What is the future of the International drug control treaties?

Wayne Hall
UQ Centre for Youth Substance Abuse Research
and
National Addiction Centre
Kings College London

Outline

- What are the international drug control treaties?
    - What drugs do they cover? How did they come about?
- Major criticisms of the international system
    - Inclusion of specific drugs
    - Failed to prevent drug use and harm
    - Has increased harms: BBV infection; imprisonment; violence
- Major reform proposals
    - Radical and more piecemeal reforms
- Policy reform options for:
    - Cannabis
    - Party drugs and NPS
    - Opioids and stimulants

Declaration of interest

- Role in the international system
  - A member of WHO expert committees
  - Worked on Global Burden of Disease 2001-2010
  - Member of INCB from 2012-2014

- Speaking in a purely personal capacity
  - Not reflecting the views of any of these agencies

What are the international drug control treaties?

- UN treaties that
  - Only allow use of specified drugs for medical and scientific purposes
  - Criminalise all other adult use, manufacture and sale
- How did they come about?
  - 1912 Opium Treaty
  - Single Convention 1961 and 1972 amendment
  - 1971 Psychotropic Drugs Treaty;
  - 1988 Treaty
- What do they require of signatories?
  - Criminalise nonmedical possession and use
  - Prohibit production and sale
- How many nation states have signed the treaties?
  - 180/203 nation states

Which drugs are covered by the treaties?

- The treaties prohibit use by adults, except for medical and scientific purposes of:
  - Cannabis
  - Heroin and other opioids
  - Cocaine
  - Amphetamine-type stimulants
  - Party drugs (MDMA, LSD, ketamine, GBH etc)
  - Benzodiazepines

Implications for national policy

- Variations between countries but in most focus on
  - Law enforcement & supply control
  - Punitive policies towards drug users
    - Imprisonment and forced treatment
  - Much less attention to demand reduction
    - Limited state provision of addiction treatment
    - Ineffective prevention approaches: harms of drug use
  - Opposition to harm reduction approaches
    - Opioid substitution treatment
    - Needle and syringe programs
    - Supervised injecting facilities

Ensuring compliance with the treaties

- Oversight by International Narcotics Control Board
  - National estimates system
  - Naming and shaming of countries in annual reports
    - Critical of decriminalisation and HR polices
  - Reluctance to criticise punitive policies
- Commission on Narcotic Drugs makes policy
  - Admonishes states to comply with treaties
  - Resistant to change because unanimity required
  - Pressure from supporters of international system
    - e.g. USA, Russia, China, Sweden, France etc

The Contribution of Illicit Drugs to the Global Burden of Disease

How GBD measures health loss

DALYs = YLLs + YLDs

(disability-adjusted life years) (years of life lost) (years of life lived with disability)

