BEYOND PUNITIVE PROHIBITION: LIBERALIZING
THE DIALOGUE ON INTERNATIONAL
DRUG POLICY

MELISSA T. Aoyagi*

I. INTRODUCTION

We are all deeply concerned about the threat
that drugs pose to our children, our fellow citizens
and our societies. There is no choice but to work to-
gether, both within our countries and across borders,
to reduce the harms associated with drugs. The
United Nations has a legitimate and important role
to play in this regard—but only if it is willing to ask
and address tough questions about the success or fail-
ure of its efforts.

We believe that the global war on drugs is now
cause more harm than drug abuse itself.

Every decade the United Nations adopts new in-
ternational conventions, focused largely on criminal-
ization and punishment, that restrict the ability of in-
dividual nations to devise effective solutions to local
drug problems. Every year governments enact more
punitive and costly drug control measures. Every day
politicians endorse harsher new drug war strategies

In many parts of the world, drug war politics im-
pede public health efforts to stem the spread of HIV,
hepatitis and other infectious diseases. Human rights
are violated, environmental assaults perpetrated and
prisons inundated with hundreds of thousands of
drug law violators . . . .

Mr. Secretary General, we appeal to you to initi-
ate a truly open and honest dialogue regarding the

* B.A. 1997, Williams College; J.D. 2003, New York University School of
Law. I would like to thank Professors Daniel Abrahamson and William Nel-
son, Timothy Aoyagi, and Marc Lanoue for their useful feedback, and the
staff of the Journal of International Law and Politics for their invaluable as-
stance.
future of global drug control policies—one in which fear, prejudice and punitive prohibitions yield to common sense, science, public health and human rights.¹

The preceding excerpts from a public letter sent to Kofi Annan on the eve of the United Nations General Assembly Special Session on Drugs in New York (June 1998) illustrate an escalating concern in the international community about the deleterious effects of “drug-war politics.” The global debate² over drug policy has become increasingly divisive,³ despite the existence of a system of treaties that govern such policy.⁴ Some commentators have rejected punitive prohibitionist poli-

1. Open Letter to U.N. Secretary General Kofi Annan (June 1, 1998). This letter was signed by members of the judiciary, parliamentarians, Nobel Laureates, professors, and representatives of the medical profession, such as Adolfo Perez Esquivel, Nobel Laureate (Peace, 1980); John C. Polanyi, Nobel Laureate (Chemistry, 1986); Oscar Arias, Fmr. President of Costa Rica and Nobel Laureate (Peace, 1987); Michele Barzach, Fmr. Minister of Health (Fr.); Daniel Cohn-Bendit, Member, European Parliament (Ger.); Perfecto Andrés Ibáñez, Judge, Presidente de la Secc. 15. Audiencia provincial de Madrid (Sp.); Joycelyn Elders, Fmr. U.S. Surgeon General; Milton Friedman, Nobel Laureate (Economics) (U.S.); Robert Sweet, Federal Judge, New York, NY; Richard E. Smalley, Nobel Laureate (Chemistry, 1996) (U.S.); Austin N.E. Amissah, Judge, London; Peter Albrecht, Judge, Court of Bâle-Ville (Switz.); Claes Örtendahl, Fmr. Director General, Swedish Board of Health and Welfare.

2. That the problem is essentially global in nature is relatively uncontroversial. See, e.g., PAUL B. STARES, GLOBAL HABIT: THE DRUG PROBLEM IN A BORDERLESS WORLD (Brookings Institute 1996) (discussing the global market for drugs); Harald Klingemann & Geoffrey Hunt, INTRODUCTION TO DRUG TREATMENT SYSTEMS IN AN INTERNATIONAL PERSPECTIVE, at xi (Harald Klingemann & Geoffrey Hunt eds., 1998).

3. See, e.g., Jay Branegan, Holland is Being Blamed by Neighbors for Abetting Europe’s Narcotics Habit, That May Not Be Fair, TIME MAGAZINE, Apr. 29, 1996, at 28; Susan Taylor Martin, U.S. Policy Not Limited to Borders, ST. PETERSBURG TIMES, July 29, 2001, at 1A (describing several examples of U.S. campaigns to block harm reduction programs in other countries, in particular the successful intimidation of Australian officials into rejecting an innovative heroin plan).

cies closely linked to the American “war on drugs,” advocating for the treatment of drug abuse as a public health, rather than a criminal justice, issue. Proponents of prohibitionist policies have responded by asserting that harm minimization and legalization approaches neglect the obligations of parties to the major, non-self-executing U.N. drug conventions: the Single Convention on Narcotic Drugs of 19617

5. See, e.g., Introduction: The Search for Harm Reduction, in HARM REDUCTION: A NEW DIRECTION FOR DRUG POLICIES AND PROGRAMS 3, 4-5 (Patricia G. Erickson et al. eds., 1997) (noting criticism of the “war on drugs” and describing the “medical” model to drug use and treatment); Leon Wever, Drugs as a Public Health Problem: Assistance and Treatment, in BETWEEN PROHIBITION AND LEGALIZATION: THE DUTCH EXPERIMENT IN DRUG POLICY 59 (Ed. Leuw & I. Haen Marshall eds., 1994); see also Douglas N. Husak, Two Rationales for Drug Policy: How They Shape the Content of Reform, in HOW TO LEGALIZE DRUGS 29, 29 (Jefferson M. Fish ed., 1998) (noting that “[e]very week an academic from one discipline or another discovers anew that the ‘war on drugs’ has been a disaster. Each successive book recites all-too-familiar arguments about the failures of what might be called our criminal justice drug policy.”). Even members of the law enforcement community have voiced objection to policies of drug prohibition and in favor of legalization. See, e.g., Joseph D. McNamara, The War the Police Didn’t Declare and Can’t Win, in AFTER PROHIBITION: AN ADULT APPROACH TO DRUG POLICIES IN THE 21ST CENTURY 119, 125 (Timothy Lynch ed., 2000) (former police officer arguing for the decriminalization of marijuana and observing that “the nation has been unable to face the failure of its drug policies or to examine alternatives that would truly lessen dangerous drug use. We remain captive to myths about drug use and false stereotypes of users created a century ago by religious zealots.”); David Klinger, Call off the Hounds, in AFTER PROHIBITION, supra, at 127, 134 (noting, as a former police officer in Los Angeles and Redmond, Washington, that with respect to the proposal that drugs be legalized, his “hardest supporters” and “harshest critics came from the same group. . . [his] law enforcement associates”); Michael Levine, Fight Back: A Solution Between Prohibition and Legalization, in AFTER PROHIBITION, supra, at 91, 99, 103-09 (criticizing, as a former federal narcotic officer, media manipulation to sell a “failed, inept government policy” and considering legalization and treatment as better alternatives to prohibition).

Non-prohibitionist policies encompass a wide array of alternatives, including legalization (the rights-based, libertarian approach) and harm reduction (the public health/utilitarian approach), see Preface to HOW TO LEGALIZE DRUGS, supra, at xi, xii, which will be discussed in greater detail in Part II.

6. See infra Part II.B.

7. The United States provided the initiative for the Single Convention. 1 OFFICIAL RECORDS OF THE U.N. CONFERENCE FOR THE ADOPTION OF A SINGLE
INTERNATIONAL LAW AND POLITICS

(Single Convention); the Protocol of 1972 Amending the Single Convention (175 States parties) (1972 Protocol); the Convention on Psychotropic Substances of 1971 (174 States parties) (1971 Convention); and the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (170 States parties) (1988 Convention). In particular, the International Narcotics Control Board (INCB), created pursuant to the Single Convention to supervise the enforcement of the Convention through a system of narcotic drug estimates and statistical returns, has been outspoken in its disapproval of harm reduction measures undertaken by states such as Portugal, Germany, the Netherlands, and Switzerland.

The primary objective of this paper is to evaluate whether the drug conventions permit states to experiment with alterna-
tives to the punitive prohibitionist policies that have typified the global approach to combating the negative effects of personal drug use. Because harm minimization encompasses most policies providing alternatives to punitive prohibition, the analysis that follows will focus on comparing the two strategies, in an effort to frame the current debate on drug policy. This paper represents an effort to clarify the permissible legal confines for the debate over international drug policy and to encourage a more liberal dialogue between the advocates of punitive prohibition and those of its alternatives. Accordingly, Part II will outline the current drug policy discourse, examining punitive prohibition and various non-prohibitionist options as well as the potential effects of various policy choices. Part III will introduce the relevant treaties. Part IV will consider the proper role, if any, that the treaties permit non-prohibitionist policies to play in the modern international context. Finally, Part V will propose changes to the vocabulary of the drug policy dialogue to encourage clarity and foster the emergence of new ideas in the drug policy debate.

II. PUNITIVE DRUG PROHIBITION AND ITS ALTERNATIVES

A. The "Drug Problem"

Given the breadth of the “drug problem”, this paper does not address international drug trafficking and related problems, such as money laundering or crop eradication. Rather, in the discussion that follows, the term “drug problem” refers to drug consumption, as well as acquisition and possession of illicit substances for personal use. As noted, most major policy alternatives fall within the ambit of either punitive prohibition, or harm-reduction. Of course, even restricted to personal consumption, the “drug problem” is complicated for several reasons, such as the following. First, the drug policy vernacular is rife with loosely medical/scientific and political/legal phraseology that is shaped by the differing underlying cultural, religious, and social assumptions of the drafting parties. Second, people often refer to drug categories beyond simply “licit” and “illicit” drugs, such as natural and

10. The categorization of drugs as “licit” or “illicit” is at the center of many debates over the use of medical marijuana. See Preface to The Control
synthetic drugs or “hard” and “soft” drugs. Some of these categories are defined by law, others by science, and still others by political rhetoric. Third, it is rather difficult to speak of the drug problem as with respect to all drugs or a category of drugs because, precisely speaking, each drug constitutes a separate “problem” depending on its effects on the user and on society as a whole. Finally, the “facts” relating to the drug problem are often distorted, which tends to obfuscate useful discussion.

B. Punitive Prohibition and the War on Drugs

Prohibitionist policies, which focus on outlawing drugs and drug use, are reflected to varying degrees in all countries’ approaches to the drug problem. “Punitive drug prohibition” refers to policies that rely on penal sanctions (incarceration) to punish those who use “illicit” drugs. This approach to drug use is sometimes referred to as the “moral” or
“criminal justice” model because it presumes that “illicit drug use is morally wrong” and thus should be criminalized. The basic assumption of punitive drug prohibition is that it is possible to attain a society free from illegal drug use. For purposes of this paper, the terms “prohibition” and “punitive prohibition” are used interchangeably, unless otherwise noted.

The effects of this choice are usefully illustrated through consideration of the prohibitionist drug policy practiced in the United States through its war on drugs. This strategy is relevant to the international debate over drug policy not only because it “most vividly represent[s]” the prohibitionist approach, but also because of the commonly held belief that drug prohibition is, in large part, an American ideological export.

---


19. The label "war on drugs" comes from the Nixon administration’s declaration of a “total war” on drugs in the late 1960s–early 1970s. See STARES, supra note 2, at 26. It is often analogized to the failed experimentation with alcohol prohibition in the United States. See Timothy Lynch, Tabula Rasa for Drug Policy, in AFTER PROHIBITION, supra note 5, at 3, 10-11 ("Students of American history will someday wonder how today’s lawmakers could readily admit that alcohol prohibition was a disastrous mistake but recklessly pursue a policy of drug prohibition. . . . The time has come to put an end to this tragic revisit of Prohibition."); Michael Woodiwiss, Reform, Racism and Rackets: Alcohol and Drug Prohibition in the United States, in THE CONTROL OF DRUGS AND DRUG USERS, supra note 10, at 13; John C. Lawn, The Issue of Legalizing Drugs, 18 HOFSTRA L. REV. 703, 703-04 (1990); see also Bruce K. Alexander & Govert F. Van de Wijngaart, Readiness for Harm Reduction: Coming to Grips with the “Temperance Mentality,” in HARM REDUCTION, supra note 5, at 80.


