BEYOND PUNITIVE PROHIBITION: LIBERALIZING THE DIALOGUE ON INTERNATIONAL DRUG POLICY

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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 together, 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 failure of its efforts.
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> We believe that the global war on drugs is now causing more harm than drug abuse itself.
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> Every decade the United Nations adopts new international conventions, focused largely on criminalization and punishment, that restrict the ability of individual 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 . . . .
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> In many parts of the world, drug war politics impede 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 . . . .
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> Mr. Secretary General, we appeal to you to initiate a truly open and honest dialogue regarding the

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> 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 debate[2] 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-

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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); Michèle Barzach, Fmr. Minister of Health (Fr.); Daniel Cohn-Bendit, Member, European Parliament (Ger.); Perfecto Andrés Ibañez, 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).

4. *See* Single Convention on Narcotic Drugs, 1961, Mar. 30, 1961, 18 U.S.T. 1407, 520 U.N.T.S. 151 (entered into force Dec. 13, 1964), *amended by* Protocol of 1972 Amending the Single Convention on Narcotic Drugs, 1961, Mar. 25, 1972, 26 U.S.T. 1439, 976 U.N.T.S. 3 (entered into force Aug. 8, 1975); Convention on Psychotropic Substances, 1971, Feb. 21, 1971, 32 U.S.T. 543, 1019 U.N.T.S. 175 (entered into force Aug. 16, 1976); Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances,

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.[5] 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:[6] the Single Convention on Narcotic Drugs of 1961[7] (180 States parties)

Dec. 20, 1988, 1582 U.N.T.S. 164, 28 I.L.M. 497 (entered into force Nov. 11, 1990) [hereinafter 1988 Convention].

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 "hardiest 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

(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).[8] 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,[9] 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-

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CONVENTION ON NARCOTIC DRUGS, 24 JANUARY–25 MARCH 1961, 2d plen. mtg. at 6, U.N. Docs. E/Conf.34/24, E/Conf.34/24.Add.1, U.N. Sales Nos. E.63.XI.4, E.63.XI.5 (1963) [hereinafter 1 OFFICIAL RECORDS OF THE SINGLE CONVENTION] (statement of U.S. delegate that "the idea of a Single Convention had been a United States initiative").

8. Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board. for 2004*, ¶¶ 53, 55, 57, U.N. Doc. E/INCB/2004/1 (2005), *available at* http://www.incb.org/incb/en/annual_report_2004.html [hereinafter INCB, *2004 Report*] (providing number of State parties to the major drug treaties as of November 1, 2004); *see also* U.N. Office on Drugs and Crime, Monthly Status of Treaty Adherence (Jan. 1, 2005), *available at* http://www.unodc.org/unodc/en/treaty_adherence.html (last visited Oct. 9, 2005) [hereinafter UNODC, Monthly Status] (reporting same).

9. *See* Single Convention on Narcotic Drugs, 1961, *supra* note 4. The major administrative bodies involved in international drug control include the Commission on Narcotic Drugs (CND) (with policy-making responsibilities), the 13-member INCB (monitoring the implementation of treaties and provide yearly reports on the status of treaty adherence), and the U.N. Office on Drugs and Crime (umbrella office for the Drug Programme and the Crime Programme). Originally the INCB had 11 members, but membership increased under the Protocol of 1972 Amending the Single Convention on Narcotic Drugs, 1961. *See* U.N. OFFICE OF DRUGS AND CRIME, COMMENTARY ON THE PROTOCOL AMENDING THE SINGLE CONVENTION ON NARCOTIC DRUGS, 1961, at 7-9, U.N. Doc. E/CN.7/588, U.N. Sales No. E.76.XI.6 (1976) [hereinafter COMMENTARY ON THE 1961 PROTOCOL]. Three members are to have "medical, pharmacological or pharmaceutical experience," selected from among five nominations by the World Health Organization. *See id.* Members serve five-year terms and may be re-elected. *See id.* at 16. Although the United States has "long dominated" the INCB, the U.S. candidate failed to be elected to the Board in 2001. *The World Today: Direction of the UN Drug Body in Question After US Loses Seat* (ABC radio broadcast May 8, 2001), *available at* http://www.abc.net.au/worldtoday/stories/s291714.htm. R

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,[10] 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.[11] 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.[12] Finally, the "facts" relating to the drug problem are often distorted, which tends to obfuscate useful discussion.[13]

B. *Punitive Prohibition and the War on Drugs*

Prohibitionist policies, which focus on outlawing drugs and drug use,[14] are reflected to varying degrees in all countries' approaches to the drug problem.[15] "Punitive drug prohibition" refers to policies that rely on penal sanctions (incarceration)[16] to punish those who use "illicit" drugs.[17] This approach to drug use is sometimes referred to as the "moral" or

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OF DRUGS AND DRUG USERS: REASON OR REACTION?, at xvi (Ross Coomber ed., 1998).

11. *See* Ed Leuw & I. Haen Marshall, *Introduction* to BETWEEN PROHIBITION AND LEGALIZATION, *supra* note 5, at vii. R

12. *See, e.g.*, Dana Graham, Comment, *Decriminalization of Marijuana: An Analysis of the Laws in the United States and the Netherlands and Suggestions for Reform*, 23 LOY. L.A. INT'L & COMP. L. REV. 297 (2001); Amanda Kay, Comment, *The Agony of Ecstasy: Reconsidering the Punitive Approach to United States Drug Policy*, 29 FORDHAM URB. L.J. 2133 (2001).

13. For example, statistical "facts," which should help to clarify the efficacy of such measures, are often misrepresented. *See, e.g.*, Robert J. MacCoun, *American Distortion of Dutch Drug Statistics*, SOCIETY, Mar./Apr. 2001, at 23; Martin T. Schechter, *Science, Ideology, and Needle Exchange Programs*, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 94 (2002).

14. *See* Richard Hartnoll, *International Trends in Drug Policy*, *in* THE CONTROL OF DRUGS AND DRUG USERS, *supra* note 10, at 233. R

15. *See also* Harry G. Levine, *The Secret of Worldwide Drug Prohibition: The Varieties and Uses of Drug Prohibition*, 7 INDEP. REV. 165, 167-68 (2002).

