Prohibition and Beyond

A Critical History of Drug Control

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Introduction

Semantic issues

In 1987, during Ronald Reagan's second term as President of the United States, the Partnership for a Drug-Free America launched a short commercial that remains one of the most famous and influential public service announcements of all time. In a modest kitchen, a sturdy, middle-class white man with the demeanor of a good-natured family man cracks an egg («This is your brain») into a hot frying pan («This is drugs») and, holding up the fried egg, admonishes: «This is your brain on drugs.» Then, looking directly into the camera: «Any questions?»

Indeed, some questions are necessary. American comedian Bill Hicks, in his 1991 show *One Night Stand*, joked about this commercial:

> *That's what I hate about the war on drugs, I'll be honest with you, what I can't stand it's all day long we see those commercials: «Here is your brain, here is you brain on drugs», «Just say no», «Why do you think they call it dope?», and then the next commercial is: «This Bud's for you!»*[1]*.(...) It's ok to drink your drugs! We meant those* other *drugs! Those* untaxed *drugs! Those are the ones that are bad for you.*

The questions that emerge from Hicks's sketch are among those raised by William B. McAllister in the introduction to his *Drug Diplomacy in the Twentieth Century: An International History*:

> *What is a drug? Are drugs really that bad? What is the difference (if any) between "drugs" and "medicine"? Why do people use substances that are so*

[1] Bud is the popular name for *Budweiser* beer.

> *obviously harmful? Why is alcohol legal (at least for adults), considering its many negative effects? Why don't other countries quit making drugs – don't they see it's bad? Why can't the police keep it out? Who determines which drugs are bad and which are good? How do they decide?* (McAllister 1999, p. ix)

It is evident that any discussion concerning the regulation of drug use and trafficking must be preceded by a critical examination of the term «drug» itself—a term whose meaning is inherently vague.

As McAllister suggests, the word drug can, depending on the context, denote either a psychoactive substance or a pharmaceutical, a medicine. Going further back in time, the Greek term *pharmakon* (φάρμακον) similarly exhibited a duality of meaning, referring simultaneously to both a remedy and a poison. This seemingly polarized dichotomy finds not only etymological but also historical confirmation: many substances now classified as illicit—such as cocaine, heroin, morphine, amphetamine, methamphetamine, MDMA, and LSD—were originally synthesized in the laboratories of major pharmaceutical companies and were long prescribed and sold as legitimate medicines. At the same time, the therapeutic potential of natural molecules such as THC, psilocybin, mescaline, and DMT—despite being subject to the most rigid forms of international control—has been increasingly rediscovered.

Thus, the question remains, both politically and epistemologically urgent: what, exactly, is a drug?

The concept of drugs

According to the Single Convention on Narcotic Drugs (1961), Article 1, letter j), «"Drug" means any of the substances in Schedules I and II, whether natural or synthetic.»

This shortcut was also adopted in the Convention on Psychotropic Substances (1971), whose Article 1 does not define the word «drug» but, in letter e), provides a definition for «psychotropic substance»: «"Psychotropic substance" means any substance, natural or synthetic, or any natural material in Schedules I, II, III, or IV.»

Article 1 of the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988), in letters n) and r), employs the same formula: «"Narcotic drug" means any of the substances, natural or synthetic, in Schedules I and II of the Single Convention on Narcotic Drugs (…),» and «"Psychotropic substance" means any substance, natural or synthetic, or any natural material in Schedules I, II, III, and IV of the Convention on Psychotropic Substances (…).»

Thus, according to the Conventions, any substance, natural or synthetic, and any natural material included in the aforementioned schedules qualifies as a «drug.» Conversely, substances not included therein would not be considered drugs, regardless of the risks they may pose to individual or public health. This classification approach is clearly formal rather than substantive, and it reflects a regulatory necessity rather than an attempt at scientific precision. It should be noted, however, that the Conventions do provide more specific criteria for the inclusion of substances in the relevant schedules—a matter to which we will return later.

From the perspective of the principle of legality, the criterion adopted by the Conventions is arguably the most appropriate for a regulatory framework. Nevertheless, its almost mechanical application underscores the observation, made by Vincenzo Ruggiero, that the concept of «drugs» is not descriptive but evaluative: it serves to express social and political judgments, rather than to offer a neutral categorization (Ruggiero 1999, p. 123).

A comprehensive discussion of the regulation of drug trafficking and use—and of its historical origins and consequences—requires, or at least deserves, a stipulative definition of its object of analysis. Such a definition, later cited by McAllister (1999, p. xv), is offered by Franklin E. Zimring and Gordon Hawkins in their essay *The Search for Rational Drug Control*. The authors write: «we will define a drug as a psychoactive substance capable of being used recreationally».

This definition, in particular, has the virtue of moving beyond legal classifications, which often reflect political and economic interests rather than scientific realities, and allows for the inclusion of both licit and illicit substances—such as alcohol, tobacco, and pharmaceuticals—whose legal status has varied over time based on shifting power dynamics, social norms, and economic incentives. This broader perspective is essential for understanding how drug policies have been historically constructed and contested.

Furthermore, the dual criterion of psychoactive effect and recreational suitability allows for the exclusion of doping substances, whose use is aimed at enhancing performance, as well as many substances that do influence mood but are not genuinely suitable for recreational use. Substances like caffeine and tobacco remain at the margins of this spectrum: while they exert some influence on mood, their effects are modest in consumers who are not already dependent (Zimring, Hawkins 1992, pp. 31–32).

The concept of addiction

As for tobacco, one of its defining characteristics is its strong capacity to induce dependence—an element often central to discussions on combating drug use and trafficking, yet notably absent from the definition discussed above.

In fact, not all substances commonly considered drugs (i.e., those listed in the schedules of the Conventions) induce dependence; conversely, not all substances that generate dependence are suitable for recreational use. Nonetheless, given its centrality in the history of drugs and drug policies, it may be useful, if not to formulate a definition of dependence, at least to illustrate its complexity.

Although Zimring and Hawkins' definition of «drugs» does not include addictive potential as a requirement, they have nonetheless attempted to frame the concept of addiction:

> *With regard to drug addiction, what we define as addictive behavior is drug use that is habitual and assumes a functional importance for the individual concerned, such that it renders his or her other social roles and preferences increasingly unimportant.* (Zimring, Hawkins 1992, p. 32).

This is a definition developed by two criminologists, concise and clearly different from that offered by a diagnostic manual.

In the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5-TR; American Psychiatric Association, 2022), two previously distinct and hierarchically ordered disorders—«substance abuse» and «substance dependence»—were merged into a single construct: «substance use disorders». The diagnosis of this disorder is based on the presence of two or more of the following eleven criteria within a twelve-month period:

1. The individual may take the substance in larger amounts or over a longer period than originally intended;
2. The individual may express a persistent desire to cut down or regulate substance use and may report multiple unsuccessful efforts to decrease or discontinue use;

3. The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects;
4. The individual may experience an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug was previously obtained or used (craving);
5. Recurrent substance use may result in failure to fulfill major role obligations at work, school, or home;
6. The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance;
7. Important social, occupational, or recreational activities may be given up or reduced because of substance use;
8. Recurrent substance use may take place in situations where it is physically hazardous;
9. The individual may continue substance use despite knowing they have a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance;
10. The individual may require a markedly increased dose of the substance to achieve the desired effect or may experience a markedly reduced effect when the usual dose is consumed (tolerance);
11. The individual may develop withdrawal symptoms, after which the individual is likely to consume the substance to relieve them.

The presence of two or three criteria suggests a mild substance use disorder; four or five indicate a moderate disorder; six or more indicate a severe disorder.

Both the DSM-5-TR's criteria and the definition proposed by Zimring and Hawkins differ from those formulated by researchers who study the psyche through its physical counterpart—the brain.

In 1997, the journal *Science* published an article by Alan Leshner, a psychologist and then director of the National Institute on Drug Abuse (NIDA), which may be considered the manifesto of the so-called Brain Disease Model of Addiction. The title of the article leaves little room for interpretation: *Addiction Is a Brain Disease, and It Matters*. Leshner writes:

> *Although each drug that has been studied has some idiosyncratic mechanisms of action, virtually all drugs of abuse have common effects, either directly or indirectly, on a single pathway deep within the brain. (…) Activation of [the mesolimbic reward system] appears to be a common element in what keeps drug users taking drugs. This activity is not unique to any one drug; all addictive substances affect this circuit.* (Leshner 1997, p. 46).

While Zimring and Hawkins (and a good part of the criteria provided by the DSM-5-TR) focus on behavior—that is, on the individual and their social roles—to define addiction, an important figure in physiological psychology such as Leshner instead focuses on the neural circuits (and short circuits) presumed to underlie such behaviors.

A similar approach has been adopted by Nora Volkow, director of NIDA since 2003, who has devoted years of research to the biological roots and brain mechanisms of addiction. Using new technologies and neuroimaging techniques, particularly Positron Emission Tomography (PET), Volkow observed and compared the brains of healthy subjects with those of chronic drug users (such as cocaine and methamphetamine users), but also with those of pathologically obese individuals. She found several analogies between those who develop drug addictions and those who engage in compulsive eating behaviors (Volkow et al. 2017).

The study of the same phenomenon by different disciplines can generate divergent interpretations, giving rise to misunderstandings, tensions, and

accusations of reductionism or determinism. There is also a widespread concern that systemic problems may be pathologized and medicalized, thereby individualized and depoliticized.

Although clinical psychiatry, criminology, and neuroscience offer different perspectives, their definitions are not ideologically neutral: each carries implicit assumptions about addiction, personal responsibility, and the appropriate forms of intervention. Whether addiction is framed as a behavioral disorder, a brain disease, or a socially embedded phenomenon leads to very different regulatory and policy responses—criminalization, medicalization, or social support. Thus, the way addiction is conceptualized not only shapes scientific discourse but also determines the design and justification of public policies.

In light of these complexities, a multidisciplinary and integrated approach has become not only desirable but necessary—an approach explicitly recognized and promoted by the most recent national and international drug action plans, which emphasize the need to combine medical, psychological, and social perspectives in addressing drug-related issues.

Prohibition, legalization, control

Beyond the concept of drug, other key terms that require clarification are «prohibition» and «prohibitionism». Let us again borrow the words of William McAllister:

> *Observers frequently use* prohibition *when* control *more accurately reflects the design of legislation and other measures. Control denotes regulation, restriction, and/or limitation, but not proscription. At both the national and international levels, substances are rarely banned altogether.* (McAllister 1999, p. xv)

To speak simply of prohibition is, in fact, a simplification. However, it cannot be ignored that this terminology has been in common use for over a century, rooted in the very provisions that have historically regulated—and continue to regulate—the matter: the verb «prohibit» and the noun «prohibition» appear repeatedly in the articles of the First and Second International Opium Conventions (The Hague, 1912; Geneva, 1925), as well as in the Single Convention on Narcotic Drugs and the Convention on Psychotropic Substances.

The current system can rightly be called prohibitionist because the production, importation, exportation, sale, and other dealings in scheduled substances are generally prohibited, and permitted only under specific conditions, for specific purposes, and by authorized actors.

In this sense, the term «control» is more accurate but also more generic. According to the definition provided in the introduction to *The Gentlemen's Club*, it encompasses:

> *all those factors which bear on the legal, economic, and physical (the "real") availability of drugs to the individual; it embraces all efforts, whether penal, preventive, educational, or therapeutic.* (Bruun et al. 1975, p. 4)

Thus, the potential overcoming of prohibitionism—and the likely fragmentary transition toward alternative models such as depenalization, decriminalization, or legalization—would not entail an abandonment of control over the production, trafficking, possession, and consumption of certain substances. Rather, it would signal the redefinition of control: from a punitive and exclusionary system to one based on public health, harm reduction, and social justice. Control, therefore, would persist, but through different tools and rationales.

Even within the most radical and libertarian anti-prohibitionist utopia—or rather, dystopia—in which branded packages of cocaine and heroin might be found on supermarket shelves, there would still be laws: laws governing product quality standards, taxation levels, and mandatory consumer information; laws safeguarding essential services and the right to health, including for people who use drugs; laws regulating educational and prevention programs involving schools, healthcare personnel, and the third sector. Moreover, criminal laws would remain in place to prohibit the unauthorized production and sale of substances, to sanction public consumption and driving under the influence, and to restrict sales to minors.

The transition from the current prohibitionist regime to alternative models would therefore not involve the end of state intervention, but rather its reconfiguration toward objectives that are hopefully more compatible with public health, human rights, and sustainable development. Successfully managing this transition would require a careful balance between reducing the harms of criminalization and preventing the uncontrolled commercialization of drug markets.

Thus, much like the term «prohibition»—which carries a hyperbolic value, since no drug is prohibited without exception—the term «legalization» is itself extremely vague, acquiring concrete meaning only through the specific laws that would govern the production and distribution chains, define mechanisms for controlling supply and demand, and delineate the role of public authorities, the market, and what has sadly become the «stone guest» of every political and institutional debate: profit.

Purpose, method and summary

As of today, October 31, 2024, the number of States Parties to the Single Convention on Narcotic Drugs (1961), the Convention on Psychotropic Substances (1971), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988) stands at 186, 184, and 192, respectively. This near-universal adherence may contribute to concealing, particularly in the eyes of the general public, the profound crisis currently afflicting the system— obscuring both the vested interests that shaped the drafting of each treaty and the political tensions that preceded and followed their adoption.

Drug policies, much like any other legal framework—and perhaps more so—are not the product of an immaculate conception: they are intrinsically political constructs, shaped by specific historical and ideological contingencies, and therefore far from neutral. The aim of this book is therefore to retrace the historical evolution of the current international drug control regime and to examine the economic, social, and public health factors that have influenced its formation and development. It seeks to compare the objectives formally declared in international conventions, national legislation, and the rhetoric of the regime's proponents with the more opaque and contested aims discernible in other sources, as well as with the unsatisfactory outcomes observed to date.

In recent years, the prohibitionist paradigm has come under growing and sustained scrutiny. What initially appeared as a gradual and incremental erosion of the regime has evolved into more assertive policy shifts, particularly by those States that, in explicit contravention of the Single Convention, have legalized the production and distribution of cannabis. This trend has been further compounded by a significant institutional development: the 67th session of the Commission on Narcotic Drugs

marked an unprecedented departure from the longstanding practice of consensus-based decision-making, with several resolutions adopted, for the first time, through majority voting.

Still too little to announce a requiem? Almost certainly, yes. However, as Caroline Chatwin (2018, p. 1) notes, many theories of regulatory change maintain that norms often experience long periods of stability and gradual adjustment before a «window of opportunity» opens for rapid and substantial change—and for drug policies, such a juncture may be imminent or already underway. This is not merely a theoretical possibility: a growing number of scholars, activists, civil society organizations, NGOs, and representatives of both national and international institutions are actively working to seize this moment, advocating for a radical rethinking of the current paradigm.

If this is indeed the case—if a paradigm shift is truly on the horizon—we must ask ourselves: what comes after prohibition? If the drug-free world envisioned in 1998 by the United Nations International Drug Control Programme is neither feasible nor, perhaps, even desirable, what is the best alternative?

The failure and eventual collapse of the prohibitionist regime would bring both opportunities and risks. This is why understanding the history of drug policies and identifying the drivers that have guided their evolution is critical: because without preparation or with naïve optimism, the errors and tragedies of the past—and even of the very recent past—could be repeated. Unlike Marx's famous observation in *The Eighteenth Brumaire of Louis Bonaparte*, in this case, history would not repeat itself first as tragedy and then as farce, but rather as tragedy once more.

If change does come, it will be crucial to ensure that the new regulatory framework is built upon the respect for and protection of human rights, and that its primary objective is the well-being of peoples and individuals. This

imperative aligns with the principles of the 2030 Agenda for Sustainable Development, which calls for inclusive, equitable, and evidence-based policies in pursuit of health, justice, and social equity. We must ensure that reform is not driven merely by the profit motives of multinational corporations and shareholders, and that a new system does not become yet another tool of colonial and social oppression.

Historical analysis is thus not only a lens through which to understand the present, but also a resource for shaping a more just and sustainable future—one that avoids repeating the mistakes of the past.

Nadelmann's model

In retracing the evolution of international drug policies, this book adopts the five-stage model theorized by Ethan A. Nadelmann in his seminal 1990 article, *Global Prohibition Regimes: The Evolution of Norms in International Society*, published in *International Organization*.

Nadelmann focuses on a specific category of international norms—those that aim to prohibit certain conduct domestically, through criminal law, and internationally, through the creation of prohibitionist regimes. Such regimes limit state sovereignty, constrain states' power to authorize or participate in the prohibited conduct, and impose obligations of cooperation and standardization of control activities.

According to Nadelmann (1990, p. 481), the emergence and consolidation of an international prohibitionist regime require that the targeted conduct possess a transnational dimension. While domestic crimes such as murder or theft are almost universally condemned, they do not typically require international control mechanisms; extradition treaties usually suffice. In contrast, phenomena like drug trafficking necessitate international coordination because domestic countermeasures and bilateral agreements

prove inadequate: no single government can effectively patrol the seas, skies, and foreign territories without infringing upon other states' sovereignty. A prohibitionist regime serves to standardize national laws, minimize or eliminate safe havens for offenders, and coordinate enforcement efforts across borders. Without such a regime, domestic laws would risk remaining largely ineffective.

Over the past two centuries, various activities once tolerated—including piracy, human trafficking, counterfeiting, money laundering, and the trade in protected species—have become the subject of international prohibitionist regimes. The formation of these regimes has often been driven by the economic and political interests of dominant powers, but has also been shaped by religious, humanitarian, and moral motivations—sometimes overlapping, sometimes clashing with one antother (Nadelmann 1990, pp. 480, 484).

The development of such regimes has been neither linear nor uniform. Rather, it unfolds as a gradual and often discontinuous process, marked by shifts in geopolitical leadership, alternating periods of inertia and reform, and moments of both progress and regression. Nadelmann identifies five evolutionary stages, the last of which—defined by the disappearance or significant reduction of the prohibited activity—remains more an aspirational goal than a predictable outcome.

This book adopts Nadelmann's model as a central analytical framework, examining how the international drug control regime has traversed these stages and where it currently stands. In the final chapter, building upon this framework, I propose a critical extension of the model: the hypothesis that the persistent failure to attain the fifth stage may signal the emergence of a sixth, which I refer to as *remission*. While this extension departs from the formal structure outlined by Nadelmann, it remains in continuity with some

of his own reflections on the potential trajectories of normative decline and regime transformation. This stage would not entail the abandonment of regulatory control, but rather its substantial redefinition, marked by a transformation in objectives, instruments, and symbolic logics.

The analysis will explore how this potential sixth stage is beginning to materialize—albeit unevenly—through national-level reforms, intensifying international tensions, and the contested reframing of drug policy narratives. It will also assess the opportunities and risks that such a transition might entail, particularly in a global context where commercial imperatives often prevail over social and humanitarian considerations.

Structure of the book

The first chapter examines the first three stages of Nadelmann's model. It explores how the perception of drugs and their use changed: substances that for millennia served as food, spiritual aids, and therapeutic tools came to be constructed as problems—public health problems, but not only. It investigates the moral and religious demands that animated early prohibitionist activists, as well as the economic and geopolitical interests behind the strategies of major international players and their ruling classes. We will witness the failure of the League of Nations, the outbreak of conflicts that redefined global balances, and the consequences that these adjustments had on international drug policy.

The second chapter addresses the fourth stage of Nadelmann's model: the global entrenchment of the prohibitionist regime. From the ashes of World War II, a new international order will emerge—tragically similar, in many respects, to the old one, rife with latent tensions and subject to the will of the strongest. It analyse the political and diplomatic processes that led to the drafting, signing, and ratification of the Single Convention on Narcotic

Drugs (1961), the Convention on Psychotropic Substances (1971), and the Convention against Illicit Traffic (1988). Particular attention is devoted to developments in the United States, including the Nixon and Reagan administrations, the racial dynamics underpinning drug policy, the boom in drug trafficking, and the devastating impact of the AIDS epidemic.

The third chapter examines the crisis of the conventional regime. It shows how the optimism that characterized much of the international community in the 1990s gave way to the emergence of an increasingly heterogeneous front, critical of the existing system and prepared to engage in open defiance. The analysis addresses the tragedy of the opioid epidemic that continues to ravage the United States and Canada, discussing its causes and the lessons that can be drawn from it. The chapter questions the compatibility of the drug control system with its declared goals, evaluating its economic and social benefits and costs—both expected and unexpected, desired and undesired. It further assesses the system's impact on public spending, public health, security, human rights, and the environment, and reviews the harm reduction policies adopted by many countries to mitigate the damage caused by the criminalization of drug use and of cultivation and possession for personal use.

The final chapter is dedicated to the conclusions. The debate over how to regulate drug use and trafficking remains open—not only because of the intrinsically interdisciplinary nature of the issue but also because, as William B. McAllister has pointed out, «the "drug problem" cannot be solved but only managed» (1999, p. x). This chapter draws on the lessons of history and the critical analysis of regulatory change to identify both the opportunities and the risks presented by the profound crisis of the prohibitionist regime. It examines the factors that hinder reform and those that could facilitate it, discusses the national and international alternatives currently in play, and

reaffirms the principles that must be upheld to avoid repeating past catastrophes. Above all, it stresses that the end of prohibition does not mean the end of control—but rather, the possibility of achieving a better, more just form of control.

The rise of the question

The age of innocence

The establishment of a global prohibition regime is a process that can span decades, characterized by discontinuous development, shifts in geopolitical leadership, and alternating periods of stagnation, missteps, and rapid progress. Building upon the theoretical framework outlined by Ethan A. Nadelmann, this chapter addresses the first three stages of the evolution of international drug control regimes.

It therefore retraces the history of drug policies and their prohibition from what can be termed the "age of innocence"—a time when drug consumption was not yet, or not yet perceived as, a social problem—through to the Second World War, when drug use, cultivation, production, and trafficking were increasingly labeled as public issues and became central concerns in international diplomacy.

Nadelmann writes:

> *During the first stage, most societies regard the targeted activity as entirely legitimate under certain conditions and with respect to certain groups of people; states often are the principal protagonists and abettors of the activity; and the central constraints on involvement in the activity have far more to do with political prudence and bilateral treaties than with moral notions or evolving international norms.* (Nadelmann 1990, p. 484)

The history of drug use predates not only the agricultural revolution but history itself: men and women began consuming consciousness-altering

substances before any written record could document the phenomenon (Kleiman et al. 2011, p. xviii).

Drug use has spanned thousands of kilometers and thousands of years: thirteen thousand years ago, the inhabitants of Timor consumed areca nuts containing arecoline, a natural alkaloid similar to nicotine; centuries, or perhaps millennia, before European colonization, plants containing nicotine were used in Australia and the Americas, while qat, a shrub containing an amphetamine-like alkaloid, was consumed in Ethiopia and North Africa. The use of coca leaves by the Andean peoples dates back approximately seven thousand years. Archaeological evidence suggests that European populations have been producing alcoholic beverages based on honey, fruit, and sometimes cereals since at least the Bronze Age. Other examples include the historical use of coffee, cannabis, hallucinogenic cacti, and mushrooms—all of which have traditions spanning centuries (Saah 2005; Sherratt 1995, p. 24).

Unlike today's world, the use of these substances was only rarely motivated by purely recreational purposes. Many ancient civilizations viewed psychoactive plants primarily as food resources: in addition to being rich in proteins, minerals, and vitamins, such plants provided greater energy, resilience to fatigue and climatic variations, and increased tolerance to hunger. These advantages were crucial for survival during migrations, periods of scarcity, and arduous labor.

Even when substances were used to achieve intoxication, the aim was not necessarily recreational in the modern sense: often, cultures did not sharply distinguish between the "normal" waking state and "altered" states of consciousness induced by sleep or psychoactive substances. Experiences obtained during intoxication or dreams were considered equally real, albeit related to a different plane of existence (Inglis 1975). Drugs thus became a

means to access the divine, the metaphysical, the universal—and in many cultures, they continue to serve this purpose.

As Erich Goode summarized:

> *Humans have been ingesting drugs for thousands of years. And throughout recorded time, significant numbers of nearly every society on earth have used one or more drugs to achieve certain desired physical or mental states. Drug use comes close to being a universal, both worldwide and throughout history.* (Goode 2008, p. 176).

Opium: a special case

Among these substances, we have not yet mentioned opium—a deliberate omission, given its crucial role in the history we are about to recount.

Opium is obtained by scoring the immature seed capsules of the *Papaver somniferum* plant and collecting the latex that emerges. Seeds and capsules of *Papaver somniferum* have been found in a Neolithic village in Switzerland (Booth 1998), although it remains unclear whether its inhabitants understood the narcotic properties of opium.

However, we know with certainty that the Sumerians, around five thousand years ago, were aware of its properties. The Ebers Papyrus—named after its 19th-century European purchaser, Georg Ebers—dating back to around 1550 BCE, recommends opium-based remedies for various ailments.

Opium was well known in Ancient Greece: Hippocrates prescribed it as a purgative, a narcotic, and a treatment for leucorrhoea (Macht 1915). However, it is likely that during Hippocrates' time, the full analgesic potential of opium was not yet understood (Prioreschi et al. 1998). By contrast, the Roman physician Aulus Cornelius Celsus, author of *De Medicina*, regarded as the first complete medical treatise in Latin, appears to have been aware of its

pain-relieving properties, for which he developed several opium-based preparations.

About a century later, his illustrious successor Aelius Galenus (also known as Galen) understood both the therapeutic potential of opium and its dangers: he warned against abuse, a problem that would tragically afflict one of his most renowned patients, Emperor Marcus Aurelius (Africa 1961, pp. 98–99).

With the fall of the Roman Empire, opium usage declined in Europe. However, through the works of Dioscorides Pedanius, the knowledge of Greek and Latin medicine was preserved, adopted, and further developed by Muslim civilization. At the height of its expansion, through trade and conquest, this civilization spread the use of opium to regions that, centuries later, would become epicenters of the problems of drug production and addiction—namely India and China.

Between trade, sovereignty and temperance

The emergence of non-occasional, compulsive drug use — what we commonly refer to as addiction — is not a timeless or universal phenomenon, but rather a relatively recent development rooted in specific historical transformations. A constellation of technical, economic, social, and cultural changes has created the conditions for drug use to become problematic for a subset of individuals.

Nadelmann continues:

> *During the second stage, the activity is redefined as a problem and as an evil - generally by international legal scholars, religious groups, and other moral entrepreneurs - and explicit government involvement in the activity is gradually delegitimized, although many individual governments continue to tolerate or even sponsor the involvement of private groups and individuals in the activity.* (*Ibid.*, p. 485)

Between the seventeenth and eighteenth centuries, global trade experienced a phase of extraordinary expansion: the reduction in storage and transport costs, the development of more sophisticated distribution methods, and the structuring of specialized, economically robust companies contributed to the birth of a new era of commercial exchanges and cultural interactions. Among the countless goods moving across continents were chocolate, tea, coffee, tobacco, alcohol, and other psychoactive substances—products that generated immense profits through taxation and monopolistic regimes (McAllister 1999, pp. 9–10), especially for the colonial powers that controlled entire supply chains, from the acquisition of low-cost raw materials to the distribution of finished goods.

It was within this context of mercantile fervor that, at the end of the 1830s, the Chinese imperial government attempted to block the importation of

opium from India, then under British control. This was not China's first attempt: the first ban on opium dates back to 1729, when Emperor Yongzheng of the Qing Dynasty prohibited the recreational use of madak (Fay 2000, p. 73), a mixture of opium and tobacco whose consumption had become increasingly widespread in China. Over the years, successive edicts prohibited the use, cultivation, importation, and sale of opium, yet consumption continued to rise: while approximately two hundred chests of opium were imported in 1729, between 30,000 and 40,000 chests were imported annually between 1830 and 1839[2] (Brown 2002, pp. 629–630), alongside an increase in domestic production (International Anti-Opium Association 1922, pp. 14–16).

It is important to note that, for the Celestial Empire, the primary concern regarding the growth of the opium trade and consumption was not initially public health, but rather the balance of trade:

> *(…) it was mainly the threat to sovereignty, and the economic crisis due to the loss of silver specie that precipitated vigorous Chinese action against the import and spread of the drug.* (Brown 2002, p. 630)

This does not mean that the social, health, and moral consequences of opium use were neglected by the Chinese authorities. Although references to the opium poppy appear in Chinese sources as early as 618 CE, the arrival of the more potent Indian opium and the practice of smoking rather than ingesting it—thereby intensifying its effects and addictive potential (Brown 1973, pp. 99, 104)—made the substance's harmful effects increasingly evident (Fay 2000, pp. 73–74). Nonetheless, as frequently occurs in history, economic considerations ultimately carried more weight in shaping political

[2] Each chest contained approximately 60-65 kilograms of opium (UNODC 2009b, p. 19).

strategy: the primary objective of the Chinese imperial government was to stem the outflow of silver and prevent the erosion of national sovereignty.

A parallel argument can be made regarding the British Empire. During the eighteenth and early nineteenth centuries, Britain imported vast quantities of spices, rice, porcelain, silk, cotton, tea, and other goods from China. In exchange, China accepted only silver and precious metals, showing no interest in Western manufactured goods or technologies (Nencini 2017, p. 57). The burgeoning popularity of opium among the Chinese offered Britain a partial solution to its trade deficit (McAllister 1999, pp. 9–10).

Long managed by the Portuguese through their possession of Macao, the opium trade came under the control of the East India Company in 1773. The Company controlled the entire production of Indian opium and held a monopoly on trade with China granted by the British Parliament. As Paolo Nencini explains:

> *(...) the Company avoided using its own ships to ship the drug to China because, since its importation was illegal, it could have endangered the other trade, the very lucrative tea trade, which was the absolute monopoly of the Company itself. The opium was therefore sold, through public auctions in India, to private merchants, mainly English but also Indian, who resold it to Chinese traffickers in Canton and along the Chinese coast.* (Nencini 2017, p. 54)

With the moral support of the Crown, the logistical support of merchants and traffickers, and the cooperation of corrupt customs officials, the flow of opium into China continued to increase. What had once been a British problem—the depletion of silver due to the large trade deficit—thus became a Chinese problem.

Strategies for responding to the crisis were debated within the imperial court: some officials proposed legalizing opium to moderate its price and increase tax revenues, an approach similarly advocated by British diplomats. Dissatisfied with the stagnation of its commercial expansion in the East, the British Parliament had revoked the East India Company's monopoly and dispatched Lord William John Napier to convince China to legalize opium and open additional ports to British ships beyond Canton (Brown 2002, p. 631). Napier's mission, however, ended in failure: Emperor Daoguang issued new, more severe laws, punishing both traffickers and consumers with death, and appointed the resolute and incorruptible official Lin Zexu to enforce them.

The Opium Wars and the Treaties of Nanking and Tientsin

In 1839, Lin Zexu ordered the arrest of all British merchants residing in Canton, seized the opium stored on ships anchored in the river, sold part of it for the benefit of the treasury, and destroyed the remainder (Arminjon 1884, pp. 334–335; Nencini 2017, pp. 58–59). This assertive move by Lin Zexu was perceived by Britain not merely as an affront to its commercial interests, but as a direct challenge to its imperial prestige and expanding global influence. It led to the outbreak of the first of two Opium Wars, fought respectively from 1839 to 1842 and from 1856 to 1860, both culminating in the defeat—and, to a significant extent, the humiliation—of the Chinese Empire through the Treaties of Nanking (1842) and Tientsin (1858).

Under the Treaty of Nanking, followed in 1843 by the supplementary Anglo-Chinese Treaty of Hu-men-chai, Britain obtained twenty-one million dollars in war reparations, sovereignty over Hong Kong, the opening of the ports of Canton, Amoy, Foochow, Ningpo, and Shanghai to international trade, highly favorable customs tariffs, and the immunity of British citizens

from the Chinese judicial system (Brown 2002, p. 631; Nencini 2017, pp. 60–61). However, the legalization of the opium trade was not yet secured.

The Treaty of Tientsin, signed not only by China and Great Britain but also by France, Russia, and the United States, further entrenched Western privileges: it imposed new war reparations, revised customs duties in favor of the Western powers, affirmed the freedom of movement and trade for foreigners throughout Chinese territory, and opened eleven additional ports to foreign trade. Although the opium trade was not explicitly mentioned, the subsequent Shanghai Accords and the Peking Convention of 1860 effectively established a de facto legalization, institutionalizing what military force had already rendered unavoidable.

Richard H. Brown succinctly summarizes the situation:

> *Thus, the history of opium use in China is a story of the impotence of state edicts when opposed by powerful economic interests backed by military force. For 130 years beginning in 1729, the opium trade in China was illegal, yet it expanded continuously. By 1859, it had been legalized. At one point, India's exports of opium to China provided an estimated 14 per cent of the official revenue for British India.* (*Ibid.*)

The collapse of Chinese sovereignty over its own territory and trade policy was emblematic of broader patterns of imperial domination that would reshape Asia in the nineteenth century.

Within just a few decades, however, the balance of power and the underlying interests shifted dramatically. The epicenter of this transformation was, according to Nadelmann (1990, p. 503), Great Britain.

From Imperial Interest to Moral Awakening

While one might be tempted to argue that the transition from the first to the second stage in Nadelmann's model had already taken place in China during the early eighteenth century, such an interpretation would risk overlooking a crucial aspect of his framework. It is true that, in China, the traffic and consumption of opium had already been «redefined as a problem and as an evil», and that the involvement—or at least the tolerance—of the imperial authorities, who had included opium among taxable goods as early as 1589 (Yongming 1999, p. 11; UNODC 2008, p. 19), was gradually delegitimized. However, these efforts—although sincere and persistent—would not have led to the establishment of a prohibition regime on a global scale.

As Nadelmann points out:

> *Virtually all of the norms that are now identified as essential ingredients of international law and global society have their roots in the jurisprudence of European scholars of international law and in the notions and patterns of acceptable behavior established by the more powerful Western European states.* (Nadelmann 1990, p. 484)

The emergence of global prohibition regimes is therefore not merely the result of moral disapproval or domestic prohibition efforts, but of the ability of hegemonic powers to elevate their own normative frameworks to the level of international standards.

From this perspective, the actual shift from the first to the second stage in the evolution of the global drug control regime occurred not in Qing China but in late-nineteenth-century Britain, when the opium trade began to be challenged from within the imperial core. According to Nadelmann, opposition to the trade first emerged during the Opium Wars and gained

momentum as the century progressed. Much like the abolitionist movement, it was the British Quakers who quickly assumed a leading role as moral entrepreneurs of the anti-opium cause. In 1874, they founded the Anglo-Oriental Society for the Suppression of the Opium Trade, which over the following four decades would play a crucial role in mobilizing public opinion, engaging in religious and humanitarian advocacy, and lobbying Parliament to end the trade.

The campaign led by Quakers, missionaries, and liberal parliamentarians did not merely express a moral awakening. Rather, it coincided with and was reinforced by a broader set of economic, strategic, and ideological realignments within the British Empire. It was this convergence of moral discourse and imperial capacity that ultimately marked the transition to a new phase in the genealogy of prohibition. Beginning with the outbreak of the First Opium War and, more markedly, from the 1870s onward, the British government faced mounting internal opposition to the moral, economic, and geopolitical foundations of its opium policy. This internal front would ultimately prevail, leading in 1906 to a formal commitment by the newly elected Liberal government, led by Sir Henry Campbell-Bannerman, to end opium exports from British India to China (Nadelmann 1990, p. 504).

To fully assess the extent to which this shift represented a «triumph of moral (religious and humanitarian) impulses over political and economic interests» (ibid.), it is necessary to take a step back and evaluate the broader factors that contributed to changing the historical and geopolitical landscape.