21. See Drug War, American Style: The Internationalization of Failed Policy and Its Alternatives (Jurg Gerber & Eric L. Jensen eds., 2001) (presenting a collection of essays examining the export of U.S. policy to countries such as Canada, Australia and Latin America); Tom Blom & Hans van Mastrigt, The Future of the Dutch Model in the Context of the War on Drugs, in BETWEEN PROHIBITION AND LEGALIZATION, supra note 5, at 255, 271 (“Many countries have joined the American War on Drugs. . . . [which has] been transformed from an American war into a world war . . . .”). For an argument explicitly linking the policies contained in the U.N. Conventions and American influence, see Neil Boister, Penal Aspects of the U.N Drug Conventions 535 (2001); Woodiwiss, supra note 19, at 27 (“[I]ronically, a man [Harry Anslinger, then-Commissioner of the Federal Bureau of Narcotics] whose racist assumptions hardly fitted comfortably with the U.N. Charter influenced a convention often thought to be one of the international
American drug prohibition predates the label “war on drugs,” and has a questionable pedigree, particularly given the moral foundation current proponents espouse. As punitive prohibition evolved into a war on drugs, international drug policy, due largely to the influence of the United States, similarly came to be discussed explicitly in terms of a battle against organisation’s main achievements.”). For an argument that the United States purposefully exported the war on drugs, see Jurg Gerber & Eric L. Jensen, The Internationalization of U.S. Policy on Illicit Drug Control, in DRUG WAR, AMERICAN STYLE, supra, at 7 (arguing that there are “at least three reasons” that the United States has tried and generally succeeded in exporting the war on drugs: “(1) states need enemies, (2) the disappearance of the Red Scare, and (3) the United States has become the police force of the world,” and further noting that there are innocuous reasons, i.e., drug control policy is legitimately transnational).

22. For a description of the origins and development of American drug prohibition policies, see STARES, supra note 2, at 16-46.

23. See, e.g., Woodiwiss, supra note 19, at 13-14 (finding that “[f]rom the late nineteenth century moral crusaders exploited the country’s endemic racism and xenophobia to spread the prohibition message” and noting in particular that “[p]rejudice against the Chinese . . . was behind the earliest . . . legislation prohibiting the smoking of opium” and “prejudice against blacks added fuel to the arguments of those seeking to suppress the use of cocaine” because of claims that cocaine made “rapists of black males.”). For a slightly different interpretation of the history of the “cocaine menace,” see Craig Reinarman, Moral Entrepreneurs and Political Economy: Historical and Ethnographic Notes on the Construction of the Cocaine Menace, 3 CONTEMPORARY CRISIS 225, 235 (1979), reprinted in 1 DRUGS, CRIME AND CRIMINAL JUSTICE 101, 111 (Nigel South ed., 1995), noting that “basic economic conflict was transformed into racial conflict, and racial conflict, in turn was expressed (in part) as conflict over drug use.”
the “scourge” of drugs, an enemy destroying society’s youth.


25. See Lynch, supra note 19, at 9 (quoting William J. Bennett, Should Drugs Be Legalized?, Reader’s Digest, Mar. 1990, at 94) (“Imagine if, in the darkest days of 1940, Winston Churchill had rallied the West by saying, ‘This war looks hopeless, and besides, it will cost too much. Hitler can’t be that bad. Let’s surrender and see what happens.’ This is essentially what we hear from legalizers.”). War rhetoric echoes in the plenary meetings of the U.N. Conference for the Adoption of a Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. See, e.g., 2 Official Records of the 1988 Convention, supra note 24, 1st plen. mtg. ¶ 7, at 2 (“The time [has] come . . . to make it forcefully known that [the international community will] no longer tolerate the poisoning of future generations. . . . A strong new convention . . . would be the clearest possible demonstration [it] meant business . . . to deal with a common enemy whose tentacles now infiltrated all regions of the world.”).

\footnote{26. See, e.g., Henry McDonald, Why We Should Legalise Hard Drugs, GUARDIAN UNLIMITED, Feb. 23, 2003, http://www.guardian.co.uk/drugs/Story/0,2763,901219,00.html (noting that "there seems to no [sic] logic to prolonging what is arguably the most futile conflict in human history: this so-called war against drugs. This war, equivalent to fighting a thousand Vietnams at once, can never be won.").}
offenses; (2) increased incarceration that has fallen disproportionately on underprivileged members of society, particularly African and Hispanic Americans, resulting in what some have labeled a return to Jim Crow; (3) worsened health conditions for prisoners (e.g., HIV-infected inmates who do not receive proper treatment and may endanger fellow inmates through unsafe needle practices); (4) further marginalization policing” may also impact rates of state/local incarceration, creating a net-widening effect through the execution of “reverse stings.” Compare Tracey L. Meares & Dan M. Kahan, Law and (Norms of) Order in the Inner City, 32 LAW & SOC’Y REV. 805, 816-19 (1998) (describing the rationale underlying reverse stings and promoting order maintenance policing) with BERNARD E. HARCOURT, ILLUSION OF ORDER: THE FALSE PROMISE OF BROKEN WINDOWS POLICING 6 (2001) (“The broken windows theory... has become not a substitute but a supplement.... What we are left with... is a system of severe punishments for major offenders and severe treatment of minor offenders and ordinary citizens, especially minorities.... We are left with the worst of both worlds.”).

29. See Note, Winning the War on Drugs: A “Second Chance” for Nonviolent Drug Offenders, 113 HARV. L. REV. 1485 (2000) (noting that the “war on drugs,” which “includes three-strikes laws and lengthy first-time drug offender sentences, have fundamentally changed the criminal justice system,” and that “African-Americans dominate this new prison population,” citing 1992 estimates from the U.S. Public Health Service indicating that although 92% of illicit drug users were white, 14% African American, and 8% Hispanic, African-Americans “account for 35% of all drug arrests, 55% of all drug convictions, and 74% of all drug sentences” due to the focus on punishing use and sales of crack cocaine).

30. See, e.g., Loic Wacquant, Deadly Symbiosis: Rethinking Race and Imprisonment in Twenty-First Century America, BOSTON REV., Apr./May 2002, available at http://bostonreview.net/BR27.2/wacquant.html; Benjamin D. Steiner & Victor Argothy, White Addiction: Racial Inequality, Racial Ideology, and the War on Drugs, 10 TEMP. POL. & CIV. RTS. L. REV. 443 (2001); Steven J. Boretos, The Role of Discrimination and Drug Policy in Excessive Incarceration in the United States, 6 UDC/DCSL L. REV. 73 (2001); see also Bart Majoor, Drug Policy in the Netherlands: Waiting for a Change, in HOW TO LEGALIZE DRUGS, supra note 5, at 129, 157. See generally Kevin Alexander Gray, A Call for an Anti-War Movement, in HOW TO LEGALIZE DRUGS, supra note 5, at 165 (arguing that the war on drugs has been waged on black people). But see Levine, supra note 5, at 97 (arguing that the drug war does not “target” minorities, but that the high numbers of incarcerated minorities results from a philosophy targeting suppliers and dealers rather than buyers).

tion of both drug offenders and their families through the collateral consequences of conviction, such as loss of job opportunities and the destabilization of families;\(^\text{32}\) (5) the imposition of a weighty fiscal burden at state and federal levels necessary to apprehend, process, and accommodate a total inmate population estimated at two million in 2003;\(^\text{33}\) and (6) a curtailment of civil rights, particularly with regard to the Fourth Amendment.\(^\text{34}\) Prohibition has also led to the creation of a profitable black market for illicit substances\(^\text{35}\) and the rejection of federal funding for harm reduction measures, such as safe needle exchanges.\(^\text{36}\)


\(^\text{36}.\) Despite agreeing with evidence illustrating that needle exchanges reduce the risk of HIV transmission, the Clinton administration denied federal funding for these programs. See Health and Human Services, *Needle Exchange Programs: Part of a Comprehensive HIV Prevention Strategy* (Apr.
Proponents of the U.S. drug war have several responses to these arguments. Among other things, advocates of prohibition argue that criminal sanctions have a deterrent effect, prevent collateral crimes associated with drug use, and promote moral health. Further, they argue that there are new non-punitive measures gaining acceptance in the United States in the form of a relatively small number of drug treatment courts.


40. In drug treatment courts, a defendant pleads guilty in exchange for the acceptance of placement in a court-mandated program of drug treat-
Support for prohibition is often phrased in moral terms, reflecting the different criteria that harm reductionists and prohibitionists use to judge what is “correct.” Consequently, it is difficult, if not impossible, to compare the “correctness” of the arguments. Nonetheless, it is important to consider the effect of the use of the language of punitive prohibition, See Michael C. Dorf & Charles F. Sabel, Drug Treatment Courts and Emergent Experimentalist Government, 53 Vand. L. Rev. 831, 832 (2000). Whether drug courts are, on balance, beneficial (represent cost savings, greater flexibility, and less punitive measures), see, e.g., White House, National Drug Control Strategy Update 23 (Feb. 2003) [hereinafter 2003 National Drug Control Strategy] (“Intrusive and carefully modulated programs like drug courts are often the only way to free a drug user from the grip of addiction. Such programs represent one of the most promising innovations in recent memory.”); White House, National Drug Control Strategy Update 23 (Feb. 2005) [hereinafter 2005 National Drug Control Strategy] (describing the benefits of drug courts and charting increasing number of such courts nationwide), or harmful—erode protection traditionally afforded by defense counsel, distort the role of the judge, have a net-widening effect, amount to same deprivation of liberty—is not yet clear. See generally Symposium, What Does the Future Hold for Drug Courts?, 29 Fordham Urb. L.J. 1858 (2002); Symposium, The Impact of Problem Solving on the Lawyer’s Role and Ethics, 29 Fordham Urb. L.J. 1892 (2002).

41. See Bush, supra note 38 (“There is a moral reason to achieve this grand . . . objective, and it’s this: drugs rob men and women and children of their dignity and their character. Illegal drugs are the enemies of ambition and hope.”); U.S. International Drug Policy, U.N. Convention Against Illicit Drugs: Hearing Before the S. Caucus on Int’l Narcotics Control, 101st Cong. 3 (1989) (statement of Sen. Joseph Biden, Jr.) (stating, with respect to the “symbolic force” of the 1988 Convention, that “[I]f the first time, the community of nations has come together to affirm a basic value: drug trafficking and abuse are morally repugnant.”); Roseanne Scotti, Comment, The “Almost Overwhelming Temptation”: The Hegemony of Drug War Discourse in Recent Federal Court Decisions Involving Fourth Amendment Rights, 10 Temp. Pol. & Civ. Rts. L. Rev. 139, 140 (2000) (quoting former “Drug Czar” William Bennett: “the simple fact is drug use is wrong. And the moral argument in the end is the most compelling argument.” (footnote omitted)). Interestingly, the representative of the Holy See to the U.N. Conference convened to consider amendments to the Single Convention also linked the moral aspects of drug abuse to its “root causes, to the immorality and pornography by which modern youth was surrounded. It was the permissive present-day society which lay at the root of the problem.” 2 Official Records of the Amendments to the Single Convention, supra note 24, 2d plen. mtg. at 7.

42. For a discussion of the effect of the drug discourse in Fourth Amendment jurisprudence, see Scotti, supra note 41. Scotti argues, “the discourse undermines legal reasoning, limits judicial independence, and circumscribes the scope of intelligent discussion about drug issues in American jurisprudence.” Id. at 141.
particularly because drug war rhetoric has permeated international drug policy discourse. The invocation of symbolism through language shapes the debate over appropriate measures to address this war/public health crisis.\textsuperscript{43} It may be difficult to alter the rhetoric deployed against drug use for cultural/social reasons cited by many observers, such as:\textsuperscript{44} (1) longstanding racial prejudice;\textsuperscript{45} (2) media manipulation or political or institutional self-interest;\textsuperscript{46} (3) fear that the destigmatization of drug use might encourage it;\textsuperscript{47} (4) a need

\textsuperscript{43} See \textit{GRAY}, supra note 32, at 123 (“Unfortunately, most Americans have not learned [that drug-addicted people are human beings like themselves] . . . and they continue to allow people who take illegal drugs to be stereotyped, demonized, prosecuted, and jailed.”). For a discussion of the impact of socially constructed meaning in the study of drug policy, see Jefferson M. Fish, \textit{Methodological Considerations and Drug Prohibition}, in \textit{HOW TO LEGALIZE DRUGS}, supra note 5, at 12, 12-18.

\textsuperscript{44} For a discussion of the war on drugs as a social construction, see \textit{DRUG WAR, AMERICAN STYLE}, supra note 21, at 1.

\textsuperscript{45} See supra notes 23, 30.