16. *See* Husak, *supra* note 5, at 29 ("According to this [criminal justice] policy, the best way to deal with those drugs used largely for recreational purposes—in particular, marijuana, cocaine, and heroine—is by severely punishing persons who use them."). R

17. *See* Harry G. Levine & Craig Reinarman, *The Transition from Prohibition to Regulation: Lessons from Alcohol Policy for Drug Policy*, in HOW TO LEGALIZE DRUGS, *supra* note 5, at 259, 282. Levine and Reinarman distinguish between punitive drug prohibition and regulatory drug prohibition, the latter of which encompasses policies of regulated, normalized drug use (decriminalization). *See id.* at 282. R

"criminal justice" model because it presumes that "illicit drug use is morally wrong" and thus should be criminalized.[18] 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.[19] This strategy is relevant to the international debate over drug policy not only because it "most vividly represent[s]" the prohibitionist approach,[20] but also because of the commonly held belief that drug prohibition is, in large part, an American ideological export.[21]

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18. G. Alan Marlatt, *Basic Principles and Strategies of Harm Reduction*, *in* HARM REDUCTION: PRAGMATIC STRATEGIES FOR MANAGING HIGH-RISK BEHAVIORS (G. Alan Marlatt ed. 1998), 49, 49.

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. R R R R

20. *Introduction: The Search for Harm Reduction*, *supra* note 5, at 4. R

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 UN 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 R R

American drug prohibition predates the label "war on drugs,"[22] and has a questionable pedigree, particularly given the moral foundation current proponents espouse.[23] 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. R

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 CRISES 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." R

the "scourge"[24] of drugs, an enemy destroying society's youth.[25]

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24. The descriptive term "scourge" appears countless times throughout the meeting records of the various conferences. *See, e.g.*, 1 OFFICIAL RECORDS OF THE SINGLE CONVENTION, *supra* note 7, 2d plen. mtg. at 6 ("The United Arab Republic fully appreciated the efforts made by the United Nations to rid the world of [the narcotic drug] scourge . . . ."); 2 OFFICIAL RECORDS OF THE U.N. CONFERENCE TO CONSIDER AMENDMENTS TO THE SINGLE CONVENTION ON NARCOTIC DRUGS, 6 MARCH–24 MARCH 1972, 1st plen. mtg. at 1, U.N. Doc. E/Conf.63/10.Add.1, U.N. Sales No. E.73.XI.8 (1974) [hereinafter 2 OFFICIAL RECORDS OF THE AMENDMENTS TO THE SINGLE CONVENTION] (reflecting opening remarks by the Acting President, in which he noted that "[i]n recent years, drug abuse had taken on the proportions of a veritable scourge, sparing no class of society and spreading in a tragic way among the young"); *id.* 2d plen. mtg. at 9 ("[T]he abuse of narcotic drugs had reached such proportions in the world that it constituted a veritable scourge."); 2 OFFICIAL RECORDS OF THE U.N. CONFERENCE FOR THE ADOPTION OF A PROTOCOL ON PSYCHOTROPIC SUBSTANCES, 11 JANUARY–19 FEBRUARY 1971, 4th plen. mtg. ¶ 63, at 13, U.N. Doc. E/Conf.58/7.Add.1, U.N. Sales No. E.73.XI.4 (1973) [hereinafter 2 OFFICIAL RECORDS OF THE PROTOCOL ON PSYCHOTROPIC SUBSTANCES] (international law enforcement observer remarking that "It was logical that the world should make . . . [an] effort . . . to fight the modern scourge as it had made earlier to fight the scourge of narcotic drugs abuse"); 2 OFFICIAL RECORDS OF THE U.N. CONFERENCE FOR THE ADOPTION OF A CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES, 25 NOVEMBER–20 DECEMBER 1998, 1st plen. mtg. ¶ 20, at 3, U.N. Doc. E/Conf.82/16/Add.1, U.N. Sales No. E.91.XI.1 (1991) [hereinafter 2 OFFICIAL RECORDS OF THE 1988 CONVENTION] ("Drugs had become a scourge of humanity and a world alliance of forces was needed to isolate the common enemy and put him to rout."). Analogizing the drug problem to a "scourge" has not lost its appeal. *See, e.g.*, Press Release, INCB, Combating the Scourge of Synthetic Drugs Worldwide (Feb. 26, 2003), *available at* http://www.incb.org/pdf/e/press/2003/press_release_2003_02_26_6.pdf. R

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."). R R

Despite continued American adherence to a policy of punitive prohibition, critics increasingly call the war on drugs a failure.[26] Many include the following among the deleterious effects of the U.S. commitment to waging the drug war: (1) mass incarceration of drug users in federal and state prisons, jails, and other closed facilities[27] due in part to lengthier sentences for drug crimes[28] and the criminalization of minor

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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.").

27. *See* Paige M. Harrison & Allen J. Beck, *Prisoners in 2002*, BULL. (U.S. Dep't of Justice: Bureau of Justice Statistics), July 2003, at 11, *available at* http://www.ojp.gov/bjs/pub/pdf/p02.pdf (revised Aug. 27, 2003) (finding that inmates convicted of drug offenses "constitute the largest group of Federal inmates (55%) in 2001, . . . On September 30, 2001, Federal prisons held 78,501 sentenced drug offenders, compared to 52,782 in 1995); *id.* at 10 (reporting that in 2001, 20.4% of sentenced State inmates were incarcerated on the basis of drug offenses); John Scalia, *Federal Drug Offenders, 1999 with Trends 1984-1999*, SPECIAL REP. (U.S. Dep't of Justice: Bureau of Justice Statistics), Aug. 2001, at 1, *available at*, http://www.ojp.usdoj.gov/bjs/pub/pdf/fdo99.pdf (noting that from 1984 to 1999, the number of defendants charged with a federal drug offense increased from 11, 854 to 29,306); *see also* Christopher Mascharka, Comment, *Mandatory Minimum Sentences: Exemplifying the Law of Unintended Consequences*, 28 FLA. ST. U. L. REV. 935 (2001) (describing the use of mandatory minimum sentencing for nonviolent drug offenses). For a comparative analysis, see Roy Walmsley, *World Prison Population List* (3d ed.), FINDINGS 166 (Home Office Research, Development and Statistics Directorate, London, U.K.), 2002, at 1, *available at* http://www.homeoffice.gov.uk/rds/pdfs/r166.pdf, who notes that the United States has the "highest prison population rate in the world, some 700 per 100,000 of the national population, followed by Russia (665) . . . ."