While the official prohibition of opium poppy cultivation remained in force in China, after repeated failures to block imports, the imperial authorities gradually shifted their position: they first tolerated, and then actively encouraged, domestic production in an effort to stem the haemorrhage of silver (Brown 1973, pp. 99–100).

Meanwhile, Persia's economy, unable to compete with European manufactured goods, fell into crisis; this led many Persian farmers to convert their fields to the cultivation of *Papaver somniferum*, from which opium was extracted and exported in increasing quantities throughout the latter half of the nineteenth century (McAllister 1999, p. 13). Despite being under British control, Malaysia also became a significant supplier of low-cost opium to China (ibid.).

The expansion of domestic Chinese production and the growth of alternative sources of supply meant that British India's revenues from opium exports slowly but steadily declined. As a result, the idea of abandoning the opium trade altogether became less heretical with each passing year (Brown 1973, p. 104).

This does not mean, of course, that the campaign to abolish the opium trade was simple or that its success was inevitable. Many anti-opium movements had emerged and disappeared within short periods, and even the Anglo-Oriental Society for the Suppression of the Opium Trade—the organization that would prove most influential—did not enjoy a particularly promising start (Brown 1973, p. 100).

What likely made the difference was the substantial economic and political support provided by the Pease family, a dynasty of Quaker industrialists whose investments spanned manufacturing, banking, railways, and mining. Their influence was amplified by the presence of several family members in the British Parliament, including Sir Joseph Whitwell Pease, who would later become president of the Society.

Another key factor in the Society's success was its alignment—whether organic or partly strategic—with prevailing British imperialist and colonialist ideologies. As J.B. Brown reports:

> *(…) the anti-opium movement advocated the abolition of the drug's production precisely on the grounds that termination would make British imperialism more efficient. The (Anglo-Oriental) Society claimed that drug addiction had retarded the advance of "legitimate trade" and of Christianity in both India and China.* (Brown 1973, p. 98)

There was, in fact, an internal division within the British capitalist class regarding the opium issue. The aforementioned growth in domestic opium production in China offered easy leverage to Indian opium traders and their representatives within British institutions: according to many parliamentarians—primarily Tories—such as George Curzon, the future Viceroy of India and British Foreign Secretary, without Indian opium the Chinese would simply have continued to consume the lower-quality domestically produced opium (Curzon 1894, p. 304; Brown 1973, p. 103). Thus, the true victims of a crusade against the opium trade, they argued, would have been Indian citizens, who would face the bankruptcy of their government (ibid.).

On the other side, opponents of the opium trade contended that the diffusion of opium was draining China's silver reserves and contributing to the stagnation of British exports of other goods to the East (Brown 1973, p. 102).

As previously mentioned, there was also widespread concern that the opium trade constituted a major obstacle to the evangelization of China, as the Chinese population found it difficult to distinguish missionaries from opium traffickers (ibid.). This concern was explicitly articulated in a letter published in October 1897 in *The Friend of China*, a periodical edited by the Anglo-Oriental Society, which stated:

> *(…) the past history and present enormous extent of the Opium Trade with India produces…suspicion and dislike in the minds of the Chinese people towards foreigners and is thus a serious hindrance to their reception of the Gospel.* (Lodwick 1996, p. 61)

The reflections of several members of the Society were, however, marked by a substantial degree of paternalism. According to Donald Matheson, only external intervention could save the Chinese from opium addiction, as they allegedly lacked «the moral and Christian energy necessary to break their own slavery» (Matheson 1857, p. 15; Brown 1973, p. 101). Similarly, Joseph G. Alexander asserted that: «It is the hard working Chinese…who ask to be protected from themselves in this vice of opium»[3] (Brown 1973, p. 110).

It would not be correct, however, to suggest that the campaign for the suppression of the opium trade was merely the result of internal conflicts within the capitalist class converging with paternalistic demands and the strategies of religious proselytism. It is undeniable that many members of the Anglo-Oriental Society for the Suppression of the Opium Trade were driven by sincere humanitarian concerns: Donald Matheson and Joseph G. Alexander stand as particularly notable examples of this spirit.

Matheson came from a wealthy family that co-owned Jardine, Matheson and Co., a company engaged in the trade of tea, silk, and a variety of other goods, the most lucrative of which was Indian opium. This was not just any company: it was the one that, at the end of the monopoly regime, secured the largest share of the opium market formerly controlled by the East India Company. Indeed, Jardine, Matheson and Co. had played a decisive role in pressuring Lord Palmerston, then Foreign Secretary, to initiate the First Opium War, effectively dictating its strategic objectives (Grace 2014, p. 259 e ss.).

[3] *The Times*, May 19, 1908.

From a strictly personal and utilitarian perspective, Donald Matheson would have had every incentive to defend such a profitable enterprise. Yet he explicitly and publicly dissociated himself from it:

> *In short, every Christian who will examine the matter, will find that the opium trade with China cannot for one moment be defended on Christian principles; and that by applying such a test, it is at once disclosed to view as an evil which is devastating the East, and of which he, if he is engaged in it, should wash his hands at all hazards.* (Matheson 1857, p. 17)

As for Joseph G. Alexander, honorary secretary of the Society, the genuineness of his dedication to the cause was recognized even by initially skeptical Chinese diplomats. Among those he encountered during his travels in the Celestial Empire were Zhang Zhidong, Viceroy of Liangjiang and future member of the Grand Council; Tsai Sih-ying, senior official of Wuchang and assistant to Zhang; Chang Yin-hwan, president of the Board of Revenue; and Li Hongzhang, Viceroy of Zhili and Minister of Commerce of Beiyang (Alexander 1894, p. 91; Lodwick 1996, p. 58).

Alexander personally observed the near-unanimous condemnation of the opium trade among diplomats and missionaries and emphasized the empirical and non-ideological basis of their opposition:

> *This cannot be the result of any bias due to their religion (…). The Chinese objection to Opium is solely derived from observation… It is based on moral, not on religious sanctions.* (Alexander 1894, p. 93)

From Moral Pressure to Political Reform

On 10 April 1891, the anti-opium camp achieved a major victory when the House of Commons passed a motion calling for an end to the sale of Indian

opium for purposes other than medical use (Mills, Barton 2007, pp. 131–132).

Two years later, in 1893, the British government led by Sir William Gladstone established the Royal Commission on Opium. The initial purpose of the Commission was to determine how best to minimize the financial damage resulting from the cessation of the opium trade and to assist the Indian economy during the transition. However, to avoid the risk of splitting his party, Gladstone amended the Commission's mandate: it would instead assess whether prohibition was advisable, economically viable, and supported within India (Madancy 2013, pp. 41–42).

The Royal Commission on Opium delivered its report in 1895. After two years of investigations—not entirely impartial (Woodcock 1995)—the Commission defended the existing monopoly system and the opium trade, downgraded the problem of consumption in China to an internal matter for the Celestial Empire, and compared moderate opium use in India to moderate alcohol consumption in Britain.

Impartial or not, the report of the Royal Commission was a severe blow to the prohibitionist movement, which rapidly lost enthusiasm and influence (Barop 2015, p. 123).

A decade passed before the British government reconsidered the issue. As was often the case, it was not humanitarian concerns but more cynical calculations regarding the precarious Chinese situation that altered the balance of interests.

Since 1839, the year of the outbreak of the First Opium War, China had endured a series of crises: in addition to the Second Opium War (1856–1860), the imperial government had faced the devastating Taiping Rebellion, a civil war lasting fourteen years (1851–1864) and costing an estimated

twenty to thirty million lives—nearly one-tenth of China's population (Platt 2012, p. xxiii).

In 1894, following years of tensions, the First Sino-Japanese War erupted. Japan, despite facing a larger Chinese army (Fairbank, Kwang-Ching 1978, pp. 268–269), emerged victorious within months, aided by its superior equipment (Jowett 2013, p. 27). As a result, China was forced to recognize the independence of Korea and cede the Liaodong Peninsula, Manchuria, Taiwan, and the Penghu Islands to Japan. Russia, France, and Germany seized the opportunity to extract territorial concessions and commercial privileges, aiming to check Japan's expansion (Iklé 1967, pp. 122–123).

At the turn of the twentieth century, the Boxer Rebellion further destabilized China, leading to foreign intervention by the Eight-Nation Alliance—comprising Germany, Japan, Russia, Britain, France, the United States, Italy, and Austria-Hungary—which occupied Tientsin and Beijing (Hunt 1979, p. 506) and imposed yet another "unequal treaty," the Boxer Protocol.

Although Britain had contributed significantly to China's long decline, by the early twentieth century its officials recognized that preserving Chinese territorial integrity better served British interests.

> *Officials in London generally agreed that Great Britain's interests were best served by maintaining Chinese territorial integrity. British sales and investments were more widespread throughout the Middle Kingdom than were those of any of her rivals.* (McAllister 1999, p. 24)

Although not the primary factor, opium consumption was considered one of several elements undermining China's internal stability.

The Chinese imperial government shared this view: in 1906, an imperial edict ordered the gradual suppression of opium cultivation, aiming for

complete eradication within ten years, with an annual 10% reduction in harvests. Imports were likewise to be reduced at the same rate.

In contrast to previous decades, the British government did not firmly oppose these measures. Although skeptical about China's ability to implement the plan, British diplomats initiated negotiations that culminated, in 1907, in the signing of the Ten Year Agreement: India would reduce opium exports to China by 10% annually, contingent upon a corresponding reduction in Chinese domestic production; London would appoint an inspector to monitor the progress in eradicating poppies, the first time in three years.

The Ten Year Agreement initially showed promising results: both China and India adhered to the reduction schedule and even exceeded initial expectations. The last legal shipment of opium from India to China took place in 1913 (ibid., p. 25).

However, the internal political landscape in China had changed dramatically. Between 1911 and 1912, the Xinhai Revolution overthrew the Qing Dynasty and established the Republic of China. The new central government soon struggled to assert authority over provincial warlords, many of whom financed their armies through the cultivation and trafficking of opium, leading to a resurgence of production (ibid.).

Meanwhile, global attention shifted elsewhere: in 1914, Europe plunged into the First World War.

The internationalization of the problem

The reasons that led to the redefinition of the opium trade and consumption as an evil—and the consequent characterization of governmental involvement in such trade as problematic—are, as we have seen, highly complex. In the transition from the first to the second stage of Ethan A. Nadelmann's model, factors such as economic and military power relations, colonialist mentalities, religious sentiment, and the moral postures of the protagonists of the debate all played a role whose individual weight is difficult to assess with precision.

What can be asserted with a reasonable degree of certainty is that, without an internal fracture within the British capitalist class—due at least in part, though perhaps not primarily, to divergent economic interests—and without the rapid transformation of the Asian geopolitical landscape, it is unlikely that the Treaties of Nanking and Tientsin would have been followed by a humanitarian-driven retraction.

The journey toward a global drug prohibition regime was only beginning. The twentieth century would witness the definitive ascent of the United States to the status of an economic and political superpower, along with its increasingly prominent role in shaping the international regulation of drug production, trade, and consumption.

Nadelmann writes:

> *During the third stage, regime proponents begin to agitate actively for the suppression and criminalization of the activity by all states and the formation of international conventions. The regime proponents include governments, typically those able to exert "hegemonic" influence in a particular issue-area, as well as transnational moral entrepreneurs. Their agitation takes many forms, ranging from the diplomatic pressures, economic inducements, military*

> *interventions, and propaganda campaigns of governments to the domestic and transnational lobbying, educational, organizational, and proselytizing efforts of individuals and nongovernmental organizations.* (Nadelmann 1990, p. 485)

As we shall see, the transition from the second to the third stage—like the previous transition—is neither a linear trajectory nor a politically, economically, or socially neutral process.

The pharmaceutical industry and the new medical class

At the dawn of the nineteenth century, the voluptuous consumption of opium was a marginal phenomenon in both Europe and the United States, but its therapeutic properties became the subject of increasingly advanced scientific studies.

Between 1804 and 1806, the German chemist and pharmacist Friedrich Wilhelm Adam Sertürner succeeded in isolating the most abundant alkaloid contained in opium: morphine (Coenen, Sertürner 1954; Mosher, Akins 2014, p. 142). Sertürner named the compound *morphium*, with a clear reference to Morpheus, the Greek god of dreams. He meticulously described the processes of isolation and crystallization, the crystalline structure, and the pharmacological properties of the alkaloid, before marketing it in 1817 both as a painkiller and as a treatment for opium and alcohol addiction.

One major advantage of morphine was the precision with which it could be dosed, especially compared to the crude drug from which it was extracted (Nencini 2017, p. 25). The success of morphine was further amplified by the French physiologist François Magendie, who published an article on its medicinal properties in 1818 and included it in his *Formulaire pour la préparation et l'emploi de plusieurs nouveaux médicaments* in 1821, illustrating procedures for extraction and salification (ibid.; Magendie 1818; Magendie 1821).

It was during the first decades of the nineteenth century that the traditional *apothecaries* began the professional transition into *pharmacists*. Many experimented with producing and selling morphine and other promising alkaloids. Among them was Heinrich Emanuel Merck, a German from Darmstadt, who began producing morphine with his own method in 1823 and, four years later, started supplying it to other pharmacies as well (Nencini 2017, p. 26). Thus, a spice shop purchased by Merck's ancestors in 1668 evolved into a pharmacy and eventually into the chemical and pharmaceutical enterprise that gave rise to Merck KGaA and Merck & Co., still two of the most influential companies in the sector today.

For decades, morphine and other opiate-based preparations were employed as analgesics and anesthetics, even in surgical contexts, as well as remedies for a range of conditions, including mental illnesses, delirium tremens, rheumatic pain, dysmenorrhea, and sexually transmitted diseases (Nencini 2017, pp. 27–30). They were also used as sedatives for children whose parents either could not or would not care for them adequately (ibid.). Their low cost contributed to their widespread use, particularly in industrialized and urbanized societies such as France, Britain, and the United States, where they quickly gained popularity as recreational substances competing with alcohol (ibid., p. 33)

The invention of the hypodermic syringe in 1855, despite its immense benefits for medical science, introduced two significant problems in morphine consumption: the increased risk of acute (and potentially fatal) intoxication due to the direct introduction of the substance into the bloodstream, and the extreme immediacy between administration and effect, which is now recognized as a major factor in the development of addictive behaviors (Nencini 2017, p. 34).

In the same year, the German chemist Friedrich Gaedcke first isolated cocaine, the active alkaloid contained in the leaves of *Erythroxylum coca*, a plant native to South America. In 1859, Albert Niemann, then a doctoral student at the University of Göttingen, improved the purification process and gave the alkaloid the name it bears today (Niemann 1860; Gootenberg 1999, p. 84).

Europeans were already familiar with coca, but its popularity had remained limited, partly due to the degradation of the raw material during long transoceanic voyages (McAllister 1999, pp. 14–15). German companies such as Merck solved the problem by establishing laboratories to extract cocaine alkaloids directly at the source in South America, thereby transporting only semi-finished products, which were easier to store and less perishable (Courtwright 2002, p. 48). By contrast, American pharmaceutical companies opted not to relocate any phase of production overseas but to import coca leaves directly, taking advantage of technological advances in transport and preservation and a tariff regime that made the import of the raw material advantageous compared to that of the semi-finished product (ibid., p. 49).

Coca cultivation was soon transplanted beyond South America: initially on a small scale in Europe and the United States, and then on a much larger scale in colonial territories. In 1875, two coca plants were introduced into the botanical gardens of Buitenzorg, on the island of Java, then a Dutch colony. Less than fifty years later, Java had become the world's largest exporter of coca leaves (Van der Hoogte, Pieters 2013, pp. 90–91), producing varieties with up to twice the alkaloid concentration of Peruvian coca (Courtwright 2002, p. 50).

As with opium-based preparations, the rapid expansion of production drove down the price of cocaine, allowing the three largest firms—Merck (Germany), Parke-Davis (USA), and Nederlandsche Cocaïne Fabriek

(Netherlands)—to dominate the market and operate under oligopoly conditions in a largely unregulated environment (Nencini 2017, pp. 47–48).

Manufacturers had no scruples about extolling cocaine's analgesic and stimulant properties. It was introduced into cigars, cigarettes, alcoholic beverages such as Mariani's Vin Tonique and Coca Cordial, non-alcoholic beverages such as Coca-Cola, as well as tablets, ointments, and nebulizers (Musto 1999, p. 7; Nencini 2017, p. 48). In the 1880s, demand for cocaine skyrocketed (McAllister 1999, p. 15)

Meanwhile, in 1874, the English chemist C.R. Alder Wright had synthesized diacetylmorphine for the first time. His debut was not very promising; small doses of diacetylmorphine were administered subcutaneously to some dogs and rabbits, causing, among other symptoms, prostration, fear, drowsiness, weakness, irregular heart activity (Wright 1874, p. 1043). Things changed twenty-three years later, in 1897, when the molecule was synthesized again, in the laboratories of Bayer, by the German chemist Felix Hoffmann, who just eleven days earlier had also synthesized aspirin[4]. It was Bayer itself, the following year, that introduced diacetylmorphine onto the market as an over-the-counter drug, to which it gave the trade name *Heroin*.

The introduction of heroin by Bayer in 1898 marked a turning point: presented as a powerful analgesic, an effective cough syrup, and a remedy for tuberculosis, bronchitis, asthma, and dyspnea (UNODC 1953). Unlike morphine, Bayer claimed, heroin did not induce addiction (Paladini et al. 2023, p. 2). The marketing was so persuasive that organizations like the Saint James Society proposed distributing free samples of heroin to morphine addicts seeking detoxification (White 2014, p. 1).

It did not take long, however, for health professionals to realize that heroin induced tolerance and, more importantly, severe addiction. Long before

[4] Hoffmann's paternity of aspirin is however disputed (Sneader, 2000).

physicians fully understood these risks, the euphoric effects of heroin had already captivated a growing population of users, creating a burgeoning demand that, when unmet by legitimate channels, was quickly exploited by traffickers seeking easy profits.

The first synthesis of amphetamine by Romanian chemist Lazăr Edeleanu dates back to 1887. However, the stimulant properties of amphetamine remained undiscovered until 1927, and its medical use was only recognized starting in 1933, when it was marketed as a decongestant under the trade name Benzedrine. Consequently, amphetamine did not significantly influence the early twentieth-century debates and conflicts surrounding drug regulation.

While the opium crisis had already profoundly impacted China in previous decades, the drug situation in the West underwent a phase of rapid transformation in the second half of the nineteenth century. Owing to the availability and accessibility of both traditional and newly synthesized substances and their diffusion among various segments of the population, the need for more rigorous control soon became evident.

> *By the early twentieth century, western societies generally viewed unrestricted drug availability and use with concern. (…) the question was not* whether *access to drugs ought to be regulated, but* what *level and type of regulation was appropriate.* (McAllister 1999, p. 16)

What had changed most significantly was the growing awareness of the dangers posed by certain substances. Friedrich Sertürner himself had revised his initial view of morphine: although he had originally hypothesized that morphine, being effective at low doses, would be less addictive than crude opium, by the end of his studies—and now personally addicted—he considered it his duty «to attract attention to the terrible effects of this new

substance I called morphium in order that calamity may be averted» (Offit 2017).

Similar concerns were expressed by George Dujardin-Beaumetz, a French physician, member of the Académie Nationale de Médecine, and director of the *Bulletin général de thérapeutique médicale, chirurgicale, obstétricale et pharmaceutique*. Dujardin-Beaumetz warned that morphine should only be administered when strictly necessary, as habitual use would not only render weaker analgesics ineffective but could also lead to the development of «the morphine habit», a dependency so entrenched that it would persist even after the initial need had disappeared (Nencini 2017, pp. 40–41).

From this perspective, the synthesis and commercialization of new analgesic drugs, such as aspirin, acetanilide, and phenazone (Brune 1997, p. 33), helped curb the overly widespread use of opioid analgesics (McAllister 1999, p. 16).

Alongside the growing awareness of health risks and the increasing levels of consumption (which will be discussed in more detail in the next section), another factor played a crucial role in the shift toward more stringent regulation: the professionalization of doctors and pharmacists, and the consequent political pressure exerted by their associations, seeking to consolidate prestige and exclusive control over the distribution of medicinal substances.

Nadelmann writes:

> *Also influential were the increasingly powerful associations of doctors and pharmacists, whose altruistic motives were closely intertwined with their financial and professional interests in better controlling and even monopolizing the public's access to medicinal advice and substances.* (Nadelmann 1990, p. 505)

After years of hesitation, the British Parliament passed the Pharmacy Act in 1868. Under this law, fifteen substances—including strychnine, potassium cyanide, ergot, arsenic, and opium—could only be sold by qualified professionals, and only in containers clearly bearing the seller's name and address. However, the legislation imposed no limits on the quantity that an individual could purchase or possess (Brown 2002, p. 634).

In the United States, a comparable federal statute, the Pure Food and Drug Act, would be enacted in 1906, almost forty years later. Scholars widely recognize the decisive lobbying efforts of professional associations such as the Pharmaceutical Society (Harding 1986; Holloway 1995), the American Medical Association (Law, Libecap 2004, p. 18), and the American Pharmaceutical Association (Musto 1999, pp. 13–15) in securing a privileged role for their affiliates in the distribution of controlled substances. Similar pressures would also significantly influence the drafting of the Harrison Narcotics Tax Act in 1914, to which we shall return later (Kaplan 1983, pp. 62–63; Zimring, Hawkins 1992, p. 57).

New awareness and newly emerging economic and social interests thus helped reorient the regulatory compass of Western nations. Nonetheless, the convergence of medical, political, and economic forces had not yet fully crystallized into the coherent international system that Nadelmann describes as the third stage of a global prohibition regime. As we will see, it would take further diplomatic, ideological, and geopolitical developments to complete this transformative process.

The spread of consumption

In both the United States and Europe, the use of opiates soared during the late nineteenth and early twentieth centuries. Among the groups most affected by problematic use were war veterans, healthcare workers and their

families, and women of all social classes, to whom opium derivatives were presented and sold as a panacea for virtually all female ailments (Nencini 2017, pp. 36–37). The iatrogenic etiology of a significant proportion of opiate addictions was therefore evident.

Cocaine followed a different trajectory. Having proven highly effective as a local anesthetic in surgery, cocaine quickly attracted the attention of physicians. Their enthusiastic uptake exhausted the initially limited supplies, driving prices upward and stimulating larger-scale production.

The success of cocaine was also tied to the prevailing zeitgeist, particularly the fervor for scientific and technological progress, which profoundly influenced the new, ambitious medical class:

> *Cocaine appealed to physicians not only because it promised better treatment for a variety of maladies, but also because it represented "progress" and modern scientific techniques that reinforced their specialist expertise.* (McAllister 1999, p. 15)

However, systemic use of cocaine—necessary for the development of addiction—remained sporadic and generally unsuccessful in clinical contexts (Nencini 2017, p. 46). Thus, it is likely that most cases of cocaine addiction originated from recreational, rather than therapeutic, use.

The dramatic collapse in price—from $280 per ounce in 1885 («an obstacle to all further experiments», as Sigmund Freud lamented) to approximately $3 in 1914 (Courtwright 2002, pp. 48–50)—certainly fueled the drug's diffusion. Despite its limited therapeutic value, cocaine lent itself to a range of uses.

The stimulant properties of coca leaves had been exploited centuries earlier by the Spanish conquistadores, who distributed them to subjugated Andean populations to increase endurance, suppress hunger, and boost the productivity of forced laborers (Zapata-Ortiz 1970, pp. 287–288; Musto

1999, p. 8). These properties were rediscovered by German military physician Theodor Aschenbrandt, who administered cocaine to soldiers and observed the same performance-enhancing effects (Nencini 2017, p. 43; Aschenbrandt 1883).

At the turn of the twentieth century, these stimulant effects found practical application among American steerage workers, construction laborers, and agricultural workers, particularly Black workers, who used cocaine to withstand grueling workloads (Nencini 2017, pp. 43–44; Courtwright 1995, p. 209).

Courtwright notes:

> *From the docks, construction sites and plantations cocaine spread to the Black underworld, where it flourished in the early twentieth century. A 1902 report from a Georgia correspondent to a special committee of the American Pharmaceutical Association declared that almost every coloured prostitute was addicted to cocaine.* (*Ibid.*)

Estimating the true extent of cocaine use among Black populations in the United States is a far from straightforward task. The available data from the period are disorganized by contemporary standards, and any analysis must account for the pervasive racist propaganda of the era. For instance, while the aforementioned 1902 report suggested near-universal addiction among Black prostitutes, a 1914 report indicated that among more than two thousand admissions of Black individuals to psychiatric hospitals in Georgia over the previous five years, only two were cocaine users (Green 1914; Musto 1999, p. 8).

As Courtwright astutely observes, however, the gap between reality and public perception often has little bearing on regulatory outcomes. Public

perceptions, even if exaggerated or false, can generate political pressure that ultimately shapes legislation:

> *Whenever use of a psychoactive substance is perceived to entail significant personal and public health problems, to cause crime (…) and to be associated with disliked or deviant groups, a public outcry is likely to ensue, to which politicians generally respond by enacting restrictions or outright prohibition.* (Courtwright 1995, p. 209)

Crucially, the rise in drug consumption coincided with accelerating urbanization processes in both Europe and North America. Expanding industrial cities created anonymous, densely populated environments where informal social controls were weakened and the distribution and use of psychoactive substances became easier to conceal and normalize.

The association of cocaine with Black individuals and homosexuals (Keire 1998; Nencini 2017, p. 49), of opium with Asian coolies, and of marijuana with Mexicans[5] undoubtedly contributed to the transformation of the public reputation of these substances. Their use was increasingly regarded—sometimes based on exaggerated fears but not entirely without foundation—as harmful both to individuals and to society at large. Whereas the consumption of and addiction to such substances had initially been primarily associated with war veterans and other members of so-called respectable society, the situation had changed markedly within just a few decades. Urban centers, with their concentrated poverty, migration flows, and subcultural diversification, played a central role in this shift, providing fertile ground for new patterns of drug use that were more visible, recreational, and socially stigmatized.

[5] Charles M. Goethe, a prominent member of the American Coalition, wrote in the *New York Times* on September 15, 1935: «Marijuana, perhaps now the most insidious of our narcotics, is a direct by-product of unrestricted Mexican immigration.»

> *A more frightening group of users replaced them, primarily younger, urban addicts, often minorities, who took drugs openly rather than in isolation, and for pleasure rather than to relieve pain. These marginal members of society were associated with an emerging underground scene that rejected bourgeois convention. Drug use of that type symbolized for many the social deviancy and moral deficiency inherent in increasingly public displays of vice. In the mind of contemporaries, a perceived decline in traditional morality, especially among the underclass, merited a more punitive response.* (McAllister 1999, p. 17)

The vast majority of sources agree that the early drug prohibition laws in the United States were deeply rooted in racism (see, among others: Smith 1966; Mark 1975; Cohen 2006).

In 1875, the city of San Francisco enacted an ordinance prohibiting the smoking of opium in dens—establishments frequented almost exclusively by Chinese immigrants. The charge of racism might seem excessive were it not for the fact that this ordinance formed part of a larger patchwork of local, state, and federal laws aimed specifically at marginalizing the Chinese community in America.

Consider, for example, that as early as 1850, the state of California imposed a monthly tax on foreign miners, with Chinese laborers providing 90% of the revenue generated (Mark 1975, p. 67). In 1870, San Francisco County passed the Cubic Air Ordinance, ostensibly to protect public health, which imposed fines and/or prison terms on individuals living in overcrowded rental housing—a situation that disproportionately affected Chinese immigrants.

When enforcement of the ordinance forced Chinese tenants out of rental housing and into county jails, authorities introduced the so-called Pigtail Ordinance, which required all prisoners to shave their heads, allegedly to prevent the spread of fleas and lice. However, the ordinance clearly targeted the Chinese population (Healy, Chew 1905, pp. 250ff.). Under the Qing

dynasty, Han Chinese men were required to shave their foreheads and wear a long braid to demonstrate loyalty to the imperial government; those who did not risked being labeled revolutionaries. Many Chinese immigrants came to California with the goal of earning money to provide for their families and then return to China; for them, forced shaving severed ties with cultural and political identity, making return to China perilous. The true goal was not to keep Chinese immigrants in the United States, but rather to discourage further immigration (Ibidem).

The anti-Chinese sentiment found formal expression in the California Constitution of 1879, which devoted an entire article (Article XIX) to restricting the rights of Chinese and Mongolian immigrants: prohibiting their employment by corporations (Sec. 2), barring their participation in public works projects except as convict laborers (Sec. 3), and branding their presence as a threat to the welfare of the state.

In 1882, Congress intervened at the federal level with the Chinese Exclusion Act, which suspended all Chinese immigration to the United States[6].

It was in this fervently anti-Chinese climate that San Francisco's ordinance on opium dens—and similar measures in other counties and states along the West Coast—emerged. But what were the deeper causes of this resentment?

[6] Some sources (e.g., Zimring and Hawkins 1992, p. 57) include among the consequences of anti-Chinese sentiment the 1887 measure by which the United States Congress prohibited the importation of opium by Chinese nationals, while leaving American citizens unaffected. Although it cannot be excluded that this measure was also intended to target the Chinese community—similar to the Chinese Exclusion Act—it should be noted that the law was enacted in implementation of the Angell Treaty of 1880. That treaty contained a reciprocity clause stipulating that Americans were prohibited from importing, selling, and transporting opium into or out of China, while Chinese nationals were subject to the same prohibitions within the United States (Mark 1975, p. 53). By contrast, the immigration ban was a unilateral measure not reciprocated by China and marked a reversal of the principles established by the earlier Burlingame Treaty, which had encouraged Chinese immigration to the United States.

Since the early 1840s, the United States had witnessed a significant influx of Chinese immigrants, driven by the devastation of the Opium Wars and the subsequent political and economic collapse of the Qing Empire. Many Chinese emigrated to California, where they easily found employment as laborers, miners, or agricultural workers.

Their arrival had complex implications. During the Gold Rush, Chinese labor helped fill critical workforce shortages and contributed to major infrastructure projects such as the construction of the Central Pacific Railroad (Mark 1975, p. 59). However, many Chinese immigrants, driven by the need to support their families back home and repay debts for passage, accepted wages far lower than their white counterparts, exacerbating racial and economic tensions during periods of economic downturn.

Rather than directing their anger at those who profited from worker exploitation irrespective of race, white laborers and unions often scapegoated the Chinese (U.S. Department of State).

Before the economic crisis, Chinese opium use had been known but largely ignored; it became a public concern only when recession exposed the competitive instincts inherent in the capitalist economic structure, undermining class solidarity and replacing it with what Hoffmann (1990, pp. 128–129) calls a «false group consciousness.»

If the power of dominant ideology and the harsh realities of material life were insufficient to incite mass resentment, sensationalist newspapers helped fuel racial animosity by disseminating alarmist stories about the «yellow peril», opium dens, and alleged seduction of white women by Chinese men (Morgan 1978; Courtwright 1982, pp. 77–78). In the ensuing years, similar media campaigns would associate cocaine with Black Americans and cannabis with Mexican immigrants (Hoffmann 1990, pp. 130–132).

Early drug prohibition laws, then, were not primarily the result of noble aspirations toward health and public safety. Rather, they arose from a complex interplay of particularistic economic interests, distorted public perceptions, and well-founded fears for the future. What we are confronting is not a simple conspiracy orchestrated by a cabal of powerful elites, but a deeply rooted structural process: one in which the precarious material conditions endured by millions and the widespread racism that permeated all levels of society together fostered norms that would shape criminal law well into the twentieth and twenty-first centuries.

From the Shanghai Commission to the Hague Convention

Following the Depression, the American capitalist class increasingly viewed the expansion of trade with China as the most promising pathway to recovery and future prosperity (Musto 1999, p. 24). However, the inhumane treatment of Chinese immigrants in the United States had severely strained relations between the two countries, culminating in the 1905 boycott of American products declared by numerous Chinese merchants (ibid., p. 30). Although the boycott had little tangible impact on exports to China and lacked the endorsement of the central government, it nevertheless prompted American merchants to pressure their government to take decisive action (Remer, Palmer 1933).

Tensions with China were not the only international challenge facing American President Theodore Roosevelt. Following the acquisition of Hawaii and the Philippines in 1898, the United States began to view British dominance over the Pacific not necessarily as a threat, but as an obstacle to its own ambitions for commercial and diplomatic expansion in the region (Brown 2002, p. 632).

The Philippines themselves offered the Americans a revealing case study of the opium problem: consumption was widespread among both the native population and the resident Chinese, the latter being the only group formally authorized to purchase the drug. The Spanish colonial authorities had long tolerated the opium trade for the tax revenues it generated; the responsibility for regulating the issue now fell to the United States. Following a polarized public debate—during which proponents of maintaining the status quo seemed close to prevailing (Musto 1999, pp. 26–27)—Governor William Howard Taft appointed a three-member commission to study the matter: Commissioner of Health and Army Major Edward C. Carter, Dr. José Albert, and Charles Henry Brent, the first Episcopal bishop of the Philippines and a future pivotal figure in international drug control diplomacy.

The commission departed Manila on August 17, 1903, embarking on a months-long expedition across Japan, the islands of Java and Formosa (modern Taiwan), Shanghai, Hong Kong, Saigon, Singapore, and Burma (modern Myanmar), gathering information and examining local approaches to opium regulation.

Upon returning, the commission submitted its report to Governor Taft. It recommended establishing a government monopoly on the sale of opium for a three-year transitional period, during which sales would be restricted to individuals over the age of twenty-one. Over this period, individual rations would be gradually reduced until the sale of opium and its derivatives would cease entirely, except for therapeutic products. Schools and healthcare centers were to play a key role in educating the public about the dangers of opium and discouraging new users. Immediate prohibition, however, was deemed imprudent: there was significant concern that sudden withdrawal among widespread users could lead to social unrest and that illicit traffickers

would quickly fill the vacuum, undermining the effectiveness of the ban (ibid., pp. 27–28).

In March 1905, Congress intervened but disregarded the commission's recommendations. Instead, it confirmed the ethnic distinction that the committee had proposed to eliminate: for the next three years, only Chinese residents in the Philippines would be permitted to legally consume opium, while for all other groups the ban would take immediate effect.

The following year, on July 24, 1906, Bishop Brent wrote directly to President Theodore Roosevelt to propose the organization of an international conference on the opium trade, involving the United States, China, Japan, and other major powers exerting influence in the Far East.

Two principal reasons convinced Brent of the necessity of an international discussion on opium. The first was moral: Brent regarded the consumption of opium as legitimate only for therapeutic purposes and viewed state involvement in the opium trade as a source of corruption (McAllister 1999, p. 28). The second was pragmatic: without an international solution, any attempt to prohibit opium in the Philippines would have been futile (ibid.).

Roosevelt enthusiastically embraced the proposal. A global regulation of the opium trade would have had negligible consequences for the U.S. economy, given its marginal role in the market, while simultaneously advancing several important geopolitical objectives.

First, sponsoring an international conference would consolidate the United States' status among the major world powers—a goal Roosevelt was already pursuing, having mediated the Russo-Japanese War and inspired the Second Hague Peace Conference, which would take place the following year (Musto 1999, pp. 30–31).

Second, the meeting would offer an opportunity to mend relations with China by addressing grievances regarding the mistreatment of Chinese

immigrants in the United States (ibid.). Moreover, there was hope that strengthening the Chinese central government by addressing the opium issue would help preserve China's territorial integrity. The United States feared that the collapse of the Chinese government would allow Japan and the European powers, particularly the British Empire, to expand their influence, partition Chinese territory, and exclude the United States from access to a market critical to future economic prosperity (Brown 2002, p. 642).