\textsuperscript{46} See Levine, supra note 5, at 97-103; see also \textit{GRAY}, supra note 32, at 125-26 (noting that “most politicians dare not be labeled ‘soft on drugs’ . . . one does not get elected by taking positions that run counter to numerous, wealthy, and well-established vested interests.”); Benedikt Fischer, \textit{Canada’s New Drug Law Brings Few Changes}, ADDICTION RES. FOUND., Sept.-Oct. 1996, at 8 (asserting that Canadian parliamentary failure to enact non-prohibition measures stems from “political self-interest in perpetuating the myth that the criminal law can solve . . . drug problems. . . . Canada has once again mimicked the U.S. ‘McCarthyist’ model of drug policy.”); Nick Davies, \textit{Demonising Druggies Wins Votes: That’s All That Counts}, GUARDIAN, June 15, 2001, available at http://society.guardian.co.uk/drugsandalcohol/comment/0,,507396,00. html (same for British politicians); Gerber & Jensen, supra note 21, at 4-5 (linking the war on drugs to the self interest of the media, politicians and criminal justice administrators). For an example of the media tilt with respect to drug statistics, see MacCoun, supra note 13; Schechter, supra note 13, at 99.

\textsuperscript{47} See Fish, supra note 43, at 22 (citing the common fear that drug legalization will make the United States a “nation of addicts”); \textit{COMMENTARY ON THE 1961 PROTOCOL}, supra note 9, at 86 (“Governments should not overlook the danger that spreading of knowledge about narcotic drugs may in some situations lead to the spread of their abuse. That risk may have to be kept in mind specially where such abuse does not exist or is only rare.”). \textit{But see} Ethan A. Nadelmann, \textit{Thinking Seriously About Alternatives to Drug Prohibition}, in \textit{HOW TO LEGALIZE DRUGS}, supra note 5, at 578, 609 (noting that opinion polls indicate that drug abuse would not dramatically increase under a non-prohibitionist regime).
to justify a lengthy, historical commitment to a drug war; and (5) a need to divide “good” from “bad” drugs, or “drug-abusing criminals” from “law-abiding citizens.” Yet, to confront the drug problem, the impact that language has on the debate must be taken into account.

C. Alternatives to Punitive Prohibition

There are a variety of alternatives to punitive prohibition that, for analytical convenience, this paper will generally consider under the imprecise rubric of “non-prohibition.” On the other hand, due to the analytical differences between them, it is important to distinguish legalization from what is loosely termed “harm minimization.”

48. See Lynch, supra note 19, at 7-10 (discussing the “never say die” drug war mentality).

49. See Wayne M. Harding, Informal Social Controls and the Liberalization of Drug Laws and Policies, in The Control of Drugs and Drug Users, supra note 10, at 213, 214 (describing cultural mythology behind the distinction between “good” drugs such as caffeine and “bad,” and thus illicit, drugs).

50. See Leuw & Marshall, supra note 11, at viii; see also Gregory Howard Williams & Sara C. Williams, America’s Drug Policy: Who Are the Addicts?, 75 IOWA L. REV. 1119, 1119 (1990) (“We abuse a wide variety of illicit drugs as well as alcohol, nicotine, caffeine, food, anti-depressants, tranquilizers, pain-killers, and other legal drugs. One could view drug abuse as a symptom of the addictive nature of our society.”). For an exploration of the prevalence of attraction to deviant behavior in law-abiding citizens, see generally Jack Katz, Seductions of Crime: Moral and Sensual Attractions in Doing Evil (1988).

51. See Reinarkman, supra note 23, at 250, reprinted in 1 Drugs, Crime and Criminal Justice 126 (Nigel South ed., 1995) (“[W]e must be willing to admit that the ‘drug problem’ is more likely a battlefield of material and ideological conflict than a symbol of concern for public safety.”); Robert W. Sweet & Edward A. Harris, Moral and Constitutional Considerations in Support of the Decriminalization of Drugs, in How to Legalize Drugs, supra note 5, at 430, 430-47.

52. Because punitive prohibition has long been the prevailing international view and non-prohibitive alternatives tend to be defined, at least currently, primarily in opposition to it, such an approach is particularly appropriate.

53. It should be noted that, like prohibition, harm reduction is susceptible to the potential dangers of language manipulation. For example, what is “harm”? How should one conceptualize harm? See Husak, supra note 5, at 34-38 (critiquing the harm reduction approach).
Although legalization appears in several policy forms, it is most often affiliated with decriminalization. Advocates for drug legalization most frequently set forth arguments that: (1) drug regulation curtails personal rights, particularly because drug use arguably constitutes a "victimless crime," and (2) deregulation of drugs is preferable under a cost-benefit matrix.

54. These include outright legalization (treatment of drugs as any other good), decriminalization (removal of penal sanctions from some or all currently illicit drugs, most frequently associated with marijuana, and, in particular the cannabis policy in the Netherlands), limitation plans (providing limited access to drugs), and regulation and taxation plans (analogous to the current tobacco tax). See Gary E. Johnson, It’s Time to Legalize Drugs, After Prohibition, supra note 5, at 13, 17. See generally Richard M. Evans, What is “Legalization”? What are “Drugs”? in How to Legalize Drugs, supra note 5, at 371-81 (describing each of these alternatives).

55. Note that the term “decriminalization” is used here in a broad sense to cover both de facto and de jure legalization. In a narrow sense, it is true that “[c]ommentaries that refer to a decriminalisation of possession or legalisation of cannabis or of other controlled drugs in the Netherlands are incorrect,” NICHOLAS D ORN & ALISON JAMIESON, DRUGSCOPE: ROOM FOR MANOEUVRE: OVERVIEW REPORT 5 (March 2000), but there is a policy of tolerance for the use and possession of specified amounts of soft drugs.

Dutch drug policy has encompassed both “legalization” (with respect to small amounts of “soft” drugs, such as marijuana and hashish) and harm minimization (for hard drugs). See Leuw & Marshall, supra note 11, at vii. Dutch policy with respect to cannabis and hashish is described in A.C.M. Jansen, The Development of a “Legal” Consumers’ Market for Cannabis: The “Coffee Shop” Phenomenon, in Between Prohibition and Legalization, supra note 5, at 169. Jansen notes that the “Dutch soft drugs policy, when compared with virtually all other countries in the Western world, is less repressive, [but] . . . has not resulted in an explosive increase in the use of soft drugs.” Id. at 180. The difference between Dutch “law-on-the-books” and “law-in-action” is discussed in Silvis, supra note 35, at 43-44. Dutch policy has, in recent years, however, become less liberal. For example, in August of 2004, the Government of the Netherlands recognized that “cannabis is not harmless,” neither for abusers nor for the community, and stressed the importance of strengthening ‘measures against street dealing, drug tourism and cannabis cultivation’ and of continuing to ‘reduce the number of coffee shops.’” INCB, 2004 Report, supra note 8, ¶ 216.


56. See Sweet & HARRIS, supra note 51, at 447-51 (describing the “consequentialist” and “rights-based” arguments for decriminalization). Note, however, that the cost-benefit approach is more often associated with harm re-
The first of these contentions implicates a person’s moral right to make his or her own choice regarding drug consumption. According to this viewpoint, such a decision must be “free from governmental control, interference, or restriction.” For example, some submit that an individual has a constitutional right to self-determination that includes the right to use drugs. The underlying assumption is not that drugs are “good” or “bad,” but that personal autonomy requires that each person be free to choose whether and to what extent to use drugs.

Arguments based on theories of morality defy easy resolution, of course, and, consequently, the most potent criticisms of legalization focus on the adverse consequences that might result from the greater availability of potentially harmful substances. These arguments, explicitly or by implication, rebut the contention that drug legalization is preferable on a cost-benefit basis.

By contrast, the primary objective of the harm reduction movement is to mitigate the harm caused by illicit drug use, such as the risk to the individual using drugs, those in the user’s environment, and to society in general. In other words, rather than focusing on whether drug use is morally wrong, harm reduction focuses on the consequences of this behavior on the user and on society.


58. See Sweet & Harris, supra note 51, at 459-50 (“The foremost constitutional issue is that of balancing the drug user’s rights against the rights of others . . . . Therefore, defining the scope of the right to drugs as a fundamental constitutional right poses no greater difficulty than defining the scope of other unenumerated constitutional rights that [the Court has] recognized and protected previously . . . .”).

59. See Nadelmann, supra note 47, at 581 (describing the development of the harm minimization movement); see also Weingardt & Marlatt, supra note 57, at 367-70 (distinguishing legalization from harm reduction).


61. See Marlatt, supra note 18, at 50.
Harm minimization has gained increasing acceptance in much of Western Europe. It is rooted in pragmatism, premised on the assumption that drug use cannot be eradicated, i.e., "idealistic visions of a drug-free society are unlikely to become reality." Accordingly, proponents of this movement assert that public policy should address the realities of drug use, particularly in light of the public health risks such as those posed by the transmission of HIV through unclean needles.

As the foregoing suggests, harm minimization has as its goals the mitigation of the adverse effects of drug use to both the individual and society as a whole, including, inter alia, death, disease, suffering, marginalization, and incarceration. Unlike punitive prohibition, the primary objective of harm minimization is not the suppression of drug use. Thus, one does not measure the success of harm reduction policies by the volume of drugs seized or the prevalence of substance use. Although "prevention and treatment efforts designed to reduce demand for drugs are an important subset of harm reduction strategies. . . .the harm reduction approach goes beyond [these] efforts . . . ." An important part of harm reduction is the destigmatization of drug users. Successful destigmatization requires viewing the "drug problem" as a public health concern instead of primarily a moral issue. Practically speaking, harm minimization programs include: (1) supervised injection rooms providing users with "clean equipment and facilities under the supervision of medically trained personnel" (e.g., State of New

62. Although harm minimization is accepted to varying degrees in countries such as the Netherlands, Portugal, Spain and Switzerland, Sweden is currently closer to the United States in terms of its drug policy. See Leif Lenke & Boerje Olsson, Swedish Drug Policy in the Twenty-First Century: A Policy Model Going Astray, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 64, 76 (2002). Both France and Sweden prohibit and criminalize drug use. See DORN & JAMIESON, supra note 55, at 4.
63. Marlatt, supra note 18, at 50.
64. See Nadelmann, supra note 47, at 609; Marlatt, supra note 18, at 57-58.
65. See Weingardt & Marlatt, supra note 57, at 367.
66. This should be distinguished from the encouragement of drug use—drug use still is perceived as a problem, simply one of a different nature requiring different solutions. See Marshall & Marshall, supra note 60, at 206-08 (describing "normalization" of drug users).
South Wales in Australia, Canada, Germany); 67 (2) methadone clinics or other maintenance programs focused on drug treatment; 68 (3) free needle exchange programs (e.g., Czech Republic, Poland, Romania, Slovakia, Canada, Netherlands, and the United States); 69 (4) needle deregulation programs


68. See Nadelmann, supra note 47, at 581. Dutch drug policy incorporates the use of methadone, see Leuw & Marshall, supra note 11, at ix, as does Australian drug policy, see Gabriele Bammer et al., Harm Minimization in a Prohibition Context—Australia, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 80, 91-92 (2002), and in a surprising shift toward harm reduction, so does French policy, see Henri Bergeron & Pierre Kopp, Policy Paradigms, Ideas, and Interests: The Case of the French Public Health Policy Toward Drug Abuse, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 37, 44-47 (2002). But see Paul Webster, France to Toughen Laws on Cannabis, GUARDIAN, Dec. 27, 2002, http://www.guardian.co.uk/international/story/0,,865299,00.html.