28. *See* Scalia, *supra* note 27, at 4 (discussing changes to the federal criminal law and the impact of the Sentencing Reform Act of 1984 and the Anti-Drug Abuse Act of 1986, which established statutory minimum sentences for drug trafficking and possession); *see also* Press Release, U.S. Dep't of Justice: Bureau of Justice Statistics, Federal Drug Law Changes Led to Longer Prison Sentences (Aug. 19, 2001), *available at* http://www.ojp.usdoj.gov/bjs/pub/press/fdo99pr.htm (reporting that from 1986 to 1999, "the average term drug offenders entering prison could expect to serve rose from an average 30 months to 66 months"). For discussions of state statutory minimum and maximum sentences, see Rudolph J. Gerber, *On Dispensing Injustice*, 43 ARIZ. L. REV. 135 (2001) (Arizona); Susan N. Herman, *Measuring Culpability by Measuring Drugs? Three Reasons to Reevaluate the Rockefeller Drug Laws*, 63 ALB. L. REV. 777 (2000) (New York). The growing popularity of "order mainte-

offenses; (2) increased incarceration that has fallen disproportionately on underprivileged members of society,[29] particularly African and Hispanic Americans, resulting in what some have labeled a return to Jim Crow;[30] (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);[31] (4) further marginaliza-

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nance 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.*, Loïc 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). R R R

31. *See* Ralf Jürgens, *Will Prisons Fail the AIDS Test?*, *in* HARM REDUCTION, *supra* note 5, at 151. *C.f.* Doris James Wilson, *Drug Use, Testing, and Treatment in Jails*, SPECIAL REP. (U.S. Dep't of Justice: Bureau of Justice Statistics), May 2000, at 3-4, *available at*, http://www.ojp.usdoj.gov/bjs/pub/pdf/duttj.pdf (describing methods designed to control drug use in jails such as random- R

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;[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;[33] and (6) a curtailment of civil rights, particularly with regard to the Fourth Amendment.[34] Prohibition has also led to the creation of a profitable black market for illicit substances[35] and the rejection of federal funding for harm reduction measures, such as safe needle exchanges.[36]

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ized drug testing and penalties imposed for positive drug tests); James Ostrowski, *Drug Prohibition Muddles Along: How a Failure of Persuasion Has Left Us with a Failed Policy*, *in* HOW TO LEGALIZE DRUGS, *supra* note 5, at 352, 356-57 (reporting on the health problems [tuberculosis and AIDS] arising from overcrowded facilities). R

32. *See* JAMES P. GRAY, WHY OUR DRUG LAWS HAVE FAILED AND WHAT WE CAN DO ABOUT IT: A JUDICIAL INDICTMENT OF THE WAR ON DRUGS 134 (2001) (noting the obstacles to societal reintegration that prisoners face when released, as well as the emotional and physical damage resulting from incarceration); ELLIOTT CURRIE, CRIME AND PUNISHMENT IN AMERICA 73 (1998) (noting the rapid increase of women behind bars, "most of them mothers, many of them imprisoned on relatively minor drug charges or for property crimes related to their addiction"); Ted Galen Carpenter, *Collateral Damage: The Wide-Ranging Consequences of America's Drug War*, *in* AFTER PROHIBITION, *supra* note 5, at 147, 159-60 (discussing anecdotes involving children who "snitched" on their parents for growing marijuana in the home, thereby precipitating the breakup of their families). R

33. *See* Paige M. Harrison & Allen J. Beck, *Prisoners in 2003*, BULL. (U.S. Dep't of Justice: Bureau of Justice Statistics), Nov. 2004, at 1, *available at* http://www.ojp.gov/bjs/pub/pdf/p03.pdf (Nov. 2004) (reporting 2,212,475 individuals incarcerated at year end 2003 for any reason by, *inter alia*, federal, state, military, and immigration authorities). For a discussion of the costs of incarceration, see Loïc Wacquant, *Four Strategies to Curb Carceral Costs: On Managing Mass Imprisonment in the United States*, 23 STUD. POL. ECON. 19 (2002); Bruce Bullington, *America's Drug War: Fact or Fiction?*, *in* THE CONTROL OF DRUGS AND DRUG USERS, *supra* note 10, at 107, 109. R

34. *See, e.g.*, Steven Duke, *The Drug War and the Constitution*, *in* AFTER PROHIBITION, *supra* note 5, at 41, 42; GRAY, *supra* note 32, at 95-122; Ostrowski, *supra* note 31, at 357-58. R R

35. *See* Jos Silvis, *Enforcing Drug Laws in the Netherlands*, *in* BETWEEN PROHIBITION AND LEGALIZATION, *supra* note 5, at 41, 51 (discussing the high-risk, high-profit drug market). R

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,[37] prevent collateral crimes associated with drug use,[38] and promote moral health.[39] 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]

20, 1998), *available at* http://www.hhs.gov/news/press/1998pres/980420b.html. In fact, on April 21, 1998, Senator Coverdell introduced the Needle Exchange Programs Prohibition Act of 1998 to ban the use of federal funds for needle distribution programs. *See* Schechter, *supra* note 13, at 97. R

37. *See, e.g.*, Robert L. DuPont & Eric A. Voth, *Drug Legalization, Harm Reduction, and Drug Policy*, 123 ANNALS OF INTERNAL MED. 6 (1995), *available at* http://www.annals.org/cgi/content/full/123/6/461?. Interestingly, opinion polls show that public attitudes increasingly favor "attacking the social and economic problems that lead to crime through better education and job training" as opposed to "deterring crime by improving law enforcement with more prisons, police, and judges." U.S. Dep't of Justice, Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics 2002 (30th ed.), *available at* http://www.albany.edu/sourcebook/pdf/t20007.pdf (reprinting Gallop Poll data).