In the months following Brent's letter, the U.S. State Department began discreetly gauging the willingness of other governments to participate. The original plan was to limit participation to the major regional powers and focus exclusively on opium consumption and trafficking in Asia. However, as McAllister (1999, p. 28) explains, the U.S. government soon realized that the task was even more complex than initially anticipated. Some countries, such as Italy and the Austro-Hungarian Empire, lacked direct interests in the matter but sought participation to assert their international status. Others, such as Turkey and Persia, were major opium-producing nations and initially resisted involvement; Turkey ultimately refused to participate, while Persia agreed only after sustained diplomatic pressure. Additionally, various governments demanded the inclusion of manufacturing states—such as Germany—whose pharmaceutical industries were key actors in transforming raw opium into more sophisticated pharmacological products (ibid., p. xvi). Finally, Britain and the Netherlands insisted that the conference not result in binding commitments, but only in non-binding recommendations (Nencini 2017, p. 74).

Despite these challenges, the mere convocation of the Commission had a notable impact: many participating countries began modifying their domestic opium policies, partly in an effort to present tangible achievements at the conference (UNODC 2009a). Indeed, several states reported significant

reductions in opium imports and sales before the delegates even convened in Shanghai (ibid.). The most consequential achievement prior to the meeting itself was the signing, in 1907, of the aforementioned Ten Year Agreement between China and the British Empire.

It was the U.S. State Department that appointed the three members of the American delegation to the Commission: alongside Dr. Charles C. Tenney, a diplomat stationed in Beijing who had been actively involved in campaigns against the Indian opium trade imposed on China by the British Empire, and Bishop Charles H. Brent, who would later assume the presidency of the Commission, Dr. Hamilton Wright was appointed.

Dr. Wright had lived and worked in the Far East, where he had studied tropical diseases; he was also the husband of Elizabeth Washburn, a member of a prominent family that included several Congressmen and Senators (Musto 1999, p. 31). Wright took his appointment with great seriousness: he reviewed all the materials on opium available through the State Department and the Library of Congress; he gathered information on the use of opium and its derivatives through visits to various cities and through questionnaires sent to prisons, police departments, and pharmaceutical companies; he also advocated for, and successfully secured, the passage of a federal opium law prior to the start of the Commission's work in Shanghai (ibid., pp. 32–33).

Drafting and passing a federal opium law presented multiple challenges. First, there was the need to strike a balance that would enable the combat of illegal trade in opium and its derivatives without impeding physicians, pharmacists, drug manufacturers, or patients who legitimately required access to these substances for therapeutic purposes. Then, there was the issue of the division of powers between the federal government and the individual states, which, under constitutional provisions, retained control over police powers.

> *(…) the lack of a federal law embarassed the commission officials, who believed that other nations would not understand the intricacies of the American Federal system. Wright and Root* [the U.S. Secretary of State] *wanted federal anti-narcotic legislation before the Shanghai meeting, only a few months away.* (*Ibid.*)

Public Law No. 221 (An Act to Prohibit the Importation and Use of Opium for Other than Medicinal Purposes) was approved on February 9, 1909, during the second week of the Commission's work. Its significance was primarily symbolic: it was a brief piece of legislation that merely prohibited the importation of opium for smoking purposes and did not entail any substantial increase in enforcement measures. In truth, the law was redundant, as the same objective could have been achieved through the application of the Pure Food and Drug Act of 1906; however, it was conceived, drafted, and enacted mainly to demonstrate American commitment to the international delegates assembled in Shanghai (ibid., pp. 34–35).

With Bishop Brent presiding, the American initiative was led by Hamilton Wright, who from the outset sought—and found—support within the Chinese delegation, while encountering determined opposition from the representatives of the European colonial powers. The American delegation proposed a narrowing of the definition of "legitimate use" of opium, advocating that any use not intended for medical or scientific purposes, according to the stringent criteria of Western science and medicine, should be considered illicit (McAllister 1999, p. 29). They also insisted on convening a plenipotentiary conference on the global opium trade.

The states accused of profiting from the opium trade raised several objections, defending the quasi-medical uses of opium in Eastern medicine and highlighting the growing issue of morphine and heroin abuse in China,

thus shifting the focus onto the manufacturing countries and their pharmaceutical industries, which continued to export their products without effective regulation (ibid.).

After four weeks of deliberations, the Commission concluded by formulating a series of rather generic and non-binding recommendations; among them, it was recommended that each participating state take reasonable measures to prevent the departure from its ports of cargoes containing opium and its alkaloids, derivatives, and preparations, destined for countries that prohibited their importation.

Despite their non-binding nature, the recommendations were not formally ratified by the states represented at the Commission (Nencini 2017, pp. 74–75), nor were they signed by the individual delegates; instead, they voted to authorize the president, Bishop Brent, to sign on behalf of all parties (UNODC 2009a).

The Commission cannot, however, be regarded as a complete failure. As previously noted, its mere convocation had compelled the participating countries to pay greater attention to the issue, to collect and share data, and in some cases to adopt measures—albeit sometimes superficial or of limited effectiveness (Ibidem). It provided an important platform for the exchange of information between delegations. Furthermore, it obliged governments to articulate their positions publicly, thereby making visible the divergence in perspectives—or, more accurately, in interests—among countries vying for economic, military, and scientific preeminence. In particular, the tensions between producing states, manufacturing states, and consuming states became apparent, categories effectively summarized by McAllister (1999, pp. xv–xvi):

> *CONSUMING STATES: In its pure form refers to states that neither produce nor manufacture drugs but require them for medicinal purposes (i.e.*

the majority of the world's nations). The terms sometimes connotes a "victim state" because such are at the mercy of both producers and manufacturers for the supply of essential medicines (at whatever price the traffic will bear). Any state, however, may consider itself a consumer since all require medicaments. (…)

MANUFACTURING STATES: The states that house the majority of advanced pharmaceutical companies' factories. (…) MANUFACTURING refers to the process of rendering agricultural raw materials and synthetic products into more pharmacologically sophisticated concoctions. (…)

PRODUCING STATES: Agrarian countries that grow agricultural raw materials such as opium, coca, marijuana/hashish, and qat.

These fault lines would reappear at the first International Opium Conference, convened in The Hague on December 1, 1911. The organization of a plenipotentiary conference less than three years after the Shanghai Commission constitutes the principal reason why the earlier meeting should not be dismissed as a failure: absent the Commission, the Conference would likely not have taken place—or at least, not so swiftly.

Once again, the United States emerged as one of the most determined proponents of the initiative, with one of its primary objectives being to further strengthen ties with China and thereby secure greater access to its market. Hamilton Wright addressed the matter candidly in his communications with Philander C. Knox, Secretary of State under President William Howard Taft:

Our move to help China in her opium reform gave us more prestige in China than any of our recent friendly acts toward her. If we continue and press steadily for the Conference, China will recognize that we are sincere in her

behalf, and the whole business may be used as oil to smooth the troubled water of our aggressive commercial policy there.
"Go ahead," replied the Secretary. (Musto 1999, p. 39)

The economic and geopolitical motivations were not the only parallels between the path that led the United States to convene the Shanghai Commission and the maneuvers preceding the Hague Conference. Hamilton Wright, who had become an increasingly central figure in American drug diplomacy, believed that a new federal law was necessary: it would reaffirm the United States' commitment to combating drug trafficking domestically and would enhance the credibility of its representatives on the international stage.

The bill proposed by Wright and introduced in the House of Representatives by Republican David J. Foster not only regulated the use and trade of opium and its derivatives, but also extended to cocaine, chloral hydrate (a hypnotic used to induce sleep), and cannabis. Given the constitutional constraints on federal police powers, the bill avoided prohibiting controlled substances outright and instead established a tax regime that mandated the registration and taxation of every transaction involving such substances; violations of this regime would be punishable by a fine of between five hundred and five thousand dollars and imprisonment for one to five years (Musto 1999, p. 41).

Hamilton Wright personally appeared before the House Committee on Ways and Means—the committee responsible, among other things, for tax policies—to express his support for the so-called Foster Bill. Instead of emphasizing the risks associated with opium smoking, which Congress had already addressed the previous year with the passage of Public Law No. 221, Wright focused on the perceived threat of cocaine. In doing so, he deliberately leveraged racist fears, presenting cocaine use among African

Americans not only as a public health threat but as a justification for urgent legislative intervention (Ibid., pp. 43–44).

As Musto explains:

> *The purpose of Wright's strong statements in regard to cocaine and Negroes was, of course, to encourage the legislation he sought, partly by motivating hesitant southern Democrats who feared any precedent of federal involvement in the police powers reserved to the states.* (*Ibid.*)

Despite Wright's direct and vigorous efforts, the Foster Bill failed to pass in Congress, largely due to strong opposition from organizations representing drug producers and retailers. In February 1911, the *American Druggist and Pharmaceutical Record* triumphantly headlined: «Foster Bill Killed» (Ibid., pp. 45, 48).

Nevertheless, although defeated on the domestic front, Wright and his allies quickly pivoted back to the international arena, where the prospects for success appeared more favorable. The principal American objective remained the convening of an international conference, which first required overcoming the hesitations of the colonial powers and the major producing states.

The recommendations of the Shanghai Commission had little impact on the policies of the participating countries. China, following the signing of the Ten Year Agreement, had made every effort to reduce the cultivation and importation of opium, but political instability and the definitive fall of the Qing Dynasty rendered much of the early progress futile. The British Empire, despite the agreement signed with China and its commitments to the American-controlled Philippines (Taylor 1969, p. 92), had no intention of completely relinquishing the revenues generated by Indian opium. Persia, along with several European states, had taken no concrete action to limit the

production and trafficking of opium and its derivatives (McAllister 1999, p. 30).

It is therefore unsurprising that nearly all the governments invited by the U.S. State Department to commit to participating in an international conference—particularly the British Empire, Germany, and the Netherlands (Musto 1999, p. 49)—were reluctant to respond and indeed did everything possible to delay the meeting (Taylor 1969, pp. 89–90, 92–96). China, despite its decades-long struggle against opium, also harbored serious reservations: its leaders were determined to ensure that any new international regulations would not provide other states with the opportunity—or the pretext—to interfere further in China's internal affairs and already fragile sovereignty (ibid., p. 88).

The United States maintained constant diplomatic pressure, seeking and securing the support of associations long active in the fight against opium trafficking, while simultaneously threatening to convene the conference on American soil—an unattractive prospect for the European powers, who preferred not to afford the United States the advantage of playing host (McAllister 1999, p. 31).

At the same time, the United States was careful not to appear domineering. In the invitation letter, it was explicitly stated that the proposed topics for the conference were neither definitive nor exhaustive, and that suggestions from the other parties would be welcome. For this reason, cannabis, coca leaves, and cocaine were not initially included among the subjects for discussion, with the expectation that another delegation would raise the issue (Taylor 1969, p. 87).

This expectation proved accurate: Italy requested that the conference address the possibility of imposing restrictions on the production and trafficking of cannabis. In practice, however, the Italian delegation

participated only in the opening session, and the other parties ultimately agreed not to treat cannabis as a serious threat (Musto 1999, p. 51). More significantly, the British Empire advocated for strict regulation of the production and sale of morphine and cocaine (Taylor 1969, p. 89).

On 1 December 1911, the International Opium Conference opened in The Hague. The Austro-Hungarian Empire, which had already been hesitant, ultimately refused to participate, a decision also made by Turkey, as had previously occurred during the Shanghai Opium Commission. Delegations at the table included those of the United States, the Republic of China, the British Empire, Portugal, France, the Netherlands, Germany, Russia, Japan, Siam, Persia, and (for the first session only) the Kingdom of Italy. Once again, Charles Brent assumed the presidency, and Hamilton Wright was confirmed in his role as chief American delegate, this time supported by Dr. Henry J. Finger.

If convening the Conference had been challenging, convincing states with competing and often conflicting interests to reach an agreement proved equally arduous. Each party was determined to defend the interests of its own industries and mercantile classes before addressing the collective need for regulation.

After securing agreements on restricting opium exports from India to China and the Philippines, the British Empire adopted a strongly prohibitionist stance regarding morphine—produced primarily by Germany—and cocaine, produced mainly by Germany and the Netherlands. In response, Germany argued that any agreement limiting the production of such substances would be unworkable unless it was signed by the governments of thirty-four additional manufacturing states, including Switzerland and Turkey, both of which had refused to attend the Conference (McAllister 1999, p. 34).

Portugal similarly defended its opium cultivation in Macao, insisting that the Convention negotiated at The Hague could only become effective if ratified by all participating states.

As had already become clear during the Shanghai Opium Commission, the fundamental lines of fracture re-emerged between producing states, manufacturing states, and consumer states, each prioritizing the defense of their national economic interests over any shared commitment to drug control.

McAllister aptly summarizes the stalemate that preceded the eventual compromise:

> *The Americans espoused radical measures, not least because the principal enforcement burdens fell on other governments. (…) States possessing significant pharmaceutical industries might support controls over raw materials, but they objected to limitations on manufactured drugs. Producing states (…) considered domestic drug use an internal matter (…). They also insisted on the right to export opium to those states that did not prohibit the trade. Territories that consumed large quantities of (smoking) opium (…) worried that reducing supplies would simply foment increased smuggling.* (*ibid.*, p. 33)

The Conference concluded its work on 23 January 1912 with the signing of the International Opium Convention. Firstly, it reaffirmed what had already been recommended at the Shanghai Opium Commission: the contracting parties were prohibited from exporting controlled substances to states that prohibited their entry.

However, the producing states, particularly the British Empire and Persia (McAllister 1999, p. 34), ensured that no clause was inserted requiring a reduction in opium cultivation, nor was any timeline established for the gradual suppression of opium smoking.

Germany succeeded in protecting its pharmaceutical interests by having codeine removed from the list of controlled substances and by ensuring that the rules regarding the production and distribution of morphine and cocaine remained vague. In Articles 10, 11, and 12, it was stipulated that: «The Contracting Powers (or Parties) shall use their best endeavours to...», a formulation deliberately leaving ample room for interpretation—and thus for inaction.

This dilution of obligations confirmed that, while the Conference symbolically represented a step forward in the international coordination of drug control efforts, the resulting Convention lacked robust enforcement mechanisms.

Finally, supported by France, Germany demanded that the Convention would only enter into force once ratified by thirty-four governments implicated, directly or indirectly, in the opium trade. Given that without this concession Germany—and perhaps France—would have refused to sign, the other parties reluctantly accepted.

The government of the Netherlands assumed responsibility for acting as the depository, collecting the ratification instruments from the signatory states and serving as the administrative and communication center for all matters related to the Convention.

The United States immediately set to work to obtain the signatures of the states that had not participated in the Conference. They encountered little difficulty in convincing many Latin American countries (Musto 1999, p. 52), but by the time the delegates reconvened for the Second Opium Conference in July 1913, twelve of the thirty-four necessary ratifications were still missing, including those of Switzerland and Turkey, both of which carried considerable weight. At the end of the session, the states willing to deposit their ratifications were permitted to do so.

In June 1914, the delegations met again at The Hague for the Third Conference. Although the Convention had been signed by forty-four states, the ratifications of Serbia and Turkey—both crucial to Germany's participation—were still lacking. To break the impasse, it was agreed that the Convention would enter into force among the parties that had deposited their ratifications (fewer than half of the signatories; Musto 1999, p. 53) on 31 December 1914.

By that time, the United States was determined to pass a new federal drug law. After the failure of the Foster Bill in 1911, the Harrison Bill had successfully passed the House of Representatives in 1913 but had stalled in the Senate. The developments at the Third Hague Conference provided fresh momentum to the American anti-drug campaign. On 14 December, the bill was passed, and on 17 December 1914, it was signed into law by President Wilson.

In a sense, the Harrison Act represented a compromise version of the Foster Bill. A joint committee appointed by the State Department and the Treasury Department had drafted the law, carefully addressing the objections previously raised by the medical profession and by drug manufacturers and distributors: the licensing and taxation system outlined by the Foster Bill was streamlined and simplified; cannabis and chloral hydrate were removed from the list of controlled substances; and many products containing small amounts of cocaine, opium, morphine, and heroin were exempted from the licensing requirement (Musto 1999, pp. 59–60).

According to Zimring and Hawkins (1992, p. 57), two primary factors contributed to the passage of the Harrison Act. One was the longstanding campaign by the American Medical Association and the American Pharmaceutical Association to secure exclusive control over certain substances, thereby ensuring prestige and authority for their members. The

second was the international commitment undertaken by the United States to regulate the use and trafficking of cocaine, opium, and their derivatives. Despite political and media narratives that linked drug use to minority groups and the urban proletariat—and feared its spread among the upper classes—the issue was not seen as particularly urgent: the passage of the Harrison Act was not even mentioned in the weekly legislative summary (Musto 1999, pp. 65–66).

Meanwhile, across the Atlantic, drug control efforts had largely stalled. Far more pressing concerns loomed. Just three days after the conclusion of the Third International Conference, on 28 June 1914, Archduke Franz Ferdinand was assassinated in Sarajevo. A month later, Austria-Hungary declared war on Serbia, setting in motion the First World War.

The Treaty of Versailles and the League of Nations.

The outbreak of war relegated the drug problem to the background while simultaneously exacerbating it. In 1915, the International Opium Convention entered into force only among the United States, China, the Netherlands, Norway, and Honduras; however, the belief that a more stringent national and international regulatory regime was necessary soon took hold elsewhere. The black market became central to the economies of war-torn countries: with normal supply channels disrupted, cities were often provisioned with basic necessities—such as food and medicine—as well as alcohol, cigarettes, and other substances, by "entrepreneurs" who saw in smuggling either the only chance for survival or an opportunity for enrichment. The prohibition on the sale of alcohol made alternatives such as cocaine and opium derivatives increasingly attractive. Meanwhile, sensationalized and often exaggerated accounts of drug use among soldiers and of prostitutes drugging

and robbing servicemen frequently appeared in the newspapers (McAllister 1999, p. 36).

The end of hostilities marked a turning point in the international control of drug trafficking. First, the British and American delegations secured the inclusion of the obligation to adhere to the International Opium Convention in the peace treaties, thereby overcoming the resistance of Germany, Turkey, and Austria-Hungary (Taylor 1969, p. 142), which, being among the defeated powers, had no choice but to comply. Furthermore, the issue gained definitive international relevance with the creation of the League of Nations, which was entrusted with the supervision of treaties relating to the traffic in women and children and to the trafficking in opium and other drugs («the traffic in opium and other dangerous drugs», Article 23, letter c, Covenant of the League of Nations).

However, neither a few lines of ink on paper nor the renewed spirit of internationalism were sufficient to overcome all criticalities. One major issue was intrinsic to the Convention itself. Born out of compromise among governments with divergent interests, the treaty employed vague formulas, leaving ample room for interpretation:

> *The treaty urged much but required little. States inclined to enhance controls found ample justification in the convention's stipulations (…). The treaty's equivocal provisions, however, allowed recalcitrants to avoid acting substantive measures.* (McAllister 1999, p. 39)

A second critical issue concerned the difficult transition from the Convention's declared objectives to their concrete implementation. Beyond governments that showed little interest in effective measures, others, even with the best intentions, lacked the capacity to meet the Convention's already loose obligations—most notably China. The Chinese central government had

largely lost control over vast portions of the national territory: regional warlords, who dominated entire provinces, often allowed or actively encouraged opium cultivation, using the proceeds to finance their armies (Taylor 1969, p. 135). In addition to the continuous increase in domestic opium production, there was the escalating scourge of morphine addiction, fueled by the steady influx of morphine from Japanese-controlled territories.

Moreover, a third critical issue arose from the changed global scenario. One major consequence of the world conflict was the expansion of the British, French, American, and Japanese pharmaceutical industries. When Germany cut off supplies of analgesics, sedatives, and other essential medicines at the outbreak of the war, the wealthiest and most technologically advanced nations mobilized resources to overcome that strategic vulnerability (McAllister 1999, p. 37). After the war, the increased production capacities created market opportunities that pharmaceutical companies were reluctant to relinquish. The strategic imperative to secure national pharmaceutical autonomy thus transformed into commercial interests that resisted international control efforts.

The spread of morphine in China, in particular, reflected this dynamic: during and after the Great War, exports of morphine from Great Britain and the United States to Japan grew exponentially, surpassing Japan's domestic needs. From Japanese-controlled territories, including the Korean peninsula and Manchuria, morphine was clandestinely trafficked across the Chinese border. Although the final destination of these shipments was well known—and despite direct testimony from missionaries and diplomats stationed in Asia—both Great Britain and the United States delayed adopting measures that might even modestly curb this profitable trade (Taylor 1969, pp. 138–140).

Finally, a fourth critical issue must be addressed: the emergence of a new actor on the international stage, the League of Nations.

One of the principal architects of the League of Nations was American President Woodrow Wilson, who was awarded the Nobel Peace Prize in 1919 for his efforts toward its creation. However, just a few months later, on March 19, 1920, the United States Senate was called to vote on the ratification of the Treaty of Versailles, whose first section included the Covenant of the League of Nations. The final tally—forty-nine votes in favor, thirty-five against, and twelve abstentions—fell short of the two-thirds majority required (Hewes Jr. 1970, p. 245). As a result, the United States neither ratified the Treaty of Versailles nor joined the League of Nations.

This decision had important consequences for the administration of international drug control, as the Treaty of Versailles had entrusted the League of Nations with the oversight of efforts to combat human trafficking and drug trafficking («the traffic in opium and other dangerous drugs», Article 23(c) of the Covenant of the League of Nations). To fulfill this mandate, the League established a specialized body, the Advisory Committee on Traffic in Opium and Other Dangerous Drugs (also known as the Opium Advisory Committee). Meeting for the first time in May 1921, the Committee promptly drafted a series of instruments it urged all States to adopt, including draft import certificates and annual drug reports. It also requested information from national governments regarding their domestic consumption of controlled substances in order to estimate legitimate global needs.

For approximately a year, the United States ignored the League's requests. As Taylor notes:

> *The State Department took the position that United States should have nothing to do with the League machinery in regard to the opium question but*

> *should continue to rely solely on the Netherlands government. Finally it decided to furnish the information requested to the government of the Netherlands for transmission to the signatories of the Hague Opium Convention, thus establishing the fiction that it was communicating with the Hague Opium Convention signatories but not with the League (…). The State Department tried to act as if the League did not exist.* (Taylor 1969, p. 149)

The Dutch government agreed to continue its role as an intermediary for those States that had ratified the Hague Convention but were not members of the League of Nations. Nevertheless, among the global powers, the position adopted by the United States was unique.

The Opium Advisory Committee was not the only international body responsible for the management of drug policy. The League's Health Committee—precursor to the World Health Organization—also assumed a significant role, creating a specialized entity within it, the Opium Committee of the League Health Committee. Additionally, the League's Secretariat established an administrative and executive support office, the Opium and Social Questions Section (also known simply as the Opium Section).

Thus, following the phase of *drug diplomacy* to which William McAllister dedicated the title of his seminal book (1999), the 1920s witnessed the emergence and consolidation of a vast *drug bureaucracy*: a necessary (or perhaps inevitable) and complex apparatus, where professionals from diverse sectors worked side-by-side, often pursuing different objectives but frequently—consciously or unconsciously—driven by the bureaucratic tendency identified by Max Weber: the impulse to preserve and expand prestige and authority (Gerth, Mills 1946, pp. 233–234).

The complexity of this apparatus became evident when the League of Nations proposed addressing the demand side of the drug problem. Until that point, international control efforts had focused primarily on supply—

restricting the cultivation, manufacturing, and exportation of certain substances—while largely neglecting the causes of drug consumption. Seeking to address this gap, the League created a Mixed Sub-Committee composed of six members: three medical experts from the Health Committee and three political appointees from the Opium Advisory Committee, one of whom was also a doctor.

The League tasked the Mixed Sub-Committee with defining the parameters of legitimate (i.e., medical) demand for drugs, determining the global volume needed for legitimate purposes, and identifying strategies to curb excessive production. This, in turn, required the Sub-Committee to define what constituted drug abuse, to understand its etiology, and to propose measures for its detection and prevention.

In practice, however, the Mixed Sub-Committee discussions quickly became entangled in conflicting interests. Rather than investigating the roots of drug consumption, debates centered almost exclusively on estimating global medical needs. The Health Committee members, concerned about iatrogenic addiction, advocated for conservative thresholds, while representatives of the Opium Advisory Committee sought to protect their countries' production and pharmaceutical sectors.

When it became clear that the manufacturing states would prevail, the Health Committee independently commissioned a study on the legitimate global consumption of opium and cocaine. Their results, significantly lower than those of the Mixed Sub-Committee—by approximately 33%—highlighted the divergence in approach (McAllister 1999, pp. 44, 47–50).

In the intense clash between divergent visions and material interests, questions concerning the social, political, and economic roots of drug addiction were once again marginalized. Perhaps this was inevitable: addressing the true causes of addiction would have required challenging the

foundational paradigms of a society built on profound class divisions—at a time when alternative models, like the one emerging in Soviet Russia, were gaining ground.

As McAllister observes:

> *While social and medical questions never disappeared entirely, the system focused on economic calculations, regulatory statutes, and enforcement measures. Medical expertise played an important role in defining which drugs possessed addiction potential, but those determinations focused on narrow physiological manifestations and eschewed the larger social implications of addiction. Supply control emerged as the regime's* raison d'être. (*Ibid.*)

Despite the difficulties, the League of Nation' commitment to addressing the drug issue did not falter; on the contrary, the urgency of understanding and regulating the matter prompted the Secretary General, following input from both the Assembly and the Council, to invite the United States to appoint a delegate to participate in the next working session of the Opium Advisory Committee (OAC), the fourth, scheduled for January 1923. The United States accepted. The reasons for this change in attitude toward the League of Nations were heterogeneous. In the 1922 elections, the Republicans retained their majority but lost seats to the Democrats in both Houses; the erosion of consensus suggested to President Harding the need to adjust his international strategy, particularly after the United States had achieved disappointing results while maintaining a stance of isolation. Renewed tensions between France, Belgium, and Germany threatened to undermine efforts to disarm and stabilize the European continent and its economy (McAllister 1999, pp. 51-52). Participating, even informally, in the activities of the League allowed the United States to step out of its self-imposed corner and to support—albeit indirectly—an institution that might

help prevent Europe from plunging into another disastrous war. Accepting the invitation to the OAC session, however, did not imply a willingness to compromise with other actors. The delegate, Dr. Rupert Blue, was instructed to avoid any appearance of acquiescence to proposals inconsistent with the American line, which had remained unchanged since the Hague Conference: only medical and scientific uses were to be recognized as legitimate; therefore, only such needs should guide the regulation of the cultivation of controlled plants and the manufacturing of derivative products. Despite its long-standing tradition in certain regions, the quasi-medical use of opium was to be categorically rejected. No form of state monopoly was acceptable, and the only appropriate method for combating the trafficking and misuse (or, according to the American interpretation, any non-medical use) of controlled substances was prohibition (Taylor 1969, p. 153).

This uncompromising position was reiterated with equal force at the fifth session of the OAC, which Blue attended alongside Bishop Brent, Edwin L. Neville, and delegation leader Stephen Porter, former chairman of the House Foreign Affairs Committee. The intransigence of the United States, which even threatened to withdraw its delegation if its proposals were not accepted without reservation, exacerbated tensions and once again swept aside any meaningful discussion of the etiology of drug use and the differing nature of the phenomenon in industrialized countries compared to elsewhere (McAllister 1999, p. 56). Nevertheless, the impasse was avoided: the OAC adopted a resolution that, although not fully embracing the American principles, reaffirmed the need to implement the provisions of the Hague Convention, called for a broader range of governments to sign and ratify it, expressed appreciation for U.S. cooperation with the League, and, crucially, recommended that the Council convene one or two plenipotentiary

conferences (the ambiguous wording generating various interpretations) to reconsider the matter (Taylor 1969, pp. 166-167).

The Geneva Convention

The adoption of a formal recommendation to convene an international conference was a significant diplomatic achievement. However, actual success would depend on its implementation: organizing the conference, securing participation, and brokering agreements.

The responsibility for this fell to Sir Malcolm Delevingne, the United Kingdom's representative to the OAC. An experienced, respected, and even feared diplomat, Delevingne understood that, in a fragmented geopolitical landscape, the Americans' rigid and unrealistic approach had to be mitigated. His strategy was thus to organize two separate plenipotentiary conferences, involving different actors and addressing complementary issues. The first conference would involve the countries and colonial powers that controlled territories in the Far East where opium cultivation was widespread—namely China, India, Siam, Japan, Great Britain, France, the Netherlands, and Portugal. The United States was excluded, as the Philippines, according to McAllister's classification [see pp. 59-60], was considered a consuming state, not a producing one. More pragmatically, Delevingne sought to exclude the Americans to prevent the reemergence of their stringent, maximalist proposals concerning poppy cultivation, which risked stalling negotiations.

The second conference would focus solely on manufacturing states:

> *Delevingne pinned his hopes on agreement among manufacturing states. He aimed to control the manufacturing bottleneck. A relatively small number of factories in a few industrialized states manufactured the world's morphine, heroin, coaine, and similar substances. Delevingne reasoned that, if those*

governements limited output, excess supply would dry up. (McAllister 1999, p. 58)

The League of Nations accepted Delevingne's proposal to organize two conferences, but against his advice extended the invitation to the second conference to governments of countries not directly involved in drug manufacturing.

The delegates to the first conference met in Geneva on November 3, 1924. Despite Delevingne's foresight in excluding the Americans, the proceedings did not unfold as smoothly as hoped. The session quickly became mired in a dispute between Great Britain and Japan regarding the traffic of morphine into China. That same year, the British had begun to deny the sale of morphine to the Japanese whenever import certificates appeared suspicious: British authorities viewed Japanese penetration into China as a threat, and they feared that the spread of morphine consumption would further destabilize China's already fragile sovereignty—sovereignty the British wished to preserve to protect their own commercial interests in the region. Conversely, the Japanese delegation insisted that all import certificates be honored and even threatened to withdraw from the conference if reassurances were not provided (McAllister 1999, p. 68).

The angry Japanese reaction to what appeared, from a British perspective, to be a reasonable precaution can be better understood against the broader historical context. Since the end of *sakoku* (Japan's isolationist policy) in 1853, Japan had encountered white racism firsthand. Like China, it had been forced to sign several "unequal treaties" and to open its ports to American and European powers. In 1901, the White Australia Policy barred Japanese immigration to Australia, and a few months before the Geneva conference, the U.S. Immigration Act had similarly excluded Japanese immigrants.

Tensions had also arisen during the negotiations leading to the Treaty of Versailles and the founding of the League of Nations.

At that time, the Japanese delegation had proposed inserting an article recognizing racial equality into the Covenant of the League of Nations. Although eleven of the seventeen delegates present (those of Japan, China, Italy, France, Serbia, Czechoslovakia, Greece, and Brazil) voted in favor, Belgium's delegates were absent, and the United States, the British Empire, Portugal, and Romania abstained. Woodrow Wilson, chairing the session and simultaneously President of the United States, declined to validate the vote, arguing that a unanimous decision was necessary (Temperley 1924, p. 352). Wilson attempted to appease the Japanese by supporting their claims over German possessions in China and governance of Pacific islands, but the damage to Japanese pride had been done (MacMillan 2003, p. 321). The episode at the Geneva conference concerning morphine certificates reopened these wounds.

Ultimately, the British-Japanese dispute was resolved, but it was the only major outcome of a conference that extended well beyond its original two-week schedule. The resulting treaty, completed in early December, established a state monopoly over the importation, sale, and distribution of opium, regulated limits and procedures, prohibited sales to minors, and set guidelines for information exchange and periodic assessment of opium preparations (Taylor 1969, p. 183). Only India signed the treaty; the other delegations withheld their signatures as the second conference had already begun, and the shortcomings of the first became a central issue (McAllister 1999, p. 69).

The second conference, convened on November 17, 1924, expanded participation to forty-one delegations—exactly the scenario Delevingne had hoped to avoid. However, many of these delegates belonged to diplomatic

corps stationed in Geneva, lacked detailed knowledge of the subject, and represented governments with little vested interest. Consequently, participation diminished over time, leaving the major consumer, producer, and manufacturing countries to dominate discussions.

Compromise, however, was not the primary aim of the United States. Stephen Porter, who had headed the American delegation at the fifth session of the Opium Advisory Committee and was confirmed in his role for Geneva, had insisted that the United States attend with a new federal law clearly outlining its approach to narcotics control. Porter believed such a move would lend legitimacy to American demands for stronger international commitments (House Committee on Ways and Means 1924, p. 41). His strategy echoed that of Hamilton Wright in 1911, who had similarly pushed for passage of the Foster Bill before the Hague Conference, albeit unsuccessfully. This time, however, ideological fervor and symbolic value prevailed over practical objections, and Porter succeeded where Wright had failed: Congress passed a law prohibiting the production of heroin on American soil (Musto 1999, pp. 200-202).

Moreover, the resolution adopted unanimously by Congress barred the American delegation from signing any international agreement that did not meet «the conditions necessary for the suppression of the habit-forming narcotic drug traffic» (ibid.).

The United States came to Geneva determined to limit the production of raw opium to quantities needed solely for medical and scientific purposes and to eradicate opium smoking within ten years. However, some delegations, including those of India, Britain, and the Netherlands, viewed these goals as far beyond the conference's intended scope.

When the final document of the first conference was finally approved in early December, the American delegation expressed deep dissatisfaction with

its vagueness and weakness. Bishop Brent urged his colleagues at the second conference to broaden the discussions beyond Delevingne's proposed separation of competencies, encouraging them to revisit issues the first conference had failed to resolve (Brent 1924). Brent also traveled to France and England to persuade their governments not to sign the document. His efforts bore fruit: on December 13, the day scheduled for signature, the French and British delegations requested a postponement, followed by the others—only India proceeded to sign (Taylor 1969, p. 189). When the conference reconvened after the Christmas recess, the stalemate persisted. Despite serious efforts by all parties—through plenary sessions, committees, and subcommittees—the divide proved unbridgeable. On February 1, Stephen Porter sought and received permission from the State Department to withdraw the American delegation. After waiting a few more days for procedural reasons, Porter withdrew the American delegation, followed closely by the Chinese.

A few days later, on February 11, the first conference formally concluded with the signing of an agreement little different from the document that had previously failed to secure support from seven of the eight delegations.

On February 19, the second conference presented its final document, the International Opium Convention of 1925. McAllister summarizes its major provisions as follows:

> *(1) the creation of the Permanent Central Opium Board, (2) a system of import certificates and export authorizations designed to eliminate diversion of drugs in transit from one country to another, (3) various provisions for the enhancement of domestic control measures, (4) restrictions on the trade in coca leaves and marijuana, (5) controls on processed drugs such as crude cocaine and ecgonine, and (6) procedures to add new drugs to the list of controlled substances.* (McAllister 1999, p. 76)

However, several shortcomings remained: the procedures for adding new drugs to the list of controlled substances were not detailed; the system of certificates and permits did not apply to imports and exports involving non-signatory states; and there were no binding limits on the production of raw opium, the manufacture of its derivatives, or their consumption, apart from the requirement to submit accurate reports to the newly created Permanent Central Board—an entity whose powers were limited and ambiguously defined.

The initial proposal for the Board envisioned a much stronger and more independent body than the one ultimately established by the Convention. Initially, it was to be composed of technical experts, endowed with powers to scrutinize government reports, correct excessive estimates, determine authorized production, import, and export quantities, and impose sanctions for violations.

In response, several governments—notably those of France, Switzerland, and the Netherlands—proposed a weaker model: a Board composed of representatives from producing, manufacturing, and consuming states, with three-year mandates and operating under the authority of the League of Nations. This version envisaged a limited power to monitor traffic, no power to impose sanctions, and, in case of irregularities, the possibility to seek clarifications only through the Secretary-General (McAllister 1999, p. 72).