69. See INCB, 2003 Report, supra note 67, ¶ 538. Free needle exchange programs have shown promise in reducing risks associated with HIV. In the United States, needle exchange programs are funded at the local, rather than federal level, and exist in some major metropolitan areas, such as Baltimore and San Francisco. There has been considerable debate over the efficacy of needle exchange programs, some of which has been impacted by misconceptions regarding the data emerging from trials conducted in, for example, Canada. See Needle Exchange, Legalization, and the Failure of the Swiss Heroin Experiments: Hearings Before the Subcomm. on National Security, International Affairs and Criminal Justice of the Comm. on Government Reform and Oversight, 105th Cong. 64 (1998) (statement of Rep. Robert Barr) (noting that the Canadian study reported increased probability of HIV in needle exchange program participants and concluding that “this study is important . . . to state that those here who think we ought to rush forward with a needle exchange program because it seems on the surface to be benign and compassionate, which it is, that there may be some dangers out there.”). On the manipulation of the data from the Canadian study, see Schechter, supra note 13, at 97, 99.
(United States); 70 (5) educational campaigns regarding how to use drugs safely; 71 (6) treatment as an alternative to punishment (United States, Britain72); and (7) drug content testing.73

The difficulty with assessing the effects of harm reduction programs lies in familiar data problems (e.g., cross-cultural differences, inconsistent data-gathering techniques)74 as well as with non-prohibitionist experimentation itself.75

D. Education and Treatment

Both prohibitionist and harm reduction policies incorporate aspects of education and treatment. Education under the typical prohibitionist approach involves anti-drug programs

70. This is a new policy favored as more politically feasible in the United States, in light of the failure of needle exchange programs to garner federal support. See generally Scott Burris & Mitzi Ng, Deregulation of Hypodermic Needles and Syringes as a Public Health Measure: A Report on Emerging Policy and Law in the United States, 12 GEO. MASON U. CIV. RTS. L.J. 69 (2001); Scott Burris et al., Harm Reduction in the Health Care System: The Legality of Prescribing and Dispensing Syringes to Drug Users, 11 HEALTH MATRIX 5 (2001).

71. See, e.g., H. Pollack, Controlling Infectious Diseases Among Injection Drug Users: Learning (the Right) Lessons from Acquired Immunodeficiency Syndrome (AIDS), 53 BULL. ON NARCOTICS 91, 95, U.N. Sales No. E.02.XI.6 (2002) (arguing that measures such as providing instruction on the proper use of bleach for needle sterilization are essential).

72. See Alan Travis, ‘Tough Love’ Policy at Heart of New Drugs Strategy, GUARDIAN, available at http://www.guardian.co.uk/uk_news/story/0,,85326,00.html (reporting on a 2003 policy under which “offenders who test positive for heroin or cocaine will be faced with a choice of treatment or prison”); see also Simon Jeffery, Police to Get New Anti-Drug Powers, GUARDIAN, Nov. 25, 2004, available at http://politics.guardian.co.uk/homeaffairs/story/0,,1359360,00.html (“The government insists its efforts to tackle drugs are working. No 10 said nearly 1,500 offenders were entering treatment each month, and crime was falling faster in those areas where drug intervention programmes were in place.”).


75. First, a reason for abandoning the prohibition paradigm is to develop innovative approaches, given the diversity among types of drugs, drug users, and the social environments in which drug use occurs. The nuanced nature of many of these new approaches makes comparison very difficult. Second, many of these programs are relatively new and, to enhance the reliability of impact data, must be given time to develop before one draws any conclusions as to their efficacy.
and media campaigns seeking to reduce drug use. Abstinence-only drug education may lead to the perpetuation of ignorance about safer drug use, which may in turn give rise to serious health consequences. Where drug use is characterized as a public health problem, education is used both to discourage drug use and to advocate safe drug use. Because drug use is not considered an “evil,” prevention programs tend to be low key. Advocacy with respect to safe drug use is a response to the dangers associated with unsafe injection or other methods of drug use. There is, however, debate over the permissibility of such campaigns under the international conventions.

Like education, treatment has taken a variety of forms. Under the public health approach most measures are state-sponsored and fall under the general umbrella of “treatment.”


77. See Rodney Skager & Joel H. Brown, On the Reconstruction of Drug Education in the United States, in HOW TO LEGALIZE DRUGS, supra note 5, at 310; Zero Tolerance Conceals Drug Use in Schools, GUARDIAN UNLIMITED, Feb. 3, 2003, http://www.guardian.co.uk/drugs/Story/0,2763,888221,00.html (reporting Home Office research regarding the dangers of zero-tolerance drug policies, which may encourage children to conceal drug problems).

78. See Marshall & Marshall, supra note 60 (comparing U.S. and Dutch drug prevention programs).

79. See, e.g., Kay, supra note 12, at 2181-83 (arguing for safer-use problems to address the dangers associated with improper use of Ecstasy).

80. See Bullington, supra note 33, at 116-20 (considering the impact of the drug war on the treatment of users).
so the availability of treatment is generally more extensive.81 Treatment has played a significant role in drug war rhetoric, but currently, public treatment for drug users remains inadequate.82 In fact, only one in six of the approximately 800,000 inmates that have drug and alcohol abuse problems is provided with drug treatment.83 Furthermore, insurance policies do not generally cover treatment costs associated with drug abuse.84 These shortcomings in the availability of treatment exist despite the fact that, by some estimates, drug treatment is seven times more cost effective than law enforcement strategies.85

III. THE DRUG TREATIES

A. Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol

On August 3, 1948, the U.N. Economic and Social Council adopted a resolution asking the Secretary-General to prepare a draft convention to incorporate the nine then-existing conventions.86 Representatives of 73 states attended the resulting plenary conference, and adopted the Single Convention on March 30, 1961. This convention is perhaps the most important of the drug treaties because it forms the basic framework upon which later treaties were written. In short, the Single Convention introduced a system classifying certain substances according to potential abuse and medical benefit.87 It also “mandated production of, trade in, or use of scheduled drugs exclusively for ‘medical and scientific’ needs, set global targets for how much legal opium or coca needed to be pro-

81. For a discussion of the availability of drug treatment services in the Netherlands, which are free, see Wever, supra note 5, at 67-70.
82. See Bullington, supra note 33, at 118-19 (observing that treatment facilities are available for the “relatively well off” but that the targeted drug users do not generally fall in this category and thus suffer from a lack of adequate treatment facilities).
83. Kay, supra note 12, at 2175.
85. Kay, supra note 12, at 2175.
86. Boister, supra note 21, at 41-42.
duced to meet such needs, and required states to prevent production or diversion of drugs into illegal markets.\footnote{Daniel Wolfe, Open Society Institute, Illicit Drug Policies and the Global HIV Epidemic: Effects of UN and National Government Approaches 21 (2004).}

Following adoption of the 1971 Convention, the Single Convention was amended by the 1972 Protocol to bring it into conformity with the 1971 Convention.\footnote{See supra note 4.} Relevant articles for the purposes of the international debate over drug policy regarding personal use of narcotic substances include Article 2 (substances under control), Article 4 (general obligations), Article 28 (control of cannabis), Article 33 (possession), Article 36 (penal provisions), and Article 38 (measures against the abuse of drugs).\footnote{Single Convention on Narcotic Drugs, 1961, supra note 4, arts. 2, 4, 28, 33, 36, 38. In these provisions, Single Convention refers to narcotics in four “schedules,” subject to varying controls.}

**B. Convention on Psychotropic Substances**

The 1971 Convention extended the international drug control system to psychotropic substances, which are “stimulants of the central nervous system and hallucinogens” that became increasingly popular in the 1960s, such as LSD and methamphetamine.\footnote{Boister, supra note 21, at 46; see also Wolfe, supra note 88, at 21.} The 1971 Convention generally mirrored the Single Convention, but focused on drug manufacturing instead of agricultural states.\footnote{Boister, supra note 21, at 47.}

Notably, the provisions under this Convention were not intended to set up a strict system of control and are less rigorous than those of the Single Convention, as originally enacted.\footnote{See 2 Official Records of the Protocol on Psychotropic Substances, supra note 24, 1st plen. mtg. ¶¶ 10-11, at 1-2 (opening statement of the Acting President) (noting that the treaty should be balanced, creating neither “a watertight scheme of control” nor too much flexibility); see also Boister, supra note 21, at 47 (“As a whole the 1971 Convention was modelled on the 1961 Convention but because it was aimed at drug manufacturing states rather than agricultural states, its provisions are not as rigorous as those of the 1961 Convention.”).} For example, the preamble of the Single Convention focuses on the “evil” of drug addiction: “The Parties, [c]oncerned with the health and welfare of mankind, . . .
recognizing that addiction to narcotic drugs constitutes a serious evil . . . [c]onscious of their duty to prevent and combat this evil . . . .”94 By contrast, the Convention on Psychotropic Substances of 1971 describes drug abuse as a public health problem: “Being concerned with the health and welfare of mankind, [n]oting with concern the public health and social problems resulting from the abuse of certain psychotropic substances. . . .”95

C. Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988

The 1988 Convention expanded the scope of the international treaties by adding to the drug schedules “‘precursor chemicals’ used for manufacture of illicit drugs to the list of controlled substances, and created a host of measures regulating fiscal matters such as money laundering and seizure of assets.”96 It also required members to criminalize “possession, purchase or cultivation of narcotic or psychotropic drugs for personal consumption” and mandates that the incitement of another to use illicit drugs be made illegal.97

Aimed at international drug trafficking, the 1988 Convention reflects the strongest punitive measures to date and is characterized by the lowest membership of the international agreements.98 The United States played an important role in determining the contours of the treaty, advocating the adoption of “strong penal provisions.”99 Ironically, the U.S. delegation focused on non-personal use offenses (e.g., money laun-

96. WOLFE, supra note 88, at 21.
97. Id.
98. See 1988 Convention, supra note 4, at 165 n.1.
dering and jurisdiction) and opposed the inclusion of personal use offenses in the Convention. Arguably, however, a strong stand on the implementation of trafficking penalties (taken by producer countries such as the United States) prompted the response from consumer countries that personal consumption should also be penalized.100

D. *International Treaty Structure*

The aforementioned treaties operate in concert, and must therefore be taken together as providing the framework for a single drug control system. Nevertheless, it should be noted that, although the difference is not significant, the 1988 Convention has fewer members than the previous agreements.101 Switzerland, for instance, has not become a party to the 1988 Convention despite the fact that it has signed both the Single Convention of 1961 and the 1972 Protocol and the Convention on Psychotropic Substances of 1971.102

The treaties represent a balancing of interests, and therefore should be construed to provide the maximum flexibility for member parties. Moreover, permitting the exercise of discretion, particularly with respect to national penal systems and personal drug use—which are outside the ambit of the treaties, due to their focus on supply-reduction measures—helps facilitate widespread acceptance of the conventions. Subsequent state practice illustrates that member parties have interpreted the treaties differently. For instance, the United States has, on balance, maintained strict penal controls on personal drug use. By contrast, "state practice in [other parts of] the developed world has shown a steady if narrow trend toward a limited legalisation or decriminalisation of personal use and a much wider de facto decriminalisation of personal use."103


102. *Id.*

103. Boister, *supra* note 21, at 129.
The technical provisions of the treaties are primarily implemented by the INCB, a role that was enhanced primarily through amendment to the Single Convention.104 If a government fails to fulfill its obligations to provide required data in the form prescribed by the INCB and does not either provide a reasonable explanation for this failure or adopt remedial measures as requested by the INCB, the INCB may (by 2/3 majority)105 take additional actions, such as (1) ordering a study of the matter or (2) if other measures fail, notifying the parties, the CND, and the Economic and Social Council (ECOSOC) of the matter and suggesting appropriate international cooperative measures.106 In performing its duties, the INCB must take measures that are “most consistent with the intent to further the co-operation of Governments with the Board” and “provide the mechanism for a continuing dialogue between Governments and the Board.”107 The INCB is also required to prepare an annual report.108


105. See Single Convention on Narcotic Drugs, 1961, supra note 4, art. 14(6); Convention on Psychotropic Substances, 1971, supra note 4, art. 19(6); 1988 Convention, supra note 4, art. 22(4).

106. See Single Convention on Narcotic Drugs, 1961, supra note 4, art. 14. One course of action may be to stop the import or export of drugs to the offending state. Id. art 14(2). An alternative course of action, if appropriate, is to advise the competent U.N. bodies that technical and/or financial assistance be rendered to the non-complying party. Id. art. 14 bis. For corresponding provisions in the subsequent conventions, see Convention on Psychotropic Substances, 1971, supra note 4, art. 19; 1988 Convention, supra note 4, art. 22.

107. See Single Convention on Narcotic Drugs, 1961, supra note 4, art. 9(5).

108. See id. art. 15; Convention on Psychotropic Substances, 1971, supra note 4, art. 18; 1988 Convention, supra note 4, art. 23.
IV. APPLICATION OF THE DRUG TREATIES TO CURRENT DRUG POLICY DISPUTES

A. The Confines of the Debate

“Although prohibition is the official national and international policy in respect of drugs today, against this background it seems inevitable that not all states should . . . share a common conception of the drug problem or its solution.”\textsuperscript{109} There is considerable controversy as to whether non-prohibitionist drug policies violate international treaty obligations, much of it generated by the United States and the INCB.\textsuperscript{110} For example, reflecting the U.S. prohibitionist perspective, a Drug Enforcement Administration official stated that under its treaty obligations, the United States:

\begin{quote}
must enact and carry out legislation disallowing the use of Schedule I drugs outside of research; make it a criminal offense, subject to imprisonment, to traffic in illicit or to aid and abet such trafficking; and prohibit cultivation of marijuana except by persons licensed by, and under the direct supervision of the federal government.\textsuperscript{111}
\end{quote}

\textsuperscript{109} Boister, supra note 21, at 10.