38. *See, e.g.*, U.S. Dep't of Justice, Bureau of Justice Statistics, Drug Use and Crime: Drug-Related Crime, http://www.ojp.usdoj.gov/bjs/dcf/duc.htm (last visited Sept. 8, 2005) (reporting that in 1996, 15.8% of jail inmates indicated that they committed criminal act to obtain money to purchase drugs); *U.S. International Drug Policy: Hearing Before the Senate Caucus on International Narcotics Control*, 101st Cong. 27 (1989) (statement of Bruce Wald, Director, Key Program) ("Crime and drugs are so intertwined that they cannot be extricated from one another. Those involved inpredatory [sic] crimes commit 6-8 times more crime . . . during their active drug use."); Barry R. McCaffrey, Address Before Members of Drug Control Committee of the National District Attorneys Association (Dec. 5, 1997), *in* 32 THE PROSECUTOR 2, 32 (1998) ("Drug use is common among the criminal offenders you deal with on a daily basis. It is also a driving cause of their criminal behavior."). President George W. Bush further argues that a collateral effect of drug use is the support of terrorism. President George W. Bush, Remarks on the 2002 National Drug Control Strategy (Feb. 12, 2002), *available at* http://www.whitehouse.gov/news/releases/2002/02/20020212-8.html [hereinafter Bush] ("[T]he drug trade supports terrorist networks. When people purchase drugs, they put money in the hands of those who want to hurt America, hurt our allies. Drugs attack everything that is the best about this country . . . .").

39. *See* WILLIAM J. BENNETT ET AL., BODY COUNT: MORAL POVERTY . . . AND HOW TO WIN AMERICA'S WAR AGAINST CRIME AND DRUGS 16, 120-27 (1996).

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,[41] 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,[42] par-

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ment. *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 "[f]or 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. **R**

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. **R**

ticularly 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.[43] It may be difficult to alter the rhetoric deployed against drug use for cultural/social reasons cited by many observers, such as:[44] (1) longstanding racial prejudice;[45] (2) media manipulation or political or institutional self-interest;[46] (3) fear that the destigmatization of drug use might encourage it;[47] (4) a need

43. *See* 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, *Methodological Considerations and Drug Prohibition*, *in* HOW TO LEGALIZE DRUGS, *supra* note 5, at 12, 12-18. R

44. For a discussion of the war on drugs as a social construction, see DRUG WAR, AMERICAN STYLE, *supra* note 21, at 1. R

45. *See supra* notes 23, 30. R

46. *See* Levine, *supra* note 5, at 97-103; *see also* 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, *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, *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. R R R

47. *See* Fish, *supra* note 43, at 22 (citing the common fear that drug legalization will make the United States a "nation of addicts"); 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."). *But see* Ethan A. Nadelmann, *Thinking Seriously About Alternatives to Drug Prohibition*, *in* 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). R R R

to justify a lengthy, historical commitment to a drug war;[48] and (5) a need to divide "good" from "bad" drugs,[49] or "drug-abusing criminals" from "law-abiding citizens."[50] Yet, to confront the drug problem, the impact that language has on the debate must be taken into account.[51]

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".[52] On the other hand, due to the analytical differences between them, it is important to distinguish legalization from what is loosely termed "harm minimization".[53]

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

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). R

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, painkillers, 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). R

51. *See* Reinarman, *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. R R

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). R

Although legalization appears in several policy forms,[54] it is most often affiliated with decriminalization.[55] 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.[56]

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54. These include outright legalization (treatment of drugs as any other good), decriminalization (removing 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). R

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 DORN & 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 viii. 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. R R R R

There is a growing trend elsewhere in Europe toward decriminalization (Portugal, Spain, Italy, Luxembourg). *See* T.R. Reid, *Europe Moves Drug War from Prisons to Clinics*, WASH. POST, May 3, 2002, at A1. For a discussion of Portugal's approach to decriminalization, see Mirjam van het Loo et al., *Decriminalization of Drug Use in Portugal: The Development of a Policy*, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 49, 57-62 (2002).

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- R

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."[57] For example, some submit that an individual has a constitutional right to self-determination that includes the right to use drugs.[58] 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[59] 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.[60] 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.[61]

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duction. *See, e.g.*, Conference, *Is Our Drug Policy Effective? Are There Alternatives?*, 28 FORDHAM URB. L.J. 3, 178 (2000) (statement of Dr. Jefferson Fish).

57. Kenneth R. Weingardt & G. Alan Marlatt, *Harm Reduction and Public Policy*, *in* HARM REDUCTION, *supra* note *18, at 353, 368.* R

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 . . . ."). R

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).* R R

60. *See* Ineke Haen Marshall & Chris E. Marshall, *Drug Prevention in the Netherlands: A Low-Key Approach*, *in* BETWEEN PROHIBITION AND LEGALIZATION, *supra* note 5, at 205, 209. R

61. *See* Marlatt, *supra* note 18, at 50. R

Harm minimization has gained increasing acceptance in much of Western Europe.[62] 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."[63] 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.[64]

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 . . . ."[65]

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.[66] 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. R

63. Marlatt, *supra* note 18, at 50. R

64. *See* Nadelmann, *supra* note 47, at 609; Marlatt, *supra* note 18, at 57-58. R

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). R

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

67. *See* Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board. for 2003*, *supra* note 8, ¶¶ 343, 559-61, 576, U.N. Doc. E/INCB/2003/1 (2004), *available at* http://www.incb.org/incb/en/annual_report_2003.html [hereinafter INCB, *2003 Report*]; Ian Malkin, *Establishing Supervised Injecting Facilities: A Responsible Way to Minimise Harm*, 25 MELB. U. L. REV. 680, 680-82 (2001). The underlying justification for the use of supervised injection rooms is that they lower the risk of the transmission of HIV/AIDS or hepatitis B or C, reduce the risks associated with street violence, needle stick injuries, and overdose. *Id.* at 685-86. Malkin presents the results of an Australian survey indicating that 47% of respondents shared needles because of "cost or nonavailablity, or because they feared police apprehension." *Id.* at 686. The U.N. strongly criticized Australia's decision to open supervised injecting rooms. *See, e.g.*, Gavin Yamey, 320 BRIT. MED. J. 667 (2000). R

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. R R

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. R R

(United States);[70] (5) educational campaigns regarding how to use drugs safely;[71] (6) treatment as an alternative to punishment (United States, Britain[72]); 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

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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,,8532 26,00.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.").