Chapter VI of the Convention (Articles 19–27) attempted to balance these opposing positions by establishing a Board with limited but not negligible powers. It would be composed of individuals with expertise on drug issues both in producing/manufacturing and consuming countries, ensuring equitable representation between the two groups. Articles 19 and 20 regulated the relationship between the Board and the League of Nations: members would be appointed by the Council of the League, while Germany

and the United States—then non-members—would be invited to appoint representatives to participate in its work.

Furthermore, the Council was tasked with consulting with the Board to ensure its technical independence, while retaining oversight of administrative matters. Nonetheless, Articles 19 and 20 left many ambiguities concerning the precise boundaries between the Board's autonomy and the League's authority, ambiguities that were never fully resolved. These ambiguities, however, would later allow the Board to survive the dissolution of the League and be integrated into the International Narcotics Control Board in 1968.

The failure of China and the United States, among others, to sign the 1925 Convention led many to view it—if not as a failure—then as an underwhelming outcome, much like the proverbial mountain giving birth to a mouse (a metaphor Bishop Brent himself used to describe the 1924 conference's outcome; Brent 1924). However, such a reading may be influenced by unrealistic American expectations.

In fact, the 1925 Convention represented a decisive shift: it moved the center of gravity for drug control from the domestic to the international sphere (Musto 1999, p. 52), laying the foundation for the political, diplomatic, and bureaucratic structure that—albeit heavily amended—remains in place today.

The Convention also significantly altered the cost-benefit calculus for drug production and distribution, pushing many reluctant governments to adopt stricter measures to avoid reputational and economic damage. Countries such as Great Britain, India, the Netherlands, Switzerland, France, and Japan, some with genuine commitment and others less enthusiastically, tightened their domestic controls. Even the United States, though not a party to the

Convention, applied many of its principles and continued to send observers to the Opium Advisory Committee meetings (McAllister 1999, pp. 80–82).

Nonetheless, the advances in regulatory frameworks and international cooperation were not matched by concrete results. Production and manufacturing merely shifted to states that had not ratified the Convention or enforced looser controls; consumption patterns adapted to the available supply, with a decline in opium smoking and a corresponding rise in the consumption of opium derivatives. Meanwhile, traffickers improved their methods for transporting and distributing illicit substances, often aided by corrupt officials in politics and law enforcement (McAllister 1999, p. 86).

From the 1931 Convention to World War II

Towards the end of the 1920s, the proponents of the international control regime found an opportunity to revive the discussion. In 1928, a distribution center for substances destined for the illicit market was discovered in the heart of Europe, implicating Dutch, German, Swiss, and French companies. At the time, estimates suggested that the center had distributed a quantity of heroin amounting to approximately half of the world's annual production. In 1929, somewhat unexpectedly, France—previously among the most reluctant countries to adopt restrictions—announced stricter laws on drug manufacturing and trafficking. The French government's decision was driven primarily by fears of international censure after the significant involvement of French companies and citizens in the illicit drug trade had come to light. Seizing this moment, Duncan Hall, a member of the Opium Section, and Sir Malcolm Delevingne approached representatives of the main manufacturing countries and successfully proposed the organization of a new international conference dedicated to regulating the manufacturing sector (Taylor 1969, pp. 231–232).

Delevingne remained convinced that the most rational solution was to require states to estimate their annual need for controlled substances, aggregating these figures to establish the global requirement. Production quotas would then be assigned to the few companies capable of manufacturing the substances. In Delevingne's view, this would effectively dry up the illegal market.

Experience had also left him with another conviction: reaching an agreement would be easier if the pharmaceutical companies themselves, rather than the governments, first discussed and found a compromise.

> *In the spring of 1930, [Delevingne] istigated direct discussions among the European pharmaceutical houses. Transnational cartel agreements already existed among some European pharmaceutical firms; Delevingne reasoned that if manufacturers could settle among themselves, governments would go along.* (McAllister 1999, p. 89)

A seasoned and sophisticated diplomat, Delevingne thus believed it was not only possible but likely that governments would ratify an agreement privately reached by a handful of powerful industrialists. The credibility of this strategy is evidenced by the reaction it provoked across the Atlantic: in the United States, the prospect of a European cartel was not a hope, but a cause for serious concern. Although negotiations dragged on and ultimately failed, when the United States was invited to attend the preliminary conference of manufacturing countries, American pharmaceutical companies lobbied for the dispatch of a delegation capable of protecting their commercial interests (McAllister 1999, pp. 90–91).

At the time, American firms were not major exporters of cocaine or opiates, but they were wary of foreclosing future access to global markets. A system based on production quotas risked marginalizing them, particularly if

the quotas were determined by a European cartel operating under the imprimatur of the League of Nations. Moreover, American pharmaceutical companies were subjected to more stringent standards regarding sourcing, production, and distribution; extending similar rules globally would level the competitive playing field and enhance their position (ibid.; Taylor 1969, pp. 236–237).

The principal obstacle to active cooperation with the League remained Stephen Porter. Porter maintained that American participation in the preliminary conference would imply tacit acceptance of a regulatory system focused exclusively on manufacturing, while continuing to neglect the problem of raw opium overproduction—an issue that he, and much of the American delegation, regarded as the true root of the drug crisis (Musto 1999, pp. 214–215).

Following the U.S. delegation's withdrawal from the Geneva Conference, the State Department had begun to rethink its position. It sought a détente with the League of Nations, maintaining engagement by sending observers to OAC sessions and applying selected measures from the Geneva Convention. Nevertheless, before sending John K. Caldwell to the preliminary conference, the State Department sought to secure Porter's support to avoid internal conflict. There were compelling reasons to participate: in the United States, the drug problem concerned manufactured derivatives, not raw opium, and production standards for these substances were already strictly enforced domestically but not abroad. Even in China, consumption patterns had evolved, with manufactured drugs now posing a greater threat than raw opium. Tighter control over manufacturing was also consistent with the provisions of the Hague Convention, which had already restricted drug use to medical and scientific purposes.

Moreover, a renewed commitment to manufacturing control would not preclude continued U.S. advocacy for raw opium control. Ultimately, Porter acknowledged that participation was in America's best interest (Taylor 1969, pp. 233–234)—although, shortly thereafter, his opinion became moot: he died in June of that year.

Another actor had recently entered the scene and, closely associated with Porter, was advocating for greater American participation in the international community: Harry J. Anslinger's Federal Bureau of Narcotics (FBN). A law signed by Porter in the spring of 1930 had separated the FBN, tasked with monitoring the use and trafficking of narcotics, from the Bureau of Prohibition, which, amid widespread accusations of violence and corruption, had by then seen its prestige destroyed (Musto 1999, pp. 207, 209). The newly formed FBN had a strong interest in proving its utility and consolidating its position; its efforts were soon rewarded when Anslinger was included among the delegates accompanying Caldwell to Geneva in May of the following year.

The conference ultimately sank Delevingne's ambitious plan to divide up the global market for controlled substances: in addition to the lack of agreement among both pharmaceutical companies and governments, there were concerns about the scheme's potential effects on prices and production itself, which risked increasing rather than decreasing (McAllister 1999, p. 95). However, the idea of establishing an annual estimate of national drug needs survived and became the cornerstone of the 1931 Convention. Under this system, each country was required, by 1 August each year, to submit an estimate of the amount of controlled substances it anticipated needing in the following year. Estimates could be revised in case of a health emergency. Once a nation reached its declared quota, it was obligated to cease production or importation.

Importantly, supplier countries did not have to be named in advance, allowing buyers to procure drugs at the most favorable market price. Controlled substances were categorized into schedules, allowing differentiated regulatory regimes based on their perceived dangerousness. An additional oversight authority, the Drug Supervisory Body, was created to examine the estimates of each country and territory, even of non-signatory states. However, its authority was deliberately limited: governments accepted only a system of indirect and subsequent scrutiny of their estimates and left enforcement authority solely in the hands of the Permanent Central Board, which had gained a reputation for caution and a non-confrontational approach (Musto 1999, p. 215; McAllister 1999, pp. 96–97).

A few months later, in November, delegations from Great Britain, France, the Netherlands, Portugal, Siam, India, and Japan met in Bangkok. These same delegations had participated six years earlier, alongside China, in the first of the two conferences held in Geneva. Based on the agreements reached there, they convened again—two years behind schedule—for a conference focused on repressing the practice of opium smoking. China's absence sent a clear signal of the low expectations surrounding the meeting, which in fact concluded with an agreement that reaffirmed principles already established at The Hague and Geneva, without introducing any new mechanisms of control (Taylor 1969, p. 279).

The 1931 Convention had succeeded in replacing some of the vague principles adopted in previous meetings with more precise and binding rules. Many countries, convinced of the control regime's effectiveness, rigorously applied its provisions, cooperating actively with the Permanent Central Board and the Drug Supervisory Body, which collected data and monitored global drug traffic. Even the most reluctant governments were pressured into compliance through significant diplomatic and economic measures: for

instance, when the United States threatened to inspect all ships arriving from countries that had not meaningfully committed to controlling drug production, manufacture, and export, Turkey swiftly adjusted its policies (McAllister 1999, p. 108).

Of course, not everything went as hoped. The almost exclusive focus on the supply side had led to a sharp reduction in the legal manufacture and trade of drugs, but the absence of corresponding investigations into the demand side left major gaps in understanding both the etiology and true scope of drug consumption. The entry into force of the conventions had, somewhat unexpectedly, fostered the rapid growth of criminal organizations engaged in illegal drug production and trafficking (ibid., p. 120), along with the accompanying violence, corruption, and crime that inevitably accompanies black market economies.

This reality soon prompted discussions about the need for a new treaty to standardize penalties for traffickers and their accomplices and to facilitate international extradition agreements (ibid.).

Various national and international actors began to consider the advisability of convening a new conference. The League of Nations, in particular, was desperate for a diplomatic success that might revive its crumbling prestige as international tensions escalated.

On 24 February 1933, the League's Assembly passed a resolution urging Japan to return Manchuria to China, approved by forty-two votes in favor and only one against—that of the Japanese representative Yosuke Matsuoka. When the President of the Assembly, Belgian diplomat Paul Hymans, declared the resolution unanimously adopted, discounting the votes of the directly involved parties, Matsuoka left the Assembly, vowing not to return (Brown 1933). A month later, on 27 March, Japan formally notified its withdrawal from the League of Nations.

In October of the same year, only seven years after its initial accession, Germany under the newly appointed Chancellor Adolf Hitler also announced its withdrawal from both the League of Nations and the World Disarmament Conference, which subsequently collapsed in 1934.

These two defections alone posed a serious risk of dismantling the control regime developed under the 1925 and 1931 Conventions. The League of Nations moved swiftly to maintain open lines of communication and, in part, succeeded: although Japan did not ratify the 1931 Convention, it maintained representation on the Opium Advisory Committee and the Permanent Central Board. Germany, for its part, withdrew its delegates but continued to comply with the treaties' provisions.

Meanwhile, the situation in Asia continued to spiral out of control. India's commitment to reducing opium exports was severely undermined by the growing exports from Persia, whose economy had become even more reliant on opium following the 1929 financial crisis. One of the main destinations for Persian opium was the puppet state of Manchukuo, established in Manchuria under Japanese control.

Manchukuo quickly expanded its imports, including opium from Turkey and Afghanistan. It sold part of this opium domestically and across the Chinese border, while using the rest to produce heroin and morphine, which subsequently flowed in large quantities across the Pacific to the United States and Canada (McAllister 1999, pp. 114–115).

In China, meanwhile, opium cultivation oscillated between prohibition and encouragement under Chiang Kai-shek's nationalist government. On one hand, the government recognized the immense threat posed by opium to Chinese society and sought international legitimacy by cracking down on its production. On the other, financial desperation drove it to tolerate or even

encourage opium production to fund the struggle against warlords, Japanese forces, and Communist insurgents (ibid.).

Complicating matters further, rising global tensions led governments to increase drug production, imports, and stockpiling as a precautionary measure in anticipation of future conflicts (ibid., p. 106).

In this deteriorating context, the League of Nations sought to reassert its relevance by convening the Conference for the Suppression of the Illicit Traffic in Dangerous Drugs in Geneva. In February 1936, the United States received an invitation to participate.

Only four years earlier, the American government had expressed disinterest in attending further international drug conferences, arguing that the 1931 Convention already provided the necessary instruments to combat drug trafficking and that the real challenge lay in effective implementation. Moreover, since the 1920s, the United States had signed numerous bilateral agreements on extradition and information-sharing regarding drug offenses (Taylor 1969, p. 290).

Even within the Federal Bureau of Narcotics (FBN), there were significant reservations. The draft agreement promoted by the League envisioned criminal sanctions for drug violations, a domain that, under the U.S. Constitution, was reserved to individual states. The Harrison Act had survived Supreme Court scrutiny only because it was structured as a tax measure, not a criminal statute.

Thus, adopting a framework similar to the League's proposal could have jeopardized both the constitutionality of federal drug policy and the autonomy of the FBN itself.

Adding to the Bureau's anxieties, Secretary of the Treasury Henry Morgenthau Jr. had even proposed its dismantlement. The FBN's leadership, notably Director Harry J. Anslinger and his allies, fought to preserve the

Bureau, arguing that international obligations made its existence not only legitimate but indispensable. As McAllister notes:

> *The threat to the FBN caused Fuller and Anslinger to reconsider their opposition to the upcoming anti-trafficking convention. It would hardly do to reject the League's invitation at the same time that the FBN claimed international cooperation as a key* raison d'être. (McAllister 1999, p. 89)

According to Musto, another factor that influenced the United States' decision to accept the League of Nations' invitation was the possibility of finally achieving a convention that would impose controls not only on opium poppy cultivation but also on another plant that had recently come under scrutiny: cannabis.

Although early attempts to regulate cannabis date back to the beginning of the twentieth century, before the Marihuana Tax Act of 1937 the only federal law addressing the issue was the Pure Food and Drug Act of 1906, which merely required that the presence of cannabis (among other substances) be indicated on the labels of products sold to the public. Cannabis—then commonly referred to as Indian hemp—had various uses beyond its medicinal applications: it was employed industrially in the production of rope, paper, and textiles, and its seeds were used in bird feed and in the manufacture of paints and varnishes (Becker 1966, p. 143).

In the absence of comprehensive federal legislation, several American states had adopted measures to restrict the sale and possession of cannabis, yet during the 1920s, the plant did not provoke significant public concern (Musto 1999, p. 219).

Public perceptions of cannabis' risks, harmfulness, and moral standing were not uniform across the United States. In particular, southern states exhibited heightened alarm, largely because cannabis use was associated with Mexican

immigrants, who had arrived in large numbers during and after the Mexican civil war (1910–1920).

The narrative surrounding Mexican immigrants and cannabis paralleled earlier dynamics involving Chinese immigrants and opium: while Mexican labor had made substantial contributions to the American economy, racism was deeply entrenched, and the influx of immigrants was perceived as a threat to local workers, especially during the economic downturn triggered by the Great Depression. As unemployment soared, working-class resentment merged with the agendas of racist organizations such as the American Coalition (Musto 1999, pp. 219–220).

In this climate, cannabis—now increasingly referred to by its Spanish name, *marijuana* or *marihuana*—was recast in public discourse as an exotic and menacing substance, a linguistic shift that served to intensify xenophobic fears.

Initially, the Federal Bureau of Narcotics (FBN) did not regard cannabis as a significant national issue, preferring to leave its regulation to state authorities. In its 1932 annual report, the Bureau suggested that the press was devoting disproportionate attention to cannabis, unnecessarily alarming the public; even FBN Director Harry J. Anslinger endorsed this view (Musto 1999, pp. 221–222).

However, the Bureau's stance shifted by 1935. By January 1936, Anslinger was actively campaigning for the passage of federal legislation to regulate cannabis, a goal achieved in 1937 with the enactment of the Marihuana Tax Act. Like the Harrison Act of 1914, this new law adopted a fiscal guise, imposing a tax regime as a means of criminalizing the substance.

Various theories have circulated regarding the motivations behind the Marihuana Tax Act. Some claim that figures such as Andrew Mellon, Randolph Hearst, and the Du Pont family championed the legislation to

eliminate hemp as a competitor to their commercial interests. While this narrative has gained traction (as a quick Google search will confirm), it lacks definitive documentary support.

A more plausible and historically grounded explanation attributes the federal crackdown on cannabis to a combination of racism, sensationalist media coverage, and pseudo-scientific studies that had little to do with rigorous scientific inquiry.

This perspective was later affirmed by the Commission on Marihuana and Drug Abuse, whose report *Marihuana: A Signal of Misunderstanding*—commissioned and then disregarded by the Nixon administration—highlighted the distorted foundations of early cannabis policy.

> *Not once during this entire period was any comprehensive scientific study undertaken in this country of marihuana or its effects. The drug was assumed to be a "narcotic", to render the user psychologically dependent, to provoke violent crime, and to cause insanity. Although media attention (…), public awareness was low and public debate non-existent. (…)*
>
> *The belief that marihuana is causally linked to crime and other antisocial conduct first assumed prominence during the 1930's as the result of a concerted effort by governmental agencies and the press to alert the American populace to the dangers of marihuana use. Newspapers all over the country began to publish lurid accounts of "marihuana atrocities". In the absence of adequate understanding of the effects of the drug, these largely unsubstantiated stories profoundly influenced public opinion and gave birth to the stereotype of the marihuana user as physically aggressive, lacking in self-control, irresponsible, mentally ill and, perhaps most alarming, criminally inclined and dangerous.* (National Commission on Marihuana and Drug Abuse 1972, pp. 14, 68-69)

A year before the Marihuana Tax Act, between June 8 and 26, 1936, delegates from forty-two countries convened in Geneva for the Conference for the Suppression of Illicit Traffic in Dangerous Drugs.

The American delegation, which included Harry J. Anslinger, immediately adopted an assertive stance, proposing an amendment that would have extended the scope of the new convention to include all substances already regulated by previous treaties—such as raw opium, cannabis, and coca leaves—and criminalized all activities related to cultivation, production, manufacturing, and distribution conducted for purposes other than medical or scientific use. The amendment was ultimately rejected (Taylor 1969, pp. 291–292).

The 1936 convention did not bring about significant changes to the existing regulatory framework. While the United States appreciated certain clauses, it ultimately chose not to sign the document. It took more than three years to secure the ten ratifications necessary for the treaty's entry into force. This objective was achieved on October 26, 1939—almost two months after the outbreak of the Second World War (ibid., p. 296; McAllister 1999, p. 123).

Handovers

The escalating tensions leading to the outbreak of the war, and the conflict itself, drastically altered the landscape.

Since the mid-1930s, the United States had classified opium, coca leaves, and cannabis as essential raw materials for national defense, stockpiling significant reserves and even considering, as a last resort, the cultivation of opium poppies on American soil. By 1940, the United States had accumulated approximately three hundred tons of opium, sufficient to meet domestic needs for four years (McAllister 1999, pp. 130–132).

Throughout the war, the American pharmaceutical industry—unlike those of other major powers—remained largely untouched by the destruction of military operations. This strategic advantage allowed U.S. companies to continue production and trade with fewer obstacles than their competitors. Operating from this position of strength, the United States leveraged its production capabilities to compel other nations to ratify and adhere to international drug control treaties, particularly those countries wishing either to purchase American-produced drugs or to maintain trade relations for cocaine and opium (ibid., pp. 144–145).

The prospect of the United States advancing in Asia and taking control of former European colonial territories—temporarily under Japanese rule—also influenced global drug policy. On November 10, 1943, Great Britain and the Netherlands declared their intention to prohibit opium smoking and dismantle the monopolistic opium systems in their colonial territories (ibid., pp. 150–152).

In the meantime, the international drug control apparatus had entered a period of profound crisis. In 1939, the Soviet Union was expelled from the League of Nations and consequently ceased cooperating with the Permanent Central Opium Board, reflecting deep skepticism about the Board's independence. Great Britain, Germany, and Italy also stopped submitting statistics on drug consumption and production capacity, concerned that such information could aid their enemies. These disruptions, compounded by the operational, political, and financial difficulties brought about by the ongoing conflict, severely weakened the system (McAllister 1999, pp. 136ff.).

When it became apparent that the League of Nations' Secretary General, Joseph Avenol of France, was prepared to hand over the organization to the Third Reich, the United States intervened. Washington offered to relocate the League's technical offices to American soil, initially at the Institute for

Advanced Study in Princeton and later in Washington, D.C. The invitation, however, was strictly limited to technical offices, excluding all political departments. This necessitated a prior assessment of whether the Permanent Central Opium Board (PCOB), the Drug Supervisory Body (DSB), and the Drug Control Service (formerly the Opium Section) could be considered sufficiently independent to justify their transfer. Given their partial autonomy and complex relationships with the League, this was not an obvious determination.

Ultimately, the United States granted visas, financial support, and office space to the members of the DSB and PCOB without formally inviting the organizations themselves. It further prohibited any activities that could be construed as political, including those connected to the Opium Advisory Committee—a body with which the United States had historically maintained a tense relationship (ibid.).

The League of Nations was effectively doomed. Created in the aftermath of the First World War, the outbreak of the Second World War symbolized its failure. Its responsibilities would soon be transferred to a new international organization, the United Nations, which would shift the center of global diplomacy from Geneva to New York and would include among its founding members two major powers absent from or expelled by the League: the United States and the Soviet Union.

Despite the political, administrative, and financial entanglements with the League of Nations, the partial independence of the drug control bodies allowed them to survive through a process of restructuring. The Permanent Central Opium Board and the Drug Supervisory Body were preserved, while the functions of the Opium Section were absorbed by the newly established Division of Narcotic Drugs (DND).

The Opium Advisory Committee, whose last meeting had taken place in 1940, was quietly abandoned. In its place, under the authority of the United Nations Economic and Social Council (ECOSOC), the Commission on Narcotic Drugs (CND) was created. Also involved in the new system, though with a broader mandate, was the World Health Organization (WHO), which succeeded the Health Organization of the League of Nations.

The decision to place the CND under ECOSOC generated concern among some of the most influential figures in international drug policy, including Harry Anslinger and Charles Sharman (head of the Canadian Narcotics Division and the CND's first chairman). They had strongly advocated for a Commission as independent as possible. McAllister writes:

> *If drug control were subsumed within a larger health or social-issues organization, stringent control advocates feared that doctors would pursue ill-advised (i.e. lenient) schemes. To avoid questions about etiology and treatment that challenged their conceptions about the drug problem, Anslinger and Sharman wanted enforcement officials to represent governements. They deprecated the efforts of physicians and others who might espouse a medical or social approach to the problem.* (*ibid.*, pp. 153-154)

The struggle was not merely bureaucratic; it was deeply ideological. It extended beyond figures like Anslinger and Sharman to reflect broader geopolitical tensions. The Soviet Union insisted on granting greater centrality to the WHO's Expert Committee, which Western powers ultimately relegated to a merely advisory role, limited to assessing the addictive potential of substances proposed for international control.

As McAllister notes:

> *Moscow's attention to the social factors underlying abuse made it all the more imperative for western control advocates to subdue consideration of etiological*

> *questions and alternatives to the predominant enforcement paradigm. An admission that addiction might be attributable to factors other than deficiencies residing within the individual would undermine the west's Cold War position.* (*ibid.*, p. 161)

The near-exclusive focus on the supply side of drug control endured, supported by determined allies, a series of robust international conventions valid for years or even decades, and a bureaucratic apparatus established by those conventions. It soon became apparent, however, that a direct confrontation with the Soviet Union was a short-sighted strategy that could threaten the survival of the control regime itself. Consequently, the fierce opposition concerning the division of authority between commissions and committees, and ultimately over a potential rethinking of the ideological foundations of the prohibitionist system, was tempered by a certain tolerance on other sensitive issues. Notably, the Soviets rejected inspections of their production and manufacturing sites and any interference in their domestic trade and consumption, a stance that was tacitly accommodated by Western actors (McAllister 1999).

The division of the world into two opposing blocs generated further complications. Exploiting the postwar chaos, Iran—having reclaimed its original name from Persia—resumed opium production on a massive scale. According to some estimates, between 1947 and 1948, Iran produced approximately 1,800 tons of opium per year, while the global "legitimate" medical demand was around 340 tons annually. Nonetheless, given Iran's valuable oil reserves and the geopolitical risk of pushing Tehran into the Soviet camp, the United States and Britain preferred to avoid confrontation. Indeed, not long thereafter, the United States purchased Iranian opium both to meet the demands of the Korean War and to replenish its strategic reserves in anticipation of a potential conflict with the Soviet Union, which

had completed Operation First Lightning—the detonation of its first nuclear bomb—on August 29, 1949, in Semipalatinsk, Kazakhstan (ibid., pp. 169–170).

Just over a month later, a decisive turning point occurred in the Chinese Civil War (ongoing intermittently since 1927), with Mao Zedong's proclamation of the founding of the People's Republic of China. Despite substantial economic and military support from the United States, Chiang Kai-shek and the Kuomintang nationalists were defeated and retreated to Taiwan, losing control over mainland China. The People's Republic adopted a markedly different approach to drug control compared to the often-ambiguous policies of the Kuomintang—who, in exile, continued financing their operations through the opium trade. Quietly but effectively, within the first three years of Mao's rule, the new government launched a vigorous campaign against opium production and consumption, achieving unprecedented success in curbing the problem (Yongming 2000, pp. 380ff.).

Although opium and derivative consumption in China was under control for the first time in decades, and despite the rapid reactivation of the international drug control apparatus, the global bifurcation into East and West significantly weakened the authority of the Commission on Narcotic Drugs (CND), the Permanent Central Opium Board (PCOB), the Drug Supervisory Body (DSB), and the Division of Narcotic Drugs (DND). These institutions were now forced to operate within a political landscape increasingly shaped by considerations unrelated to drug production, manufacture, or consumption.

Meanwhile, the production of opium and coca continued at levels vastly exceeding legitimate global medical needs, and technological advancements presented new challenges. The emergence of synthetic narcotics, such as pethidine (Demerol) and methadone, posed the first major test for the

postwar control regime. Unlike traditional narcotics, synthetic drugs could be manufactured without processing opium or its derivatives, placing them outside the scope of the 1931 Convention or any prior international treaty on drugs. While the synthesis of these substances offered the tantalizing prospect of eventually eliminating the need for opium cultivation, the absence of regulatory frameworks for synthetic drugs risked creating dangerous loopholes in the global control system.

Recognizing this risk, the international community acted swiftly. On November 19, 1948, the Protocol on Synthetic Narcotics was signed in Paris and entered into force the following year.

The Paris Protocol was the eighth multilateral treaty on drugs[7]; it was during the preliminary work leading to its signature that serious discussions began regarding a rationalization of the prohibitionist system. In two separate resolutions—one adopted in August 1948, the other in July 1949—ECOSOC endorsed the CND's recommendation to negotiate a unified convention that would replace the previous agreements, conventions, and protocols.

However, the Single Convention would have to wait. Leon Steinig, the ambitious director of the UN Division of Narcotic Drugs, entered the scene with a proposal to create an international opium monopoly managed by a specialized agency, with Steinig himself, unsurprisingly, at its head. The agency would set prices, purchase opium from producing countries, and sell it to manufacturing countries. Producing countries would be guaranteed

[7] The six multilateral treaties preceding the Paris Protocol are: the International Opium Convention of 1912 (The Hague); the Agreement on the Manufacture, Internal Trade and Use of Prepared Opium of 1925 (Geneva); the International Opium Convention of 1925 (Geneva); the Convention for the Limitation of the Manufacture and Regulation of the Distribution of Narcotic Drugs of 1931 (Geneva); the Agreement for the Control of Opium Smoking in the Far East of 1931 (Bangkok); the Convention for the Suppression of the Illicit Traffic in Narcotic Drugs of 1936 (Geneva); and the Protocol Transferring Powers and Authority from the League of Nations to the United Nations of 1946 (Lake Success).

stable revenues; manufacturing countries would benefit from stable raw material prices; and consuming countries would continue to buy drugs on the free market, choosing the best offers available. According to Steinig, this mechanism would solve the problem of overproduction (McAllister 1999, p. 173).

Steinig's plan, however, shared the same Achilles' heel as Delevingne's earlier proposal: the impossibility of reaching an agreement among producing countries on the division of market shares. Although his detractors foresaw its failure, there was an unforeseen factor—still hidden—that initially fostered the illusion that the establishment of an international opium monopoly might be feasible: China.

At the end of the civil war, Mao Zedong's communists were determined to eradicate domestic opium consumption. At the same time, they urgently needed resources to finance their programs. The Chinese government decided to offer, on the open market, nearly five hundred tons of opium seized from Chiang Kai-shek's retreating forces. The prospect that China might become a major competitor in the legal opium market pushed the four largest global producers—Turkey, Iran, India, and Yugoslavia—to negotiate and reach a preliminary agreement within just two weeks (ibid., p. 174).

Yet Steinig's illusion was short-lived. Afghanistan, another producing country, demanded a share of the market; agreeing on a fair price for raw opium proved impossible; pharmaceutical companies, fearing an increase in prices, exerted strong pressure on their governments to oppose the plan; manufacturing countries insisted on a strong Agency empowered to inspect production and guarantee compliance with production quotas, while producing countries refused to accept any infringement on their sovereignty. Finally, many governments were unwilling to allocate the necessary initial budget to fund the Agency's purchase operations (ibid., pp. 175–176).

By August 1950, Steinig's plan was effectively dead. The final blow came from one of its fiercest opponents, the French delegate Charles Vaille, who at the sixth session of the CND, held in March and April 1951, proposed instead the convening of a new plenipotentiary conference dedicated to opium cultivation and production, a proposal the CND approved and that ECOSOC subsequently endorsed, scheduling the conference for May 1953.

The conference's objectives were no less ambitious than Steinig's project. Producing countries would have been required to agree on limiting production, to report accurately on cultivated areas and produced quantities, to ensure the safekeeping of opium stocks, and to allow international inspections and potential sanctions.

The Soviet bloc, jealous of its sovereignty and made even more cautious by the sudden death of Joseph Stalin, refused to participate. Iran, on the other hand, found itself in a particularly vulnerable economic position. The nationalization of its oil industry by the government of Mohammad Mossadeq had provoked fierce retaliation from Britain and the United States, including the freezing of Iranian assets abroad and a boycott of Iranian oil exports. By early 1953, Mossadeq's government—destined to fall in August following a coup orchestrated by the CIA and MI6—was desperately short of liquidity and in no position to negotiate forcefully: Iranian delegates at the conference were thus willing to sign measures they would have firmly rejected just a few years earlier (ibid., p. 180)

The Opium Protocol (Protocol for Limiting and Regulating the Cultivation of the Poppy Plant, the Production of, International and Wholesale Trade in, and Use of Opium) was signed in New York on June 23, 1953. The Protocol extended to raw opium the provisions that the 1931 Convention had established for narcotic drugs; it required signatory countries to submit to the DSB and the PCOB estimates regarding opium cultivation, harvesting,

domestic consumption, exports, and stocks. It also provided for sanctions and set a fifteen-year deadline after which only medical and scientific use of opium would be considered legitimate.

The producing countries agreed to sign largely because they succeeded in severely limiting the inspection and enforcement powers of the DSB and PCOB and, most importantly, because they obtained a monopoly on the legal sale of opium. These countries were India, Iran, Yugoslavia, and Turkey. To prevent the agreement from collapsing before its entry into force, Great Britain managed to secure the inclusion of Bulgaria and the Soviet Union, which had not participated in the Conference. Greece was also included, after its delegate threatened to oppose Bulgaria's participation. Vietnam, however, was unsuccessful in its attempt to join (McAllister 1999, p. 181).

As always, signatures were only the beginning: for the Protocol to enter into force, the ratification of at least three producing countries was required. Most manufacturing countries ratified promptly, while Latin American states ignored the Protocol, hoping it would soon be forgotten. Meanwhile, Soviet bloc countries outright rejected it. Besides concerns over sovereignty infringements due to inspection clauses, the Soviet Union raised a political objection to the Protocol's closed list of producers, arguing that all developing countries had the right to exploit their natural resources as they deemed fit (McAllister 1999, p. 207; UNODC 2009b, p. 61).

With the Soviet Union and Bulgaria refusing ratification, only five countries remained as potential ratifiers: India, Iran, Turkey, Yugoslavia, and Greece. India, eager to rehabilitate its international image, had already ratified the Protocol in 1954 and taken measures against the illegal opium trade and quasi-medical use (McAllister 1999, p. 196).

Iran's position changed even more dramatically. Following the 1953 coup that deposed Mohammad Mossadeq and brought Fazlollah Zahedi, a Shah loyalist favored by Britain and the United States, to power, Iran banned poppy cultivation and opium consumption in 1955. Although Iran could no longer supply the global market, it appeared willing to ratify the Protocol. Nevertheless, ratification was repeatedly delayed, as the Iranian government sought to leverage it for greater international financial aid. Under mounting diplomatic pressure, Iran finally ratified in 1959 (McAllister 1999, pp. 196-197, 202-203).

At that point, only one more ratification was needed. Turkey, benefiting from Iran's withdrawal from the opium market, saw no reason to make concessions. Yugoslavia and Greece, meanwhile, were unwilling to ratify unless Turkey did so first.

Turkey also had another reason for stalling: the forthcoming Single Convention, which the CND had been preparing, promised to consolidate all previous treaties. Turkey hoped that through the Single Convention it could secure better conditions, with less stringent regulations and weakened control authorities.

This Turkish hope mirrored the fears of Harry Anslinger and Charles Vaille. Leveraging his position on the CND, Vaille deliberately slowed the progress of the Single Convention and simultaneously worked to strengthen its provisions, aiming to make it less attractive to producer countries. Together with Anslinger, Vaille promoted greater producer representation in the control bodies by supporting the election of Greek and Yugoslav delegates to the PCOB and DSB, and the Turkish representative to the vice-chairmanship of the CND. They hoped such gestures would persuade at least one of the reluctant states to ratify the Protocol.

Whether Vaille's strategy would have succeeded remains unknown: before its effects could materialize, Vaille was appointed Inspector General of Health in Paris and left the international scene. Without his influence, Turkey, Yugoslavia, and Greece delayed further. Greece ratified the Protocol on March 8, 1963, followed by Turkey a few months later. However, by that time, the Single Convention on Narcotic Drugs had already been signed in New York, and its entry into force on December 13, 1964, definitively annulled the Protocol, which had been active for less than two years (UNODC 2009b, p. 60).

The global commitment

The establishment of the prohibitionist regime

The current era of international drug control began on March 30, 1961, with the signing of the Single Convention on Narcotic Drugs in New York—or, more formally, on December 13, 1964, with the entry into force of the treaty following its fortieth ratification, by India.

As Nadelmann explains:

> *If the efforts of the regime proponents prove successful, a fourth stage begins. During this stage, the activity becomes the subject of criminal laws and police action throughout much of the world, and international institutions and conventions emerge to play a coordinating role - that is, a global prohibition regime now comes into existence.* (Nadelmann 1990, p. 485)

It could be argued that the fourth stage of Nadelmann's model had already been reached with the entry into force of the 1925 Conventions, the 1931 Convention, or even the 1953 Protocol. However, it was the Single Convention that definitively placed under international control the world's most widely used (illegal) drug: cannabis (UNODC 2023b).

On the other hand, it could be contended that the mere entry into force of the Single Convention was not sufficient to mark the full establishment of the fourth stage, considering that, as of December 13, 1964, several major players—including Turkey (ratified on May 23, 1967), the United States (May 25, 1967), France (February 19, 1969), Iran (August 30, 1972), Germany

(December 3, 1973), and Yugoslavia (June 23, 1978)—had yet to ratify the treaty.

As previously noted, the history of drug policies is too multilayered and intricate to be divided neatly into rigid phases, and any chosen date for crossing the Rubicon of Nadelmann's fourth stage must inevitably carry a degree of symbolic arbitrariness. What matters is that, during the three decades examined in this chapter—from the early 1960s to the late 1980s—the international drug control system, a system that can legitimately be defined as prohibitionist, achieved for the first time a desired universality.