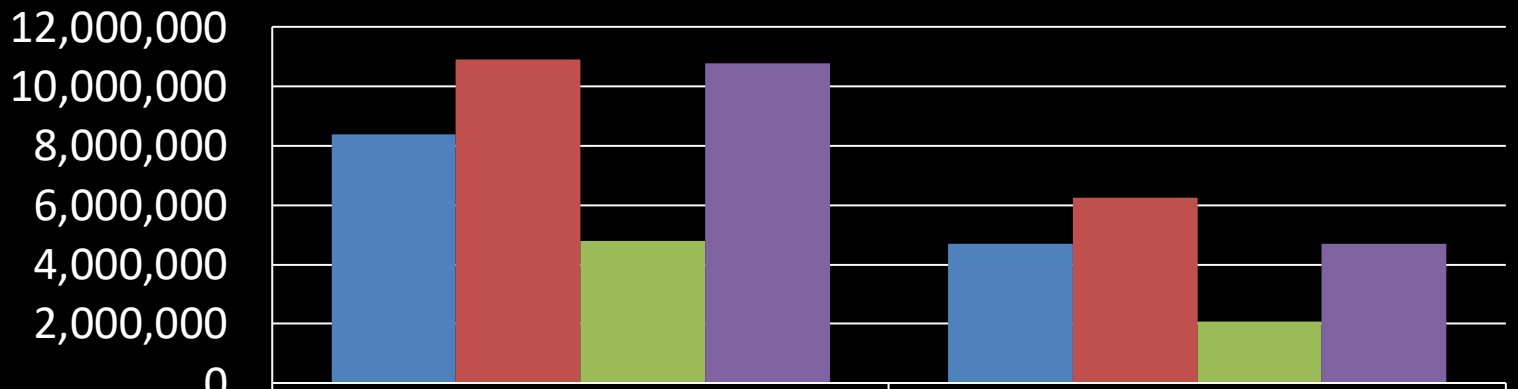
↓ ↓ ↓

Overall health loss

health loss due to premature mortality

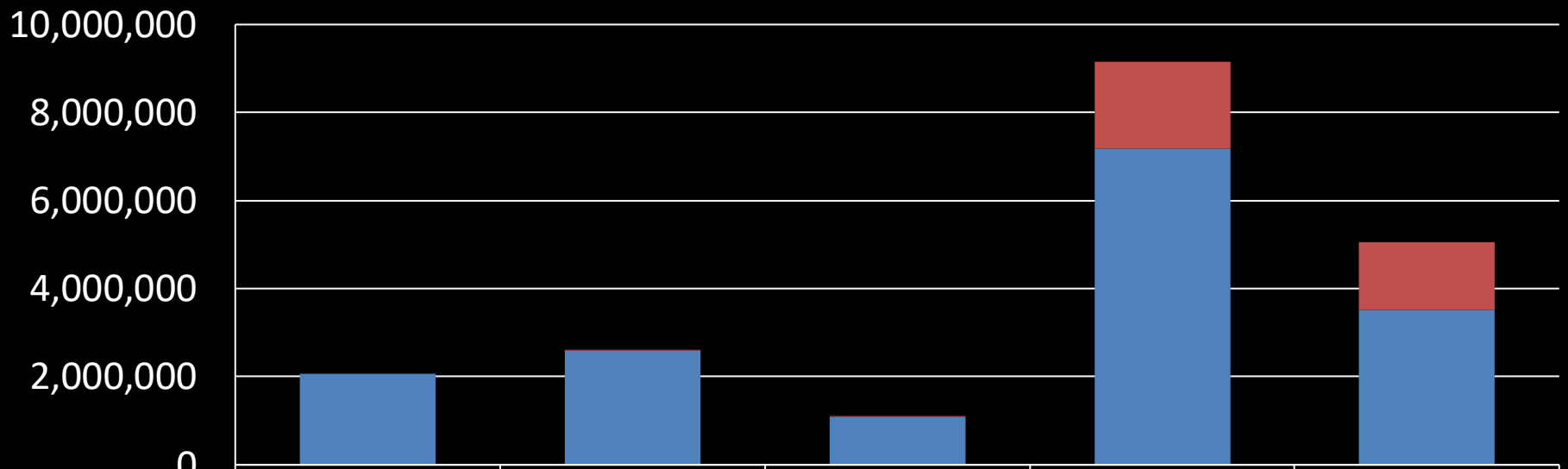
health loss due to living with disability

