adequate to combat illicit trafficking.[106] In 1984, the UN General Assembly adopted Resolution 39/141, which requested ECOSOC to instruct the CND to "as a matter of priority" prepare a draft convention considering "the various aspects of the problem [of illicit drug trafficking] as a whole and, in particular, those not envisaged in existing international instruments." Thus, the goal was to add an additional "trafficking-specific" layer to the drug control system to complement the two existing Conventions.

The draft treaty was finalized during the 1987 UN Conference on Drug Abuse and Illicit Trafficking. Also during this Conference, a non-legally-binding Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control[107] (CMO) was adopted to encourage states to implement existing treaty obligations. The CMO focused on four areas: (1) prevention and reduction of illicit demand; (2) control of supply; (3) suppression of illicit trafficking; and (4) treatment and rehabilitation. Many of the targets set out in the CMO were reflected in the draft treaty. Between 25 November and 20 December 1988, 106 states met in Vienna to negotiate a final text. The result was the Trafficking Convention.

The Trafficking Convention is essentially an instrument of international criminal law. The intent of the treaty is to harmonize national, drug-related criminal laws and enforcement actions around the world to attempt to decrease illicit drug trafficking through the use of criminalization and punishment. Under the Convention, Parties are obligated to create and implement very specific criminal laws aimed at suppressing illicit trafficking. These laws relate to such aspects of the problem as money laundering, confiscation of assets, extradition, mutual legal assistance, illicit cultivation, and trade in chemicals, materials and equipment used in the manufacture of controlled substances. As with the other two Conventions, the CND and the INCB are charged with administration of the Convention. Furthermore, the Trafficking Convention allows demand-side elements to be used in addition to or – for minor offences – as an alternative to conviction or punishment.[108]

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(106) Bewley-Taylor (1999), p. 167; David P. Stewart, "Internationalizing The War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances," *Denver Journal of International Law and Policy*, Vol. 18, No. 3, Spring 1990, p. 387-404.

(107) *Declaration of the Conference on Drug Abuse and Illicit Trafficking and Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control*, U.N. doc. ST/NAR/14, 1988.

(108) For detailed descriptions of the provisions of the Trafficking Convention, see: William Gilmore, *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, London: Commonwealth Secretariat, 1991; Stewart (1990). As Stewart was part of the U.S. delegation that took part in negotiations, his article provides a U.S. perspective of the treaty.

The Preamble describes illicit traffic as "an international criminal activity" and highlights the "links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States." Emphasis is put on "the importance of strengthening and enhancing effective legal means for international co-operation in criminal matters for suppressing the international criminal activities of illicit traffic." Even the single reference in the Preamble to demand-side issues is couched in criminal law language: "Desiring to eliminate the root causes of the problem of abuse of narcotic drugs and psychotropic substances, including the *illicit demand* for such drugs and substances and the enormous profits derived from illicit traffic" (emphasis added). The implication is that drug users are also to be considered criminals. The Preamble clearly reflects its prohibitionist roots – even explicitly as it reaffirms "the guiding principles of existing treaties in the field of narcotic drugs and psychotropic substances and the system of control which they embody."

Accordingly, the cornerstone of the Trafficking Convention is Article 3: "Offences and Sanctions." Here the treaty breaks new ground by *requiring* that Parties "legislate as necessary to establish a modern code of criminal offences relating to the various aspects of illicit trafficking and to ensure that such illicit activities are dealt with as serious offences by each State's judiciary and prosecutorial authorities."[109] The mandatory offences are set out in Article 3(1), and include the following:

- The production, manufacture, distribution or sale of any narcotic drug or psychotropic substance contrary to the provisions of the Single Convention or the Psychotropics Convention;
- The cultivation of opium poppy, coca bush or cannabis plant contrary to those earlier Conventions;
- The possession or purchase of any narcotic drug or psychotropic substance for the purpose of illicit trafficking;
- The manufacture, transport or distribution of materials, equipment and substances for the purpose of illicit cultivation, production or manufacture of narcotic drugs or psychotropic substances; and
- The organization, management or financing of any of the above offences.[110]

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(109) United Nations, *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988*, New York: United Nations, 1976, p. 48.

(110) See Stewart (1990), p. 392; Gilmore (1991), p. 5.

Furthermore, Article 3(2) of the Trafficking Convention requires each Party – subject to its constitutional principles and the basic concepts of its legal system – to establish criminal offences for the intentional possession, purchase or cultivation of drugs for personal consumption.