Yet, in this context, universality did not equate to harmony; rather, it rested upon its antithesis: conflict. Conflict among national interests, economic priorities, and between those wielding regulatory authority and those subjected to it. There is nothing exceptional about this: the clash of divergent wills is the driving force behind both history and law, and the synthesis of these conflicts into a new equilibrium orbiting around—or coinciding with—the will of the strongest remains one of the oldest axioms of human civilization. It was thus inevitable that the evolution of international drug legislation would follow the same logic.

What had changed over time were the geography of power, scientific knowledge, technological capacity, and even the very concept of "drugs" itself. These transformations, as we shall see, would feed an ideological fervor aimed at transforming the citizen into a consumer, the agora into a market, society into a collection of individuals, and drug regulation into the ideal pretext for defending and reinvigorating a pre-existing social order.

A world in turmoil

The world advancing toward the 1960s was undergoing rapid and profound change, witnessing the birth and growth of new hopes, ambitions, and prospects. It was a world thirsty for rights and freedoms, poised for the exploration of space, yet fractured into blocs, teetering on the brink of nuclear war, and tormented by regional conflicts and coups d'état. Formerly wary allies in the war against the Nazi-Fascist regimes—and relatively cooperative at least until the Yalta Conference in February 1945—the United States and the Soviet Union had already rediscovered their rivalry by the Potsdam Conference, which began in July of the same year. By then, the Third Reich had been definitively defeated, and the new American president, Harry Truman—who had succeeded Franklin Delano Roosevelt in April—was preparing to drop nuclear weapons on Hiroshima (August 6) and Nagasaki (August 9). These bombings not only annihilated Japan but also sent a clear signal to the rest of the world, especially to the Soviets. Driven by diametrically opposed ideologies, the two superpowers increasingly found themselves on opposite sides of a rapidly evolving international chessboard. The process of decolonization proceeded unevenly, giving rise to new states—sometimes even to new peoples—and often to fragile governments in search of funding, allies, and legitimacy. Some succeeded in achieving emancipation, others struggled to establish stability, and many found themselves repeatedly confronting the geopolitical and ideological pressures of old empires unwilling to abdicate and new empires eager to inherit the world.

The United Nations, born from the ashes of the ill-fated League of Nations and thanks in part to the efforts of the United States and the Soviet Union, set as its primary objective the maintenance of international peace. Yet, soon after its establishment, the United States and the Soviet Union each created

international alliances of a very different nature: NATO (1949) and the Warsaw Pact (1955), although formally defensive alliances and thus consistent with the Preamble and principles of the UN Charter, effectively relaunched gunboat diplomacy in a nuclear age. The countries and regions caught in this renewed imperial contest included Indochina (1946), Iran (1946 and again in 1953), Korea (1950), Guatemala (1954), and Hungary (1956).

Politics, like history, does not operate within watertight compartments: external tensions inevitably had repercussions on the domestic front, giving rise to years of suspicion, censorship, and witch hunts. In the Soviet Union, the death of Stalin (1953) and the subsequent thaw and de-Stalinization initiated by Nikita Khrushchev led to a gradual loosening of control over the media, arts, and cultural life, and to a cautious opening toward the West. Meanwhile, in the United States, the decline and death of Senator Joseph McCarthy formally put an end to McCarthyism, only to be replaced by a less crude, more insidious approach that would come to characterize the 1960s. Historian Ellen Schrecker (1998, p. 203) has termed this phase Hooverism, after J. Edgar Hoover, who served as director of the FBI from 1935 until his death in 1972. Hoover promoted the infamous COINTELPRO (Counter Intelligence Program), a covert campaign of illegal activities—including infiltration, surveillance, and blackmail—aimed at discrediting and destroying political figures and organizations deemed subversive by the FBI (Church Committee 1976). Targets included Martin Luther King Jr., Malcolm X, the Black Panther Party, the Communist Party USA, the American Indian Movement, and numerous feminist, pacifist, and environmentalist activists and organizations.

In the United States, drugs and drug legislation would play a crucial role in propaganda, the repression of dissent, and, ultimately, geopolitics. In the

1950s, Harry J. Anslinger, as reported in the press (Horvath 2020, p. 28), claimed that Communist China was smuggling heroin into the West to poison its youth and undermine its morale. In the 1960s, J. Edgar Hoover urged federal authorities to seize the opportunity to arrest left-wing activists for possession of marijuana or other prohibited substances (Woodiwiss 1988, p. 167). In the 1970s, Alfred W. McCoy, Cathleen B. Read, and Leonard P. Adams II exposed the CIA's involvement in the surge of heroin production in the so-called Golden Triangle—a vast mountainous area encompassing parts of Myanmar, Laos, and Thailand—the profits of which were used to fund anti-Communist guerrilla forces. In the 1980s, Ronald Reagan relaunched the War on Drugs both domestically and in what, in the parlance of political science and international relations, is often cynically referred to as "America's backyard": Latin America.

Amid this climate of trust and suspicion, hope and tension, revolution and reaction, two additional factors emerged that would profoundly reshape the landscape, first in the United States and later globally.

The first factor was the success of a new medium that would forever transform communication, culture, politics, and society: television. Television had a significant impact on public perceptions of the drug problem. In 1950, the U.S. Senate established the Special Committee to Investigate Organized Crime in Interstate Commerce, chaired by Senator Estes Kefauver. The Committee's hearings, which included discussions on drug trafficking, were broadcast nationwide and attracted massive public interest. One year later, *Life* magazine reported that "[t]he Senate investigation into interstate crime was almost the sole subject of national conversation. Newspapers gave it 10 times as much space as the Korean War" (Horvath 2020, p. 15). The Federal Bureau of Narcotics (FBN) and its director, Harry J. Anslinger, seized this golden opportunity to present their work and achievements in a favorable

light, while calling for greater resources and harsher penalties for drug traffickers. Although the Committee also heard from proponents of a public health–oriented approach to drug policy, from the outset it was clearly receptive to Anslinger's charismatic advocacy, ultimately endorsing his conclusions. Its final recommendations to the Senate were realized with the passage of the Boggs Act in 1951 (ibid., pp. 19–20), that strengthened the enforcement of the Marihuana Tax Act of 1937 and the Narcotic Drug Import and Export Act of 1922 by enforcing harsh penalties on individuals convicted of drug law violations and marked the first time that marijuana and narcotic drugs were considered together in an act of legislation (Kleiman, Hawdon 2011, pp. 96-97).

Although marginalized by the enactment of the Boggs Act, the public health perspective did not disappear from national and international debates on drug regulation. In 1955, the New York Academy of Medicine officially endorsed a social-therapeutic approach to addiction, offering clear and well-founded criticisms of the prevailing system, which it described as ineffective, unjust, and criminogenic (New York Academy of Medicine 1955). While one might argue that the authors of the report were advocating in their own institutional interest, subsequent decades would largely vindicate their observations and conclusions. Nevertheless, 1955 also saw the establishment of the Senate Subcommittee on Improvements in the Federal Criminal Code, chaired by Senator Price Daniel. Its hearings became the new battleground between the FBN and advocates of a public health approach. Recognizing the political opportunity, Daniel arranged for the Subcommittee's hearings to be televised and chose to hold most sessions in his home state of Texas, where he was preparing to run for (and was subsequently elected) governor. In Texas, Daniel adopted a hardline, moralistic stance aligned with local electoral sentiments, and exaggerated the scale of the drug problem—

particularly trafficking across the Mexican border—to such an extent that he even drew criticism from the FBN, whose effectiveness his alarmist rhetoric appeared to call into question. Daniel ultimately mended relations with the FBN in the Subcommittee's final report, which endorsed Anslinger's views and reiterated the unsupported allegation that the spread of drug addiction was a longstanding objective of Communist China (Horvath 2020, pp. 41–44). The result was the passage of the draconian Narcotic Control Act, also known as the Daniel Act, on July 9, 1956. The act introduced minimum sentences for first offenders, increased the penalties and mandatory minimum prison sentences outlined by the Boggs Act of 1951 and introduced the death penalty for those found guilty of selling heroin to anyone under the age of 18 (Kleiman, Hawdon 2011, pp. 543-544).

The second transformative factor was the rapid proliferation of so-called psychotropic drugs: substances such as hallucinogens, barbiturates, tranquilizers, and amphetamines, which for the first time made it possible to treat mental disorders that had previously lacked effective therapies. The quantity and diversity of available psychotropic substances expanded significantly during and after the Second World War (Bruun et al. 1975, p. 17). In Japan, the overproduction of methamphetamine during the war led to a massive surge in its abuse once supplies entered the illicit market. Methamphetamine use quickly spread across the Pacific, while amphetamine consumption rose sharply worldwide (UNODC 2009b, pp. 63–64). The growing use of these new substances alarmed the World Health Organization, whose experts raised concerns as early as 1949 and continued to do so throughout the 1950s (Bruun et al. 1975, p. 17). Nevertheless, driven by the pursuit of profit, pharmaceutical companies and manufacturing states largely ignored the WHO's warnings, downplaying the risks of abuse

(McAllister 1999, p. 201) and resisting efforts to impose stricter regulation at both national and international levels.

Exploiting the regulatory vacuum, pharmaceutical companies aggressively marketed psychotropic drugs. American housewives were among the primary targets of these campaigns: contemporary newspapers and magazines frequently featured advertisements depicting women engaged in household chores alongside slogans such as, «You can't set her free, but you can help her feel less anxious. (…) To help you relieve anxiety and tension, Serax (oxazepam)», «Now she can cope… thanks to Butisol Sodium», «Now she can cook breakfast again… when you prescribe new Mornidine». Thus, psychotropic drugs became integrated into the consumer culture of the postwar economic boom, serving both as an individual coping mechanism and as a tool for sustaining a hierarchical social order structured by wealth, ethnicity, and gender. The legitimate frustrations of millions of women—systematically denied opportunities for self-determination—were pathologized and treated as symptoms of a chemical imbalance: a positivist, ideological, and deliberately myopic approach designed to obscure the social, economic, and political roots of their discontent.

The abuse of psychotropic substances was by no means confined to housewives or the middle class. Between 1949 and 1958, amphetamine production in the United States increased nearly fivefold, from approximately seven tons to thirty-four tons, with at least half of it consumed without legitimate medical need. This was the apex of what Courtwright (2002, p. 79) terms the «amphetamine democracy», whose citizens included students, veterans, truck drivers, celebrities, and politicians alike.

As the world moved into the 1960s, it was a profoundly transformed world, yet still haunted by age-old problems—a world in which history accelerated

but paradoxically repeated itself, making it difficult at times to discern, in Marx's famous formulation (1852), the boundary between tragedy and farce.

The Single Convention on Narcotic Drugs of 1961

The process leading to the adoption of the Single Convention began, as previously noted, in 1948 with the CND's recommendation to negotiate a new convention aimed at rationalizing the existing system by replacing earlier agreements, conventions, and protocols, as well as with two ECOSOC resolutions that formally endorsed this objective. However, Leon Steinig's maneuvers to establish an international opium monopoly, along with the counter-maneuvers by Vaille and Anslinger in support of the 1953 Protocol, delayed and impeded progress.

The first draft of the new convention did not materialize until 1955—seven years after the initial ECOSOC resolution—and instead of simply consolidating existing treaties, it proposed the establishment of a new regime, clearly echoing Steinig's earlier vision of an international opium monopoly. This draft was immediately rejected (McAllister 1999, pp. 204–205).

A second draft was presented the following year. Vaille and his allies had regrouped, integrating many of the provisions of the 1953 Protocol into the new text. Their objective was not only to neutralize Steinig's influence but also to signal to producing countries that had yet to ratify the Protocol that the forthcoming Single Convention would not offer a more favorable alternative than the system approved three years earlier. However, the second draft also proved unsatisfactory, primarily due to its lack of clarity. During the preceding years, the United Nations Division of Narcotic Drugs had undergone significant personnel changes: Gilbert Yates had succeeded Leon Steinig and replaced much of the existing staff. As a result, the responsibility

for drafting the text fell to officials who lacked the necessary expertise for such a delicate task, with predictably disappointing outcomes (ibid.).

Between 1957 and 1958, the CND worked on a third draft, which was simpler and more concise than its predecessor. Although still divisive in certain respects, it was deemed a sufficiently solid basis for negotiation at the future conference convened in New York in January 1961 (ibid.).

The legacy of the 1950s with regard to the control of drug production was complex and ambivalent. On the one hand, the experiences of Iran and India suggested that the concerted efforts of national governments, supported by international cooperation, could yield significant results—specifically, the effective regulation and reduction of opium production. On the other hand, the limitations of such an approach were increasingly evident.

First, early successes in restricting production did not guarantee the achievement of long-term objectives, especially once traffickers and illicit networks had time to adapt and reorganize. More critically, the system's fragility became evident: the failure of a single producing state to replicate enforcement efforts, or its inability to apply regulations uniformly across its territory, was sufficient for production to migrate from more strictly controlled regions to less controlled ones, resulting in no net reduction— a phenomenon later known as the «balloon effect», to which we shall return in a subsequent chapter [see p. 311, 331, 336].

Recognizing that the complete eradication of illicit production was, if not virtually impossible, at least extremely difficult, states increasingly focused on regional control strategies aimed at intercepting traffickers and preventing raw materials from being exported beyond production areas. Both governments and the United Nations promoted cooperation protocols that gave rise to a proliferation of new offices, cabinets, and organizations,

employing an ever-growing number of diplomats, officials, and agents (ibid., p. 200).

Given the often divergent interests of the actors involved, the balance between cooperation and conflict was inevitably fragile. The economic and military power of the United States and European countries had played a significant role in distributing the burdens of the control regime, burdens that fell predominantly on the producing countries. During the 1950s, however, as previously discussed, there was a sharp increase in the manufacture, sale, and consumption of psychotropic substances, often synthetic and produced entirely in the laboratories of pharmaceutical companies based in manufacturing countries.

Despite their undeniable therapeutic value, and despite the interested reassurances of the patent-holding companies, the potential for abuse of amphetamines, barbiturates, and tranquilizers soon became impossible to ignore. Alongside the World Health Organization, the Scandinavian countries were among the first to raise the alarm, reporting an increase in the trafficking and consumption of amphetamines within their territories, exacerbated by the excessively permissive regulations of other European states. Producing countries, led by Turkey, seized the opportunity to demand that international controls and restrictions similar to those imposed on opiates and coca products be extended to psychotropic drugs (ibid., p. 201). While framed in terms of public health protection, this move was likely motivated by strategic considerations: namely, to divert some of the prohibitionist pressure away from narcotics, thereby gaining leverage at the negotiating table and securing a relaxation of the restrictions imposed by the 1953 Protocol, which many producing states had signed reluctantly and had yet to ratify.

In January 1961, seventy-three delegations convened in New York to negotiate the Single Convention. For producing countries, as in previous conferences, the objective was to loosen controls on narcotics—more precisely, on raw materials—and to reduce both the powers of international supervisory bodies and the administrative burdens associated with production. They also advocated for the inclusion of psychotropic substances in the Convention's schedules. Opposing them was a British-led coalition of European powers and Japan, determined to preserve, with minimal adjustments, the existing regulatory framework and to resist any attempt to extend restrictions to psychotropic drugs.

The United States, historically a driving force in previous conferences, adopted a less prominent role on this occasion. This shift was closely linked to the personal trajectory of Harry J. Anslinger. The hearings before Senator Kefauver's Special Committee and Senator Daniel's Subcommittee had provided a major platform for Anslinger and the Federal Bureau of Narcotics (FBN), resulting in two key legislative victories: the Boggs Act and the Narcotic Control Act. Nevertheless, the Bureau's standing had been weakened by rumors of corruption involving some of its officials and by an apparent rise in drug consumption—«apparent» because no reliable data on drug use and addiction existed at the time, largely due to the FBN's systematic refusal to collect such statistics (ibid., p. 191).

Anslinger's international stature had also declined. Frustrated by the relocation of the United Nations Division of Narcotic Drugs from New York to Geneva, he began boycotting CND sessions held in Switzerland, attending (and presiding over) only the 1957 session in New York. Meanwhile, Anslinger had lost two key allies: Colonel Sharman, who ceased to represent Canada at the CND in 1954 and left the DSB in 1958, and Charles Vaille, who was replaced shortly before the 1959 CND session

(though he remained a member of the DSB until 1962). Adding to these setbacks, the illness of Anslinger's wife, Martha, had drained his energy and ambition (ibid., pp. 192, 207).

Despite these circumstances, Anslinger's highly centralized leadership style prevented him from delegating authority effectively, leaving the U.S. State Department and Treasury Department—formally responsible for American drug policy—without clear direction. For the first time, the United States participated in an international drug control conference without any pretense of leadership.

The conference resulted in a significant simplification of the drug control regime, terminating nine of the ten existing treaties; only the 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs remained in force, except for Article 9, which was replaced by Article 36 of the Single Convention. The new provision addressed the criminal measures to be incorporated into the national laws of the contracting parties, including offences related to drug trafficking (such as the laundering of proceeds derived from trafficking) and extradition procedures. The simplification process also extended to the control bodies, with the establishment of the International Narcotics Control Board (INCB), which assumed the functions previously held by the Permanent Central Opium Board and the Drug Supervisory Body. The Division of Narcotic Drugs, however, survived this rationalization.

The fundamental structure of the system remained intact: states were required to submit to the INCB their estimates of annual needs, as well as statistics on quantities imported, exported, produced, consumed, and held in stock. All actors involved in the production, manufacture, and sale of controlled substances were required to be licensed by national authorities and to maintain detailed records of their transactions. The import and export

certification system was also retained, as was the division of substances into schedules subject to different control regimes, a framework first introduced by the 1931 Geneva Convention. However, under the Single Convention, the number of schedules increased from two to four.

The decision-making process regarding the inclusion of substances in the schedules remained a political process, firmly controlled by governmental representatives, with WHO experts relegated to a consultative role, or little more.

Against the advice of the United States, no closed list of producing countries was adopted. In the late 1950s, the legal opium market had experienced an unexpected shortage. Exploiting Iran's prohibition of opium and the declining quality of Indian opium, Turkey concealed its actual stockpiles, compelling buyers to pay inflated prices (ibid., p. 198)—a situation that pharmaceutical companies and manufacturing countries were determined to prevent from recurring. A closed list was also opposed by the Soviet bloc countries, who rejected inspections as infringements upon their sovereignty and objected to the preemptive exclusion of other states they regarded as entitled to exploit their natural resources. Although the United States feared that this concession would trigger a global increase in opium production, it found itself in the minority.

The power imbalance between manufacturing and producing countries influenced the content of the schedules. Manufacturing countries succeeded in excluding psychotropic substances from control and secured the inclusion of synthetic narcotics in Schedules II and III, which entailed less stringent regulation. In contrast, producing countries had to accept the classification of raw materials and simple preparations, including heroin and cocaine, within Schedules I and IV (Schedule IV being a subset of Schedule I and subject to the most restrictive controls). They were also required to comply with a

series of administrative obligations, such as the establishment of specialized agencies responsible for managing the production, storage, and sale of narcotics. Thanks in part to British diplomatic efforts—motivated by the desire to maximize the number of signatures and ratifications—producing countries succeeded in limiting the inspection and disciplinary powers of the control bodies, obtaining a relatively favorable regime for coca production, and avoiding the imposition of strict limitations on cannabis cultivation (ibid., p. 208).

Although the primary focus remained on reducing supply and criminal law continued to serve as the principal strategy of enforcement, the public health approach that had gained traction during the 1950s also found its way into the Single Convention. While severe in combating production and trafficking, the Convention afforded governments a degree of flexibility in addressing drug abuse: it did not mandate the harsh punishment of possession for personal use and, for the first time, required signatory states to guarantee adequate facilities for the treatment and rehabilitation of individuals affected by drug dependence (UNODC 2009b, p. 62).

The final text of the Single Convention represented a defeat for the FBN and for Harry J. Anslinger personally. Since its creation in 1930, the Bureau had cultivated influential allies but also encountered fierce opponents who criticized its modus operandi and doubted its effectiveness, favoring a redistribution of its responsibilities among other agencies. The FBN had defended itself by claiming that its legitimacy—and indeed its necessity—stemmed directly from international obligations. These obligations were effectively undermined with the adoption of the Single Convention. Although Article 17 reaffirmed the duty of parties to «maintain a special administration for the purpose of applying the provisions of this

Convention», its general formulation significantly weakened the FBN's institutional position.

Overall, the United States regarded the Single Convention as more permissive than the combined provisions of the previous treaties it was intended to replace and feared that its implementation would stimulate greater opium production and trafficking. Consequently, it initially refused to sign the treaty. Only six years after the New York conference, in 1967, did the U.S. State Department conclude that the earlier concerns were unfounded and recommend ratification. The United States ultimately ratified the treaty on May 8, 1967, and it entered into force domestically on June 24 of that year (Taylor 1969, p. 336).

The purpose of the Single Convention and the criteria for the formation of the schedules

What, then, was—and remains—the ultimate purpose of the Single Convention? What is the value that, through its fifty-one articles, the parties intended to safeguard?

We have already examined some of the historical events, and the political, economic, social, and personal interests that, through their accumulation and interaction, contributed to constructing the edifice of norms that would later consolidate and evolve into the Single Convention. However, if we attempt to provide a formal answer to the above questions—namely, to identify the good or goods theoretically protected by the Single Convention—we can momentarily set history aside and instead focus on the opening lines of its Preamble, which state:

> *The Parties,*
>
> *Concerned with the health and welfare of mankind,*

> *Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes,*
>
> *Recognizing that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind, (…)*
>
> (UN 1972)

The good that the signatory states intended to protect through the Single Convention and its corresponding domestic implementation measures was therefore, first and foremost, public health, threatened by the abuse (i.e., non-medical use) of certain substances labeled as drugs (or, imprecisely, as narcotics). Secondly, the Convention aimed to prevent the economic and social harms associated with drug abuse, and more precisely, with drug addiction.

This is not the appropriate moment to analyze the consistency between the declared objectives and the means chosen to pursue them; this issue will be examined in detail at a later stage [see pp. 296 ff.]. For now, it is important to understand, given the stated aims, what criteria were used to determine which substances were included in the four Schedules, and why a given substance was assigned to one schedule rather than another.

Article 2, which introduces the Schedules, does not explicitly articulate these criteria; it instead describes the distinct control regimes applicable to each Schedule. Restrictions are progressively relaxed from Schedule I to Schedule III, while Schedule IV is a subset of Schedule I and imposes the strictest controls.

Some insight into the criteria emerges from Article 3, which regulates the procedure for updating the Schedules. Our focus will be primarily on Schedules I and IV, which included, among others, opium, morphine, heroin, coca leaves, cocaine, and cannabis. Article 3 provides that if the World

Health Organization determines that a substance «is liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or Schedule II or is convertible into a drug» the CND may decide to include that substance in Schedule I or Schedule II; if WHO finds that a Schedule I substance «is particularly liable to abuse and to produce ill effects … and that such liability is not offset by substantial therapeutic advantages not possessed by substances other than drugs in Schedule IV», the CND may place that substance in Schedule IV.

Although Article 3 regulates the updating process, the Single Convention remains vague concerning the decision-making criteria originally used to compile Schedules I and IV. More detailed information can be found in the *Commentary on the Single Convention on Narcotic Drugs, 1961*. Its author, Adolf Lande—a former expert member of the Division of Narcotic Drugs and secretary of the PCOB/DSB, and principal drafter of the Single Convention—explains that the Technical Committee of the Plenipotentiary Conference applied two criteria: the «degree of liability to abuse» and the «risk to public health and social welfare».

Specifically, the Technical Committee stated that substances included in Schedule I were those: (a) possessing addiction-producing or addiction-sustaining properties greater than those of codeine and more or less comparable to those of morphine; (b) convertible into substances possessing such properties with an ease or yield sufficient to constitute a risk of abuse greater than codeine; (c) possessing a liability to abuse comparable to that of cannabis, cannabis resin, or cocaine; or (d) convertible into substances with a comparable liability to abuse (UN 1973, p. 86).

As for Schedule IV, the Committee indicated that it included substances already listed in Schedule I which: (a) possessed strong addiction-producing properties or a liability to abuse not offset by therapeutic advantages that

could not be provided by other substances; and/or (b) were deemed appropriate for elimination from general medical practice due to their risk to public health (ibid., p. 94).

Despite these additional specifications, it is evident that a considerable degree of discretion remained. It is not possible to establish objectively—and beyond rough approximation—which substances have «addiction-producing or addiction-sustaining properties greater than those of codeine and more or less comparable to those of morphine», nor to determine with precision which substances exhibite a liability to abuse comparable to entirely different substances such as cannabis and cocaine.

The coca leaves in Schedule I

In 2023, Bolivia submitted a formal request to the World Health Organization for the review of the current classification of coca leaves. The notification to the UN Secretary-General was accompanied by a Supporting Dossier (Estado Plurinacional de Bolivia 2023), which outlined the rationale behind the request and retraced the steps that had led to the inclusion of coca leaves in Schedule I of the Single Convention.

The traditional use of coca leaves among certain South American populations was already a subject of discussion at the first session of the Commission on Narcotic Drugs in 1946; the following year, Peru proposed that the CND study the effects of coca chewing (CND 1947). On 10 August 1948, the Economic and Social Council authorized the dispatch of a commission of inquiry to Peru «to investigate the effects of chewing the coca leaf and the possibilities of limiting its production and controlling its distribution» (ECOSOC 1948); shortly thereafter, the Bolivian government requested that the inquiry also extend to its territory.

The preparatory materials for the commission of inquiry were drafted by the Argentine physician Pablo Osvaldo Wolff, who would later become head of the WHO's Addiction-producing Drugs Section. In 1949, even before the commission departed for Peru and Bolivia, Wolff had already formed a clear opinion on coca leaf chewing. At a meeting on addiction issues in South America, he stated:

> *The indio who does not chew coca leaves is clear-sighted, intelligent, and light-hearted, willing to work, vigorous, and resistant to diseases; the coquero, on the contrary, is abulic, apathetic, lazy, insensitive to his surroundings, his mind is befogged; his emotional reactions are rare and violent, he is morally and intellectually 'anaesthetized,' socially subdued, almost a slave. […] Moral degeneration accompanies the physical; lying is one of the outstanding characteristics, probably due to lack of moral equilibrium. Criminality is high, and barbaric forms of homicide can only be explained by a certain moral insensibility. There is no doubt that the habit of chewing coca leaves is one of the most powerful reasons for the backwardness and misery of the Indian population.* (Wolff 1949, p. 73)

Howard B. Fonda, Vice President of the American Pharmaceutical Association, was appointed to lead the commission of inquiry. Upon his arrival in Lima, he was approached by a journalist from *El Comercio*, who asked whether he considered coca chewing harmful to the inhabitants of the Peruvian highlands. Fonda replied:

> *[the habit of chewing coca leaf] is not only definitely harmful and deleterious, but is the cause of the racial degeneration of many population groups and of the decadence which is obvious in many native inhabitants, and even the half-castes, of certain regions of Peru and Bolivia. Our studies will confirm the truth of our statements, and we hope to be able to submit a rational plan of*

action based on the realities of the situation and on experience in the field, to secure the total eradication of this pernicious habit. (CND 1952, p. 11)

Despite the overtly biased view of both coca leaves and the populations that consumed them, the Commission's final report defined coca chewing as a habit rather than an addiction and noted the absence of withdrawal symptoms (ECOSOC 1950, p. 31). Nevertheless, it recommended limiting coca leaf production to quantities necessary for medical and scientific purposes and called for the complete cessation of coca leaf production for chewing within fifteen years (ibid., pp. 96–98).

Peru and Bolivia raised numerous objections to the report, criticizing its poor scientific value, its lack of objectivity («[the Peruvian Government] will refrain from citing biased and baseless comments and assertions of the kind to which the [Commission] has had such frequent recourse») and calling for a serious and impartial study on the matter (CND 1952, p. 3).

The WHO Expert Committee on Drugs Liable to Produce Addiction discussed the issue at its 1952 and 1954 sessions, with Wolff serving as secretary on both occasions. The Committee defended the commission's findings to the point of contradiction:

The Report of the Commission of Enquiry on the Coca Leaf clearly shows that coca chewing is detrimental to the individual and to society. The Committee therefore was of the opinion that coca chewing comes so closely to the characteristics of addiction, [...] that is must be defined and treated as an addiction, in spite of the occasional absence of some of these characteristics. (WHO 1952, p. 10)

(…) it has taken notice of evidence showing the absorption of cocaine during the chewing process. It was pointed out that there is a wide variation in the amount of cocaine ingested between coca chewers, just as there is among

> *individuals who take pure alkaloid for non-medical purposes. The term cocainism is applicable to the latter and […] coca chewing (cocaism) must be considered a form of cocainism.* (WHO 1954, p. 10)

Based on a report from a highly partial commission of inquiry and its creative and pejorative reinterpretation by an equally biased expert committee, coca leaves were placed in Schedule I of the Single Convention. Coca chewing—a practice with millennia-old roots in South American culture (Dillehay et al. 2010)—was to be completely abolished within twenty-five years of the Convention's entry into force. Meanwhile, under Article 27, the Coca-Cola Company was allowed to continue importing coca leaves for use as a flavoring agent. This exception was secured largely thanks to Harry J. Anslinger, who, since the 1930s, had cultivated strong ties with Ralph Hayes, Vice President of the Coca-Cola Company, and representatives of Maywood Chemical Works, which supplied Coca-Cola with various ingredients, including caffeine from kola nuts and Merchandise No. 5, the flavoring derived from coca leaves (Cortés 2012; McAllister 1999, p. 210). *Quod licet Iovi, non licet bovi*.

The distortions described above were insufficient to prompt reconsideration by the international drug control bodies, leading Bolivia to withdraw from the Single Convention in 2011 and to re-accede in 2013 with a special reservation regarding the traditional practice of coca chewing. Of the 183 contracting parties at the time, only fifteen opposed Bolivia's re-accession with reservations: the United States, the United Kingdom, Sweden, Italy, Canada, France, Germany, Russia, the Netherlands, Portugal, Finland, Israel, Ireland, Japan, and Mexico—the latter being the only Latin American country among them.

One criticism raised against Bolivia by some opposing countries and by the International Narcotics Control Board was that the procedure used was

invalid and that, by setting a precedent, it threatened the integrity of the international drug control system (INCB 2011). However, critics overlooked the fact that Bolivia had adhered to the Single Convention without reservations in 1976, during a period of brutal military dictatorship characterized by a profound disregard for indigenous rights.

A second criticism, notably advanced by the United States, argued that such a reservation would likely increase the availability of coca and, consequently, cocaine on the global market (United States Mission to the United Nations 2012). This position echoed the arguments presented by the WHO Expert Committee on Drug Dependence in 1992, when, again at Bolivia's request, it first reconsidered the removal of coca leaves from Schedule I: the Committee reaffirmed its original stance, asserting that cocaine was «readily extractable» from the leaf (WHO 1993, p. 39). However, even if coca leaves were removed from the schedules, the Single Convention still obliges parties to take measures to prevent their use as a raw material for the illicit production of cocaine. Moreover, the notion that the retail market for coca leaves and derived products such as tea and flour could supply cocaine manufacturers is unfounded. Criminal organizations already have far more direct, secure, and cost-effective sources of supply, and, contrary to the claims of the Expert Committee, cocaine is not «readily extractable»: the extraction process is complex, and, as confirmed by recent UNODC research, approximately one ton of fresh coca leaves is required to produce less than 1.5 kilograms of cocaine at 80% purity (UNODC 2022, p. 169).

From Bolivia's perspective—and increasingly from that of Peru, Colombia, and Argentina—the removal of coca leaves from the schedules of the Single Convention constitutes a necessary step in the broader process of decolonizing Latin America and the Global South, and in restoring the cultural rights of indigenous peoples. This position is now echoed by the

United Nations High Commissioner for Human Rights, whose 2023 report cited the United Nations Declaration on the Rights of Indigenous Peoples, which, in Article 24, affirms that «Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants», as well as the International Guidelines on Human Rights and Drug Policy, which recognize the right of indigenous peoples to be consulted and to give their free, prior, and informed consent regarding measures—including drug control regimes—that affect their lands, resources, cultures, and identities (OHCHR 2023, pp. 12, 17).

At Bolivia's request, the WHO Expert Committee on Drug Dependence has initiated a new assessment of the legal status of coca leaves. Preparatory work began in May 2024, and the conclusions are not expected before the end of 2025. Any recommendation by the WHO to amend the current classification cannot be discussed and voted on by the CND before its sixty-eighth session in December 2025, and it is more likely that the issue will become a central topic at the following session in March 2026.

Cannabis in Schedule IV

Cannabis made its debut on the international drug control agenda in 1925 with its inclusion in the Opium Convention. The Convention did not restrict the cultivation or domestic sale of cannabis but only limited the export of the female inflorescences of *Cannabis sativa* to countries where its importation, sale, and consumption were prohibited; other parts of the plant, useful for various industrial purposes, remained unrestricted, as did the export of flowers to countries that did not prohibit their use. Cannabis was incorporated into the Convention at the proposal of Egypt and approved by

numerous delegations, many of which admitted that they had no prior familiarity with the substance (Kozma 2011, p. 63).

The Convention entered into force in 1928, but this did not prevent cannabis from crossing international borders and reaching the United States and Europe. In 1934, within the Advisory Committee on the Traffic in Opium and Other Dangerous Drugs, the League of Nations established a subcommittee tasked with reviewing cannabis regulation, assessing the consequences of a potential ban on its cultivation, and examining its therapeutic and commercial value. As might be expected, the subcommittee's work and discussions were heavily influenced by the colonialist, moralistic, and classist attitudes of the time, with cannabis users—particularly Arabs and Muslims—depicted as idle, morally lax, and prone to deviant sexual behavior (ibid., pp. 64–67). The subcommittee, however, reached no definitive conclusions, as the outbreak of the Second World War halted its activities.

Cannabis reemerged on the international agenda in 1950, when, at ECOSOC's initiative, the UN Secretariat began drafting the future Single Convention. The starting premise of any discussion on cannabis was that its only legitimate use was medical and scientific, while recreational use was considered inherently harmful. Yet, the lack of robust data on the therapeutic value of cannabis prevented the CND from reaching consensus. Consequently, in 1953, it was decided to gather systematic information on the physical and mental effects of cannabis consumption and to adopt the term «cannabis» in place of the earlier designation «Indian hemp» (Mills 2016).

The research mandate was assigned to the WHO, whose Expert Committee on Drugs Liable to Produce Addiction had previously concluded, after merely fifteen days of work spread over four years, that cannabis and its preparations lacked any medical value (WHO 1952, p. 11). It was unrealistic

to expect a different conclusion in such a brief timeframe. Indeed, the WHO not only confirmed its earlier stance but intensified its position, claiming that cannabis «apparently brings to the surface of the subconscious, vices and tendencies which have been submerged by education and environment, or, in other words, it unleashes the wild beast which is in all of us» (WHO 1955). The author of the final report was Pablo Osvaldo Wolff, whose views have been discussed previously. To a report already deficient in scientific rigor—based in part on documentation provided by the South African government, the architect of the apartheid regime—Wolff appended newspaper clippings describing crimes speciously attributed to cannabis use, which he presented as evidence that cannabis was «a dangerous drug from every point of view, whether physical, mental, social or criminological» (WHO 1955, p. 32).

Not all countries accepted the campaign against cannabis and the complete denial of its potential therapeutic value. India objected that cannabis was used extensively in indigenous medical systems and for treating large segments of the population. Indian representatives inquired whether the WHO study had considered non-Western medical traditions—several of which recognized the therapeutic efficacy of cannabis. The WHO admitted that alternative medical systems had not been considered and reiterated its opposition to any medical use of cannabis (Mills 2016).