Number of people estimated to be drug dependent by drug type globally, 2010



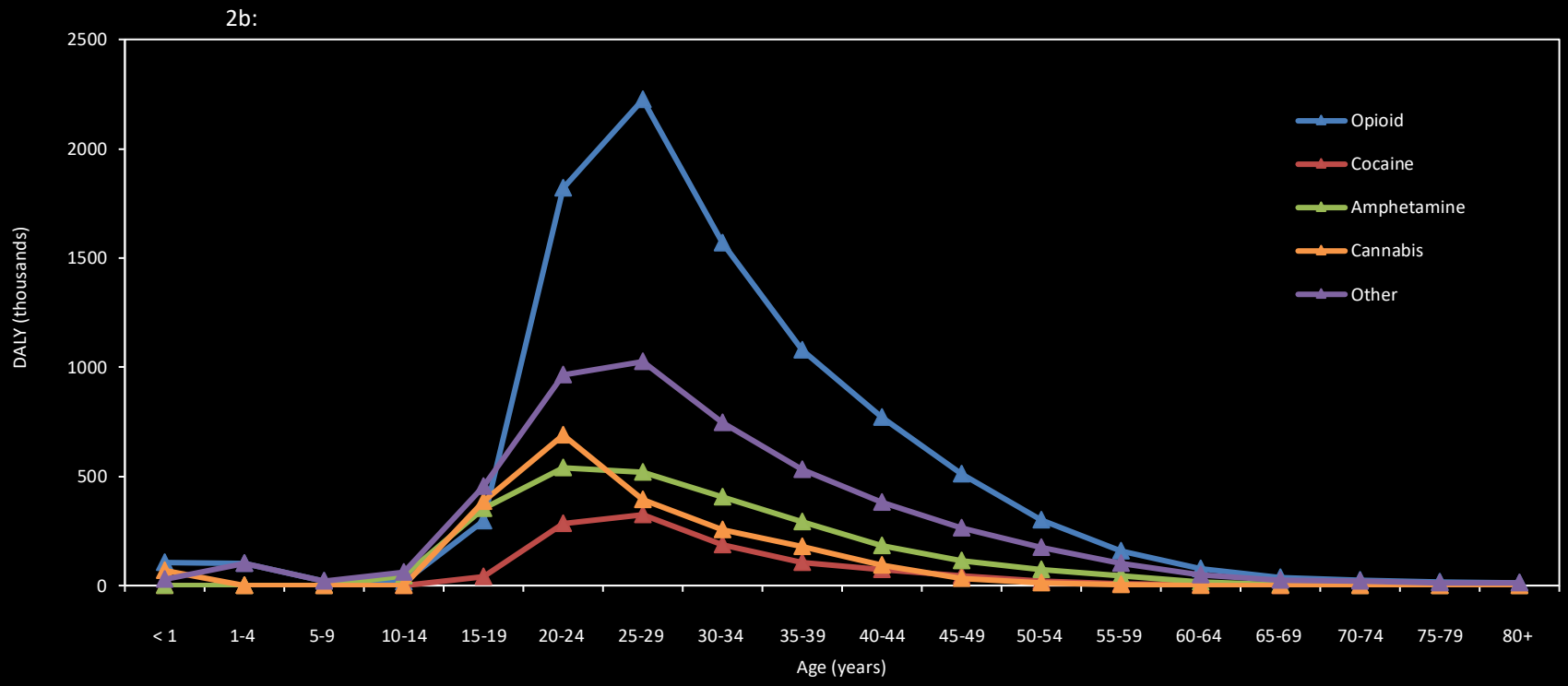
	Males	Females
Cannabis	8,377,000	4,696,000
Amphetamines	10,928,000	6,256,000
Cocaine	4,801,000	2,090,000
Opioids	10,781,000	4,698,000

DALYs due to drug dependence, 2010



	Cannabis	Amphetamines	Cocaine	Opioids	Other drugs
YLLs	0	21,000	25,000	1,981,000	1,555,000
YLDs	2,057,000	2,596,000	1,085,000	7,170,000	3,503,000

DALYs attributable to each type of drug dependence by age, 2010 (thousands)



Comparison with other diseases and risk factors

- Illicit drugs responsible for 1% of GBD
  - 8th largest contributor to disability (YLDs) among males
- 1/4 of alcohol (3.9%) and 1/6th of tobacco (6.3%)
  - Despite lower prevalence than alcohol and tobacco
- Larger than maternal + neonatal conditions

The international system under strain

- Increasing defections by governments
  - Decriminalisation of personal use of ilicit drugs
  - Cannabis and party drugs
  - Allowing de facto legal sales in Netherlands
- Criticism by scholars & civil society organisations
  - Counterproductive to public health
  - Violation of human rights
  - Over-reliance on severe criminal justice penalties
  - Increasing violence in source countries e.g. S America

Are the treaties worth saving?

If so, in what form?

The “war on drugs” has failed

- The treaties have failed to reduce drug use:
  - Widely violated by illicit drug users
  - Illicit drug use has increased over time
  - Prices have fallen and purity has increased
- The treaties have increased harms
  - harms to users e.g. BBV, overdoses, stigma
  - Increased harm to others e.g. crime, violence
- The treaties have violated human rights
  - imprisonment as “treatment”
  - Capital punishment for low level drug offenders
  - Extrajudicial killings of drug user/dealers

“Ending the War on Drugs”

- We should leave policies to individual states
  - Allow policy experiments in drug regulation
- We should treat drugs as a public health issue
  - Drugs not just a public health issue even when legal
  - e.g. alcohol and third party effects
- We should regulate drugs in proportion to their harms
  - Simple in principle but more difficult in practice

What are the leading reform proposals?