73. INCB, *2003 Report*, *supra* note 67, ¶ 225. R

74. *See generally* Robert McCoun & Peter Reuter, *Preface: The Varieties of Drug Control at the Dawn of the Twenty-First Century*, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 7, 8-9 (2002).

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.[76] 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.[77] 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.[78] Advocacy with respect to safe drug use is a response to the dangers associated with unsafe injection or other methods of drug use.[79] There is, however, debate over the permissibility of such campaigns under the international conventions.

Like education, treatment has taken a variety of forms.[80] Under the public health approach most measures are state-sponsored and fall under the general umbrella of "treatment,"

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76. In the United States, educational campaigns target youths seeking to "reduce drug use through changes in adolescents' perceptions of danger and social disapproval of drugs,"" 2003 NATIONAL DRUG CONTROL STRATEGY, *supra* note 40, at 8, by reaching out to parents through, *inter alia*, media campaigns, *see* 2005 NATIONAL DRUG CONTROL STRATEGY, *supra* note 40, at 15, 18. In recent years, these strategies have embraced a "harder-hitting ad style," *id.*, focused on depicting the dangers associated with marijuana use. S*ee, e.g.*, Office of Nat'l Drug Control Policy, TV Public Service Announcement: Couple (2003), *available at* http://www.mediacampaign.org/mg/transcripts/tr_couple.html (marijuana and date rape); Office of Nat'l Drug Control Policy, TV Public Service Announcement: Den (2003), *available at* http://www.mediacampaign.org/mg/transcripts/tr_den.html (marijuana and accidental shooting); Office of Nat'l Drug Control Policy, TV Public Service Announcement: Okay (2003), *available at* http://www.mediacampaign.org/mg/transcripts/tr_okay.html (link between terrorism and personal drug use); *see also* Frank Ahrens, *New Pitch in Anti-Drug Ads: Antiterrorism*, WASH. POST, Feb. 4, 2002, at A3 (discussing advertisements, televised during the Super Bowl, linking the purchase of illicit substances to the support of terrorism).

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). R

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

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). R

80. *See* Bullington, *supra* note 33, at 116-20 (considering the impact of the drug war on the treatment of users). R

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. R

84. *See* Sonja B. Starr, *Simple Fairness: Ending Discrimination in Health Insurance Coverage of Addiction Treatment*, 111 Yale L.J. 2321, 2323 (2002) (arguing for insurance parity for drug and alcohol addiction treatment).

85. Kay, *supra* note 12, at 2175. R

86. Boister, *supra* note 21, at 41-42. R

87. *See generally* Single Convention on Narcotic Drugs, 1961, *supra* note 4. R

duced to meet such needs, and required states to prevent production or diversion of drugs into illegal markets."[88]

Following adoption of the 1971 Convention, the Single Convention was amended by the 1972 Protocol to bring it into conformity with the 1971 Convention.[89] 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).[90]

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.[91] The 1971 Convention generally mirrored the Single Convention, but focused on drug manufacturing instead of agricultural states.[92]

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.[93] 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, . . .

88. DANIEL WOLFE, OPEN SOCIETY INSTITUTE, ILLICIT DRUG POLICIES AND THE GLOBAL HIV EPIDEMIC: EFFECTS OF UN AND NATIONAL GOVERNMENT APPROACHES 21 (2004).

89. *See supra* note 4.

90. 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. R

91. BOISTER, *supra* note 21, at 46; *see also* WOLFE, *supra* note 88, at 21. R

92. BOISTER, *supra* note 21, at 47. R

93. *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."). R R

[r]ecognizing 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-

94. Single Convention on Narcotic Drugs, 1961, *supra* note 4, pmbl. R

95. Convention on Psychotropic Substances, 1971, *supra* note 4, pmbl. R

96. WOLFE, *supra* note 88, at 21.

97. *Id.*

98. *See* 1988 Convention, *supra* note 4, at 165 n.1. R

99. REPORT ON THE STATUS OF THE DRAFT CONVENTION, THE U.S. NEGOTIATING POSITION, AND ISSUES FOR THE SENATE, S.REP. NO. 100-64 (1st Sess. 1987), Annex, at 14; *see also* David P. Stewart, *Internationalizing the War on Drugs: The UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*, 18 DENV. J. INT'L L. & POL'Y 387, 388 (1990) (reflecting thoughts of member of U.S. delegation to the conference adopting the 1988 Convention that "[t]he U.S. participated actively in the negotiation of the Convention, and many of its provisions reflect legal approaches and devices already found in U.S. law"). *See generally* REPORT ON THE STATUS OF THE DRAFT CONVENTION, THE U.S. NEGOTIATING POSITION, AND ISSUES FOR THE SENATE, S. PRT. NO. 100-64 (1987) (providing U.S. proposals and comments).

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 suppy-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]

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100. REPORT ON THE STATUS OF THE DRAFT CONVENTION, *supra* note 99, Annex at 14-15; *see also* Stewart, *supra* note 99, at 393 (describing the offenses under Article 3(1), aimed at trafficking and money laundering, as "the cornerstone of the [1988] Convention"). For a description of the dispute between the United States and Mexico over the inclusion of personal use offenses in what is essentially a trafficking agreement, see BOISTER, *supra* note 21, at 124. **R**

101. *See* UNODC, Monthly Status, *supra* note 8.