Nevertheless, India secured a compromise: the CND recommended that governments abolish the medical use of cannabis, except within three indigenous medical systems—Ayurvedic, Unani, and Tibbi—and that non-medical uses be eliminated within a reasonable timeframe (CND 1957, pp. 33–34). During the same session, the CND was scheduled to consider eighteen national reports from countries where cannabis use was widespread. These reports documented diverse social contexts for cannabis consumption, including poetry contests, folk dances, sporting events, and afternoon social

gatherings—settings far removed from the criminal behaviors described in Wolff's narratives and the sensationalist press accounts he had compiled. The Commission, however, devoted a mere hour and a half to the discussion of these eighteen reports (Mills 2016).

The UN Secretariat reiterated the CND's position, presenting cannabis as a dangerous drug «from every point of view», as Wolff had previously concluded, and framing its use as a grave social evil (UN Secretary-General 1957, p. 11). Nevertheless, it acknowledged that cannabis did not induce physical dependence comparable to that caused by morphine.

Just two years later, the Western dogma denying the medical value of cannabis faced a potential challenge: emerging studies suggested that certain extracts of the cannabis plant possessed antibiotic properties (Krejci 1958; Rabinovich et al. 1959). The discovery of antibiotics—mass-produced since the 1940s—had revolutionized medicine by enabling the treatment of infections that had previously been fatal. In a rare display of unity, the United Kingdom, the United States, Canada, France, the Soviet Union, China, India, Iran, and others supported a resolution urging the WHO to investigate these findings.

Yet, the initial response of Dr. Hans Halbach, WHO representative to the CND, indicated that scientific impartiality was unlikely to prevail. Halbach promptly expressed his belief that the Expert Committee's conclusions would not change and that, given its prior assessments, it was difficult to envisage the reintroduction of cannabis into legitimate medical practice (CND 1959). The WHO's subsequent report, *The Merits of Antibiotic Substances Obtainable from Cannabis Sativa* (1960), confirmed these suspicions: the authors dismissed the new studies as unreliable, argued that the lack of commercial investment in cannabis-derived antibiotics was indicative of their ineffectiveness, and speculated—without providing comparative studies—

that alternative antibiotics developed through «more orthodox» methods yielded better results (Mills 2016).

The WHO, supported by the United Nations Secretariat, advocated for the complete prohibition of cannabis production, except for small quantities necessary for scientific research. This proposal was rejected outright by many governments, including those of the United Kingdom, India, and Iran, which argued that the production of any substance for medical purposes could not be prohibited under the terms of the Convention. Even Harry J. Anslinger intervened in defense of cannabis, noting that some cannabis-derived products appeared promising for the treatment of certain mental illnesses (ibid.).

Following the conclusion of the negotiations, the Single Convention restricted the production, import, export, distribution, trade, use, and possession of cannabis exclusively to medical and scientific purposes. Cannabis and its resin were placed not only in Schedule I but also in Schedule IV—the most restrictive category—intended, as previously discussed, for substances characterized by a high potential for abuse and dependency, without sufficient therapeutic benefit to justify their availability. Initially, Schedule IV included only cannabis, cannabis resin, heroin, ketobemidone (a potent synthetic opioid), and desomorphine, an opioid approximately ten times stronger than morphine and later infamous as the primary ingredient in Krokodil (Gahr et al. 2012).

Over the decades, numerous opportunities arose to correct the initial distortions. Already at the sixteenth session of the CND—the session immediately following the New York Conference—the representative of the Netherlands reported that several Dutch newspapers, citing the opinions of professionals, had drawn a parallel between cannabis addiction and

alcoholism, asserting that cannabis was no more harmful than alcohol. The observer representing the International Criminal Police Organization (ICPO, now known as Interpol) responded by claiming that cannabis use increased aggressiveness, while the WHO representative insisted that cannabis abuse could be fully equated with addiction and portrayed it as a precursor to the use of more dangerous drugs. The CND reaffirmed its earlier decisions, denouncing dissenting views as «misleading and dangerous» (CND 1961, p. 18).

Throughout the 1960s and 1970s, various national commissions were established to study the effects and regulation of cannabis in greater depth. Among the most notable were the Commission of Inquiry into the Non-Medical Use of Drugs (the Le Dain Commission, Canada) and the National Commission on Marijuana and Drug Abuse (the Shafer Commission, United States). Both commissions completed their work in 1972, reaching similar conclusions: they criticized the unscientific basis of the prohibitionist approach and recommended alternatives to the criminalization of cannabis. Nevertheless, these findings were ignored by the very governments that had commissioned them and failed to influence the international debate.

A revealing illustration of this ideological rigidity is found in a statement by Charles Vaille—by then President of the French *Académie Nationale de Pharmacie* and once again a delegate to the CND—who declared:

> *The question of the relative harmfulness of different variants of cannabis, of taking the drug in small or large doses, etc., was doubtless of theoretical and clinical interest and WHO should certainly continue its investigations along those lines, but such investigations should not be allowed to influence international control measures in any way whatsoever.* (Bruun et al. 1975, p. 202)

Even the theoretical development (in the mid-1970s) and experimental discovery (in the mid-1980s) of the endocannabinoid system—along with the growing understanding of its crucial role in multiple neural functions, including motor control, coordination, learning, memory, emotion, and pain modulation (de Melo Reis et al. 2021)—failed to prompt the WHO or the CND to reassess their positions.

Cannabis remained classified under Schedule IV until 2021, following the CND's decision (based on the ECDD's recommendation) of 2 December 2020. After nearly two years of postponements, the recommendation was approved by a narrow margin: twenty-seven votes in favor, twenty-five against, and one abstention.

The removal of cannabis from Schedule IV finally acknowledged its therapeutic potential and exposed the opacity of the processes by which alleged experts had evaluated substances for inclusion in the Single Convention schedules. Nevertheless, this was not a revolution: for historical and political reasons—rather than medical or scientific considerations—cannabis remains listed in Schedule I, alongside substances such as cocaine, oxycodone, fentanyl, and, notably, the coca leaf.

The non-inclusion of psychotropics

What occurred in New York in March 1961 represented, above all, yet another victory for manufacturing countries and a corresponding defeat for producing countries. Although the latter succeeded in limiting the investigative and sanctioning powers of international organizations, they continued to bear the majority of the burdens associated with drug control. Nevertheless, producing countries had had, at least theoretically, an opportunity to reverse this dynamic and present themselves as the most zealous defenders of public health. This opportunity, as previously noted,

had arisen with the sudden proliferation of so-called «psychotropics»: substances such as hallucinogens, barbiturates, tranquilizers, and stimulants, recently synthesized and marketed not only as remedies for previously untreatable medical conditions but also as a form of social, occupational, and at times even spiritual enhancement for otherwise healthy individuals.

Pharmaceutical companies cynically denied or minimized the risks of abuse and dependence associated with their products. However, the reality soon became evident. As early as 1950, the Expert Committee on Habit-forming Drugs had addressed the issue of chronic barbiturate intoxication, commenting on a study conducted by the United States Public Health Service Hospital in Lexington. The Committee noted that barbiturate intoxication was becoming a source of growing concern among physicians, public health associations, law enforcement agencies, and legislators—not only in the United States—and that the production of barbiturates had been increasing steadily for years, far exceeding legitimate medical needs. In 1948 alone, 336 tons of barbiturates were produced in the United States, a quantity sufficient to provide twenty-four doses to every citizen, and cases of acute intoxication had risen significantly (WHO 1950, pp. 13–14). In response, the Lexington hospital organized a small study to analyze the effects of chronic barbiturate intoxication and the consequences of sudden withdrawal, which indeed occurred in all five subjects:

> *Since chronic barbiturate intoxication resulted in the development of tolerance and dependence, as manifested by a characteristic abstinence syndrome, it must be concluded that the barbiturate are capable of producing addiction.* (*Ibid.*)

Throughout the 1950s, WHO experts consistently acknowledged the addictive potential of barbiturates, amphetamines, and tranquilizers and repeatedly called for stricter control measures. However, unlike narcotics,

these recommendations were directed at individual governments rather than framed within an international regulatory framework, suggesting that national controls were considered sufficient to address the issue (WHO 1954, p. 11; WHO 1957, pp. 9–10).

Manufacturing countries, for their part, prioritized the interests of their pharmaceutical industries both within the CND—where they systematically diluted any resolution aimed at tightening regulation of psychotropics (McAllister 1999, pp. 201–202)—and during the New York Conference, where they successfully prevented the inclusion of psychotropic substances in the convention schedules. Following the failure to integrate psychotropics into the same regulatory framework as narcotics, proponents of international control supported a resolution, appended to the final document, recommending the limitation of psychotropic drug production. Although non-binding, the resolution narrowly failed to pass, falling short by a single vote (ibid., p. 208).

After the boom of the 1950s, the market for psychotropics continued to expand throughout the 1960s, exacerbating problems of abuse and dependence. This development persuaded many Western governments to adopt stricter national regulations, prompting pharmaceutical companies to pursue more aggressive marketing strategies in Asian, African, and Latin American markets. What initially appeared as isolated cases of amphetamine, barbiturate, and tranquilizer abuse gradually coalesced into a global phenomenon by the mid-1960s (UNODC 2009b, p. 64). Although an increasing number of governments introduced restrictions on the production and sale of psychotropic substances, disparities among national regulations allowed manufacturers to relocate production to more permissive jurisdictions and created opportunities for traffickers to link these producers with markets subject to stricter controls.

Protests against manufacturing countries multiplied, fueled by their perceived lack of cooperation. Bypassing the CND—which had proven reluctant to act in a concerted manner—Sweden, in 1965, appealed directly to the relevant WHO commissions to advocate for the imposition of international controls over psychotropic substances. This initiative was soon supported by producing countries, eager to redress earlier imbalances, and by Soviet bloc states, which recognized the political advantages of the battle. Even within manufacturing countries, growing awareness of the risks associated with psychotropic drug abuse prompted numerous doctors, associations, policymakers, and ordinary citizens to call for the establishment of an international control regime similar to that already in place for narcotics.

Between dream and reality

The decade that led to the adoption of the Convention on Psychotropic Substances (1971) and the Protocol Amending the Single Convention (1972) was even more eventful than the previous one. The 1960s, both historically and in the collective imagination, represent the era of counterculture, the collapse of social taboos, and the emergence of new norms concerning civil rights, sexuality, education, fashion, and music. In 1969, humankind would finally set foot on the moon, but not before witnessing the construction of the Berlin Wall (1961), the Cuban Missile Crisis (1962), the assassinations of John F. Kennedy (1963), Malcolm X (1965), and Martin Luther King Jr. (1968), the American escalation in Vietnam (1965), and the Soviet invasion of Czechoslovakia (1968), among other major events.

In this volatile world, drug use surged globally. Nearly one billion people—approximately one-third of the world's population at the beginning of the 1960s—had been born between 1940 and 1955 (Courtwright 2002, p. 45).

During the 1960s, the baby boomer generation reached an age traditionally associated with experimentation, risk-taking, drug use, violence, and crime. They did so within an economic context of unprecedented prosperity, where calorically dense foods, soft drinks, and consumer products promising to simplify life rapidly disappeared from store shelves (Musto 1999, p. 247). Cannabis and heroin were not among these readily available commodities, but their allure nonetheless resonated with the era's broader ideal of freedom—an ideal expressed through increasingly divergent means and objectives, rooted either in the celebration of consumption or in its radical rejection. Drug use became an integral part of the broader protest against traditional culture and values, including patriotism, patriarchy, and hierarchical structures.

For decades, drugs had been framed as symbols of deviance, degeneration, and criminality. Their consumption was associated primarily with ethnic minorities and social groups perceived as alien by mainstream society. Newspapers routinely repeated or fabricated sensationalist narratives, attributing to drug use a causal relationship with murder, robbery, rape, suicide, and the alleged sexual promiscuity of women from «respectable» families who ventured into Black, Hispanic, or Asian neighborhoods.

As Musto observed:

> *(…) members of the generation born in the 1920s grew to maturity with diminishing direct knowledge of, but a great deal of animosity toward, the substances. Their parents had lived through the drawn-out, intense experience with drugs that marked the nation's first wave of narcotics use, peaking around the turn of the century. (…) Not only could the parents convey their fear of drugs, but they had the advantage of direct knowledge, which sustained their conviction and helped instill it in their children. The next generation, the grandchildren or great-grandchildren of those who new about drugs, carried into*

> *the 1960s no direct knowledge of narcotics but had heard exaggerations about them that were in fact minatory rather than informative.* (Musto 1999, p. 245)

As baby boomers began experimenting with drugs—particularly cannabis—they grew increasingly skeptical of the terrifying and obscene tales passed down by earlier generations. If cannabis had been so baselessly demonized, they reasoned, perhaps cocaine and opiates had been similarly misrepresented (Courtwright 2002, p. 51). While this suspicion contained a kernel of truth, it also fostered a new and equally dangerous misconception: the assumption that cannabis, opiates, and cocaine were all relatively harmless and manageable.

With amphetamines still widely available through legal channels, cocaine remained a localized phenomenon, while the use of cannabis and heroin expanded sharply (Musto 1999, p. 248). In the United States, the number of drug-related arrests rose dramatically, from fewer than 30,000 in 1963 to approximately 233,000 in 1969, and would reach 644,000 by 1974 (Mandel, Feldman 1986, pp. 31, 33).

The rise in illicit drug use was paralleled by growing problems related to the abuse of legal substances, including alcohol and pharmaceuticals. In the introduction to a comparative study of the United States and the United Kingdom commissioned by the WHO, Dr. Thomas H. Bewley noted:

> *Like the United Kingdom, [in the United States] far and away the largest problem is alcoholism, with probably at least six million alcoholics, compared with three hundred thousand in the United Kingdom.* (Bewley 1969)

Nevertheless, Bewley specified that he would not address alcoholism in his study, which would instead focus on what he termed the «socially non-acceptable drugs» (ibid.).

Regarding pharmaceuticals, by 1971 the WHO reported:

> *A decade earlier, the pharmacodependence problem concerned only a few countries and was linked with opium derivatives. Today the problem has the size of a pandemic, to which have been added a range of psychotropic substances to which too many young people are addicted.* (Marchant 2013, p. 104)

Throughout the 1960s, several pharmaceuticals crossed the boundary from legitimate medications to substances socially and legally reclassified as drugs. Some substances—such as amphetamines, barbiturates, and tranquilizers—retained their place within the official pharmacopoeia owing to their recognized therapeutic value, although they were subsequently subjected to stricter controls. Others, regardless of any potential medical utility, underwent a process of demonization and criminalization similar to that experienced by cannabis; among the most notable of these was LSD.

Lysergic acid diethylamide (LSD, from the German acronym *Lysergsäure-diethylamid*) was first synthesized in 1938 by Albert Hofmann, a Swiss chemist employed by the pharmaceutical company Sandoz (now Novartis). The aim of his research was to develop a circulatory and respiratory stimulant (an analeptic); from this perspective, however, the new molecule failed to produce the expected results. Five years later, Hofmann, driven by what he later described as «a peculiar presentiment» (Hofmann 1983, p. 14), obtained permission from Sandoz to resume his experiments with LSD. On 16 April 1943, while purifying and crystallizing lysergic acid diethylamide in tartrate form, Hofmann experienced «unusual sensations»—likely the result of accidental dermal absorption of minute quantities of LSD. Upon returning home, he «sank into a not unpleasant intoxicated-like condition, characterized by an extremely stimulated imagination» (ibid., p. 15).

Three days later, intrigued by the experience, Hofmann undertook a self-experiment:

> *4/19/43 16:20: 0.5 cc of ½ promil aqueous solution of diethylamide tartrate orally = 0.25 mg tartrate. Taken diluted with about 10 cc water. Tasteless.*
>
> *17:00: Beginning dizziness, feeling of anxiety, visual distortions, symptoms of paralysis, desire to laugh.*
>
> *Supplement of 4/21: Home by bicycle. From 18:00-ca. 20:00 most sever crisis. (See special report.)* (ibid. p. 16)

Having established the cause-and-effect relationship between LSD and the «unusual sensations» he had experienced, Sandoz sought to determine the potential uses—and commercial viability—of the substance. Initially, Delysid (the trade name for LSD) was distributed as a psychotomimetic agent, a drug capable of temporarily simulating psychotic states; it was believed that such a tool could facilitate a deeper understanding of certain psychiatric disorders, if not their cure. Meanwhile, Sandoz made substantial quantities of Delysid freely available to any researcher who requested it, in the hope of discovering and eventually capitalizing on its therapeutic and commercial potential. LSD was thus tested on a wide range of subjects, across diverse settings, and for various purposes. It quickly gained favor among psychotherapists, who saw in its capacity to «manifest the mind»—the etymological root of the term «psychedelic»—a powerful means of accessing the unconscious.

Research progressed at an intense pace. LSD, along with other psychedelics such as psilocybin (the active compound in hallucinogenic mushrooms, isolated by Hofmann himself for Sandoz in 1958), demonstrated remarkable therapeutic potential from the outset, showing promise in the treatment of depression, addiction, post-traumatic stress disorder, eating disorders, end-

of-life anxiety, and other conditions. Before its prohibition, the United States federal government had invested millions of dollars and funded over one hundred research studies on LSD alone (Pollan 2015).

The relative ease of access to LSD—and later to psilocybin, which Sandoz also distributed with few formal restrictions—fostered not only formal medical and pharmacological research but also a vast field of more empirical and personal experimentation. This broader experimentation engaged a diverse range of individuals, including students, professors, artists, psychologists, scientists, celebrities, and common people.

Many prominent figures spoke publicly about their experiences. In 1959, *Look Magazine* published an article titled *The Curious Story Behind the New Cary Grant*, in which the actor attributed his personal transformation to repeated lysergic experiences (Bergquist 1959). Similarly, in an interview with Thomas Thompson later published in *Queen* and *Life*, Paul McCartney, singer and bassist of the Beatles, declared:

> *After I took it (LSD), it opened my eyes. We only use one-tenth of our brain. Just think what we could accomplish if we could only tap that hidden part. It would mean a whole new world. If the politicians would take LSD, there wouldn't be any more war, poverty or famine.* (Thompson 1967)

It is not difficult to understand the extraordinary appeal of the psychedelic experience—the feeling of connectedness with all things, the dissolution of the ego—particularly in a world increasingly criticized for succumbing to the individualistic and consumerist spiral of the capitalist and militaristic paradigm. Psychedelics quickly found a home among some of the most passionate (or at least the most visible and colorful) opponents of the military-industrial complex, becoming a defining element of a growing countercultural movement.

Timothy Leary emerged as perhaps the most prominent and uncompromising advocate for LSD. A professor of psychology at Harvard University, founder of the Harvard Psilocybin Project, and a leading figure in the counterculture of the time, Leary was captivated by the potential of psychedelics to expand consciousness and reprogram the human mind. Abandoning his early ambitions to contribute to scientific and technical progress, he devoted himself instead to spreading the message of liberation and emancipation associated with the psychedelic experience. His impassioned proselytism would eventually prompt Richard Nixon to label him «the most dangerous man in America», contributing to an already tense climate that led to Sandoz's suspension of LSD production in August 1965, to the prohibition of its manufacture, sale, and possession in many countries over the following years, and ultimately to its inclusion in the schedules of the 1971 Convention on Psychotropic Substances.

In a United States torn apart by protests against the Vietnam War and by the riots following the assassination of Martin Luther King Jr., President Lyndon B. Johnson's decision not to seek re-election, coupled with the subsequent assassination of Robert Kennedy—then the leading candidate in the Democratic primaries—paved the way for the underdog Richard Nixon to secure a narrow victory over Vice President Hubert Humphrey and to capture the White House. Nixon and the Republican Party had relied on the support of Americans who did not take to the streets to challenge the system and who were, in fact, increasingly frustrated by the unrest. To this «silent majority», Nixon promised «peace with honor» in Vietnam and a platform centered on law and order at home.

Like his National Security Advisor and later Secretary of State, Henry Kissinger, Nixon was far from a pacifist: during his presidency, the United States continued to bomb Vietnam, Laos, and Cambodia, and supported

paramilitary groups that overthrew democratically elected governments—including that of Salvador Allende in Chile—in order to establish brutal military dictatorships more aligned with American interests and those of local economic elites. Nonetheless, Nixon fulfilled his pledge to withdraw from Southeast Asia, initiating American disengagement during his first year in office and concluding it with the signing of the Paris Peace Accords in January 1973, at the outset of his second term.

On the domestic front, consistent with his campaign promises, Nixon launched an offensive against what he would later call «public enemy number one»: drug addiction. A war that was nearing its end would be replaced by another war, one that would profoundly shape the following decades.

Nixon's role and intentions in the so-called War on Drugs have been the subject of extensive debate, often complicated by misunderstandings and speculative interpretations. According to journalist Dan Baum, a contributor to the *Wall Street Journal*, the *New York Times Magazine*, and *The New Yorker*, John Ehrlichman—Nixon's longtime advisor for domestic affairs—stated in a 1994 interview:

> *The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying? We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate hippies with marijuana and blacks with heroin, and then criminalizing both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news. Did we know we were lying about the drugs? Of course we did.* (Baum 2016)

The authenticity of Ehrlichman's alleged remarks has been disputed by his children and by several former colleagues, who claimed that the statement

did not reflect the person they knew. Although these defenses may have been motivated by self-interest, it is worth noting that Ehrlichman's relationship with Nixon had deteriorated significantly following the Watergate scandal, in which Ehrlichman played a central role, ultimately serving a prison sentence of eighteen months and being denied a presidential pardon. In later years, Ehrlichman would describe Nixon as «a very pathetic figure in American history» and portray him in an unflattering light in his book *Witness to Power: The Nixon Years* (Ehrlichman 1982). Thus, even if Ehrlichman's statement were genuine, it might reasonably be interpreted as influenced by personal animosity, aimed at casting Nixon's anti-drug policies in a deliberately racist and authoritarian light.

This reading, while plausible, must be approached with caution. Nixon's racism is a well-documented historical fact, evident in both his public and private statements (Bass 2020). Nevertheless, the narrative allegedly proposed by Ehrlichman and reported by Baum risks being overly partial and reductive. Nixon's deep and genuine contempt for drug use is also widely attested (Sherin 2016), and the legislation he enacted does not fully align with the cynical objectives attributed to him. The Comprehensive Drug Abuse Prevention and Control Act, signed into law by Nixon on 27 October 1970, repealed most mandatory minimum sentences for drug-related offenses and reclassified simple possession as a misdemeanor, punishable by a maximum of one year in prison for a first offense. Even in terms of budget allocations, during Nixon's presidency approximately 70% of federal spending on drug policy was directed toward public health initiatives, treatment, education, and prevention programs, while only about 30% was devoted to supply-side interdiction measures—a distribution never again matched in the decades that followed (Lopez 2016a).

The credit for this shift in approach cannot, of course, be attributed solely to the Nixon administration. Already in 1962, President John Fitzgerald Kennedy had convened the White House Conference on Drug Abuse; in January 1963, the Presidential Advisory Commission on Narcotics and Drug Abuse was established. In its final report, the Commission recommended more extensive research on the demand side of drug use and addiction, as well as the dismantling of the Federal Bureau of Narcotics (FBN), with its functions to be reassigned to the Department of Justice and the Department of Health, Education, and Welfare.

The growing recognition of the limitations of punitive measures in combating drug use, combined with the poor results in suppressing trafficking, had tarnished the reputation of the FBN. Orphaned by the retirement of Harry Anslinger in 1962, the Bureau was absorbed in 1968—one year after the United States ratified the Single Convention—by the newly created Bureau of Narcotics and Dangerous Drugs (BNDD), which was incorporated into the Department of Justice rather than the Department of the Treasury. In 1973, the BNDD itself would be absorbed into the Drug Enforcement Administration (DEA).

Meanwhile, the redefinition of addiction as a psychological and physical disorder enabled medical professionals and their public health–oriented approach to gain significant ground. Beginning in 1963, the federal government invested heavily in the creation of community mental health centers, which, unlike the federal narcotic farms championed by Anslinger, did not rigidly adhere to a punitive or penitentiary model. The advocacy of the National Institute of Mental Health, the support of medical and psychiatric associations, and the documented ineffectiveness of punitive policies also contributed to a landmark decision by the Supreme Court in 1962, which characterized addiction as a medical condition rather than a

criminal offense (Robinson v. California). Following this judicial shift, courts increasingly adopted an approach consistent with the medical model (Musto 1999, p. 237).

The acceptance of this new paradigm was further facilitated by the success of methadone maintenance therapy. Unlike heroin or morphine, methadone—a synthetic opioid administered orally—offered two significant advantages: it maintained a stable concentration in the bloodstream throughout the day and lacked the euphoric effects typically associated with intravenous drug use. In addition to its positive impact on public health, methadone maintenance therapy reduced the incidence of so-called economic-compulsive crimes committed by individuals seeking funds to purchase illicit drugs (ibid., pp. 237–238), thereby also contributing to improvements in public safety.

There was yet another factor that contributed to the evolving attitude toward drug use, even within a government not generally inclined toward refined sociological analysis. This factor was directly linked to the Vietnam War. It is estimated that between 1969 and 1972, approximately 35% of Americans who began using heroin were soldiers deployed in the Indo-Pacific theater. A study conducted on a sample of soldiers returning to the United States in September 1971 found that about half had used narcotics during their deployment, and approximately one in five had developed an addiction for at least a certain period (Gfroerer 2018, pp. 10–11).

As previously noted, the formation of legal norms is profoundly influenced by the relationship between the holders of normative power and the social groups upon which those norms are imposed. In the field of drug control, when the affected individuals belonged to marginalized minority groups lacking economic and social influence, the response was often criminalization. Conversely, when the affected individuals were part of more

integrated and respected social groups—such as soldiers, as had also been the case following previous wars—a more constructive, rehabilitative approach was preferred. The widespread use of narcotics, particularly heroin, among Vietnam veterans thus suggested that the Nixon administration would have to incorporate, at least partially, a treatment-oriented strategy.

Is the association between Nixon and the advent of the War on Drugs, then, merely specious? Not exactly. Although *a* war on drugs had begun before his presidency and would escalate significantly with the election of Ronald Reagan, Nixon's two (albeit incomplete) terms represented a crucial turning point in the construction of the current prohibitionist framework and in the consolidation of its ideological tenets, its rhetoric, and its embeddedness within the broader production system.

The Comprehensive Drug Abuse Prevention and Control Act of 1970, in its Title II (the Controlled Substances Act), classified substances into five schedules, placing, among others, cannabis and hallucinogens in Schedule I—ostensibly reserved for substances with no accepted therapeutic value and a high potential for abuse. The Act also established the National Commission on Marijuana and Drug Abuse, tasked with collecting data and conducting hearings to evaluate whether cannabis's temporary classification in Schedule I should be made permanent or revised. The Commission, composed of thirteen members (nine appointed by Nixon) and characterized by a predominantly conservative orientation, immediately commenced its work. Upon learning of the Commission's preliminary conclusions, Nixon summoned its chairman, Raymond P. Shafer, and warned him that the final report would need to portray cannabis in an entirely negative light (Gfroerer 2018, p. 20). Nevertheless, Shafer remained steadfast: «The commission will go where the facts lead us and we will make recommendations accordingly», he had already declared to *The New York Times* (Graham 1972).

The final report, *Marihuana: A Signal of Misunderstanding*, published in 1972, not only criticized cannabis's classification in Schedule I but also challenged the broader criminalization of its use and possession, emphasizing the lack of evidence supporting many of the harms commonly attributed to it. However, the Nixon administration had already decided that ideological imperatives would prevail over empirical findings: the report was summarily ignored, and cannabis's Schedule I classification was confirmed. It was not until 2024 that the Drug Enforcement Administration (DEA) began the process of reclassifying cannabis from Schedule I to Schedule III, reserved for substances with lower abuse potential and recognized therapeutic uses; as of 31 October 2024, this process had yet to be completed (US Department of Justice 2024).

Simultaneously, a strategic shift was underway in the electoral tactics of Nixon and the Republican Party—a shift that had begun in the 1950s and 1960s and would later be known as the Southern Strategy. Rather than seeking to build support among the African American electorate in Northern states, Republicans increasingly courted the votes of disaffected white voters, particularly among the disadvantaged classes of the South, who were hostile to desegregation and civil rights reforms (Brown 2004, pp. 191–192).

Nixon actively worked to undermine the Supreme Court's efforts to desegregate schools (ibid.), and while avoiding overtly racist rhetoric, he consistently emphasized the need to defend law and order, strategically associating civil rights demonstrations and other progressive movements with chaos and anarchy. Nixon and his political allies employed the so-called *dog whistle* technique—a coded and suggestive language that, behind a façade of ambiguity, conveyed a clear and targeted message to white voters. In this context, being «tough on crime» effectively meant being tough on African Americans, hippies, and leftist movements, while deploying the criminal

justice system selectively against crimes associated with lower socio-economic classes, rather than white-collar offenses.

The War on Drugs naturally became intertwined with this broader offensive. In 1972, Nixon announced the creation of the Office for Drug Abuse Law Enforcement, aimed at combating drug proliferation through greater reliance on the penal system. In 1973, he proposed a plan to increase penalties for drug trafficking, including reinstating mandatory minimum sentences: «These are very harsh measures, to be applied within very rigid guidelines and providing only a minimum of sentencing discretion to judges. But circumstances warrant such provisions» (Lopez 2016a). Although this plan was ultimately derailed by the outbreak of the Watergate scandal and Nixon's subsequent resignation, the punitive machinery of prohibition had completed its warm-up phase and was preparing to accelerate. In the same year, 1973, the incarceration rate in the United States—which had remained relatively stable for fifty years—began a sustained upward trajectory that would continue for nearly four decades, largely driven by drug-related incarcerations (National Research Council 2014, p. 33; Rothwell 2015).

Another major innovation introduced at the federal level by the Nixon administration through the Comprehensive Drug Abuse Prevention and Control Act was the so-called *no-knock warrant*, which authorized federal agents to conduct unannounced raids on private homes in order to prevent the destruction of evidence related to drug offenses. Although intended to preserve the element of surprise and enhance officer safety, the practice soon proved highly controversial. Within just four years, Congress temporarily repealed the law, prompted by widespread media reports documenting violent and often unlawful raids conducted by federal agents against private citizens, sometimes entirely unrelated to the crimes under investigation (Dolan 2019, pp. 211–212).

Today, between 20,000 and 80,000 no-knock warrants are executed annually in the United States (Lind 2015). In approximately one-third of these raids, no drugs are found, and in about half of the cases, no weapons are recovered (The Justice Collaborative Institute 2020). Often, the raiding officers are specialized units, heavily armed and not immediately identifiable as law enforcement, equipped with assault rifles and stun grenades. The resulting confusion and fear frequently lead to firefights, sometimes with tragic consequences, including casualties among officers, civilians, children, and pets. Between 2010 and 2016 alone, at least eight officers and thirty-one civilians lost their lives in the course of such operations (Sack 2017).

The rhetoric adopted by Nixon and the expanded use of criminal and paramilitary instruments thus overshadowed the progress made in the fields of terminology, treatment, and sociological understanding. These advancements were not entirely lost but were significantly constrained, and their revolutionary potential remained largely unrealized. The turbulent context of the late 1960s and early 1970s—a period of hope, anger, and disorder—had triggered a reactionary backlash from a ruling power fearful of a potential alliance between the civil rights, labor, and student movements. In this environment, the rapid spread of drug use provided the perfect pretext for embedding anti-drug legislation at the heart of formal social control strategies, marking a decisive shift in the hegemonic struggle between the welfare state and the emerging penal state— a struggle increasingly fought on a terrain tilted to the right.

The 1971 Convention on Psychotropic Substances

Following the surge in consumption and the growing protests of Scandinavian countries, producing countries, the Soviet bloc, as well as various associations, medical professionals, and ordinary citizens, the

internationalization of psychotropic drug control had become inevitable. Nevertheless, the manufacturing countries succeeded in reaffirming their diplomatic influence, securing time to protect the interests of their pharmaceutical industries. In 1967, the Board, the legal office of the United Nations, and the WHO agreed that these new substances could not be incorporated into the schedules of the Single Convention on Narcotic Drugs and that a new treaty would therefore be necessary (McAllister 1999, pp. 227–228). This outcome was the result of an effective lobbying campaign by pharmaceutical companies (Jelsma 2011, pp. 4–5), which had successfully imposed a distinction between «narcotics» and «psychotropics»—a distinction lacking any objective or scientific foundation.

In 2000, the United Nations Drug Control Programme (UNDCP), predecessor of the United Nations Office on Drugs and Crime (UNODC), explicitly advised governments not to replicate this distinction in their national regulations, acknowledging that:

> *(...) the international classification into narcotic drugs and psychotropic substances according to whether the substance is governed by the 1961 Convention or by the 1971 Convention has no conceptual basis. The legal definition of many psychotropic substances is entirely applicable to narcotic drugs, and in many cases, the reverse is true. Even more important, the international classification is not dependent on the risk that the substance poses for health and welfare. Substances which cause a low level of dependence are classified together with narcotic drugs, and highly addictive substances are classified together with psychotropic substances.* (UNDCP 2000, p. 8)

In 2003, the WHO Expert Committee on Drug Dependence (ECDD) likewise confirmed the problematic and misleading nature of this division:

> *Most potent analgesics are controlled under the 1961 Convention, but a few are controlled as psychotropic substances under the 1971 Convention. Of the stimulants of the central nervous system, cocaine is under the 1961 Convention, whereas amphetamines are under the 1971 Convention. Thus, the criteria for choosing between the two Conventions are ambiguous for these classes of drug.* (WHO 2003)

Another striking example of this conceptual confusion is the classification of tetrahydrocannabinol (THC, or delta-9-tetrahydrocannabinol), the primary psychoactive component of cannabis, which is listed in Schedule I of the Convention on Psychotropic Substances, while the cannabis plant itself remains classified under Schedules I and IV of the Single Convention on Narcotic Drugs.

Confident that they could secure a favorable outcome, some pharmaceutical companies eventually shifted their strategy. After having long opposed international regulation, they began to support the establishment of a framework to govern the production and distribution of psychotropic drugs. Common international rules would facilitate global research, development, and marketing activities, streamline regulatory procedures, complicate market entry for new competitors, and potentially lower average control thresholds. Instead of initiating costly and cumbersome domestic authorization processes, many countries would likely adopt international schedules by default. Having averted the risk of seeing their products subjected to the stringent controls of the Single Convention, pharmaceutical companies aimed to secure a new treaty that would impose only minimal restrictions—restrictions whose benefits would, in their view, far outweigh the associated costs (McAllister 1999, pp. 228–231; UNODC 2009b, p. 64).

In 1968, the Commission on Narcotic Drugs entrusted the preparation of the draft of the new treaty to Adolf Lande, a former member of the Division

of Narcotic Drugs and secretary of both the Permanent Central Board and the Drug Supervisory Body. Lande had previously collaborated in the drafting of earlier treaties and had authored the official *Commentary* to the Single Convention. His appointment primarily served to reassure pharmaceutical companies and manufacturing countries, whose interests Lande had consistently defended (McAllister 1999, p. 229).

Lande prepared two drafts of differing rigor; both, however, proposed a regulatory framework significantly less restrictive than that imposed on narcotics. Subsequent negotiations confirmed the deep rift between manufacturing countries—willing to sacrifice only minimal interests—and consuming and producing countries, which advocated for a control regime as close as possible to that of the Single Convention.