- Respecting human rights principles
  - Increased use of harm reduction policies
    - OST, NSP etc
  - Discourage unjust policies
    - Imprisonment and enforced treatment
    - capital punishment and extrajudicial murders
- Removing specific drugs from the treaties
  - Cannabis
  - Party drugs and hallucinogens

Remove specific drugs from treaties

- Cannabis, MDMA and party drugs and hallucinogens
- Because these drugs are
  - less harmful than alcohol & other illicit drugs
  - criminal penalties are a disproportionate response
  - Legalisation would reduce harms of use by
    - Raising revenue for treatment and prevention
    - Reducing costs of drug law enforcement
    - Eliminating black markets and associated violence
    - Better regulating drug markets
      - removing impurities, uncertainty re doses
      - reducing uptake by the young

How do we know what works?

- Controlled evaluations
  - nonexistent for interdiction or decriminalisation
    - confounded comparisons between countries
    - “natural experiments” and time series data
- Limited range of policy counterfactuals
    - Constraints of International drug control treaties
    - Incremental changes e.g. decriminalise use
    - Doubtful relevance of historical comparisons
      - old drugs e.g. opium; poor documentation of effects

Has drug prohibition been a failure?

- "Yes" because we do not live in a "drug free world"

- Goal has not been achieved because:
  - increased illicit supply of opiates, cocaine and ATS
  - Global spread of IDU and HIV/AIDS
  - Decreasing price and increasing drug purity
  - Increasing numbers of arrests for drug offences
  - Increasing numbers of imprisoned drug users
  - Increasing violent deaths e.g. Mexico, S. America

What should we expect of prohibition?

- Zero drug use is a very high standard:
  - All policies fail by this standard
  - Don't demand this in other areas of social policy
    - Shouldn't do so in drug policy
- Utilitarian argument for prohibition (e.g. Caulkins)
  - A lesser evil than legalisation
    - reduces drug use and harms
    - at a socially acceptable cost (even in USA)
    - could be more wisely and justly implemented
  - Case stronger for some drugs than others
  - We need to consider arguments by drug class

Different policies for different drugs

- Policies proportionate to harms
- Challenges
  - Assessing harms of drug use
    - Health best studied
    - Crime and violence less well studied
  - Assessments of harms under prohibition
    - Affected by illegality
    - Policies towards drug use and drug users

What should we do about cannabis?

- Drug with the strongest case for reform:
  - not as harmful as opioids and stimulants
  - easy to grow and so hard to enforce prohibition
  - less harmful than alcohol and tobacco
- Increased “soft defections” from Single Convention
  - e.g. Netherlands, Australasia, EU and US
- Single Convention now being contravened in:
  - USA by referenda in 2012, 2014, 2016
  - Uruguay by legislation 2013
  - Canada proposed legislation in 2017

If cannabis is legalised, what next?

- The thin edge of the wedge:
  - Legalisation of MDMA, hallucinogens, cocaine?
- Low hanging fruit:
  - More resistance to legalising other drugs?
- Cannabis is different:
    - lower dependence risk; absence of OD deaths
    - less harmful than alcohol
- Legalising cannabis → a smaller global drug problem
    - From 247 million users to 164 million in 2014
    - Use of other drugs is much more stigmatised

Should we legalise the opioids?

- Strongest case for retaining some type of prohibition:
  - Addictive, high OD risk, BBV infections and other mortality
- Harms not solely due to prohibition:
  - Pharmaceutical opioid epidemic in USA and elsewhere
  - Opioid dependence in medical professionals
- We can mitigate the harms of prohibition via
  - Expanding opioid substitution treatment
  - Needle and syringe programs to prevent BBV
  - Injecting rooms and naloxone distribution to reduce ODs
  - Diverting addicted offenders into treatment

The party drugs

- MDMA or ecstasy:
  - established markets and supply since 1990s
  - Next most commonly used drugs after cannabis
  - Popular with socially advantaged drug users
- Psychedelics: LSD; psilocybin; magic mushrooms
  - Little apparent harm e.g, DAWN etc
  - Renewed advocacy for medical and spirtual use
- Much less harmful than opioids and stimulants
  - MDMA can cause fatal overdoses but rarer than opioid ODs
- Lower risk of dependence than cannabis
  - Few seek treatment for problems with these drugs

The party drugs: regulatory options

- Grudging tolerance as in the Netherlands
  - Some quality control via head shops
  - Drug testing to discipline markets
  - Harm reduction advice to users
- Licensing sellers and users:
  - Issues in implementation
  - Quality control of drug manufacture
  - Who's liable for harms: user or producer?
  - Diversion to under age consumers?
  - More use and harm with greater perceived safety?