\textsuperscript{110} The United States is also an outspoken opponent to certain harm reduction measures, such as Australia’s creation of “safe injection rooms.” See Dan Gardner, Why the War on Drugs Has Failed: Uncle Sam’s Global Campaign to End Drug Abuse Has Empowered Criminals, Corrupted Governments and Eroded Liberty, But Still There Are More Addicts Than Ever Before, OTTAWA CITIZEN, Sept. 5, 2000, at A1. In fact, some argue that the United States exerts its influence, in part, through the INCB. See id. (reporting the comment of the minister of health for the Australian Capital Territory, “[t]he American influence on the narcotics board is overwhelming and unfortunate.”); id. (reporting the comment of Dr. David Pennington, “INCB has throughout been led by the policies of the U.S. State Department”). Apparently the United States has frequently pressured U.N. bodies. For example, it subjected the World Health Organization to such “intense pressure” that it never issued its report on cocaine use, which identified certain myths regarding cocaine and its effects. See id.

\textsuperscript{111} “Medical” Marijuana, Federal Drug Law and the Constitution’s Supremacy Clause: Hearing Before the Subcomm. on Criminal Justice, Drug Policy, and Human Resources of the Comm. on Government Reform, 107th Cong. 64 (2001) (emphasis added).
Despite recent indications that it may be more amenable to certain harm reduction approaches, the INCB maintains a relatively prohibitionist stance on international drug control. In its annual reports over the last several years, the INCB has criticized non-prohibitionist measures, suggesting that the following violate international drug control treaties: (1) measures liberalizing the prosecution of activities relating to the personal consumption of cannabis (purchase, cultivation, possession, and use); (2) operation of Dutch "coffee shops";
(3) establishment of supervised injection rooms;\(^{115}\) and (4) heroin maintenance programs.\(^{116}\)

Additionally, the INCB devoted significant space to the criticism of non-prohibitionist speech in its 1997 Annual Report, labeling it as “public incitement” under the 1988 Convention. The INCB reminded each member state of its obligation to criminalize the “incitement” of drug use, subject to the speech protections contained in its constitutional framework. It then went even further, noting:


\(^{116}\) See, e.g., INCB, 2004 Report, supra note 8, ¶ 201 (reiterating its concern over the medical prescription of heroin); INCB, 2002 Report, supra note 113, ¶ 496 (same); INCB, 1995 Report, supra note 114, ¶ 385 (same).
It is possible to curb the showing by public broadcasting media . . . of favourable images of drug abuse. . . . [1]n [some countries], no restrictions are in place because freedom of information and freedom of speech are considered to be more important than limiting the promotion of illicit drugs. The Governments of those countries may need to reconsider whether unrestricted access to and the propagation of such information are detrimental to the social health and conditions of their populations.117

In its 2004 Annual Report, the INCB once again censures certain member states’ failure to criminalize public “incitement” of drug use.118 The United States’ and the INCB’s prohibitionist assertions, such as this one, do not arise solely from a textual interpretation of the treaties. That is, such conclusions often reflect the normative justifications of the prohibitionist point of view.

As touched upon in Part II, the prohibitionist position is often justified on both moral and utilitarian grounds. The moral prohibitionist argues, “Drug use is wrong because it is immoral and it is immoral because it degrades human beings.”119 Because drug use “enslaves the mind and destroys the soul[,]”120 the moral prohibitionist believes that “the government should vigorously investigate, prosecute, and jail anyone who sells, uses, or possesses mind-altering drugs.”121

The utilitarian prohibitionist, much like the supporters of harm minimization, frames the argument in terms of costs and benefits. Drug use inflicts high costs on society, including increased incidence of death from drug overdose, physical and

118. INCB, 2004 Report, supra note 8, ¶¶ 185-92.
120. Id. (quoting BENNETT ET AL., supra note 39, at 140-41).
mental impairment from drug abuse, an increased incidence of drug-related accidents, decreased worker productivity, rise in crime to pay for consumption, increased child abuse and neglect, impairment in learning, increased truancy, and negative effects on family and social relationships. The utilitarian prohibitionist implicitly justifies using the tools of punitive prohibition by assuming that they are the most effective methods for mitigating the negative societal effects of drug use.

The foregoing justifications constitute the prism though which advocates of punitive prohibition view the treaties. A straightforward analysis of the text of the treaty, however, yields a different, more flexible interpretation of the treaty’s provisions on personal drug use.

B. Analysis of Prohibitionist Assertions Under International Treaties

The INCB and the United States have made statements denying the permissibility of certain non-prohibitionist, harm reduction policies. For example: (1) the United States must enact legislation prohibiting non-medical use of Schedule I drugs of the U.S. Controlled Substances Act; (2) states party to the treaties may not implement any measures liberalizing the prosecution of activities relating to the personal consumption of cannabis; (3) the Netherlands may not permit the operation of “coffee shops”; (4) parties may not establish and operate supervised injection rooms; (5) parties may not implement heroin maintenance programs; and (6) parties may not accommodate non-prohibitionist education or speech. These assertions are evaluated in the sections that follow.

Prohibitionist Assertion 1: The United States Must Enact Legislation Prohibiting Non-Medical Use of Schedule I Drugs

The statement that the treaty obligations of the United States require it to prohibit the non-medical use of all drugs listed in Schedule I of the U.S. Controlled Substances Act is

122. STARES, supra note 2, at 100-01.
123. Schedule I drugs include: acetylmethadol (a Schedule I narcotic); pholcodine and acetyldihydrocodeine (Schedule II narcotics); acetorphine (a Schedule IV narcotic); and mescaline (a Schedule I psychotropic
technically true, but misleading. First, because the terms "medical" and "scientific" are not defined under the treaties, there is discretion for parties to determine what constitutes medical or scientific use. The line between medical and non-medical use is not always clear. Consider for instance the history of Ecstasy, which the pharmaceutical company Merck originally patented in 1914 as "an intermediate chemical used in the process of synthesizing a medicine intended to stop bleeding." Therapists then used it for nine years to assist in psychotherapy, finding it particularly "beneficial in facilitating . . . fear reduction," but in 1985, within a year of initiating an investigation into growing recreational use of the drug, the U.S. Drug Enforcement Agency classified it as illegal. The history of cannabis, which, many argue, has medical value and no proven addictive properties, provides another example of the uneasy division between medical and non-medical.

---

124. Because one of the goals of the treaty is to provide for legitimate medical and scientific narcotics work to ease "pain and suffering," Single Convention on Narcotic Drugs, 1961, supra note 4, pmbl., there is some discretion in what a signatory deems medical/scientific use, necessary to ameliorate problems of public health. Subsequent state practice supports this interpretation, as explained in the Commentary, which notes that the "term 'medical purposes' has not been uniformly interpreted by Governments when applying the provisions of the narcotics treaties containing it . . . . [It] does not necessarily have exactly the same meaning at all times and under all circumstances." U.N. OFFICE OF DRUGS AND CRIME, COMMENTARY ON THE SINGLE CONVENTION ON NARCOTIC DRUGS, 1961, at 111, U.N. Sales No. E.73.XI.1 (1973) [hereinafter COMMENTARY ON THE SINGLE CONVENTION]. Similar to the Single Convention, as amended, the 1971 Convention provides for the limitation on the use and possession of listed substances to medical and scientific purposes. See Convention on Psychotropic Substances, 1971, supra note 4, arts. 5, 7, 92. States retain discretion regarding the use and possession of all psychotropic substances, including Schedule I substances, through their interpretation of "medical and scientific purposes," because, like the Single Convention, the 1971 Convention relies on the ability to delineate between [psychotropic] drugs as used for legitimate medical or scientific purposes in an attempt to strike a balance between controlling drug abuse and not encumbering medical/scientific research. See, e.g., 2 OFFICIAL RECORDS OF THE PROTOCOL ON PSYCHOTROPIC SUBSTANCES, supra note 24, 4th plen. mtg. ¶ 42, at 12 (statement of Chilean delegate).

125. Kay, supra note 12, at 2158.
126. Id.
Second, the United States is required to prohibit all use of psychotropic substances on Schedule I of the 1971 Convention, with the exception of scientific and limited medical use by authorized individuals.128 Regarding narcotics, however, the United States must “limit exclusively” the use of drugs to medical and scientific purposes, subject to the provisions of the Single Convention.

128. Non-Schedule I substances are governed by Article 5(3), which states that “[i]t is desirable that the Parties do not permit the possession of substances in Schedules II, III, and IV except under legal authority.” Convention on Psychotropic Substances, 1971, supra note 4, art. 5(3). This reflects the notion that the parties are not required to prohibit possession for personal consumption. A party must limit by “appropriate” measures, non-medical/scientific use and possession, but under Article 5(3), parties are not required to prohibit possession of such substances. This interpretation is strongly supported by the Commentary. U.N. OFFICE OF DRUGS AND CRIME, COMMENTARY ON THE CONVENTION ON PSYCHOTROPIC SUBSTANCES, at 350, U.N. Doc. E/CN.7/589, U.N. Sales No. E.76.XI.5 (1976) [hereinafter COMMENTARY ON THE CONVENTION ON PSYCHOTROPIC SUBSTANCES] (remarking that “article 5, paragraph 3 does not impose upon Parties an obligation to prohibit the possession for personal consumption of substances in Schedules II, III, and IV, without legal authority, but only declares that prohibition to be desirable.”).

With respect to Schedule I substances, the parties shall prohibit non-medical use and shall somehow supervise (either directly or through an approval system) medical and scientific use of these substances. In addition, parties must “require that manufacture, trade, distribution and possession be under a special licence or prior authorization.” Convention on Psychotropic Substances, 1971, supra note 4, art. 7(b). One could interpret possession under Article 7(b) to cover possession for personal consumption, implying that it could be permissible under special license or prior authorization. Alternatively, the Commentary asserts that Article 7(b) should be read in reference to those permissible limited medical/scientific uses enumerated under Article 7(a), suggesting that the “only effect of the inclusion in paragraph (b) of the word ‘possession’ would be that of ensuring that any possession . . . for other purposes than authorized trade, distribution, or use for research . . . would be prohibited.” COMMENTARY ON THE CONVENTION ON PSYCHOTROPIC SUBSTANCES, supra, at 157. The Commentary concedes, however, that, “there may be some legitimate difference of opinion as to whether the text of paragraph (b) permits the conclusion that only possession for other purposes than authorized trade . . ., distribution, medical treatment or scientific research requires [authorization].” Id. Either interpretation appears reasonable, although the most conservative reading implies that Schedule I substances must be confined strictly to medical/scientific use (and therefore possession) under some kind of state supervision/approval system.
To “limit exclusively” is not precisely the same as to “prohibit”, as illustrated through comparison of Article 4(c) and Article 2 of the Single Convention. Article 4(c) imposes a general obligation to limit exclusively to “medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs,” subject to the provisions of the treaty.\footnote{See Single Convention on Narcotic Drugs, 1961, supra note 4, art. 4(c).} The term “prohibit” is also used in the Single Convention, in reference to Schedule IV drugs subject to special controls under Article 2, which states that a party may adopt special controls it deems necessary and shall:

if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.\footnote{Id. art. 2(5)(b).}

Thus, Schedule IV drugs are subject to all of the basic trade, manufacture, and data provision controls in the treaty, and may be limited further at the discretion of the party through prohibition except where deemed necessary for medical or scientific research, including supervised clinical trials.

The “limit exclusively” language seems to apply broadly to all drug schedules, whereas “prohibition” is a special measure that a party may take regarding Schedule IV drugs. This suggests that there may be other measures a party could undertake in attempting to limit the use of narcotics to medical and scientific uses other than a complete ban on non-medical use.\footnote{This may, however, be a null set.} This analysis is supported by the Commentary, which suggests that because of the controversy arising from the imposition of a mandatory prohibition on Schedule IV drugs,\footnote{Commentary on the Single Convention, supra note 124, at 49-51.} Article 2(5) represents a compromise that leaves the issue of pro-
hition to the judgment of the parties. For these reasons, measures undertaken to exclusively limit the use of narcotics to a specific purpose may include, but are not necessarily equivalent to a prohibition on non-medical use.