The Plenipotentiary Conference convened in Vienna in January 1971, attended by over three hundred delegates representing seventy-five governments, the World Health Organization, the International Narcotics Control Board, Interpol, intergovernmental and non-governmental organizations, and associations and federations representing pharmaceutical industry interests. Among the latter was Adolf Lande himself, serving as a delegate of the Pharmaceutical Manufacturers' Association. Numerous senior executives and employees of major pharmaceutical companies also participated, either as observers or as members of national delegations. The most striking case involved a group of six Latin American countries which, despite having no direct interests in pharmaceutical manufacturing, actively worked to undermine the treaty; it later emerged that their delegate, who barely spoke Spanish, was in fact an employee of Hoffmann-LaRoche (ibid., p. 232).

The Convention on Psychotropic Substances established four new schedules and placed amphetamines, barbiturates, benzodiazepines, and

psychedelics under international control. However, compared to the Single Convention, the restrictions imposed were significantly weaker. States were not required to submit annual estimates of their needs to the INCB, thereby preventing any calculation of global legitimate production. No controls were introduced on the cultivation of plants used as raw materials for certain substances. Whereas the Single Convention extended control measures to derivatives, making it unnecessary to list every possible chemical variation, the Convention on Psychotropic Substances limited itself to just thirty-two specific substances, thereby excluding hundreds—if not thousands—of compounds with similar effects that pharmaceutical companies could easily produce through minor modifications.

Moreover, unlike the Single Convention, the 1971 treaty excluded from control substances that could be converted into psychotropic drugs—many of which would later be included as precursors under the 1988 Convention, thus generating further regulatory confusion (Bewley-Taylor, Jelsma 2011, p. 79). The process for updating the schedules was made more cumbersome, with the CND retaining a dominant role. States were also granted the right to object even to key provisions of the treaty (McAllister 1999, pp. 232–234).

In a paper presented at the first meeting of the Global Commission on Drug Policy in January 2011, Professor Martin Jelsma cited the words of István Bayer, a member of the Division of Narcotic Drugs and secretary of the Technical Committee of the Plenipotentiary Conference:

> *The most important manufacturing and exporting countries tried everything to restrict the scope of control to the minimum and weaken the control measures in such a way that they should not hinder the free international trade … the 1971 Convention consists of two treaties: one for "street drug" hallucinogens in Schedule I and one for pharmaceuticals in Schedule II, III and IV. There are extremely strict control measures for Schedule I substances and very weak ones*

> *for Schedule II and III substances and nothing for Schedule IV substances. The provisions of the 1971 Convention do not allow the monitoring of the movements of international shipments which are necessary for the prevention of their diversion.* (Jelsma 2011, p. 4)

Despite its many limitations, the Convention on Psychotropic Substances did bring a wide range of substances under international control for the first time—substances that had previously been regulated only at the national level. Over the following years, governmental pressure for a more restrictive regime, improved scientific understanding, and evolving regulatory practices would gradually address some of the treaty's most glaring gaps (McAllister 1999, p. 234).

A further, albeit modest, merit of the Convention was its symbolic shift away from an exclusive emphasis on criminalization and supply control. Article 20 committed states to adopt «all practicable measures for the prevention of abuse of psychotropic substances and for the early identification, treatment, education, care, rehabilitation and social reintegration of the persons involved». Although the language was sufficiently vague to allow states to avoid making concrete commitments, it nonetheless marked a recognition—at least at the rhetorical level—of the need for a multidisciplinary approach that also addressed the demand side of the drug problem (ibid.).

The purpose of the Convention on Psychotropics and the criteria for schedules formation

At first glance, the Preamble to the Convention on Psychotropic Substances does not differ markedly from that of the Single Convention:

> *The Parties,*
>
> *Being concerned with the health and welfare of mankind,*

Noting with concern the public health and social problems resulting from the abuse of certain psychotropic substances,

Determined to prevent and combat abuse of such substances and the illicit traffic to which it gives rise, (…) (UN 1971)

A closer examination, however, reveals that the tone of the Convention on Psychotropic Substances is notably less severe. While it expresses concern about «the abuse of *certain* psychotropic substances», it does not invoke the term «addiction», which the Single Convention had characterized as «a serious evil for the individual (…) fraught with social and economic danger to mankind». Although legally non-binding, preambles serve as interpretive guides, illuminating the spirit and objectives of the treaties they introduce.

The psychotropic substances deemed at risk of abuse and illicit trafficking were categorized in a list (the so-called Green List) divided into four schedules, ranked according to the severity of the imposed restrictions, from Schedule I (the most stringent) to Schedule IV. As with the Single Convention, the criteria governing the initial placement of substances into each schedule were not explicitly stated. To reconstruct them, it is necessary to refer to the provisions governing updates to the schedules, specifically Article 2, paragraph 4:

If the World Health Organization finds:

a) That the substance has the capacity to produce

i) 1) A state of dependence, and

2) Central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood, or

ii) Similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and

b) That there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control,

the World Health Organization shall communicate to the Commission an assessment of the substance, including the extent or likelihood of abuse, the degree of seriousness of the public health and social problem and the degree of usefulness of the substance in medical therapy, together with recommendations on control measures, if any, that would be appropriate in the light of its assessment. (*Ibid.*)

Only ten substances were initially placed in Schedule I: along with tetrahydrocannabinol (THC), its isomers, and two synthetic homologues (parahexyl and DMHP), the remaining seven were psychedelic compounds: LSD, psilocybin, psilocin, DMT, DET, mescaline, and DOM. It is worth investigating the rationale behind their inclusion and whether, based on the criteria of Article 2, paragraph 4, they could be placed in Schedule I today.

Psychedelics do indeed produce «central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood»; however, to satisfy clause a) i), a substance must also induce «a state of dependence». As noted in the *Commentary on the Convention on Psychotropic Substances*:

There cannot be any doubt that most substances in the Schedules of the Vienna Convention are dependence-producing. A difference of opinion can be found only in respect of some hallucinogenic substances in Schedule I, especially also in regard to LSD. (…) One can find in reports of [WHO Expert Committee on Drug Dependence] the express or implied view that those hallucinogenics are indeed dependence-producing.

> *The WHO Scientific Group on the Evaluation of Dependence-Producing Drugs which met in 1963, however, stated: "The reports of recent outbreaks of abuse of LSD have not indicated clearly the extent of psychic dependence and there is no evidence of physical dependence".*
>
> *It has on the other hand been found that chronic users of LSD are quite uncommon, and that even they rarely use the substance more frequently than biweekly. Most users tend with time to become less interested in LSD. (…) One may perhaps consider such users as dependent on the use of drugs or psychotropic substances in general, rather than on the use of particular hallucinogenics.* (UN 1976, pp. 51-52)

The issue thus revolves around the definition of «state of dependence». The *Commentary* acknowledges that the concept is broad, encompassing both physical and psychological dimensions, ranging from a mild desire for well-being to a compulsive need for regular doses (ibid., p. 53).

Given the absence of a universally applicable definition of dependence among Schedule I substances, the *Commentary* defers to the WHO's evolving interpretation:

> *In the light of progress made in the understanding of the problem of drug abuse and of changing requirements of public health, the World Health Organization may modify its concept of dependence for the purpose of carrying out that treaty provision.* (*ibid.*, p. 54)

Since 1971, considerable advances have been made in the understanding of substance use. Today, psychedelics are regarded as physiologically safe and non-addictive (Nichols 2016); on the contrary, they are increasingly demonstrating significant therapeutic potential in the treatment of substance use disorders (Winkelman 2014)—a potential already recognized in the 1950s and 1960s before prohibitionist policies halted scientific research.

Thus, if LSD, psilocybin, DMT, and mescaline were not already included in Schedule I, it would now be difficult to justify their inclusion under Article 2, paragraph 4, letter a) i). One might alternatively invoke letter a) ii), which concerns substances capable of provoking «similar abuse and similar ill effects» as those already scheduled. However:

> *It is submitted that it can hardly be assumed that a substance which is not dependence-producing has similar harmful properties to those of a dependence-producing substance already controlled by the Vienna Convention. (…) When determining the similarity of an uncontrolled substance with a controlled dependence-producing substance, [WHO] would not only have to examine whether the uncontrolled substance is dependence-producing in any sense, but more specifically whether both substances have "similar" dependence-producing properties.* (UN 1976, p. 51)

Moreover, under Article 2, paragraph 4, letter b), WHO must establish that «there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem».

The *Commentary* clarifies:

> *If … drug abuse or dependence is likely to be, or is known to be, only sporadic or infrequent in the population, if there is little danger of its spread… and if its adverse effects are likely to be, or are known to be, limited to the individual user, there is no public health problem.* (UN 1976, p. 46)

Similarly, «social problems» must go beyond individual health issues, encompassing societal impacts such as reduced labor productivity or increased public expenditures (ibid., p. 47).

The WHO Expert Committee's Seventeenth Report summarized the criteria for Schedule I inclusion in Schedule I:

> *(a) drugs having a liability to abuse constituting an especially serious risk to public health and having very limited, if any, therapeutic usefulness.* (WHO Expert Committee on Drug Dependence, WHO 1970, p. 11)

Based on these parameters, psychedelics would not qualify for Schedule I placement. In contrast, alcohol would:

> *Alcohol appears to be covered by both definitions of dangerous substances which may be considered for control by the Vienna Convention (…). Alcohol is capable of producing a state of dependence, a central nervous system depression resulting in such disturbances as some of those referred to in clause (i). Alcohol may also be considered to be capable of producing similar abuse and similar ill effects as substances in the Schedule of the Vienna Convention. There is also ample evidence that it is being widely abused so as to constitute a very serious "public health and social problem".* (*ibid.*, pp. 47-48)

However, the *Commentary* asserts:

> *The "public health and social problem" which alcohol presents is not of such a nature as to warrant its being placed under "international control" (…). Alcohol does not "warrant" that type of control because it is not "suitable" for the regime of the Vienna Convention. It appears obvious that the application of the administrative measures for which that treaty provides would not solve or alleviate the alcohol problem.* (*Ibid.*)

Similarly, regarding tobacco:

> *Although it is capable of producing a "state of dependence", it is not capable of producing the central nervous system stimulation (or depression) resulting in any of the disturbances mentioned in the subparagraph (a), clause (i), nor does*

> *it have the capacity to produce "similar abuse and ill effects" similar to those of a substance in a Schedule of the Vienna Convention.* (UN 1976, pp. 48-49)

The author, Adolf Lande, concludes:

> *[Tobacco] is not suitable for the kinds of controls for which the Vienna Convention provides, and which if applied would not make any useful impact on the tobacco problem. That problem, however serious, therefore does not "warrant" the placing of tobacco "under international" control.* (*Ibid.*)

The certainty with which it is asserted that international control would be ineffective for alcohol and tobacco—without comparable skepticism toward the scheduling of psychedelics—is striking. Even granting the plausibility of such claims, it raises fundamental questions: if the primary aim of these conventions is to protect «the health and welfare of mankind», why are the substances responsible for the highest annual mortality rates (Peacock et al. 2018) excluded, while psychedelics—non-addictive and therapeutically promising—are subjected to the strictest controls?

Article 2, paragraph 5, grants the CND authority to update the schedules «bearing in mind the economic, social, legal, administrative and other factors it may consider relevant». This brief provision perhaps reveals more about the real drivers of prohibitionist policies than any official Commentary: rules and their application, far from being purely scientific or public health-driven, have often reflected economic and political pressures.

Unlike other psychotropics, psychedelics were sacrificed to Schedule I because they lacked the backing of governments or pharmaceutical companies convinced of their economic potential. Despite early evidence of their therapeutic promise for conditions such as anxiety, depression,

obsessive-compulsive disorder, post-traumatic stress disorder, and addictions (Carhart-Harris, Goodwin 2017), they were abandoned.

Several hypotheses might explain this neglect.

First, psychedelics were closely associated in the public imagination with the 1960s counterculture, rendering them politically toxic to the eyes of the «silent majority». While some—including Robert Kennedy (MAPS 2012)—recognized their therapeutic value, public opinion, shaped by overwhelmingly negative media coverage, proved resistant.

Second, many psychedelics occur naturally—psilocybin in mushrooms, DMT in plants—making self-cultivation and semi-autonomous treatment conceivable, thus reducing dependence on pharmaceutical companies.

Finally, there is a further consideration regarding the therapeutic purpose and mechanism of action of these substances: in many cases, psychedelics would have constituted a therapeutic alternative to amphetamines, barbiturates, and tranquilizers—an alternative that would have been significantly less profitable for pharmaceutical companies. Unlike amphetamines, barbiturates, and tranquilizers, which require continuous, often daily use, psychedelics, despite the absence of a consolidated therapeutic protocol to date, could plausibly be administered only occasionally, with a few doses over the course of a year—or even a lifetime—sufficing for therapeutic effect. This characteristic would have made them not only commercially unattractive but potentially detrimental to the interests of investors—who were often the same actors producing and profiting from amphetamines, barbiturates, and tranquilizers.

While speculative, these hypotheses converge on a stark reality: the therapeutic potential of psychedelics was suppressed for decades, depriving countless individuals of effective treatments—all sacrificed on the altar of ideology.

UNFDAC and the Protocol Amending the Single Convention

While manufacturing countries were preoccupied with safeguarding their interests by undermining the foundations of the Convention on Psychotropic Substances, the Nixon administration in the United States was increasingly convinced of the need to internationalize its new offensive against narcotics. Domestically, the government's efforts translated into greater resources allocated to treatment, rehabilitation, and prevention, but also to intensified law enforcement activities and harsher penalties for offenders. Internationally, the American strategy appeared to follow the same carrot-and-stick approach.

In 1970, at the request of the United States, ECOSOC convened a special session of the Commission on Narcotic Drugs for the month of September. The American government was dissatisfied with the lack of progress in bilateral negotiations with Turkey, which, according to contemporary estimates reported in a memorandum from the Bureau of Intelligence and Research, was the principal supplier of opium used to produce heroin imported into the United States (accounting for 80%, with an additional 15% coming from Mexico; US Department of State 1970, p. 4). Prime Minister Süleyman Demirel had agreed to reduce the number of provinces authorized to cultivate opium poppy from nine to seven and then to four. Nevertheless, his government faced mounting criticism from the opposition, which accused it of subservience to U.S. interests, claiming that Turkey was treated «like a small African country» (ibid., p. 3). The special session of the CND was thus intended, in part, to bolster Demirel's position by demonstrating that the problem of opium overproduction was a matter of global concern, not merely an American preoccupation.

Naturally, this was not the sole objective of the meeting: the United States also sought to call for enhanced action against illicit production and trafficking, to strengthen control mechanisms, to further restrict cultivation, and to curb demand by promoting treatment, rehabilitation, and education programs. An internal memorandum from the Bureau of Intelligence and Research reveals an additional goal:

> *The meeting may also give the US an opportunity to announce its proposal that the UN undertake pilot project on narcotics control, for which the US would make a special financial contribution.* (*ibid.*, p. 4)

This «pilot project», mentioned almost in passing, would become the most significant innovation to emerge from the special session. With eighteen votes in favor, five abstentions, and no votes against, the CND approved a resolution recommending that ECOSOC and the Secretary-General establish a new funding mechanism: the United Nations Fund for Drug Abuse Control (UNFDAC), intended to combat drug production, trafficking, and consumption.

The United States immediately pledged two million dollars, expressing the hope that the Fund—open to contributions from governments, associations, and private individuals—would reach a budget of five million dollars within its first year of operation.

Among the early supporters of the UNFDAC was Vladimir Kušević, director of the Division of Narcotic Drugs, who sought to encourage donations by personally contributing the five thousand dollars he had received as a reward for his commitment to the fight against drugs. However, this symbolic gesture failed to achieve the desired effect: despite the CND's overwhelming approval of the Fund, many governments viewed the UNFDAC not as a neutral institution but as a tool of American foreign

policy. The United States strongly advocated for the funds to be used primarily for law enforcement and crop replacement projects, rather than for treatment, rehabilitation, and education programs, and pushed to channel the resources toward its allies. Perplexed by these developments, Kušević himself posed a rhetorical question to John Ingersoll, director of the Bureau of Narcotics and Dangerous Drugs: «Who could in these circumstances have any doubts that the Fund is in fact an American undertaking?» (McAllister 1999, p. 238).

Another criticism directed at the Fund concerned the inefficiency and costliness of the bureaucratic machinery established to manage it:

> *A large proportion of the money allocated to the Fund's various programs is in fact spent on supporting an ever-expanding bureaucracy to administer the programs. Indeed many of the Programs appear to serve no purpose other than provide occupation for the enlarged secretariats.* (Bruun et al. 1975, p. 281)

Convinced of the effectiveness of its strategy to relentlessly combat opium production, the United States was determined to pursue this approach irrespective of the success of the United Nations Fund for Drug Abuse Control (UNFDAC). The global landscape of opium production was in constant flux: in 1969, Iran announced its intention to lift the cultivation ban that had been in place since 1955, while Afghanistan, Pakistan, and Southeast Asia continued to produce vast quantities of opium, much of which entered illicit markets (McAllister 1999, p. 235). Nevertheless, Turkey remained the principal priority for the American administration.

In March 1971, Prime Minister Demirel was deposed by the military and replaced by Nihat Erim, who, in June of the same year, issued a decree imposing a total ban on opium production, set to take effect the following year. The ban was financed by thirty-five million dollars in American aid,

intended to compensate farmers and to initiate crop replacement programs—programs that, due to poor planning, would ultimately remain incomplete (Windle 2014).

Despite all the limitations inherent in the ban (which would lead to its repeal as early as 1974), Nixon portrayed the outcome as a major diplomatic victory and described it as the most significant action undertaken to combat global heroin trafficking (Berbers 1971). However, beyond the official rhetoric, it was evident that a bilateral agreement alone would not be sufficient to exert substantial influence over the production and trafficking of opium and its derivatives. Indeed, just two weeks earlier, on June 17, 1971, speaking first before Congress and later at a White House press conference, Nixon had publicly declared what the media, adopting his characteristically militaristic language, would call the war on drugs:

> *To wage an effective war against heroin addiction, we must have international cooperation. In order to secure such cooperation, I am initiating a worldwide escalation in our existing programs for the control of narcotics traffic.* (Nixon 1971)

Washington's diplomatic pressure did not leave the United Nations indifferent: in March 1972, just over a year after the signing of the Convention on Psychotropic Substances, a new plenipotentiary conference was convened in Geneva.

At the New York Conference of 1961 and the Vienna Conference of 1971, the United States had abdicated its traditional role of leadership. In the first case, during a delicate phase of Harry J. Anslinger's long tenure, there had been a lack of coordination and communication among the institutions and diplomats involved; moreover, there was an ill-concealed desire on the American side for the conference to fail, so that the 1953 Opium Protocol

would prevail over the new convention. Ten years later, the United States—both a manufacturing country and a deeply moralistic one—had adopted an intermediate position between countries defending psychotropic substances (and thereby their own economic and political interests) and those advocating for the application of norms comparable to those imposed on narcotics.

This time, however, the United States had no intention of playing a secondary role: it had actively called for the conference, elections were only months away, and President Nixon, seeking re-election, had invested significant political capital in the war on drugs. A prestigious outcome was needed.

Within the U.S. government, there was even discussion of proposing a total ban on opium cultivation, justified by the development of synthetic narcotics that would eliminate the need for natural raw materials. Such a plan, however, had no realistic prospect of success, as it would have required producing countries to capitulate entirely to the interests of manufacturing nations and would likely have caused a surge in consumer prices (McAllister 1999, p. 235).

A more pragmatic strategy focused instead on expanding the regulatory and investigative powers of the INCB, revising the clauses related to data collection and the calculation of national and global needs, and simplifying extradition procedures for drug-related offences. These proposals encountered only limited opposition from the Soviet bloc, which, as previously noted, was particularly protective of its national sovereignty. Otherwise, the proposals were implemented without major difficulty, and a compromise was reached regarding the role of the INCB (ibid., p. 236).

The *Protocol Amending the Single Convention on Narcotic Drugs*, signed on 25 March 1972, did not revolutionize the Single Convention but consolidated its

structure. It followed the example of the Convention on Psychotropic Substances by including clauses dedicated to the treatment, rehabilitation, and prevention of substance abuse, and to alternatives to criminal sanctions for trafficking and possession offences committed by individuals with substance use disorders—although the implementation of these measures was left to the discretion of individual governments (Bewley-Taylor, Jelsma 2011, p. 79).

The previous two decades had radically transformed the landscape within which governments, international organizations, associations, physicians, and social workers operated. The demand for drugs had grown significantly, even among social groups previously perceived as immune to drug use; the very definition of drugs expanded to encompass synthetic substances not derived from opium, coca, or cannabis; and etiological investigation into the causes of drug use began to gain ground over the mere criminalization of consumption. These and other factors contributed to an intensification of national and international regulatory activity, culminating at the dawn of the 1970s with the signing of the Convention on Psychotropic Substances (1971) and the Protocol amending the Single Convention (1972).

The system had reached a high degree of completeness and internal coherence. Yet the fracture between manufacturing, producing, and consuming countries remained a persistent source of conflict, mutual vetoes, and diplomatic sabotage. Despite significant progress, and despite the fact that education, treatment, and rehabilitation had finally been incorporated into the normative framework, the international regime continued to prioritize the supply side of the drug problem and did not fully abandon the dogma of punitive repression. Meanwhile, the production, trafficking, and consumption of drugs continued to grow

The growth of illicit trafficking

The Convention on Psychotropic Substances entered into force on 16 August 1976; the Protocol Amending the Single Convention had already come into force the previous year, in August 1975.

Some of the gaps in the Convention on Psychotropic Substances were subsequently addressed through practice and expert intervention. Alongside the information and data that each country was formally required to submit, the Division of Narcotic Drugs and the International Narcotics Control Board began to collect additional information and voluntary submissions from individual governments, thereby supporting the emergence of a more stringent control regime. Although pharmaceutical companies opposed this development, an increasing number of countries adhered to the new practice, which would soon become customary. Meanwhile, with the support of the Secretariat, the WHO and the Commission on Narcotic Drugs extended control measures to cover substances derived from those already scheduled, thus overcoming one of the most evident limitations of the Convention (McAllister 1999, pp. 241–244).

Many states enacted more specific regulations, strengthened controls, and became more receptive to international cooperation. Development programs funded by national, regional, and UN sources sought to provide economically viable alternatives to the cultivation of opium, coca, and cannabis in rural areas, while Interpol, national police forces, and customs agencies organized meetings to coordinate actions against illicit drug production and trafficking (ibid.). A growing number of professionals from various sectors found employment within the expanding apparatus of drug control.

While the legal cultivation, production, manufacturing, and distribution of scheduled drugs were increasingly subject to rigorous, virtuous, and effective

oversight, the problem of illegal cultivation, production, manufacturing, and distribution was about to escalate dramatically. Whenever one country introduced strict regulations and demonstrated a genuine commitment to enforcing them, production simply shifted elsewhere. Thus, for example, when Turkey implemented its brief ban on opium production, Mexico and the countries of the so-called Golden Triangle—Myanmar, Laos, and Thailand—were ready to assume its role.

The Golden Triangle

The history of opium production in the Golden Triangle began well before the 1970s and involved the complicity—if not of entire governments, then certainly of prominent figures within the ruling classes of France and the United States, alongside various local militias and leaders.

Following the outbreak of World War II and the resulting shortage of raw materials, France actively encouraged opium production in Indochina. In 1948, the French government launched a campaign aimed at reversing this policy, but the situation proved difficult to control. Since 1946, the French colonial army had been engaged in a war against the communist Viet Minh movement, which sought Vietnam's independence. As the conflict became increasingly unpopular in France, the National Assembly drastically cut funding for the expeditionary force. Short of resources to finance clandestine and paramilitary operations against the revolutionaries, French intelligence services turned to drug trafficking to meet their financial needs, initiating what became known as Operation X.

From 1951 onwards, French intelligence controlled the production and trade of opium—from the fields in the mountains of the Golden Triangle to the opium dens of Saigon, where shipments were airlifted. The profits generated were used to forge alliances with various ethnic and religious

factions hostile to the Viet Minh: in exchange for their loyalty, the French paid local leaders, armed their militias, and granted them immunity for a range of lucrative criminal activities (McCoy et al. 1972, pp. 92–95).

In their anti-communist efforts, the French could also rely on American support. The United States provided substantial financial assistance to maintain the French expeditionary force and deployed hundreds of personnel on the ground (ibid., p. 119). Among them was Edward G. Lansdale, an officer in the U.S. Air Force and the CIA. While investigating Viet Minh activities in Laos, Lansdale traveled to the Plain of Jars, on the Xiangkhoang Plateau in northeastern Laos. There, he discovered that, on the orders of General Raoul Salan, commander-in-chief of the expeditionary force, French officers had purchased the 1953 opium crop and airlifted it to Saigon: he had uncovered Operation X.

Outraged, Lansdale immediately reported the matter to his superiors in Washington and recommended a thorough investigation. According to Lansdale himself, the response he received was unequivocal:

> *Don't you have anything else to do? We don't want you to open up this keg of worms since it will be a major embarrassment to a friendly government. So drop your investigation.* (*ibid.*, p. 102)

The Franco-American alliance in Indochina unraveled in 1954, following the convening of the Geneva Peace Conference and the decisive defeat of the French garrison at the Battle of Dien Bien Phu.

At Geneva, thanks largely to the mediation of China and the Soviet Union, the newly elected French Prime Minister, Pierre Mendès-France, and Phạm Văn Đồng, head of the Democratic Republic of Vietnam's government, reached an agreement that temporarily divided Vietnam at the seventeenth parallel. National elections aimed at reunifying the country were scheduled

for July 1956 (Karnow 1985, p. 106). Through this conciliatory move, Mendès-France hoped to maintain French cultural influence and preserve French capital investments in Vietnam.

However, the initiative was poorly received by the United States, particularly by Secretary of State John Foster Dulles, elder brother of CIA Director Allen Dulles.

For the United States, the unification of Vietnam—and the probable victory of the Viet Minh—represented a potential collapse of the anti-communist front across Southeast Asia, a risk that was deemed unacceptable. American objectives and interests differed fundamentally from those of the French. While France had been fighting a colonial war to preserve its influence in Southeast Asia and prevent the dissolution of the French Union, the United States was primarily focused on containing communism and limiting Chinese influence. As later summarized:

> *American interests and objectives were basically different from those of the French. The United States was concerned with the containment of communism and restricting the spread of Chinese influence in Southeast Asia. The immediate U.S. objective was supporting a domino. France, on the other hand, was fighting primarily a colonial war designed to maintain the French presence in Southeast Asia and avoid the crumbling of the French Union. (…)*
>
> *The fact that the American and French means - pushing for military victory -converged in 1950-1954 obscured the fact that the ends of the two nations were inherently incompatible.* (U.S. Department of Defense 1971, Part II, p. A-41)

In May 1955, John Foster Dulles met with France's new Prime Minister, Edgar Faure—who had recently replaced Pierre Mendès-France—and negotiated France's withdrawal from Vietnam. The United States, by

contrast, remained committed to the region, providing political and military support to Ngô Đình Diem, then Prime Minister of South Vietnam. In October 1955, Diem proclaimed himself President of the Republic of South Vietnam. Without sustained American support, Diem would likely have been unable to consolidate his power, and his refusal to hold the reunification elections agreed upon at Geneva would almost certainly have triggered an immediate—and probably successful—intervention by the Viet Minh (McCoy et al. 1972, p. 150).

The French withdrawal and the dismantling of Operation X caused opium imports from Laos into Vietnam to slow significantly, and they nearly ceased when Ngô Đình Diem, a fervent Catholic, launched a harsh campaign against the sale and consumption of opium. However, after only three years, Diem's brother and advisor, Ngô Đình Nhu, head of the secret police, decided to restart the trade in order to finance the repression of revolutionaries and political dissidents. To revive the business, Nhu required only two elements: contact with Laotian opium producers and access to an air fleet, without which the transportation of opium from the Laotian highlands would have been extremely difficult. Establishing contacts with producers proved straightforward, while the transportation issue was initially resolved by involving the Corsican mafia, later supplemented by the use of aircraft operated by the First Transport Group—then conducting intelligence missions for the CIA over Laos—and eventually by commercial and military planes. Soon, large quantities of opium, heroin, and morphine were once again circulating through the streets of Saigon (ibid., pp. 152ff.).

It would take several years before Diem and Nhu completely lost the confidence of the Kennedy administration. The cause was not their direct involvement in the drug trade, but rather their tolerance of widespread corruption, which implicated even the highest levels of government, and

their failure to address the communist threat effectively. On 1 November 1963, with the full support of the American embassy, Diem and Nhu were overthrown in a coup and were captured and killed within hours (ibid., p. 164).

Following a period of intense political instability, the United States recognized that the system of corruption and collusion between government officials, local lords, and criminal organizations—originally developed by the French and consolidated under Diem—was the most effective means of maintaining governance in Saigon and South Vietnam. As a result, U.S. support shifted to Nguyen Cao Kỳ, a cynical and ambiguous figure, little inclined to diplomacy, who chose the corrupt and Machiavellian General Nguyen Ngoc Loan as his chief of intelligence and tasked him with restoring the old system.

As McCoy, Read, and Adams II note:

> *After several years of watching Loan's system in action, Charles Sweet* (an official of the American embassy in Saigon) *feels that there were four major sources of graft in South Vietnam: (1) sale of government jobs by generals or their wives, (2) administrative corruption (graft, kickbacks, bribes, etc.), (3) military corruption (theft of goods and payroll frauds), and (4) the opium traffic. And out of the four, Sweet has concluded that the opium traffic was undeniably the most important source of illicit revenue.* (*ibid.*, p. 169)

The fact that the South Vietnamese government's reliance on this system was tolerated by the American administration did not mean it was accepted by all U.S. officials stationed there. In November 1967, U.S. Customs official George Roberts submitted detailed reports denouncing the involvement of high-ranking South Vietnamese officials in narcotics and gold trafficking, claiming to have gathered substantial evidence to support his allegations. The

reports were ignored by the embassy, and the matter would likely have ended there had an anonymous colleague or subordinate of Roberts not forwarded some of the reports to the Senate Subcommittee on Foreign Aid Expenditures, chaired by Democratic Senator Ernest Gruening. When Gruening declared that the Saigon government was «so corrupt and graft-ridden that it cannot begin to command the loyalty and respect of its citizens», the U.S. Embassy defended Kỳ against the accusations, continuing to do so even after Gruening made public evidence of Kỳ's involvement in the opium trade during 1961–1962 (ibid., p. 172).

The high price of the U.S. Embassy's tolerance—or complicity—became apparent during the 1970s. By the late 1960s, the Golden Triangle was producing approximately 700 tons of raw opium annually (U.S. Bureau of Narcotics and Dangerous Drugs 1970, p. 29), exporting opium and morphine to Europe and Hong Kong, from where the shipments were directed to the United States. Between 1969 and 1970, laboratories in the Golden Triangle also made significant advances in heroin refinement, producing the so-called No. 4 heroin, which had a purity of over 80%, compared to 20–30% for No. 3 heroin. Previously almost absent from Vietnam, No. 4 heroin quickly flooded the streets and military bases. By 1971, U.S. Army medical personnel estimated that 15% to 20% of American soldiers stationed in Vietnam—approximately 25,000 to 37,000 young men—were using heroin (Shuster 1971).

One might suspect that Hanoi was behind this wave of heroin use among U.S. troops; however, investigations revealed no evidence of North Vietnamese involvement. Rather, the main perpetrators of the heroin trade were once again members of the South Vietnamese government, who prioritized the millions of dollars generated by heroin sales over the

operational effectiveness of American forces (McCoy et al. 1972, pp. 182–183).

The Nixon administration, meanwhile, sought to downplay the problem: urine tests administered to soldiers prior to their return to the United States suggested that "only" 5.5% were heroin addicts, and most reportedly smoked or snorted heroin rather than injecting it, supposedly resulting in milder addiction, more easily treated upon return. However, these conclusions overlooked two critical issues: first, that the high purity of heroin in Vietnam meant that even non-injected use could lead to severe dependence; and second, that the official statistics severely underestimated the true scale of addiction.

On 22 June 1971, U.S. military command ordered that every departing soldier undergo a sophisticated urine test capable of detecting morphine in the system. Any soldier testing positive was confined to a detoxification center and barred from returning home until he could pass the test. As McCoy, Read, and Adams II recount:

> *On June 22, 1971, the U.S. military command ordered every GI leaving Vietnam to submit to a sophisticated test that can detect significant amounts of morphine in the body Any GI who tested positively was confined to a special detoxification center and could not be allowed to return home until-he had "dried out" and could pass the test. From the very first, GIs started devising ingenious ways of beating the system. Supervision of the testing centers has been notoriously lax, and many serious addicts pass by bringing a buddy's "clean" urine to the test and substituting it for their own. Since the urinalysis can only detect morphine in the body it the addict has used heroin within the last four or five days, many addicts dry themselves out voluntarily before taking the test. Army nurses have seen addicts who are in the midst of an agonizing withdrawal pass the test.* (*ibid.*, p. 219)

Despite Nixon's promises to provide care and rehabilitation for returning veterans, the U.S. Army discharged thousands of soldiers who failed urine tests twice (ibid., p. 220).

The withdrawal of U.S. troops from Vietnam did not diminish the drug trade originating from Laos: heroin simply followed the military back to the United States and beyond. Over the preceding two decades, opium production had increased at an astonishing rate throughout the Golden Triangle region, and alongside production, the entire supply chain—including global distribution networks—had expanded significantly.

By the early 1950s, Chinese nationalist forces of the Kuomintang (KMT), who had opposed Communist China, had taken refuge in Taiwan, while some troops remained deployed in Myanmar's Shan State, from where they launched unsuccessful raids into China's Yunnan province. Financed and armed by the United States, which viewed them as a crucial bulwark against the southward spread of communism, the KMT guerrillas in Myanmar did not miss the opportunity to invest their energies in the highly profitable opium trade. At that time, the Shan State was only a minor player in global opium production; however, with the arrival of the KMT, cultivation rapidly expanded: while it had produced about forty tons of opium annually at the end of the Second World War, by 1962 production had increased to between three and four hundred tons (ibid., p. 127).

Once again, as in the cases of Diem, Nhu, and Kỳ, it is difficult to believe that the United States was unaware of the parallel—and perhaps by then predominant—activities of its allies. Already in 1952, the *New York Times* and other major newspapers had published detailed reports on the KMT's involvement in opium production and trafficking. In the unlikely event that these reports had escaped the attention of the American administration, another fact highlights U.S. responsibility: opium from Myanmar was

transported to Thailand and entrusted to General Phao Siyanon, head of the Thai police and a key CIA asset. Phao and his forces dominated Bangkok, which by 1954 had emerged as the main distribution hub for opium in Asia; from Bangkok, the drug was trafficked to Malaysia, Indonesia, and Hong Kong (ibid., pp. 91–92, 135).

The support provided by the CIA to Phao and the KMT, combined with the ruthless competition for control of Vietnam, was one of the principal drivers behind the dramatic expansion of opium production and trafficking in the Golden Triangle. Equipped with modern weapons, trained militias, and access to international smuggling networks, traffickers rapidly modernized their operations: mules and riverboats were replaced by air and naval fleets. Within two decades, Southeast Asia became the source of 70% of the illicit opium circulating on the global market (ibid., pp. 144–145, 152)

Mexico and Colombia

Opium poppies arrived in Mexico during the Porfiriato, the period during which Porfirio Díaz ruled Mexico, first as president and later as dictator (briefly between November and December 1876, then from February 1877 to December 1880, and continuously from December 1884 to May 1911). The Porfiriato marked a period of significant transformation for the country: foreign investment expanded, railroads were developed, certain regions experienced rapid industrialization, and the vast plantations of Díaz's wealthy associates spread across Sinaloa, dispossessing many lower-class families of their land and forcing them to seek new means of survival (Grillo 2011, pp. 17ff.).