Several states have adapted their criminal enforcement systems to attempt to allow *de facto* possession of small amounts of certain "soft" drugs – such as cannabis and its derivatives – for personal consumption and still remain within the legal bounds of the Conventions.(111) Although the Conventions do not allow for legalization or even decriminalization of such possession, these countries have circumvented these limitations by criminalizing the possession, as required by the treaties, but they do not strictly enforce the legislation, or they have effectively "depenalized" the offences by exempting them from punishment.(112) Such approaches clearly go against the "spirit" of the Conventions, especially the Trafficking Convention, which seems to use the term "trafficking" very broadly to include demand-side activities within a supply-oriented control regime. Yet, there is a legal basis for these "softer" approaches because the treaties do not explicitly forbid them.

Criticisms of the hardcore criminal law approach adopted by the international drug control system have arisen in the human rights context. Some hold that the strict imprisonment penalties encouraged by the treaties are disproportionate to the crime when imposed in relation to "soft" drug offences, such as possession of a small amount of cannabis for personal consumption.(113) It is argued that imprisonment in such circumstances is disproportionate to the offence and therefore violates the inherent dignity of persons, the right to be free from cruel and degrading punishment, and the right to liberty, as set out in such instruments as the *Universal Declaration of Human Rights*, the *International Covenant on Civil and Political Rights*, and the *Convention against Torture and Other Cruel, Inhuman or*

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(111) For example, Belgium, Denmark, Germany, the Netherlands and Poland. For a detailed description and discussion of the Dutch approach, see Ed. Leuw and I. Haen Marshall, eds., *Between Prohibition and Legalization: The Dutch Experiment in Drug Policy*, Amsterdam: Kugler Publications, 1994.

(112) See Krzysztof Krajewski, "How flexible are the United Nations drug conventions?" *International Journal of Drug Policy*, No. 10, 1999, p. 329-338. Krajewski provides an excellent overview of the legal limits of the Conventions with respect to legalization and prohibition. He concludes that legalization or decriminalization would likely require amending Article 3(2) of the Trafficking Convention. See also, the discussion of legalization in Dupras (1998), p. 22-30; and Alfons Noll, "Drug abuse and penal provisions of the international drug control treaties," *Bulletin on Narcotics*, Vol. XXIX, No. 4, October/December 1977, p. 41-57.

(113) See, for example, the following pages of the website of Human Rights Watch, a human rights non-governmental organization: http://www.hrw.org/campaigns/drugs/ and http://www.hrw.org/worldreport99/special/drugs.html.

Degrading Treatment or Punishment.[114] It has also been argued that drug use is a human right and should be recognized as such in the *Universal Declaration of Human Rights.*[115]

The Trafficking Convention is the only one of the three Conventions that makes any mention of human rights. Article 14(2) of the Trafficking Convention explicitly obligates Parties "to respect fundamental human rights" when they take measures to prevent and eradicate the illicit cultivation of plants containing narcotic or psychotropic substances, such as opium, cannabis and coca. The same provision also requires states to take into account traditional licit uses – where there is historic evidence of such use – and protection of the environment.

Despite human rights-based criticisms and suggestions, and the fact that several states have pursued "softer" approaches within their own jurisdictions, it is unlikely that the international drug control regime will undergo any fundamental changes of philosophy or approach in the near future. The Trafficking Convention came into force in record time – just under two years – and throughout the 1990s the war on drugs continued in full force to target primarily control at the source, especially through U.S. initiatives in Latin America.[116] Furthermore, the recent election of U.S. President George W. Bush likely marks a continuation of the restrictive policies in place, or perhaps even further prohibition-based strengthening measures.

In 1991, the UN drug control apparatus was reorganized.[117] The DND and UNFDAC were integrated into the United Nations Drug Control Program (UNDCP), which also now acts as the secretariat to the CND and the INCB – both of which remain unchanged. The UNDCP reports directly to the Secretary-General. Although the restructuring helped to consolidate roles and activities in one body (the UNDCP), the inherent difficulties in administering such a hugely ambitious international drug control machine have not lessened. One of the greatest problems has been attempting to reconcile the contradiction created between the meticulously managed drug economy created by the three Conventions, and the liberal nature

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(114) The full legal text of each of these international instruments is available at the following page of the website of the United Nations High Commissioner for Human Rights: http://www.unhchr.ch/html/intlinst.htm.

(115) See Erik Van Ree, "Drugs as a Human Right," *International Journal of Drug Policy*, Vol. 10, 1999, p. 89-98. Van Ree proposes the following as a new Article 31 to the *Universal Declaration of Human Rights*: Everyone has the right to use psychotropic substances of one's own choice.