Prohibitionist Assertion 2: Parties Shall Not Implement Any Measures Liberalizing the Prosecution of Activities Relating to the Personal Consumption of Cannabis

The INCB has contended that parties to the Single Convention must "limit exclusively to medical and scientific purposes the production, manufacture, export, import and distribution of, trade in and use and possession of cannabis . . . ." As regards personal consumption of marijuana, the INCB has noted that parties to the Single Convention are "under obligation not to permit the possession of drugs for personal, non-medical consumption" and parties to the 1988 Convention are further required to "establish as criminal offences activities preparatory to personal consumption, subject to each party’s constitutional principles and the basic concepts of its legal system."

With these obligations in mind, the INCB has objected to the introduction by members of the European Union of “legislative changes involving decriminalization of the personal use of cannabis and preparatory acts to such use . . . .” In particular, the INCB has criticized states who have failed to consider marijuana possession for personal consumption a criminal offense and consequently have imposed only administrative sanctions for such activities. At the same time, the INCB has

---

133. Id. at 66. It should be noted, however, that the Commentary distinguishes between “judgment” and “discretion,” arguing that Article 2(5) did not leave the prohibition to the discretion of parties. Id.

134. For examples of those international agreements see supra note 113.

135. INCB, 2001 Report, supra note 113, ¶ 211.

136. Id.

137. Id. ¶ 214.

138. For instance, the INCB argued that Swiss draft legislation providing for the decriminalization of marijuana consumption and preparatory acts thereof and authorization for the Government to define “priorities in drug law enforcement and thereby restrict the legal obligations to prosecute certain offences,” id. ¶ 222, would be an “unprecedented move towards legalization of the consumption, cultivation, manufacture, possession, purchase and sale of cannabis for non-medical purposes,” id. ¶ 225. Further, the INCB contended that this draft legislation would not be in conformity with the
acknowledged that “the practice of exempting small quantities of drugs from criminal prosecution is consistent with the international drug control treaties.”

Responsibilities under the treaties do not prohibit parties from undertaking measures, often imprecisely referred to as “decriminalization,” that provide for prosecutorial discretion regarding the prioritization of drug-related offenses. At the outset, if a party’s creation of a personal use-related offense would be unconstitutional or otherwise offend the “basic concepts of its legal system,” which includes prosecutorial

“letter . . . spirit and essential objectives” of the international drug control treaties. Id. In particular, the INCB counseled that parties are bound by Article 4 of the Single Convention, which requires them to “limit exclusively to medical and scientific purposes the production, manufacture, . . . use, and possession of drugs.” Id.

139. INCB, 2004 Report, supra note 8, ¶ 538 (emphasis added).

140. The Single Convention defines and prescribes sanctions for a long list of activities, providing that parties shall, “subject to constitutional limitations,” “adopt such measures as will ensure that cultivation, production, manufacture, extraction, preparation, possession, offering, offering for sale, distribution, purchase, sale, . . . and any other action which in the opinion of such Party may be contrary to the provisions of this Convention, shall be punishable offenses when committed intentionally . . . .” Single Convention on Narcotic Drugs, 1961, supra note 4, art. 36(1)(a). Additionally, “nothing contained in this article shall affect the principle that the offences to which it refers shall be defined, prosecuted and punished in conformity with the domestic law of a Party.” Id. art. 36(4). Thus, it is left to the States to tailor domestic legislation to conform their drug policy to the Single Convention, as amended. Whereas the Single Convention provided for a specific list of offenses and then a general formula to supplement the enumerated offenses, Article 22 of the 1971 Convention only uses a general formula, leaving it to the parties to determine those acts that should be punishable offenses. See COMMENTARY ON THE CONVENTION ON PSYCHOTROPIC SUBSTANCES, supra note 128, at 346. As with the Single Convention, Article 22 does not require that a party create a punishable offense pursuant to the Convention if it would be contrary to the limitations of its constitution. Thus, if classifying a particular act a “punishable offense” would offend a state’s constitution, the state is under no obligation to adopt measures to create the punishable offense.

141. Article 3(2) of the 1988 Convention states:

Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase, or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention, the 1961 Convention as amended, or the 1971 Convention.
discretion, that party is not obligated to do so. As it is specifically not limited to constitutional restrictions, this provides a state with considerable opportunity to exercise discretion.

Under the narrowest reading of the 1988 Convention, a party must, if it would not offend the country’s basic legal concepts, create a punishable offense covering the purchase, possession, and cultivation of narcotics. Such party is, however,
under no obligation to impose penal sanctions.\footnote{144}{State obligations regarding punishable offenses under the 1988 Convention are governed by Article 3(4), which provides that even if a state classifies personal consumption and/or the corresponding acquisition and possession of narcotics or psychotropic substances as a criminal offense, there is no requirement that penal sanctions be imposed. \cite{1988 Convention, supra note 4, art. 3(4)}. Specifically, Article 3(4)(c), in regards to any offense under Article 3(1), states that “in appropriate cases of a minor nature, the Parties may provide, as alternatives to conviction or punishment, measures such as education, rehabilitation or social reintegration, as well as when the offender is a drug abuser, treatment and aftercare.” \cite{Id, art. 3(4)(c)}. Article 3(4)(c) illustrates that even in cases where the offense is directly related to trafficking activities, if it is deemed to be “minor” it still may be subject to non-punitive alternatives. For personal use offenses, which are considered less serious than trafficking offenses, states may always, irrespective of how serious the offense, exercise discretion in the prescription of alternative non-punitive measures. In recognition of the conscious distinction between trafficking and personal use offenses, see, e.g., \cite{Comm. on Foreign Relations, Report on United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, S. Exec. Rep. No. 101-15, at 30 (1st Sess. 1989) (explaining that the “personal use offenses were separated to allow Parties to impose alternative sanctions such as treatment and rehabilitation programs rather than incarceration in appropriate cases.”), Article 3(4) implies that “incarceration is not expected.” \cite{Boister, supra note 21, at 176}. Measures to be undertaken in response to offenses under Article 3(2) are articulated in Article 3(4)(d), which provides, “[t]he Parties may provide, either as an alternative to conviction or punishment, or in addition to}
INCB’s past censure of decisions in, for instance, Luxembourg and Portugal to eliminate the use of prison sentences for possession of cannabis cannot be grounded in international treaty obligations.\textsuperscript{145}

Cannabis, in particular, is covered under articles 22 (cultivation) and 28 of the Single Convention.\textsuperscript{146} Both articles are phrased broadly, granting parties discretionary authority to undertake “necessary” measures to prevent the “misuse” of cannabis leaves, and if deemed appropriate in light of “prevailing conditions”, to prohibit the cultivation of cannabis. What constitutes misuse is unclear, particularly in light of the debate over the medical value of cannabis. It follows that, based on a less restrictive reading of the 1988 Convention, parties are not necessarily required to classify possession of cannabis as a punishable offense.

\textit{Prohibitionist Assertion 3: The Netherlands Shall Not Permit the Operation of “Coffee Shops”}\textsuperscript{147}

A “coffee shop” is a “place where one may buy small quantities of hashish and marijuana for personal consumption,”\textsuperscript{148} strictly governed by rules precluding violence and hard drugs. Although the purchase, possession, use, and sale of cannabis are, in principle, penal offenses, law enforcement officials typically tolerate the coffee shops as long as these establishments

\textsuperscript{145. INCB, \textit{2001 Report}, supra note 113, ¶ 509.}
\textsuperscript{146. See \textit{Single Convention on Narcotic Drugs, 1961}, supra note 4, art. 22. In part, Article 28 provides, “[t]he parties shall adopt such measures as may be necessary to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant.” \textit{Id.} art. 28(3).}
\textsuperscript{147. For examples see supra note 114. Although, concededly, consumption and trafficking are particularly wedded by coffee shop phenomenon, this issue will only be examined as it relates to personal consumption; that is, as regards the drug users who may make use of coffee shops, rather than coffee shop operators.}
\textsuperscript{148. Jansen, supra note 55, at 169.
do not create a public nuisance. Benefits to the Dutch policy on coffee shops include a low fatality rate and relative decline in the number of minors who are addicted to drugs.

The INCB has asserted that the toleration of coffee shops is inconsistent with the Single Convention. In particular, the INCB has objected to various characteristics of the coffee shops, such as "the policy of 'separation of markets,' tolerating the continued cultivation of nederwiet (Dutch-grown cannabis) provided that it is of lower THC content, permitting the operation of so-called coffee shops, many of which have fallen under the control of criminal elements, and continuing to stockpile narcotic drugs for non-medical purposes."

In spite of the INCB’s criticism of the Dutch coffee shops, the international treaties provide for the exercise of prosecutorial discretion with respect to personal consumption offenses and minor trafficking. However, setting aside any internal constitutional or legal barriers, the Netherlands is not required to change its policy regarding purchase, possession, and use of small amounts of cannabis for personal consumption, for the same reasons articulated in response to Assertion 4, below (no requirement of penal sanctions as long as there are alternative measures in place to address drug use). The Dutch policy of classifying personal use-related activities as criminal offenses while prioritizing offenses involving hard

---

149. It should, however, be noted that, the Dutch government has recently begun to impose greater restrictions over coffee shops, including reducing the number of such establishments located near schools and in border areas. INCB, 2004 Report, supra note 8, ¶ 218.
150. Blom & Mastrigt, supra note 21, at 272.
153. See Silvis, supra note 35, at 43-44.
154. Arguably, the Dutch policy provides for a variety of rehabilitative and treatment programs. One might, for instance, argue that the first step toward the social reintegration of users is the normalization of drugs. Social reintegration includes "measures intended to make it possible for [the drug user] to live in an environment more favourable to him." Comment on the Convention on Psychotropic Substances, supra note 128, at 332. It is important to avoid the demonizing of drugs and drug abuse to make it easier for users to obtain employment and maintain a normal lifestyle that might enable them to stop using drugs. "Normalization" is an attempt to do this. It is a "key concept" of Dutch drug policy, and "entails a gradual process of controlled integration of the drug phenomenon into society. See Marshall & Marshall, supra note 60, at 206-08.
drugs over those involving small quantities of soft drugs is consistent with the international treaties, which formally may require that such activities be punishable offenses, but do not mandate the imposition of penal sanctions. 155

Prohibitionist Assertion 4: Parties Shall Not Establish and Operate Supervised Injection Rooms 156

The philosophy underlying medically supervised safer injecting facilities is that if people are going to use drugs, it is preferable for them to do so using clean equipment, in the presence of medical personnel. Typically, drug consumers bring their own drugs into the facilities, where medical staff are available to “assist users in avoiding the consequences of overdose and blood-borne diseases that may otherwise result . . . .” 157 The intended benefits of such facilities are numerous. Among other things, they may help to “direct drug users to treatment and rehabilitation programs,” 158 reduce the number of deaths attributable to overdose, and improve public order. 159 Reports released by some facilities indicate that the injection facilities have made progress toward these objectives. One-year data from a government-sanctioned Supervised Injection Facility opened in Vancouver indicates that of the over

155. There are at least two theories under which the Dutch coffee shops might be deemed illegal under international law. First, these establishments might be viewed as encouraging drug use in contravention of the public incitement provision of the 1988 Convention. 1988 Convention, supra note 4, art. 3(1)(c)(iii). Second, the coffee shops could be seen as violating Article 3(1)(c)(iv) of the 1988 Convention. That provision prohibits the “[p]articipation in, association or conspiracy to commit, attempts to commit and aiding, abetting, facilitating and counselling the commission of any of the offenses established in accordance with [Article 3 of the 1988 Convention].” Id. art. 3(1)(c)(iv). However, the viability of these theories is questionable. First, the permissibility of these establishments is subject to the constitutional and basic legal concepts of the Dutch legal system, which this paper does not specifically address. Second, because there is a ban on public advertisement of coffee shops, their operation does not violate the public incitement provision of the 1988 Convention. See Jansen, supra note 55, at 172.

156. For examples see supra note 115.


158. Id.

3,000 injection drug users who visited the site and the over 100 observed overdoses, there have been no fatalities and a “large number of referrals made to addiction counseling and withdrawal management services by the counselors.”

Because users bring their own drugs, “the only relevant and plausible potential infringements of these conventions involve the consumption . . . or possession of drugs for personal use.” Whether a state may permit the injection of drugs in supervised facilities depends on whether the government must deem use and possession for personal use a punishable offense, and whether it must consequently impose penalties.