Stimulants: cocaine and the amphetamines

- ATS can be used with minimal harm
  - As prescription drugs in sustained release form
  - by some recreational users who use small oral doses

- But can cause serious harm if smoked or injected:
  - Binge use much more common
  - Dependence, aggression and psychoses
  - Cardiovascular diseases: strokes and infarcts
  - Parkinson’s Disease

Stimulant regulation

- A free market like alcohol
  - Recipe for increased problem use
  - More intoxication, psychoses and violence
  - More serious medical problems
- Licensing adult users a popular option
  - Who's liable for harms to users and others?
  - Risks of diversion to adolescents
  - Ease of reprocessing to crack and crystal meth
  - Public intolerance of any adverse effects of licensing

Stimulant prohibition

- Supply control very difficult to achieve
  - Easy to manufacture from common precursors
  - Need to make an effort but rapidly diminishing returns
- Need to devote more resources to demand reduction
  - To encourage problem users to desist
    - e.g. Project HOPE?
  - To discourage new users
    - Challenges in finding credible ways of doing so
    - Capitalise on natural history of stimulant epidemics
    - Need for periodic renewal of efforts

Mitigating the harms of stimulant use

- No analogue of OST:
  - stimulant replacement not very popular or effective
- Users much more reluctant to seek treatment
  - Paranoid, aggressive, difficult to engage
  - Psychoses can be refractory, if use continues
- Stimulants have lower OD risk than opioids
  - but heavy use can cause CVD, strokes, and PD
- Users often involved in crime
  - Drug dealing to finance use which spreads use
  - Assaults and robberies and drug market violence
  - Coerced abstinence: Project Hope?

New psychoactive substances

- How serious an issue?
  - Lots of NPS trialed but low prevalence of use
    - Exceptions MDMA and mephedrone
  - Governmental over-reaction
    - Pre-emptively prohibit everything
  - New Zealand proposal for licensing NPS for sale
    - How do you establish safety?
    - Costs of compliance and risks of litigation for harm
- Is NPS use largely a by-product of prohibition?
  - Getting around existing schedules
  - Would legalising cannabis and MDMA reduce demand?

Conclusions 1

- International treaties in need of reform
  - Undermined by defections of leading states parties
  - Concerted scholarly criticism has reduced legitimacy
  - Enforced in ways that conflict with human rights treaties
- Goal of a drug free world is certain to fail
- Instead we need more reasonable policy goals
  - Managing rather than eliminating drug problems
  - Minimising harms of control policies and drug use
  - Respecting human rights principles
  - Creating space for evaluable policy experiments

Conclusions 2

- Polices should better reflect drug-related harms
- Cannabis: strongest case for reform
    - Least harmful but not harmless
    - Widely used and laws not well enforced
  - For profit markets likely to increase use
    - Need to apply lessons from alcohol and tobacco
    - Restricting promotional activities
    - Taxation to reduce heavy use
    - Not being followed in USA

Conclusions 3

- Opioids: good case for mitigated prohibition
  - Addictive and cause deaths
  - Not widely used
  - Harms of prohibition can be mitigated
    - OST reduces drug use, BBV, OD and crime
    - NSP and SIF reduce BBV, public visibility, and engage users
  - Decriminalise personal possession and use
  - Divert minor offenders into treatment
    - Reduces costs of imprisonment
    - Improves public health

Conclusions 4

- Party drugs
  - Grudging tolerance a possibility as per Netherlands
  - Need better evaluations of effects
  - Regulation of licensed sellers and users a challenge
  - Liability for damage and diversion
- NPS
  - How much demand if cannabis and MDMA legal?
  - Challenges in assessing safety
  - Liability for damages and diversion

Conclusions 5

- Stimulants: most troubling class of illicit drugs
  - Can be used with minimal harm
  - But addictive and damaging when used heavily
  - Difficult to reduce supply given ease of manufacture
- Regulation may seem attractive but problematic
- Difficult to mitigate harms of prohibition
  - Harm reduction options less available than opioids
  - Diversion of minor offenders into treatment
  - Better treatment engagement