(116) See, for example, Bruce M. Bagley and William O. Walker III, *Drug Trafficking in the Americas*, Coral Gables, Florida: University of Miami North-South Center, 1995.

(117) See Bentham (1998), p. 106-110.

of international trade agreements intended to promote the free flow of all commodities.(118) In a world of increasing trade, the UN and the international drug control system may be about to face their greatest challenge yet.

CONCLUSION

The history of international drug control is revealing: it gives insight into the philosophical and practical underpinnings of the three drug Conventions.

Beginning in an era of morally tainted racism and colonial trade wars, prohibition-based drug control grew to international proportions at the insistence of the United States. America and the colonial powers were confronted with the effects of drug addiction and abuse at home, but rather than address both demand – the socio-medical nature of such problems – and supply, they focused uniquely on the latter and attempted to stem the flow of drugs into their territories. In doing so, they earned political capital back home and shifted the cost and burden of drug control to predominantly Asian and Latin American developing countries with no cultural inclination or resources to take on such an intrusive task – and no economic or military power to refuse what was imposed on them. The Western control advocates' prohibition focus also stimulated the growth and development of the global illicit drug trade. And ironically, the system has had very little overall success in controlling the supply of drugs at the source. Nonetheless, activists such as Harry Anslinger and Colonel Sharman largely achieved their goal of creating a prohibition-based international drug control system.

The Single Convention consolidated the system under the UN into one key narcotics control document – an instrument representing the compromises between the domestic and economic interests of predominantly Western, drug manufacturing nations. The Psychotropics Convention represented a weakening of the control structure because of the overwhelming influence of European and North American pharmaceutical interests throughout negotiations. Psychotropic substances would enjoy fewer restrictions until domestic legislation and UN-initiated voluntary controls filled in the gaps. The Trafficking Convention firmly established a system of international criminal drug control law that uses criminalization and penalization to combat global drug trafficking.

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(118) Robin Room and Angela Paglia, "The international drug control system in the post-Cold War era. Managing markets or fighting a war?" *Drug and Alcohol Review*, No. 18, 1999, p. 305-315.

The three Conventions do leave Party states some leeway to craft drug control strategies shaped to their particular socio-cultural, political and economic realities. Yet this flexibility is clearly limited by an overarching structure based on prohibition and criminalization. McAllister has asked why the global drug problem has been so difficult to solve; he answers the question as follows:

> …the primary goal of the international drug control regime has never been to eliminate illicit drug use. The most important objective of the delegates to the 1961 and 1971 conventions was to protect sundry economic, social, cultural, religious, and/or geopolitical interests. The amount of time actually spent at the conferences discussing the problems of addicted individuals, how to help them, and how to prevent more people from joining their ranks was minimal. Until these priorities change, problems with widespread drug abuse, and the attendant cost in human and material capital, will continue.(119)

With a taste of the past, it becomes possible to conclude that the history of international drug control may be repeating itself today.

(119) McAllister (1992), p. 162.

BIBLIOGRAPHY

Parliamentary Research Branch Documents

Dunsmuir, Mollie, Geoffrey Kieley, James Lee and Tonina Simeone. *Drugs and Drug Trafficking*, prepared for the Canada-Mexico Interparliamentary Group. Ottawa: Parliamentary Research Branch, Library of Parliament, 25 February 2000.

Dupras, Daniel. *Canada's International Obligations Under the Leading International Conventions on the Control of Narcotic Drugs.* Ottawa: Parliamentary Research Branch, Library of Parliament, 20 October 1998.

Official Documents

Report of the International Working Group on the Single Convention on Narcotic Drugs, 1961. Toronto: Addiction Research Foundation, 1983.

United Nations.

- *The United Nations and Drug Abuse Control.* New York: United Nations, 1989.
- *Commentary* on *the Single Convention on Narcotic Drugs, 1961*. New York: United Nations, 1973.
- *Commentary on the Protocol Amending the Single Convention on Narcotic Drugs, 1961, Done at Geneva on 25 March 1972*. New York: United Nations, 1976.
- *Commentary on the Convention on Psychotropic Substances, Done at Vienna on 21 February 1971*. New York: United Nations, 1976.
- *Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, Done at Vienna on 20 December 1988.* New York: United Nations, 1976.

United Nations International Drug Control Programme. *World Drug Report.* Oxford: Oxford University Press, 1997.