Accordingly, the INCB has noted on a number of occasions that parties to the 1988 Convention must, subject to their constitutional principles and the basic principles of their legal systems, “establish as a criminal offence the possession and purchase of drugs for personal (non-medical) consumption.” From this premise, the INCB has contended that a government’s decision to “permit[ ] drug injection rooms . . . could be considered in contravention of international drug control treaties by facilitating in, aiding and/or abetting the commission of crimes involving illegal drug possession and use, as well as other criminal offences, including drug trafficking.”

However, for a variety of reasons, the treaties allow members to experiment with harm reduction measures such as supervised injection rooms. First, injection facilities may fall under the medical exception of the treaties, as discussed in detail in the following section. Second, as noted in the foregoing section, the Single Convention does not provide a man-

160. BC Center for Excellence in HIV/AIDS, Evaluation of the Supervised Injection Site: Year One Summary (Sept. 17, 2004), http://www.vch.ca/sis/Docs/esis_year_one_sept16_042.pdf; see also Ralf Gerlach, Annual Report 2002: Consumption and Injecting Room (CIR) at INDRO, Münster, Germany (Feb. 6, 2003), http://indro-online.de/cir.htm (reporting that acute medical care was provided 1,768 times and psychosocial counseling was offered 282 times, and that the injection facility reached the target group of drug users from the visible public drug scene without creating a public nuisance or any other “honey pot” effects).
161. Malkin, supra note 67, at 715.
164. See infra notes 169—177.
date regarding the creation or imposition of penalties for personal use-related offenses. Similarly, the 1971 Convention does not require that possession or personal consumption of psychotropic substances be deemed a punishable offense,\textsuperscript{165} or that it must be punished through penal sanctions. Finally, although the 1988 Convention appears to criminalize personal consumption activities, it does not require a member to implement any measures contrary to that party’s constitution and basic legal concepts. In other words, if creating a punishable offense of personal use-related consumption activities would contravene a signatory’s constitution or “basic legal concepts,” that state need not provide for the creation of such an offense.

\textsuperscript{165} As regards Schedule II, III, or IV substances, a party does not have to prohibit possession for personal consumption and is consequently under no obligation to deem possession for personal use of non-Schedule I substances a punishable offense. With respect to Schedule I substances, a party must prohibit non-medical/scientific use and possession, indicating that possession of such substances for personal use might fall under Article 22. However, as the Commentary suggests, Article 22 refers to those “actions” that contravene the treaty, which begs the question of whether possession is an “action.” \textit{Commentary on the Convention on Psychotropic Substances, supra} note 128, at 350. It is reasonable to find that possession is not an “action” as contemplated under Article 22(a). \textit{Id.} at 351. The Commentary concludes that, in this regard, “there may be legitimate difference of opinion” and that “Parties holding different views on this problem may wish to submit the problem to the International Court of Justice.” \textit{Id.} It should be noted that the jurisdiction of the International Court of Justice (ICJ) over disputes not resolvable by the parties themselves is covered by Article 31(2) of the 1971 Convention, which indicates that “at the request of any one of the parties to the dispute” the matter may be referred to the ICJ for decision. \textit{Convention on Psychotropic Substances, 1971, supra} note 4, art. 31(2). Under Article 32(2), however, parties were permitted to make reservations to Article 31. \textit{Id.} art. 32(2). Most parties, including the United States, opted not to accept ICJ jurisdiction. See Jimmy Gurule, \textit{The 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances—A Ten Year Perspective: Is International Cooperation Merely Illusory?}, 22 FORDHAM INT’L L.J. 74, 116-17, 117 n.196 (1998). The Commentary also proposes that the question of interpretation could be “resolved by...subsequent practice in the application of the treaty.” \textit{Commentary on the Convention on Psychotropic Substances, supra} note 128, at 352 (quoting the Vienna Convention on the Law of Treaties, May 23, 1969, art. 31(3)(b), U.N. Doc. A/CONF.39/27). Thus, arguably, possession for personal use, even for Schedule I substances, was not specifically addressed in either the Single Convention, as amended by the 1972 Protocol, or the 1971 Convention. Similarly then, acquisition for personal use and personal consumption are, arguably, not covered by Article 22.
Third, even if a state’s constitution and legal system allow for the creation of certain use-related offenses, the 1988 Convention does not mandate the imposition of penal sanctions as punishment for violation of these offenses. Rather, the treaty permits the use of alternative measures that arguably include the use of facilities such as supervised injection rooms.\(^\text{166}\)

Finally, beyond simply being permitted under the drug conventions, member nations to certain human rights treaties may have an affirmative obligation to introduce such a harm reduction measure. For example, one commentator suggests that the government’s refusal to introduce supervised injecting facilities in Australia “may amount to an infringement of [its] obligations” under human rights treaties such as the International Covenant on Economic, Social, and Cultural Rights and the International Covenant on Civil and Political Rights.\(^\text{167}\)

**Prohibitionist Assertion 5: Parties Shall Not Implement Heroin Maintenance Programs**\(^\text{168}\)

Heroin maintenance (akin to methadone maintenance) is a treatment by which heroin is medically prescribed to its users through supervised programs.\(^\text{169}\) It is generally deployed as part of a general program encompassing various harm minimization strategies. The objective of heroin medicalization is to “stabilise drug use and reduce involvement in the drug scene and in illicit drug use,” as well as to lower the risks associated with improper injection practices such as unsafe needle sharing.\(^\text{170}\) Sustaining a drug user on prescribed drugs (usually indefinitely) is typically a late-stage attempt to minimize

---

\(^{166}\) Critics argue that supervised injecting facilities are not rehabilitative, but that they maintain users’ dependence. Malkin asserts that there is no evidence to support this claim. Malkin, *supra* note 67, at 716.

\(^{167}\) See *id.* at 708-13.

\(^{168}\) For examples see *supra* note 116.


\(^{170}\) *Id.* at 214. Generally speaking, in addition to the injectable substance, heroin maintenance prescriptions may also make available heroin suitable for smoking or oral ingestion. Susan F. Tapert et al., *Harm Reduction Strategies for Illicit Substance and Abuse*, in HARM REDUCTION, *supra* note 18, at 145, 170.
harm where the addict is “unwilling or unable to achieve abstinence.”

Evidence in the form of “health and crime” statistics from one program incorporating drug medicalization suggests that this approach has been successful. In particular, data collected from the region employing this strategy reflect a decrease in crime and a low incidence of HIV-positive intravenous drug users. Similarly, a preliminary summary of a different heroin prescription program found:

1) Heroin prescription is feasible and has produced no black market in diverted heroin. 2) The health of the addicts in the program has clearly improved. 3) Heroin prescription alone cannot solve the problems that led to the heroin addiction in the first place. 4) Heroin prescription is less a medical program than it is a social-psychological approach to a complex personal and social problem. 5) Heroin per se causes very few, if any, problems when it is used in a controlled fashion and administered in hygienic conditions, with clients controlling their dose.

For purposes of this discussion, the key question is whether medically supervised, controlled distribution of heroin, a Schedule IV substance, might be permissible under the medical-scientific provisions of the treaties. On the one hand, the INCB repeatedly has questioned the medical and scientific value of experimental programs premised on heroin maintenance. Advocates of these programs counter that

172. *Id.* at 40 (describing the Merseyside Drug Dependency Service in England).
173. *Id.* at 42-43 (quoting from Nadelmann’s 1995 summary of the preliminary results).
174. See, e.g., U.N. ESCOR, Commission on Narcotic Drugs, *Report of the Secretariat on the Effects on Individuals, Society and International Drug Control of the Prescription of Narcotic Drug to Drug Addicts*, 40th Sess., Provisional Agenda Item 10, ¶¶ 6-14, U.N. Doc. E/CN.7/1997/7 (1997) [hereinafter Commission on Narcotic Drugs Report]. Although there was some debate over this question, “[t]he large majority of delegations remained of the opinion that treatment involving the injection of heroin should be avoided.” *Id.* ¶ 147.
the use of heroin by certain users in a controlled setting qualifies as a medical and scientific use under Article 4 of the Single Convention. Prescription of heroin to certain users might also be perceived as a research measure undertaken to protect the public health, which is made permissible by Article 2(5) of the Single Convention.

Under the Single Convention, heroin is a Schedule IV narcotic.176 Article 2(5)(b) contains special provisions for Schedule IV drugs indicating that a party must, “if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the . . . possession or use of any such drug except for amounts which may be necessary for medical and scientific research only, including clinical trials therewith to be conducted under or subject to the direct supervision and control of the Party.”177 Thus, if these programs represent the most appropriate means of protecting public health, the parties have the discretion to establish state-supervised heroin maintenance trials. The level of supervision required is not specified in the treaty, although the program must, at a minimum, be subject to “intermittent steps of [state] surveillance.”178

Even apart from Article 2(5), a party is not required to penalize the use of heroin by participants in such programs, as this qualifies as purchase for personal use. Under the 1988 Convention, the state need not impose penal sanctions (although it may be mandatory for it to deem this a punishable offense), and may alternatively prescribe treatment (which heroin maintenance programs arguably provide).

Prohibitionist Assertion 6: Parties Shall Not Accommodate Non-Prohibitionist Education or Speech179

The INCB has sought to discourage an array of “incitement” activity that it argues promotes drug use. From the INCB’s perspective, such activities are present in various fora, finding expression in popular culture (e.g., particularly through popular music lyrics), the media (e.g., newspaper or magazine advertisements, articles, and editorials that suppos-

177. Id. art 2(5)(b) (emphasis added).
178. COMMENTARY ON THE SINGLE CONVENTION, supra note 124, at 68.
179. See INCB, 1997 Report, supra note 117 and accompanying text.
edly encourage decriminalization and/or marijuana "abuse"), the internet (e.g., web pages and news groups exchanging information about drug use), and political campaigns (e.g., political debates over drug legalization). The INCB has contended that "[A]rticle 3 of [the 1988] Convention requires [its signatories] to establish as a criminal offence public incitement or inducement to use drugs illicitly" and "urges Governments to ensure that their national legislation contains such provisions and that those provisions are enforced, making violators liable to sanctions that have an appropriate deterrent effect."

As noted, the public incitement provision is Article 3(1) of the 1988 Convention. This provides for the criminalization of public incitement or inducement to others to use drugs illicitly:

Each Party shall adopt such measures as may be necessary to establish as criminal offences under its domestic law, when committed intentionally . . . subject to its constitutional principles and the basic concepts of its legal system . . . [p]ublicly inciting or inducing others, by any means, to commit any of the offences established in accordance with this article or to use narcotic drugs or psychotropic substances illicitly.

For a number of reasons, parties are not universally required to prohibit non-prohibitionist education or speech under the public incitement offense of the 1988 Convention. Although Article 3(1)(c)(iii) provides for the classifi-
ocation of public incitement to commit offenses defined under the convention or illegally to use drugs, the article is so broadly phrased that a uniform public incitement “crime” cannot exist. The potential breadth of public incitement is vast. For instance, some “treatment professionals view instruction on ‘safer injection’ as implicitly condoning drug use,” despite the strong argument that “harm reduction services are essential to protect treatment clients, given the realities of widespread relapse and non-adherence in most treatment settings.” This could qualify as “public incitement,” despite arguments for its legitimacy in reducing the harms associated with needle use.

There are several reasons that the definition of public incitement should not extend to most activities relating to education and speech. First, the public incitement offense is lim-


184. For instance, the word “publicly” poses interpretive difficulties because it is not defined in the 1988 Convention, and may differ in meaning depending upon the legal system and other circumstances. Can the distribution of literature to a small group of people constitute “public incitement?” How about setting up a limited access website? Sending an e-mail to some friends? What if the e-mail is then forwarded to a large group of people? The Commentary to the 1988 Convention acknowledges these interpretive difficulties and proposes that “the word will have to be interpreted in the light both of the particular circumstances of the conduct in question and the analogies to be found in the relevant legal system.” Commentary on the 1988 Convention, supra note 141, at 74. Similar interpretive difficulties—and hence, further opportunity for the exercise of discretion—surface with respect to the words “incitement” and “inducement,” as well as with the words “any means.” 1988 Convention, supra note 4, art. 3(1)(c)(iii).