102. *Id.*

103. BOISTER, *supra* note 21, at 129. **R**

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]

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104. *See, e.g.*, REPORT ON PROTOCOL AMENDING THE SINGLE CONVENTION OF NARCOTIC DRUGS, 1961, S. EXEC. REP. NO. 92-33, at 2-3 (1972) (describing the "strengthened international control machinery" under the 1971 Protocol). The conventions articulate the functions of the INCB in various articles. *See* Single Convention on Narcotic Drugs, 1961, *supra* note 4, arts. 12, 19 (governing estimates of drug requirements); *id.* arts. 13, 20 (governing statistical returns regarding aspects of drug trafficking); *id.* art. 14 (noncompliance with obligations); *see also* Convention on Psychotropic Substances, 1971, *supra* note 4, art. 16(4)-(6). R

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). R R R

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. R R

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

108. *See id.* art. 15; Convention on Psychotropic Substances, 1971, *supra* note 4, art. 18; 1988 Convention, *supra* note 4, art. 23. R

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."[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.[110] For example, reflecting the U.S. prohibitionist perspective, a Drug Enforcement Administration official stated that under its treaty obligations, the United States:

> *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.[111]

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109. Boister, *supra* note 21, at 10. **R**

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.*

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,[112] 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);[113] (2) operation of Dutch "coffee shops";[114]

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112. *See, e.g.*, INCB, *2004 Report*, *supra* note 8, ¶ 163 (interpreting the treaties as permitting parties to "provide treatment, education, aftercare, rehabilitation and social reintegration, either as an alternative or in addition to conviction or punishment"). R

113. *See, e.g.*, Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board. for 2002*, ¶ 184, U.N. Doc. E/INCB/2002/1 (2003), *available at* http://www.incb.org/incb/en/annual_report_2002.html [hereinafter INCB, *2002 Report*] (discussing proposed Swiss legislation, providing for the "decriminalization" of preparatory acts for the personal consumption of cannabis for non-medical purposes, retaining criminal offense status of such acts, but permitting the prioritization of prosecution; and noting that this legislation "would actually go against the provisions of the international drug treaties"); *id.* ¶ 498 ("The Board . . . welcomes the fact that the [U.K.] Government, in line with its obligations under the international drug control treaties, has categorically ruled out legalizing or regulating the non-medical use of any internationally controlled drugs."); Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board for 2001*, ¶¶ 222-26, U.N. Doc. E/INCB/2001/1 (2002), *available at* http://www.incb.org/incb/en/annual_report_2001.html [hereinafter INCB, *2001 Report*] (discussing proposed Swiss legislation); *id.* ¶ 214 (describing liberalization of Western European cannabis policies); *id.* ¶ 509 (discussing measures in Luxembourg and Portugal eliminating the use of prison sentences for the possession for personal consumption and use of cannabis for administrative sanctions such as fines or limitations of rights and reminding states that Article 3(2) of the 1988 Convention "requires each party . . . to establish [personal use offenses] as . . . criminal offence[s] under its domestic law . . . ."); Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board for 2000*, ¶ 503, U.N. Doc. E/INCB/2000/1 (2001), *available at* http://www.incb.org/incb/en/annual_report_2000.html [hereinafter INCB, *2000 Report*] (expressing concern over increased liberalization of Swiss cannabis policy as violative of the 1961 Convention); Int'l Narcotic Control Bd. [INCB], *Report of the International Narcotis Control Board for 1999*, ¶ 449, U.N. Doc. E/INCB/1999/1 (2000), *available at* http://www.incb.org/incb/en/annual_report_1999.html [hereinafter INCB, *1999 Report*] (discussing new legislation in Portugal stipulating the imposition of fines rather than prison time for drug users and noting that this is "not in line with the international drug treaties").

(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:

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114. *See, e.g.*, INCB, *2001 Report*, *supra* note 113, ¶¶ 216-17 ("[T]he operation of such 'coffee shops,' which buy, stock and sell cannabis products for non-medical use, is in contravention of the provisions of the 1961 Convention."); Int'l Narcotics Control Bd. [INCB], *Report of the International Control Board for 1996*, ¶ 359, U.N. Doc. E/INCB/1996/1 (1997), *available at* http://www.incb.org/incb/en/annual_report_1996.html [hereinafter INCB, *1996 Report*] (reaffirming "its position that the toleration of coffee shops, buying, stocking and selling cannabis products for non-medical use does not conform with the provisions of the 1961 Convention"); Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board for 1995*, ¶ 350, U.N. Doc. E/INCB/1995/1 (1996), *available at* http://www.incb.org/incb/en/annual_report_1995.html [hereinafter INCB, *1995 Report*] (expressing concern at the "persistence of certain practices," calling "into question the . . . Netherlands' fidelity to its treaty obligations," including the separation of markets (hard and soft) and "permitting the operation of so-called coffee shops, many of which have fallen under the control of criminal elements").

115. *See, e.g.*, INCB, *2004 Report*, *supra* note 8, ¶ 510 ("The Board . . . reiterates that drug injection rooms are against the central principle embodied in the international drug control treaties, namely that the use of drugs should be limited to medical and scientific purposes only."); INCB, *2001 Report*, *supra* note 113, ¶ 510 ("The Board wishes to reiterate that the establishment of drug injection rooms, where addicts can abuse drugs obtained from illicit sources, under direct or indirect supervision of the Government, is contrary to the international drug control treaties"); INCB, *2000 Report*, *supra* note 113, ¶ 460 (objecting to the establishment and operation of drug injection rooms, particularly in light of 2000 German legislation allowing for this); INCB, *1999 Report*, *supra* note 113, ¶ 176 (likening these drug injection rooms to "opium dens"); *id.* ¶¶ 451, 480 (expressing concern over the possibility of injection rooms in Luxembourg and Germany); Int'l Narcotics Control Board [INCB], *Report of the International Narcotics Control Board for 1998*, ¶ 437, U.N. Doc. E/INCB/1998/1 (1999), *available at* http://www.incb.org/incb/en/annual_report_1998.html [hereinafter INCB, *1998 Report*] (criticizing European "shooting galleries"). R R R

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). R R

> It is possible to curb the showing by public broadcasting media . . . of favourable images of drug abuse. . . . [I]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

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117. Int'l Narcotics Control Bd. [INCB], *Report of the International Narcotics Control Board for 1997*, ¶ 22, U.N. Doc. E/INCB/1997/1 (1998), *available at* http://www.incb.org/incb/en/annual_report_1997.html [hereinafter INCB, *1997 Report*]; *see also id.* ¶ 27 (noting with respect to political campaigns, "[p]rominent people have issued some very public calls to take drugs and have not been prosecuted. This flagrant refusal by governments to implement an international convention to which they are signatories is almost hypocritical").