United States. *International Narcotics Control: A Source Book of Conventions, Protocols, and Multilateral Agreements, 1909-1971*. Washington, D.C.: Bureau of Narcotics & Dangerous Drugs, 1972.

Books

Bagley, Bruce M. and William O. Walker III. *Drug Trafficking in the Americas.* Coral Gables, Florida: University of Miami North-South Center, 1995.

Belenko, Steven R., ed. *Drugs and Drug Policy in America: A Documentary History.* Westport, Connecticut: Greenwood Press, 2000.

Bentham, Mandy. *The Politics of Drug Control.* London: MacMillan Press, 1998.

Booth, Martin. *Opium: A History.* New York: St. Martin's Press, 1996.

Bruno, Francesco. *Combatting Drug Abuse and Related Crime,* Publication No. 21. Rome: United Nations Social Defence Research Institute, 1984.

Bruun, Kettil, Lynn Pan and Ingemar Rexed. *The Gentlemen's Club: International Control of Drugs and Alcohol.* Chicago: University of Chicago Press, 1975.

Chatterjee, S.K. *A Guide to the International Drugs Conventions.* London: Commonwealth Secretariat, 1988.

Courtwright, David T. *Dark Paradise: Opiate Addiction in America before 1940.* Cambridge: Harvard University Press, 1982.

Friman, H. Richard. *NarcoDiplomacy: Exporting the U.S. War on Drugs.* Ithaca, New York: Cornell University Press, 1996.

Giffen, P.J., Shirley Endicott and Sylvia Lambert. *Panic and Indifference: The Politics of Canada's Drug Laws.* Ottawa: Canadian Centre on Substance Abuse, 1991.

Gilmore, William. *Combating International Drugs Trafficking: The 1988 United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.* London: Commonwealth Secretariat, 1991.

Green, Penny. *Drugs, Trafficking and Criminal Policy: The Scapegoat Strategy.* Criminal Policy Series, Vol. III. Winchester, U.K.: Waterside Press, 1998.

Inciardi, James A., ed. *The Drug Legalization Debate,* Second Edition. Thousand Oaks, California: Sage Publications, 1999.

Inciardi, James A. *The War on Drugs: Heroin, Cocaine, Crime, and Public Policy.* Palo Alto, California: Mayfield Publishing Company, 1986.

Inglis, Brian. *The Forbidden Game: A Social History of Drugs.* London: Hodder and Stoughton, 1975.

Jamieson, Alison. *Global Drug Trafficking*, Conflict Studies 234. London: Research Institute for the Study of Conflict and Terrorism, 1990.

Leuw, Ed. and I. Haen Marshall, eds. *Between Prohibition and Legalization: The Dutch Experiment in Drug Policy.* Amsterdam: Kugler Publications, 1994.

Lowes, Peter D. *The Genesis of International Narcotics Control.* Geneva: Librairie Droz, 1966.

Manderson, Desmond. *From Mr. Sin to Mr. Big.* Oxford: Oxford University Press, 1993.

McAllister, William B. *Drug Diplomacy in the Twentieth Century.* London and New York: Routledge, 2000.

Meier, Kenneth J. *The Politics of Sin: Drugs, Alcohol and Public Policy.* Armonk, New York: M.E. Sharpe, 1994.

Mitchell, Chester Nelson. *The Drug Solution: Regulating Drugs According to the Principles of Efficiency, Justice and Democracy*. Ottawa: Carleton University Press, 1990.

Musto, David F. *The American Disease: Origins of Narcotic Control,* Third Edition. Oxford: Oxford University Press, 1999.

Rexed, Bror, K. Edmondson, Inayat Khan and Robert Samson. *Guidelines for the Control of Narcotic and Psychotropic Substances.* Geneva: World Health Organization, 1984.

Simmons, Luiz R.S. and Abdul A. Said, eds. *Drugs, Politics, and Diplomacy: The International Connection.* Beverly Hills and London: Sage Publications, 1974.

Susman, Ralph M. and Lenore R. Kupperstein. *Drugs and Social Policy.* Philadelphia: American Academy of Political and Social Science, 1975.

Taylor, Arnold H. *American diplomacy and the narcotics traffic, 1900-1939: A study in international humanitarian reform*. Durham, N.C.: Duke University Press, 1969.

Walker III, William O.

- *Drug Control in the Americas,* revised edition. Albuquerque, New Mexico: University of New Mexico Press, 1989.
- *Opium and Foreign Policy: The Anglo-American Search for Order in Asia, 1912-1954.* Chapel Hill, N.C.: University of North Carolina Press, 1991.

Walker III, William O., ed.