As the Commentary suggests, while “[i]llicit use itself is not required to be criminalized under the Convention . . . the conduct of the inciter is.” Commentary on the 1988 Convention, supra note 141, at 75. Yet, in practical terms, because of the many interpretive steps that a state must take in criminalizing incitement, and because of the boundaries, constitutional and otherwise, of the provision, it would be difficult to argue that this mandates the creation of a specific type of crime. Even if public incitement is deemed a punishable offense, the parties may determine, based upon the “grave nature” of the offense, appropriate sanctions. Treatment or other alternatives may be employed instead of conviction or punishment in minor cases and in addition to conviction or punishment in more serious cases.

185. Pollack, supra note 71, at 95.
ited by the constitutional and basic legal concepts of member states. Consequently, it cannot be said that public debates over legalization of cannabis are categorically precluded by the international treaties. A state must be permitted to have some autonomy in determining the landscape of its local or national legal system. Second, the treaties state that parties shall establish criminal offenses for public inducement to commit “any of the offenses established in accordance with this article or to use narcotic drugs or psychotropic substances illicitly.” Yet, decriminalization of possession for personal consumption or use of cannabis is neither necessarily a criminal offense, nor “illicit” use. Third, merely participating in a debate on the decriminalization of marijuana does not amount to an inducement to use cannabis illicitly. Fourth, the provision contains several phrases that require interpretation by the parties (e.g., “public”, “inducement”, etc.). Because of the interpretive difficulties associated with the establishment of a commonly shared “public incitement” crime, arguments by the INCB that label public debates or political statements as public incitement to be circumscribed pursuant to international treaty obligations, are unreasonably imprecise, implying uniformity where none exists. Fifth, taken to its logical conclusion, broadly interpreting public incitement potentially gives rise to conflicting treaty obligations for those nations who have become members to human rights conventions such as the International Covenant on Civil and Political Rights. This treaty provides:

186. The INCB does not dispute this, noting, “A safeguard clause in article 3 of the 1988 Convention makes the offence of public incitement to use drugs illicitly subject to each party’s constitutional principles and the basic concepts of its legal system.” INCB, 1997 Report, supra note 117, ¶ 10. However, the INCB opines:

It should, however, be the duty of States to find a practical way of conciliation between the contradictory exercise of rights. The freedom of expression cannot remain unrestricted when it conflicts with other essential values and rights. The Board notes that it has been possible in most countries to take measures against the unrestricted availability and propagation of pornographic literature and material; it hopes that similar measures might be feasible with respect to the promotion of drug abuse.

Id.

187. 1988 Convention, supra note 4, art. 3(1)(c)(iii).
Everyone shall have the right to hold opinions without interference.
Everyone shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice.

... It may therefore be subject to certain restrictions, but these shall only be such as are provided by law and are necessary: (a) For respect of the rights or reputations of others; (b) For the protection of national security or public order . . . , or of public health or morals.188

PART V: CHANGING THE LANGUAGE OF THE DRUG PROBLEM

Although the tenor of the drug conventions reflects punitive prohibitionist attitudes, the above discussion demonstrates that the text of the treaties allows for the coexistence of prohibition and harm minimization strategies to address the personal consumption of drugs. Perhaps these are the legal "answers," but one must now step back and address two related criticisms of the international drug control system: (1) personal drug use is not appropriately handled through the international legal apparatus, and (2) the treaties, in their open-endedness, have failed with respect to personal consumption.

The first criticism relates to the antecedent question of whether the treaties should address personal drug use in the first place. Parsing the text of the treaties in search of legal rules or exceptions presupposes that the right question is "do the treaties compel certain behavior?" Because the treaties do exist and because most countries are parties to them, this is technically the right question, but this is so only because the choice has already been made. But suppose there were a blank slate on drug use, and no international agreements existed. Then, the question would be whether the treaties should address the problem of personal drug consumption at all. Does the existence of treaties inappropriately limit the

medical, scientific, social, cultural, and psychological discussion to the legal realm? What do we lose by codifying legal rules regarding drug use? Has the international treaty system, which has continued along a relatively steady trajectory towards prohibition since the turn of the century, frozen in place this one viewpoint at the expense of all others so that the hard questions are not reached? These questions are largely unanswerable, but should be considered in order to understand and critique the international drug control system.

Accepting (1) that the drug market is global, and (2) that the drug problem, as it refers to personal consumption and trafficking activities, is better addressed through international cooperation, it follows that an international legal framework could regulate drug use. Then, perhaps the better question for the purposes of current international drug control is whether the treaties provide the right balance of cooperation and freedom to experiment with different approaches, particularly with respect to how states deal with personal drug consumption.

If one of the objectives of the drug treaties is to address drug abuse, one might conclude from the lack of binding substantive obligations regarding drug use that the treaties accomplish nothing. Such a conclusion, however, is unwarranted because the treaties do achieve something important; by their open-endedness, they provide the necessary freedom to respond to an ever-changing drug problem and by their mere existence, they ensure that a continuing dialogue on drug use and its harms takes place between and among nations.

One might ask why it is imperative that the international treaties provide room to maneuver. The lack of binding treaty obligations is appropriate because the drug problem is constantly reinventing itself, and its effect is not uniform from country to country, given differences in social, cultural, and religious circumstances. For instance, one of the fault lines in global drug policy has appeared between the United States and Western Europe due to the growing acceptance by the latter of harm reduction measures; another rift exists between so-

189. This phrase is borrowed from the title of a recent report addressing the international treaty obligations of the United Kingdom and other European states by Nicholas Dorn and Alison Jamieson entitled Room for Manoeuvre (Mar. 2000), see supra note 55.
called “consumer” states, which tend to be wealthy, developed countries and “producer” states, which tend to be less developed states, regarding natural drugs; and a third rift exists between consuming (which tend to be developing) countries and producing (which tend to be developed) countries of chemical and pharmaceutical drugs.\(^{190}\) It is impossible to foresee what the next trend in drug use will be, whether another health crisis impacted by drug use (such as HIV/AIDS) will arise, or if new scientific research will provide insights that will revolutionize current knowledge regarding drug use and its connection to medical issues. Therefore, there must be some discretion for states to incorporate new medical findings and to adopt nuanced policies that fit unique circumstances and are responsive to new trends.

One might also question the need for an international discourse rather than simply permitting states to grapple with drug policy in isolation. The reason that the drug problem should be addressed through an international dialogue is that the drug problem is global in nature, not only because the drug market transcends national boundaries but also because drug abuse represents a health risk that nearly every country must confront. Thus, there is a need to balance the necessity of tailoring policies to fit a particular country and the need to discuss and coordinate efforts on a global level. As such, the existence of an international discourse on useful or effective measures to address the harms associated with drug use is critically important.

For such useful international discourse to be possible within the framework provided by the treaties, however, there must be a common language that can be heard over the rhetoric of proponents of prohibition and harm reduction. To some extent, both prohibition and harm reduction require a leap of faith; neither is absolutely right or absolutely wrong. Both ultimately seek to address the harms associated with drug use and, in that sense, pursue a kind of “harm reduction.” But they take divergent descriptive and normative assumptions on the precise nature of those harms and how they can most effectively be addressed. Indeed, given the vastly different contexts in which drug use occurs—varying by the type of drug,

nature of the use, and the particular society—prohibition may, in certain times and places, be the most effective method of harm reduction at a given moment, just as harm reduction from a public health perspective may provide the best practical strategies for dealing with the dangers of drug use in others. Further, the strategies that are most effective at one point in time may cease to be effective as circumstances change, making flexibility in policy-making essential. Yet a common language was perhaps one of the early sacrifices among those believing in the war on drugs and those preferring public-health-oriented harm reduction, as both sides struggled to create rhetorical devices through which to communicate one viewpoint to the complete exclusion of another.\footnote{191}

The INCB has been active in shaping the drug policy debate to maintain the “status quo” of drug rhetoric and suppress viewpoints inconsistent with its own. For instance, the INCB stated that employment of the term “‘use’ or ‘consumption’ should only be applied when it refers to the use or consumption of drugs for medical or scientific purposes. When neither of those conditions applies, in line with the international drug control treaties, the drug may be considered abused.”\footnote{192} Thus, it is “important that any attempt to . . . ignore the seriousness of drug abuse by calling it drug use or drug consumption should be strongly resisted. It is also important that any careless use of terms should not lead to any contradicting or undermining of what is expressed in the treaties.”\footnote{193} The INCB has also colorfully described supervised injection rooms as “shooting galleries” and likened them to “opium dens.”\footnote{194} Moreover, this organization has been critical of the occurrence of public debates on the legalization of cannabis, as noted earlier, and on political statements “advocating” drug use.\footnote{195} Such suppression of individual expression, however, arguably violates human rights.

\footnote{191. See supra text accompanying notes 42-51.}
\footnote{192. INCB, 2001 Report, supra note 113, Foreword.}
\footnote{193. Id.}
\footnote{194. See INCB, 1999 Report, supra note 113; INCB, 1998 Report, supra note 115.}
\footnote{195. INCB, 1998 Report, supra note 115, ¶ 487 (arguing that the debates "have left the false impression that cannabis is harmless and that it has many virtues, including medical benefits.").}
Although human rights are not codified in the text of the international drug treaties, it is important to recognize that the drug problem does not operate in isolation from human rights. Rather, one should incorporate discussion of these principles into the discourse over drug policy. Because there are no established, “right” answers in the field of drug policy, as to whether certain measures protect or harm public “morals” or “health,” it seems particularly important to maintain a neutral forum for discussion. At the very least, to develop a conscious awareness of the role that language plays in the international drug policy discourse is critical.

Another step might be to amend the 1988 Convention. A party to this convention may propose amendments to the treaty under Article 31.196 If no party rejects the proposed amendment within twenty-four months following its initial circulation, it “shall be deemed to have been accepted and shall enter into force”197 with the consent of the various parties.198 Several amendments to the 1988 Convention would be appropriate. As the suppression of non-violent, political speech and continuing debate over drug policy is counterproductive, and acknowledging that the INCB has attempted to use Article 3(1)(c)(iii) of the 1988 Convention to condemn political expression, Article 3 should be amended so as to delete subsection 3(1)(c)(iii).199 Additionally, Article 3(2) should be either removed from the treaty, or, at a minimum, should be revised to read, “Subject to its constitutional principles and basic concepts of the legal system, each Party may adopt such measures. . . .” Making such changes would allow the language of the drug policy dialogue to evolve over time.

196. 1988 Convention, supra note 4, art. 31.
197. Id.
198. If any party rejects it, the “Secretary-General shall consult with the Parties and, if a majority so requests, he shall bring the matter, together with any comments made by the Parties, before the Council which may decide to call a conference” in accordance with the U.N. Charter. Id.
199. To promote the discourse on drug policy, the preamble should be amended. The phrase, “[d]esiring 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,” id. art. 3(1)(c)(iii), should be changed to read: Desiring to address 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.
PART VI: CONCLUSION

The international treaties do not preclude the coexistence of prohibition and non-prohibition programs to address drug abuse. In fact, experimentation and innovation are necessary to address the problems associated with drug use. States may use certain harm minimization and “decriminalization” policies without breaching any international drug treaty obligations. States may also use penal sanctions to attempt to deter would-be drug users. The United States could, therefore, maintain its ideological commitment to punitive prohibition. At the same time, other states, such as those in Western Europe, may pursue certain harm minimization and “decriminalization” policies and still be in compliance with the treaties.

The next step in addressing personal consumption should be to alter the dialogue of international drug control by promoting greater freedom to express differing viewpoints and suggest alternatives to punitive prohibition, the current dominant strategy.200 These changes would provide the necessary flexibility for the drug policy debate to evolve over time.

200. The most recent INCB report does evince greater acceptance of harm reduction approaches. See, e.g., INCB, 2004 Report, supra note 8, ¶¶ 46-49, 51 (g)-(i) (describing, with approval, collaboration between the criminal justice system and the treatment or healthcare system). To the extent the tenor of the INCB’s analysis has shifted, such an evolution is a positive development; however, there remains room for improvement. For example, the INCB continues to criticize governments that have not yet criminalized public incitement per Article 3, paragraph 1(c)(iii) of the 1988 Convention, arguing that:

the constitutional principles and basic legal concept that have been invoked in supporting a non-criminalizing approach to dealing with personal drug consumption activities in some countries cannot, by analogy, be extended to acts such as incitement to use illicit drugs or advertisement of such activity. Indeed, inciting or inducing others to illicitly use drugs does not belong to the private sphere of the individual and it can be clearly associated with social harm.