118. INCB, *2004 Report*, *supra* note 8, ¶¶ 185-92. **R**

119. Lynch, *supra* note 19, at 4. **R**

120. *Id.* (quoting BENNETT ET AL., *supra* note 39, at 140-41). **R**

121. *Id.* at 5 (citing William J. Bennett, *A Response to Milton Friedman*, WALL ST. J., Sep. 19, 1989, at A30).

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.[122] 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[123]

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. **R**

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.[124] 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."[125] 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.[126] 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.[127]

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substance). Controlled Substances Act, 21 U.S.C.A. § 812 (2000) (providing schedules); *see also supra* note 111 (on medical marijuana). R

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, 32. 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). R R R

125. Kay, *supra* note 12, at 2158. R

126. *Id.*

127. *See* INCB, *2003 Report*, *supra* note 67, ¶ 141. R

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.

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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."). R

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. R

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.[129] 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.[130]

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.[131] 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,[132] Article 2(5) represents a compromise that leaves the issue of pro-

129. *See* Single Convention on Narcotic Drugs, 1961, *supra* note 4, art. 4(c). **R**

130. *Id.* art. 2(5)(b).

131. This may, however, be a null set.

132. COMMENTARY ON THE SINGLE CONVENTION, *supra* note 124, at 49-51. **R**

hibition to the judgment of the parties.[133] 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[134]

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 . . . ."[135] 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."[136]

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 . . . ."[137] 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.[138] 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. R

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

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."[139]

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[140] or otherwise offend the "basic concepts of its legal system,"[141] which includes prosecutorial

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"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). R

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 R 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 R 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,[142] 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.[143] Such party is, however,

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1988 Convention, *supra* note 4, art. 3(2). Thus, two restrictions operate on the implementation of this provision: constitutional principles and the "basic concepts" of individual state legal systems. The latter phrase covers local, state, and national statutory "law, judicial decisions or ingrained practice." *See* U.N. OFFICE OF DRUGS AND CRIME, COMMENTARY ON THE UNITED NATIONS CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES, 1988, at 72, U.N. Doc. E/CN.7/590, U.N. Sales No. E.98.XI.5 (1998) [hereinafter COMMENTARY ON THE 1988 CONVENTION]. For a discussion of instances in which courts have declared the criminalization of personal use to be unconstitutional, and the INCB's negative reaction to these decisions, see BOISTER, *supra* note 21, at 125, n.228. Boister notes that courts have been "active in this regard." *Id.* R R

142. The Commentary cites as an example of the "basic concepts of its legal system," the established practice of prosecutorial discretion. *See* COMMENTARY ON THE 1988 CONVENTION, *supra* note 141, at 72. Prosecutorial discretion is one of the hallmarks of the Dutch drug policy, and underlies the dichotomy between "law-on-the-books" and "law-in-action." *See* Silvis, *supra* note 35, at 43-44. R R

143. As noted *supra* note 141, Article 3(2) of the 1988 Convention provides that: R

> [E]ach 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.*

1988 Convention, *supra* note 4, art. 3(2) (emphasis added). Aside from constitutional and other legal safeguards, the 1988 Convention vests discretionary authority in its members pursuant to Article 3(2), allowing for an escape hatch from the requirement that members must make punishable offenses of certain consumption-related activities. *Id.* This flexibility is expressed in at least two ways. First, a state has discretion to define both intention (states may exclude acts not committed "intentionally") and "necessary" measures to make criminal offenses of specified acts. R

Second, the last part of the article—"contrary to the provisions of" the Single Convention, as amended, and the 1971 Convention—could be interpreted to mean that parties may "retain the stance they had adopted regarding the interpretation of those earlier texts." *See* COMMENTARY ON THE 1988 CONVENTION, *supra* note 141, at 81. Arguably, possession for personal consumption is *not* "contrary to the provisions" of the earlier treaties. R

under no obligation to impose penal sanctions.[144] Thus, the

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On the other hand, this phrase might simply invoke the *spirit* of the prior treaties. Specifically, activities undertaken for the purpose of personal consumption are impliedly covered by the conventions because the agreements are intended to control all non-medical use of substances. This reading is supported by the inclusion of the words "personal consumption" in the text of Article 3(2). Thus, interpreted conservatively, Article 3(2) could mean that parties must make criminal offenses of the possession, purchase, or cultivation of drugs for personal consumption. For a discussion of the ambiguity created by this phrase, see BOISTER, *supra* note 21, at 127-28. R

The preparatory documents do not settle the issue, but indicate that Article 3(2) was a late addition to the treaty, perhaps overshadowed by the flood of supply-reduction measures, and the result of hasty compromise. It is possible that the parties did not sufficiently consider the matter, unintentionally creating an empty provision. Additionally, given the consistent effort in the history of crafting international drug control treaties to incorporate elements of discretion (particularly regarding demand reduction measures), it is certainly possible that the parties intended to provide for interpretive flexibility.

In sum, depending upon state interpretation of the earlier treaties, the 1988 Convention could, but need not, be read as requiring parties to make certain personal use activities into punishable offenses.

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. 1988 Convention, *supra* note 4, art. 3(4). Specifically, Article 3(4)(c), in regards to any offense R 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." *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.*, 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." BOISTER, *supra* note 21, at R 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.[145]

Cannabis, in particular, is covered under articles 22 (cultivation) and 28 of the Single Convention.[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.

Prohibitionist Assertion 3: The Netherlands Shall Not Permit the Operation of "Coffee Shops"[147]

A "coffee shop" is a "place where one may buy small quantities of hashish and marijuana for personal consumption,"[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

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conviction or punishment of an offence established in accordance with paragraph 2 of this article, measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender." 1988 Convention, *supra* note 4, art. 3(4)(d). The terms "treatment," "education," "aftercare," "rehabilitation," and "social reintegration" are not defined in the treaty, leaving the parties with discretion in determining what measures might be appropriate in dealing with the Article 3(2) or minor Article 3(1) offenses. R

145. INCB, *2001 Report*, *supra* note 113, ¶ 509. R

146. *See* Single Convention on Narcotic Drugs, 1961, *supra* note 4, art. 22. In part, Article 28 provides, "The parties shall adopt such measures as may be necessary to prevent the misuse of, and illicit traffic in, the leaves of the cannabis plant." *Id.* art. 28(3).