- *Drug Control Policy: Essays in Historical and Comparative Perspective.* University Park, Pennsylvania: Pennsylvania State University Press, 1992.
- *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict.* Wilmington, Delaware: Scholarly Resources Inc., 1996.

Wisotsky, Steven. *Beyond the War on Drugs: Overcoming a Failed Public Policy.* Buffalo, New York: Prometheus Books, 1990.

Zimring, Franklin E. and Gordon Hawkins. *The Search for Rational Drug Control.* Cambridge: Cambridge University Press, 1992.

Articles

Anslinger, Harry J. and Will Oursler. "The War against the Murderers." In Walker III, William O., ed., *Drugs in the Western Hemisphere: An Odyssey of Cultures in Conflict.* Wilmington, Delaware: Scholarly Resources Inc., 1996.

Cosh, Colby. "All thanks to an hysterical lady judge." *Alberta Report*, Vol. 24, Issue 36, 18 August 1997, p. 32.

DuPont, Robert L. and Eric A. Voth. "Drug Legalization, Harm Reduction, and Drug Policy." *Annals of Internal Medicine*, No. 123, 1995, p. 461-465.

Goodrich, Leland M. "New Trends in Narcotics Control." *International Conciliation*, No. 530, November 1960.

Hickman, Timothy A. "Drugs and Race in American Culture: Orientalism in the Turn-of-the-Century Discourse of Narcotic Addiction." *American Studies*, Vol. 41, No. 1, Spring 2000, p. 71-91.

Hicks, David C. and Michael G. Petrunik. "The Best Intentions Are Not Enough: Drug Prohibition as a Failed Intervention Strategy." *Canadian Review of Social Policy*, No. 40, Winter 1997, p. 1-17.

Kinder, Douglas Clark. "Shutting Out the Evil: Nativism and Narcotics Control in the United States." In Walker III, William O., ed., *Drug Control Policy: Essays in Historical and Comparative Perspective.* University Park, Pennsylvania: Pennsylvania State University Press, 1992, p. 117-142.

Krajewski, Krzysztof. "How flexible are the United Nations drug conventions?" *International Journal of Drug Policy*, No. 10, 1999, p. 329-338.

Kuševic, Vladimir. "Drug Abuse Control and International Treaties." *Journal of Drug Issues*, Vol. 7, No. 1, Winter 1977, p. 35-53.

Manderson, Desmond. "Trends and Influences in the History of Australian Drug Legislation." *Journal of Drug Issues*, Vol. 22, No. 3, Summer 1992, p. 507-521.

McAllister, William B. "Conflicts of Interest in the International Drug Control System." In Walker III, William O., ed., *Drug Control Policy: Essays in Historical and Comparative Perspective.* University Park, Pennsylvania: Pennsylvania State University Press, 1992, p. 143-166.

Musto, David. "International Drug Control: historical aspects and future challenges." In United Nations International Drug Control Programme. *World Drug Report.* Oxford: Oxford University Press, 1997, p. 165-167.

Nadelmann, Ethan A. "Should We Legalize Drugs? History Answers Yes." *American Heritage*, February/March 1993, p. 42-48.

Noll, Alfons. "Drug abuse and penal provisions of the international drug control treaties." *Bulletin on Narcotics*, Vol. XXIX, No. 4, October/December 1977, p. 41-57.

Peele, Stanton. "The results for drug reform goals of shifting from interdiction/punishment to treatment." *International Journal of Drug Policy*, No. 9, 1998, p. 43-56.

Room, Robin and Angela Paglia. "The international drug control system in the post-Cold War era. Managing markets or fighting a war?" *Drug and Alcohol Review*, No. 18, 1999, p. 305-315.

Room, Robin and Pia Rosenqvist. "Drugs in a Global Perspective: The International Control System's Best Foot Forward." *Addiction Research*, Vol. 7, No. 3, 1999, p. 177-192.

Scheerer, Sebastian. "The New Dutch and German Drug Laws: Social and Political Conditions for Criminalization and Decriminalization." *Law & Society Review*, Vol. 12, No. 4, Summer 1978, p. 585-606.

Stewart, David P. "Internationalizing The War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances." *Denver Journal of International Law and Policy*, Vol. 18, No. 3, Spring 1990, p. 387-404.

"The Beginnings of International Drug Control." *UN Chronicle*, Vol. 35, No. 2, 1998, p. 8-9.

Van Ree, Erik. "Drugs as a Human Right." *International Journal of Drug Policy*, Vol. 10, 1999, p. 89-98.