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. R

148. Jansen, *supra* note 55, at 169. R

do not create a public nuisance.[149] 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.[150]

The INCB has asserted that the toleration of coffee shops is inconsistent with the Single Convention.[151] 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."[152]

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.[153] 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).[154] 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. R

150. Blom & Mastrigt, *supra* note 21, at 272. R

151. *See, e.g.*, INCB, *1996 Report*, *supra* note 114, ¶ 359. R

152. INCB, *1995 Report*, *supra* note 114, ¶ 350. R

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." COMMENTARY 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. R R

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. R

156. For examples see *supra* note 115. R

157. Malkin, *supra* note 67, at 682. R

158. *Id.*

159. Evan Wood et al., *Changes in Public Order After the Opening of a Medically Supervised Injecting Facility for Illicit Injection Drug Users*, 171 CAN. MED. ASS'N J. 731, 731 (2004).

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."[160]

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."[161] 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."[162] 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."[163]

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.[164] Second, as noted in the foregoing section, the Single Convention does not provide a *man-*

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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. R

162. INCB, *1999 Report*, *supra* note 113, ¶176; *see also* INCB, *2001 Report*, *supra* note 113, ¶ 510. R R

163. INCB, *1999 Report*, *supra* note 113, ¶176. R

164. *See infra* notes 169—177. R

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,[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.

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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." 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). *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." *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. 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. *Id.* art. 32(2). Most parties, including the United States, opted not to accept ICJ jurisdiction. *See* Jimmy Gurule, *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.'" 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.

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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.[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.[167]

Prohibitionist Assertion 5: Parties Shall Not Implement Heroin Maintenance Programs[168]

Heroin maintenance (akin to methadone maintenance) is a treatment by which heroin is medically prescribed to its users through supervised programs.[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.[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. R

167. *See id.* at 708-13.

168. For examples see *supra* note 116. R

169. *See* Richard Hartnoll, *Heroin Maintenance and AIDS Prevention: Going the Whole Way?*, INT'L J. DRUG POL'Y 36, *reprinted in* 1 DRUGS, CRIME AND CRIMINAL JUSTICE, *supra* note 23, at 213. R

170. *Id.* at 214. Generally speaking, in addition to the injectible 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.* R

harm where the addict is "unwilling or unable to achieve abstinence."[171]

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.[172] 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.[173]

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.[174] On the one hand, the INCB repeatedly has questioned the medical and scientific value of experimental programs premised on heroin maintenance.[175] Advocates of these programs counter that

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171. G. Alan Marlatt, *Harm Reduction Around the World*, in HARM REDUCTION, *supra* note *18, at 30, 39*. R

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.

175. *See* Commission on Narcotic Drugs Report, *supra* note 174, ¶¶ 17-18; R
see also INCB, *1995 Report*, *supra* note 114, ¶ 385; INCB, *2002 Report*, *supra* R
note 113, ¶ 496. R

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 Speech[179]

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-

176. Single Convention on Narcotic Drugs, 1961, *supra* note 4. R
177. *Id.* art 2(5)(b) (emphasis added).
178. COMMENTARY ON THE SINGLE CONVENTION, *supra* note 124, at 68. R
179. See INCB, *1997 Report*, *supra* note 117 and accompanying text. R

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).[180] 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."[181]

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 . . . [s]ubject 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.[182]

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.[183] Although Article 3(1)(c)(iii) provides for the classifi-

180. INCB, *1997 Report*, *supra* note 117, ¶¶ 15-27. R

181. *Id.* ¶ 39.

182. Convention on Psychotropic Substances, 1971, *supra* note 4, art. 3. R

183. 1988 Convention, *supra* note 4, art. 3(1)(c)(iii). The public incitement crime, included in the 1988 Convention, was a new addition to the international drug treaty system. *Compare id.*, *with* Single Convention on Narcotic Drugs, 1961, *supra* note 4. Although public incitement does not relate specifically to personal use, possession (for personal consumption) or acquisition (for personal use), its creation is significant and worthy of some consideration. For the purposes of this article, the inclusion of a safeguard clause again provides parties with discretionary authority to avoid criminalizing "public incitement," in light of constitutional and other legal principles specific to their circumstances and in spite of the obligatory language. For example, U.S. negotiators expressed concern that implementation of this provision raised First Amendment problems, but the Committee on Foreign R R

cation 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.[184] 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."[185] 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-

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Relations determined that the limiting clause, "subject to its constitutional principles and the basic concepts of its legal system" provided sufficient discretion. *See* REPORT ON UNITED NATIONS CONVENTION AGAINST ILLICIT TRAFFIC IN NARCOTIC DRUGS AND PSYCHOTROPIC SUBSTANCES, S. EXEC. REP. NO. 101-15, at 29 (1989).

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). R R

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. R

185. Pollack, *supra* note 71, at 95. R

ited by the constitutional and basic legal concepts of member states.[186] 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."[187] 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:

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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: R

> 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). R

> 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

188. International Covenant on Civil and Political Rights, art. 19, Dec. 16, 1966, 999 U.N.T.S. 171 (entered into force Mar. 23, 1976).

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.[189] 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. R

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,

190. *See id.* at 24; M. Cherif Bassiouni, *Critical Reflections on International and National Control of Drugs*, 18 DENV. J. INT'L L. & POL'Y 311, 314 (1990).

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.[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."[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."[193] The INCB has also colorfully described supervised injection rooms as "shooting galleries" and likened them to "opium dens."[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.[195] Such suppression of individual expression, however, arguably violates human rights.

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191. *See supra* text accompanying notes 42-51. R

192. INCB, *2001 Report*, *supra* note 113, Foreword. R

193. *Id.*

194. *See* INCB, *1999 Report*, *supra* note 113; INCB, *1998 Report*, *supra* note 115. R

195. INCB, *1998 Report*, *supra* note 115, ¶ 437 (arguing that the debates "have left the false impression that cannabis is harmless and that it has many virtues, including medical benefits."). R

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.

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196. 1988 Convention, *supra* note 4, art. 31. **R**

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.

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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.