It was in this context that the cultivation of opium poppies began to spread. In 1912, the first International Opium Convention was signed in The Hague,

followed two years later by the Harrison Act in the United States, which introduced stricter regulations on the traffic of opium and other narcotics.

Everything was in place: there was opium, produced in a country that, despite having banned it, lacked the territorial control necessary to enforce its own laws; there was an army of desperate people willing to traffic opium to support themselves and their families; and there was a massive black market just across a more than three-thousand-kilometer border, whose surveillance even today remains complex—and at the time was virtually nonexistent. The opium poppy plantations in Sinaloa thus came to resemble American dollar plantations (ibid.).

Opium production in Sinaloa surged dramatically during the 1940s. One possible explanation is the existence of a secret agreement between the U.S. and Mexican governments for the supply of opium needed to manufacture morphine. Until then, the United States had relied on Turkish opium, but wartime shortages forced a search for alternatives, including domestic production, which was eventually abandoned. Purchasing Mexican opium would have presented a simpler solution. When questioned, Harry J. Anslinger strongly denied the existence of any such agreement, calling it «utterly fantastic and (…) even beyond the realm of wildest imagination» (Astorga 2003, pp. 138–139). Nevertheless, although definitive proof remains elusive, the hypothesis does not appear entirely implausible (Farfán-Méndez, Porter 2022, pp. 95ff.).

Whatever the case, the opium trade expanded in the 1940s and again in the 1970s, when the Nixon administration secured an agreement to prohibit opium production in Turkey. Once again, Mexican (illegal) opium producers capitalized on the opportunity to fill the gap left by Ankara's ban.

Meanwhile, recreational drug use, once confined to a small niche of consumers, had spread to a much broader audience. This shift profoundly

impacted numerous producing countries across Asia, North Africa, and the Americas, including Mexico. Growing demand transformed opium and cannabis farms into the economic center of one of the country's most important industries.

Unlike opium, cannabis had been cultivated and consumed recreationally in Mexico for centuries. Superior in quality to the strains grown in California and Texas, Mexican cannabis attracted numerous admirers north of the border. Their numbers grew dramatically during the 1960s, when the American cannabis market exploded, and supplies from Mexico became essential not only for their superior quality but also to meet rising demand.

The Nixon administration was not prepared to tolerate this situation. As early as June 1969, just five months after taking office, Nixon dispatched a delegation to Mexico City to persuade President Gustavo Díaz Ordaz to initiate a program aimed at destroying opium and cannabis crops through aerial defoliation. Mexican authorities, concerned about the consequences of defoliant use following the experience of Agent Orange in Vietnam, refused. In response, Nixon launched *Operation Intercept*: on September 21, despite opposition from the State Department and the Office of Management and Budget, the United States effectively "closed" the border with Mexico, patrolling it by land, sea, and air, employing military radar, and inspecting every person and vehicle crossing at checkpoints. Trucks laden with perishable goods were trapped in interminable queues; most Mexican workers with green cards were unable to reach their workplaces; the economies of border cities on both sides suffered acutely. After seventeen days of tension, complaints, mediation efforts, and disappointing seizure results, an agreement was reached leading to *Operation Cooperation*: Mexico committed to destroying opium and cannabis crops without using defoliants and authorized American agents to conduct

operations on Mexican soil, including reconnaissance flights to monitor progress.

Such efforts, however, proved insufficient to reverse consumption trends. Thus, as Nixon launched his re-election campaign, the fight against drugs—both domestically and internationally—remained a cornerstone of his political platform, with Mexico emerging as one of the main targets of U.S. diplomatic pressure. By 1975, after Nixon's resignation and Gerald Ford's assumption of the presidency, the DEA estimated that Mexico supplied 89% of the heroin circulating in the United States (Jelsma 2011, p. 6).

Ultimately, the American government achieved its objective: Mexico launched *Operation Condor*, involving the deployment of thousands of soldiers and, for the first time, the use of defoliants that devastated and poisoned opium and cannabis crops along with the surrounding ecosystem.

For the Mexican government, *Operation Condor* was not merely an act of compliance with U.S. demands. The increasingly wealthy and militarized opium and cannabis growers now posed a genuine threat to the established order. By accepting the American plan, the Mexican authorities obtained helicopters, airplanes, weapons, and funding necessary to defend and consolidate their power. Moreover, *Operation Condor* provided a pretext for attacking left-wing movements, workers, and students protesting against the authoritarian drift of the Partido Revolucionario Institucional (PRI), which had ruled uninterruptedly since 1929 and was deeply implicated in the *Dirty War*—the violent and illegal repression of all forms of dissent. The war on drugs became another arrow in the PRI's quiver, another justification for arresting, torturing, and in many cases killing or disappearing union and student leaders, guerrillas, and common criminals. These actions were carried out with the full awareness—and tacit approval—of the CIA, which knew

that the equipment supplied to Mexican forces was being used for purposes unrelated to drug control (Grillo 2011, pp. 38–54).

Meanwhile, under DEA supervision, Mexican opium crops were sprayed with 2,4-dichlorophenoxyacetic acid, and cannabis crops with paraquat. *Operation Condor* hit hard, yet some traffickers persisted: indifferent or unaware of the risks, they harvested contaminated cannabis and exported it to the United States. Consumption of this tainted product caused irreversible lung damage and, once the contamination risk became public, undermined sales of uncontaminated cannabis as well. On 19 November 1978, the *New York Times* reported:

> *The dangers of paraquat were no secret to the State Department. (…) But (…) when State started funding the Mexican program, there had been no inhalation studies. There would be none until 1977, when Senate investigators forced the issue.*
>
> *This March, Secretary of Health, Education and Welfare Joseph Califano announced the disturbing results of those tests: Heavy users of this tainted marijuana might develop fibrosis, an irreversible lung disease, and "clinically measurable damage" might befall less frequent smokers.*
>
> *(…) this poisoned marijuana is generally indistinguishable from the ordinary Mexican product.* (Kornbluth 1978)

Warnings issued by public health institutions had little impact on the volume of cannabis trafficking, but they did influence the configuration of trafficking routes. The temporary collapse of demand for Mexican cannabis created an opening for Colombia, which swiftly captured a significant share of the U.S. market and, in doing so, developed the financial resources and operational expertise that would later serve as the foundation for a new drug trafficking empire (ibid.).

Today, any mention of drug trafficking in connection with Colombia evokes an almost immediate association with cocaine. Figures such as Pablo Escobar, the Ochoa brothers and the Medellín cartel, as well as Gilberto and Miguel Rodríguez Orejuela and the Cali cartel, have firmly embedded in the collective imagination the image of Colombia as the homeland of the infamous white powder. This perception is not without basis: in 2022, it was estimated that approximately 230,000 hectares in Colombia were dedicated to coca cultivation, with the potential to yield around 1,738 tonnes of 100% pure cocaine—roughly two-thirds of global production (UNODC 2023a, p. 13).

Historically, however, Colombia first emerged as a major actor in the international drug trade through its production of cannabis (U.S. Senate Foreign Relations Committee 1989, p. 26).

Introduced by Panamanian growers in the late 19th and early 20th centuries, cannabis cultivation in Colombia remained marginal until the 1960s, when it began to expand significantly in response to growing domestic demand. The real turning point came after the United States intensified its crackdown on Mexican cannabis, including the aerial spraying of toxic defoliants on plantations in Sinaloa and Guerrero. This led to a redirection of cannabis flows, with Colombian growers stepping in to meet the demand. The transition was swift: by the late 1970s, Colombia had overtaken Mexico as the world's leading cannabis exporter (Bagley 1988, p. 78).

Any organization seeking to dominate an illicit market cannot rely solely on production; it also requires a criminal infrastructure capable of moving goods from points of origin to points of sale, personnel to manage both wholesale and retail distribution, weapons to secure and defend territory, and politicians and law enforcement officials willing to provide protection. The cannabis trade enabled Colombian traffickers to establish the logistical and

institutional foundations that would later underpin their core enterprise: cocaine trafficking (U.S. Senate Foreign Relations Committee 1989, p. 27).

Cocaine's appeal has long stemmed from several interrelated factors: it is considerably more valuable than most other illegal substances—particularly cannabis—when measured by weight and volume; it is derived from coca, a plant that, while limited in geographic adaptability, is relatively easy to cultivate under suitable conditions; and the chemical process required to extract the alkaloid is not particularly complex (Thoumi 2002, pp. 104–105).

The export of cocaine from Colombia to the United States began in the late 1960s, when a small group of Cuban-Americans based in Miami identified Florida as an ideal entry point for transporting a few kilograms of cocaine in passenger luggage on commercial flights (U.S. Senate Foreign Relations Committee 1989, p. 27). However, it was during the 1970s that this nascent trade expanded dramatically. Colombian traffickers, initially mere suppliers, developed an integrated criminal infrastructure that controlled every step of the supply chain—from coca paste production in Bolivia and Peru to processing, transport, and distribution.

The exceptionally high profit margins allowed traffickers to invest in long-term supplier relationships, build ambitious and sophisticated transport networks, and finance increasingly complex money laundering schemes. Cocaine began to flow into the United States at an accelerating and unprecedented pace. And yet, the worst was still to come.

The calm and the storm

Following the premature end of Nixon's second term, the momentum behind the war on drugs diminished on the domestic front in the United States.

Gerald Ford maintained pressure on producing countries, particularly those in Latin America, preserved the anti-drug apparatus established by his predecessor, and did not alter the administration's rhetorical approach. In a 1976 message to Congress, Ford warned:

> *Today, drug abuse constitutes a clear and present threat to the health and future of our Nation. The time has come to launch a new and more aggressive campaign to reverse the trend of increasing drug abuse in America. Americans have always stood united and strong against all enemies. Drug abuse is an enemy we can control but there must be a personal and a national dedication and commitment to the goal.* (Ford 1976)

While Ford did not refrain from using harsh language against traffickers, he consistently emphasized the importance of treatment and rehabilitation and framed drug abuse primarily as a public health issue, portraying drug users as victims rather than criminals. In the years that followed, it would emerge that his wife, Betty Ford, had been struggling with alcohol and opiate addiction, for which she sought treatment after leaving the White House (Hudak 2016, p. 66).

Perhaps partly due to these personal experiences, Ford remained committed throughout his presidency to an approach that combined empathy for problematic drug users with a militaristic and punitive stance toward traffickers and their networks.

In the 1976 presidential election, Ford was defeated by Democrat Jimmy Carter. Carter's campaign program called for reform of federal drug policies,

including the decriminalization of cannabis possession, following the model introduced by Oregon in 1973 (U.S. Senate Judiciary Committee, 1975, p. 1101).

In his 1977 *Drug Abuse Message* to Congress, Carter advanced proposals more progressive than those of any other American president for the next three decades. Carter stated:

> *Penalties against possession of a drug should not be more damaging to an individual than the use of the drug itself; and where they are, they should be changed. Nowhere is this more clear than in the laws against the possession of marijuana in private for personal use. (...) The National Commission on Marijuana and Drug Abuse concluded five years ago that marijuana use should be decriminalized, and I believe it is time to implement those basic recommendations.* (Carter 1977)

Although Carter did not drastically alter the organizational structures established by his predecessors, he renamed the Special Action Office for Drug Abuse Prevention as the Office of Drug Abuse Policy and replaced its director, appointing Peter Bourne to succeed Robert DuPont, Nixon and Ford's former "drug czar."

Dr. Bourne, a respected physician specializing in the treatment of substance dependence, was a personal friend of Carter and had collaborated with him during his tenure as Governor of Georgia, where they had jointly developed a state-wide drug abuse prevention program. Their plan at the federal level aimed to increase funding for treatment and rehabilitation while supporting the decriminalization of cannabis possession. This movement enjoyed the backing of influential organizations such as the American Medical Association, the American Bar Association, the American Public Health Association, and the National Council of Churches, and paralleled reforms

already adopted or under consideration in Alaska, Maine, Colorado, California, Ohio, Minnesota, Mississippi, New York, North Carolina, and Nebraska (Wisotsky 1990, p. xviii).

Despite favorable conditions, Carter and Bourne failed to realize their reform agenda. Their efforts were derailed by a scandal that forced Bourne to resign after less than eighteen months in office. In July 1977, Bourne prescribed methaqualone, a sedative prone to recreational abuse, to a staff member experiencing emotional distress and sleep difficulties. To protect her privacy, and concerned about creating a public record that could compromise her position, Bourne wrote the prescription using a pseudonym. However, the staff member's roommate attempted to collect the medication at a pharmacy, where a routine inspection by a state drug agent uncovered the discrepancy. The prescription, issued under the fictitious name Sarah Brown, raised suspicions when the pharmacist was unable to contact Bourne at the outdated number listed on the prescription pad. An investigation was promptly initiated, drawing media attention (Wooten 1978).

Although Bourne insisted he had acted solely for legitimate medical reasons and in accordance with psychiatric ethical standards, the growing controversy—and concerns that it might overshadow President Carter's political agenda—led him to request a leave of absence, which the President immediately granted (ibid.).

Compounding Bourne's troubles, Keith Stroup, founder of the National Organization for the Reform of Marijuana Laws (NORML), publicly accused him of using cannabis and cocaine at a NORML-hosted party, claims Bourne categorically denied. Relations between Stroup and Bourne had already soured months earlier, primarily over disagreements regarding paraquat spraying programs.

While the Carter administration supported cannabis decriminalization, it prioritized its anti-drug efforts on more dangerous substances—namely barbiturates, sedatives, and heroin—which accounted for 90% of drug-related deaths (Hudak 2016, p. 69). U.S. support for Mexico's eradication of opium crops included financial, technological, and operational aid. With regard to the paraquat spraying of cannabis fields, Bourne maintained that the decision belonged to the Mexican government, and argued that it would be hypocritical for the United States to demand the destruction of opium fields while opposing Mexico's analogous efforts against cannabis cultivation. Although Bourne acknowledged the health risks associated with paraquat-contaminated cannabis—risks under investigation by the National Institute on Drug Abuse (NIDA) and the Centers for Disease Control and Prevention (CDC)—he emphasized that the campaigns had helped achieve a dramatic 78% decrease in heroin-related deaths between 1975 and 1978 (Clark, Dufton 2015, p. 286).

Bourne's pragmatic cost-benefit analysis did not persuade Stroup, who initiated a communications and legal campaign against the Carter administration. The controversy culminated in accusations of Bourne's personal drug use, widely reported by major media outlets such as *Good Morning America* and the *Washington Post* (Shaffer 1978).

Bourne's resignation marked the collapse of Carter's reformist momentum. Public fears about paraquat-contaminated cannabis, growing concerns from parent advocacy groups, and intense media scrutiny effectively ended the brief experiment with federal decriminalization.

During the second half of Carter's term, the administration's attention shifted to other pressing domestic and international challenges: the complex Israel–Egypt peace process, the second oil crisis triggered by the Iranian Revolution, the Tehran hostage crisis, the Soviet invasion of Afghanistan,

and a deepening economic recession—all of which dominated the political agenda as Carter prepared for his 1980 re-election campaign.

The War on Drugs

In the late 1970s and early 1980s, the United States, like other Western countries, was undergoing a delicate phase of transition, one made even more precarious by economic recession. Many factories either closed or relocated their production facilities to countries with lower labor costs and weaker protections for workers. In those factories that remained, increasingly efficient and precise machinery displaced an army of workers, who faced a labor market markedly different from that of previous decades, offering few opportunities for reintegration. While technological advancement and the shift from an industrial to a service-based economy created new career opportunities for highly skilled workers, a far more uncertain future awaited the traditional working class.

Already a relatively successful actor, president of the Screen Actors Guild, governor of California from 1967 to 1975, and Gerald Ford's main rival during the 1976 Republican primaries, Ronald Reagan secured the Republican nomination in 1980. GOP voters assigned him a straightforward task: to defeat the incumbent president of a nation in crisis. Reagan did so resoundingly, winning 50.7% of the popular vote compared to Carter's 41%, and capturing 489 out of 538 votes in the Electoral College. After the de-escalation under the Ford and Carter administrations, Reagan inaugurated a new era of drug criminalization, advancing a law-and-order ideological framework that, regardless of Reagan's personal intentions, acquired distinct racial and classist overtones.

Many of Reagan's critics argue that this was no accident. During the 1976 Republican primaries and again during the 1980 presidential campaign,

Reagan allegedly revived Nixon's Southern Strategy and demonstrated masterful use of so-called *dog whistle* politics: a coded language that conveyed unmistakable yet deniable racial messages to more conservative constituencies. His speeches frequently invoked images of «welfare queens» driving Cadillacs, «strapping young buck» buying T-bone steaks with food stamps, and criminal «predators» (Mayer 2002, p. 71).

Reagan's defenders, by contrast, argue that his rhetoric merely reflected consistent conservative principles advocating for reduced federal government and greater state autonomy (Murdock 2007). They also point to his outreach to civil rights organizations, such as his speech to the Urban League in Manhattan, and to personal anecdotes, such as his hospitality toward Black teammates denied hotel accommodations and his refusal to join clubs excluding African Americans and Jews (Davis 2019).

Nonetheless, several episodes suggest either personal racism or, at the very least, a calculated appeal to racist constituencies. Notably, Reagan vetoed the Comprehensive Anti-Apartheid Act—later overridden by a bipartisan majority in Congress—and, in a 1971 telephone call with President Nixon, referred to African UN delegates as «those monkeys» who were «still uncomfortable wearing shoes» (Naftali 2019).

Regardless of his stance on race, Reagan was a staunch individualist and a fierce opponent of sociological and criminological explanations for crime. This worldview was clearly reflected in his speech of October 14, 1982, where he officially relaunched the war on drugs:

> *This rise in crime, this growth of a hardened criminal class, has partly been the result of misplaced government priorities and a misguided social philosophy.*
>
> *At the root of this philosophy lies utopian presumptions about human nature that see man as primarily a creature of his material environment. By changing this environment through expensive social programs, this philosophy holds that*

> *government can permanently change man and usher in an era of prosperity and virtue. In much the same way, individual wrongdoing is seen as the result of poor socioeconomic conditions or an underprivileged background. This philosophy suggests in short that there is crime or wrongdoing, and that society, not the individual, is to blame.*
>
> *But what has also become abundantly clear in the last few years is that a new political consensus among the American people utterly rejects this point of view. (…) the American people are reasserting certain enduring truths - the belief that right and wrong do matter, that individuals are responsible for their actions, that evil is frequently a conscious choice, and that retribution must be swift and sure for those who decide to make a career of preying on the innocent.* (Reagan 1982)

Such an interpretation of criminal behavior was and remains perfectly consistent with the neoliberal ideology of which Reagan was a chief proponent. Only two years earlier, in 1980, Milton and Rose Friedman had published *Free to Choose*, a book title that was far from accidental. According to the Friedmans, and evidently also to Reagan, a neoliberal economic system would foster responsible, independent individuals—rational actors whose choices would define them as free citizens and consumers (Seddon 2010, pp. 21, 25).

On drug policy, however, Milton Friedman and Ronald Reagan could not have been further apart: the former publicly advocated for decriminalization (Friedman 1989), while the latter was a committed prohibitionist. Reagan so fervently believed in relaunching the war on drugs that he departed, at least in this area, from his general promise of a minimal federal government: between 1980 (the final year of Carter's presidency) and 1989 (the final year of Reagan's two terms), the federal budget for domestic law enforcement and international border control increased from approximately one billion dollars

to over four billion dollars (Office of National Drug Control Policy 1992, p. 141).

The cocaine boom

Among the most significant initiatives launched by the Reagan administration was the establishment of the South Florida Task Force, coordinated through the office of Vice President Bush. Its aim was to synchronize the activities of the DEA, the FBI, and U.S. Customs to counter the burgeoning flow of Colombian cocaine through Florida. By 1981, it was estimated that 70% of the cannabis, 70% of the cocaine, and 90% of the methaqualone illegally entering the United States passed through Miami (Jaynes 1981).

Drug trafficking had fueled a dramatic surge in associated criminal activity: money laundering, corruption, and violent crime. Rival Colombian gangs and the Cuban mafia fought for control over the territory. In 1979, Miami recorded 349 homicides; the number rose to 573 in 1980 and 621 in 1981, forcing the city morgue to rent a refrigerated truck to store the overflow of bodies (Alvarado 2011)

Violence also escalated sharply in Colombia, where tensions persisted well into the 1990s. Following the spread of the more potent *sinsemilla* strain in Mexico and the United States, Colombian cannabis lost ground. While trafficking still generated millions of dollars, cocaine had firmly established itself as Colombia's primary illicit export by the early 1980s (Thoumi 2002, p. 104): by 1982, revenues from cocaine exports had surpassed those from coffee (Scruggs 2014). Historian James D. Henderson situates the symbolic end of *la década de paz en Colombia* (the decade of peace in Colombia) in November 1975, when the seizure of six quintals of cocaine intended for

U.S. markets triggered the massacre of forty people in Medellín (Henderson 2012).

The cocaine boom profoundly altered Colombia's economy and its political landscape. Once-small criminal organizations coalesced into powerful cartels, expanding their networks, arsenals, laundering operations, and logistical capacities. Coca cultivation concentrated in remote, state-neglected regions, where guerrilla and paramilitary groups replaced government authority, imposing taxes, providing rudimentary public services, and maintaining order—not from altruism, but to secure territorial autonomy and local loyalty (Thoumi 2002, p. 106). In urban areas, the boundary between legal and illegal economies blurred, as drug traffickers reinvested their profits into media, construction, agriculture, industry, sports teams, and philanthropic ventures, thereby consolidating political influence (US Senate Committee on Foreign Relations 1988, p. 29).

Violence remained endemic. Since the 1970s, leftist guerrilla movements such as the Fuerzas Armadas Revolucionarias de Colombia (FARC), Ejército de Liberación Nacional (ELN), and Movimiento 19 de Abril (M-19) had intensified their struggle against a government they perceived as aligned with landowners and complicit in human rights abuses by the military. Tactics included guerrilla warfare, theft, robbery, kidnapping, and extortion targeting soldiers, politicians, business leaders, and drug traffickers.

In November 1981, Martha Nieves, sister of the Ochoa brothers—founders of the Medellín cartel—was kidnapped. Shortly thereafter, Carlos Lehder, another prominent cartel member, narrowly escaped abduction. In response, on December 3, 1981, thousands of flyers were scattered over a stadium before a football match between América de Cali and Atlético Nacional, announcing the formation of Muerte A Secuestradores (MAS, "Death to Kidnappers"). According to the flyers, 223 cartel leaders each

pledged two million pesos and ten men to eliminate kidnappers: «The kidnappers will be hanged from trees», the statement warned, «and if not them, their fellow prisoners and their closest relatives». MAS swiftly acted, capturing and killing numerous guerrillas and publicly displaying their bodies as deterrence (US Senate Foreign Relations Committee 1988, p. 28). However, MAS activities soon expanded beyond targeting kidnappers, turning against union leaders, peasants, and political dissidents under an explicitly anti-communist agenda, with the involvement of military, landowners, and industrial elites (Centro Nacional de Memoria Histórica 2013, pp. 30-31; Procuraduría General de la Nación 1983; Santina 1998).

The bloody confrontation between cartels and the Colombian state was inevitable. On March 10, 1984, with DEA assistance, the Policía Nacional de Colombia dismantled Tranquilandia, a complex of laboratories capable of refining between two and three tons of cocaine per week (US Senate Foreign Relations Committee 1988, p. 30). Nearly fourteen tons of cocaine, valued at approximately $1.2 billion, were seized and destroyed (Bolaños 2017). Less than two months later, the Medellín cartel retaliated, assassinating Justice Minister Rodrigo Lara Bonilla. Bonilla had previously exposed Pablo Escobar's ties to drug trafficking, forcing Escobar's resignation from the Colombian Congress in January 1984—an act of bravery that ultimately cost him his life.

Exacerbating tensions was the 1981 U.S.-Colombia extradition treaty, implemented in 1982. Cartels attempted to undermine it through political campaigns challenging its constitutionality (US Senate Foreign Relations Committee 1988, p. 31), while simultaneously resorting to bribery, intimidation, and assassination to influence judicial outcomes.

Ironically, the most significant blow to extradition efforts came not from the cartels but from M-19, the guerrilla movement that had itself been a primary MAS target.

Facing setbacks in their ceasefire agreement with President Belisario Betancur's government and suffering losses inflicted by the Colombian military, M-19 sought a dramatic act to demonstrate its vitality. On November 6, 1985, M-19 commandos stormed Bogotá's Palace of Justice, taking approximately 350 hostages, including magistrates, state officials, and civilians. The guerrillas demanded a public trial of the President by the Supreme Court, to be broadcast nationwide—a demand the government rejected outright. After a brutal twenty-eight-hour siege, the army retook the building. Over one hundred people, including hostages and guerrillas, died. Amid the chaos, a fire—whose origins remain unclear—destroyed key documents related to ongoing extradition proceedings, many involving cartel figures.

While some sources allege that Pablo Escobar financed the M-19 assault to the tune of two million dollars (Comisión de la Verdad 2010, pp. 313-314), definitive evidence remains lacking. What is certain, however, is that most M-19 members were likely unaware of any such arrangement (ibid., p. 320).

Whatever the truth behind the events of November 6 and 7, 1985, if the cartels had survived the seizure of over a billion dollars' worth of cocaine without major consequences and were now engaged in open confrontation with the state, the reason lay in the insatiable American appetite for cocaine.

For cocaine, it was a remarkable comeback. After its popularity in the early twentieth century, its association with Black laborers [see p. 48] and the proliferation of legal alternatives such as amphetamines had relegated it to obscurity. Its stimulant properties were revived alongside the repression of cannabis, opiates, and psychotropics, fueled by the hedonistic and elitist

ethos that flourished in the 1970s and exploded in the 1980s. Initially rare and therefore extremely expensive, cocaine became the champagne of drugs—a social lubricant at exclusive Hollywood and Wall Street parties, and a favored aid for young urban professionals (yuppies) navigating the dynamic, often frenetic, rhythms of city life, financial markets, and electronic music scenes. Perhaps due to its limited accessibility to the upper classes, the risks associated with cocaine abuse and its impact on health were long underestimated (Massing 1998, pp. 166–167).

The United States consumed vast quantities of cocaine. Most shipments entered through Florida, where drug profits fueled the local economy: traffickers laundered their proceeds into the legitimate economy, contributing, among other things, to the rise of Miami's skyline. In 1980, the Miami branch of the Federal Reserve Bank of Atlanta was the only branch in the U.S. Federal Reserve System to report a cash surplus—a surplus amounting to $4.75 billion (Demarest 1981).

For local and federal authorities, turning a blind eye had been the path of least resistance—until gunfire erupted and morgues overflowed.

The South Florida Task Force did not render the American coastline impervious to cocaine trafficking, but it did inflict substantial damage on the cartels and gave Reagan, Vice President Bush, and the heads of the DEA and FBI the opportunity to boast about arrests and seizures, posing beside mountains of drugs destined for incineration.

Such public displays were deeply unwelcome in Medellín and Cali.

The solution had a Honduran identity card: Juan Ramón Matta-Ballesteros. It was Matta-Ballesteros who brokered the connection between the Colombian cartels and the Mexican Guadalajara cartel. The Colombians controlled a reliable U.S. distribution network and had abundant product; the Mexicans possessed more than three thousand kilometers of porous border

with the United States and well-established routes already used for trafficking cannabis and opiates, mainly heroin.

The arrangement worked so well that Mexican cartels rose through the ranks, transitioning from couriers to wholesale distributors of Colombian cocaine (Grillo 2011, pp. 55ff.). Within a quarter-century, Mexico would dominate approximately 90 percent of the cocaine traffic into the United States (Congressional Research Service 2007), alongside significant shares of the cannabis, heroin, and methamphetamine markets.

The Mexican launchpad cast a shadow over the effectiveness of the South Florida Task Force. Despite costly surveillance, seizures, and media spectacles, the retail price of cocaine fell, its consumption increased, and gang violence escalated in cities nationwide, as rival groups battled for control of lucrative drug markets.

The Reagan administration responded by enacting the Comprehensive Crime Control Act of 1984, which eliminated parole and reinstated mandatory minimum sentences—reversing reforms enacted at the federal level in 1970 but already reintroduced in many state systems (Musto 1999, p. 273). The Act imposed harsher penalties for growing, possessing, and distributing cannabis, and for repeat offenders with multiple convictions for serious drug crimes.

What the U.S. government steadfastly refused to do was to engage more deeply with the etiology of drug use. In line with its broader rejection of «expensive social programs» and the «utopian presumptions» of reforming human behavior (Reagan 1982), educational, therapeutic, and rehabilitative strategies were systematically neglected.

Although methadone maintenance had shown considerable success with heroin dependence, no similar treatment options were developed for cocaine

addiction, and the administration made no serious effort in this direction. The primary response remained moralistic: «Just say no».

Meanwhile, crack had arrived.

Crack, the media, the law

Chemically and pharmacologically, crack cocaine is not substantially different from the substance from which it is derived. The first distinction lies in its form: crack appears not as a powder, but as brittle crystals with jagged edges and a waxy consistency. The method of consumption also changes: while cocaine is typically snorted, crack is heated and inhaled. Consequently, the effects differ: crack produces a faster, more intense high, albeit of shorter duration.

There are at least three further differences. First, due to its method of administration, crack induces a stronger addiction in a shorter period. Second, owing to the potency of its effects, crack can be sold in smaller doses, making it more affordable: in 1981, in major cities such as New York, Detroit, and Philadelphia, a single dose of crack could be purchased for as little as $2.50 (United States Department of Justice 1991)—equivalent to less than nine dollars today.

This affordability led to a third, and perhaps most significant, difference: crack spread into communities where cocaine had only marginally penetrated—predominantly Black and Latino neighborhoods.

Price alone, however, cannot explain this discrepancy. Other inexpensive substances such as cannabis or alcohol exhibit considerable variation in use across different sociodemographic groups (Jeffers et al. 2021; Collins 2016), but neither substance is consumed almost exclusively by the most impoverished and marginalized populations, as was the case with crack.

As Reinarman and Granfield (2015, p. 9) note, the spread of a given substance within a given community depends on the presence of various «social precursors». Crack emerged in the United States precisely at a time when recession and deindustrialization were strangling the urban centers. As is often the case, the consequences of the economic crisis were distributed asymmetrically, with the working class bearing the brunt—especially African Americans.

Having historically supplied low-cost labor critical to the growth of the American industrial economy, African Americans were largely excluded from access to education and skilled employment, remaining on the margins of society both socially and geographically. The spatial and economic configuration of cities, the solidarity within Black communities, and the mistrust—or outright hostility—encountered outside them contributed to the formation of ghettos: isolated urban microcosms, inhabited and sustained almost exclusively by African Americans, often centered around nearby industrial workplaces.

The sustained mobilization of the civil rights movement, coupled with alliances with other protest movements, ultimately compelled the federal government to dismantle the formal legal architecture of racial segregation. However, this did not immediately eradicate the entrenched socio-economic inequalities that segregation had produced. The phenomenon of white flight to suburban areas reinforced and intensified the physical and symbolic separation of communities—in schools, public transportation, and social spaces (Wacquant 2000, pp. 381–382).

The tentative steps toward a more open and integrated society collided with the forces of recession and deindustrialization, soon followed by a new administration whose vision of «making America great again» rested on slashing welfare programs and intensifying punitive measures against crime.

> *Such policies pointed to yet another special institution capable of confining and controling, if not the entire African-American community, at least its most disruptive, disreputable and dangerous members: the prison.* (*Ibid.*)

The decline in opportunities for legitimate employment, coupled with the absence of social safety nets capable of fostering new opportunities in the short and medium term, created fertile ground for the spread of crack. Smoking it offered a brief but intense euphoria that could momentarily override the frustration of poverty and hopelessness. Its short-lasting effects encouraged compulsive use, unrestrained by the commitments (to use Howard Becker's term; 1966, pp. 27–28) typically faced by those with a job and a social role to maintain. To close the loop, the lack of income and prospects often pushed individuals to actively engage in trafficking—of crack, as with other substances—either to fund their addiction, secure their survival, or, perhaps, in hopes of getting rich. An illegal market—especially one that is new, rapidly expanding, and still lacking established hierarchies, as was the case with cocaine and crack at the time—inevitably breeds a violent underworld of threats, corruption, shootings, and murders. The sound of the gunshots attracted the attention of the newspapers.

DEA officer Robert Stutman would recall years later:

> *The agents would hear me give hundreds of presentations to the media as I attempted to call attention to the drug scourge. (…) I began lobbying effort and I used the media. The media were only too willing to cooperate, because as far the New York media was concerned, crack was the hottest combat reporting story to come along since the end of the Vietnam War.* (Stutman 1992, p. 142)

On June 19, 1986, Len Bias—a young basketball player widely regarded as one of the most promising talents of his generation, and selected just two

days earlier as the second overall pick in the NBA Draft by the defending champions, the Boston Celtics—died unexpectedly. Only eight days later, on June 27, Don Rogers, a professional football player for the Cleveland Browns, also died. Both athletes were African American, and both deaths were the result of cocaine use. However, media coverage at the time, both in print and on television, inaccurately attributed their deaths to crack cocaine (Alexander 2010, pp. 65–66). In July 1986 alone, ABC, CBS, and NBC—the three major television networks in the United States—dedicated seventy-four segments of their evening newscasts to drug-related topics, half of which specifically focused on crack.

As had occurred previously with other substances and other marginalized communities, crack cocaine use was readily and uncritically linked to African Americans in media narratives. While a superficial reading of statistical data may have lent an appearance of neutrality, closer examination reveals that, under comparable social and environmental conditions, the prevalence of crack use did not significantly differ among African Americans, Hispanics, and whites (Lillie-Blanton et al. 1993, p. 996). Crack cocaine became widespread in Black and Latino neighborhoods primarily because these were impoverished areas—just as it did in similarly disadvantaged white communities. Nonetheless, this socio-economic reality was largely obscured in mainstream media discourse, which instead perpetuated a racially charged and misleading narrative.

A particularly telling example of the speciousness of media discourse was the CBS special *48 Hours in Crack Street*, which aired on September 2, 1986. The documentary featured Senator Alphonso D'Amato and then–federal prosecutor, later New York City mayor, Rudy Giuliani—both dressed in disguise—purchasing crack in broad daylight in the city center. In another segment, a dealer offers "good stuff" to a CBS correspondent; a young

woman discusses her struggles with addiction and then demonstrates how to use a crack pipe; individuals visibly suffering from addiction appear as part of the urban landscape. Unsurprisingly, both dealers and users portrayed in the program are Black or Latino, while it is white individuals who voice outrage or dismay over the neighborhood's decline. When the camera shifts to more affluent areas, the tone changes dramatically: the previous accusatory stance is replaced by empathy. The drug use of white youth—described as "nice kids"—is framed as more tragic, more human. Viewers hear from white, well-dressed families recounting painful personal stories, testifying to how their loved ones were drawn into the abyss of addiction. It is described as "hard to believe" that crack could threaten such a "wonderful and prosperous community." Blame is instead directed toward "terrorists," "gorillas," and "rats" who allegedly infest Central Park, now described as the epicenter of the drug trade (Fitch 2016). These so-called "gorillas" are familiar: the visual and narrative framing of the documentary leaves little doubt about their racial identity.

48 Hours in Crack Street was not an isolated case. Framed in this manner, the discourse surrounding drug proliferation served to deflect political accountability onto marginalized communities, individual consumers, and low-level dealers. It concealed the structural roots of the crisis, obscuring the links between drug abuse and the rise of unemployment and poverty, between crime and inequality, and between addiction and the retrenchment of the welfare state (Mosher & Akins 2014, pp. 52–53).

> *Crack was a godsend to the Right. They used it and the drug issue as an ideological fig leaf to place over the unsightly urban ills that had increased markedly under the Reagan administration's social and economic policies.* (Reinarman, Levine 1997, p. 16)

The campaign proved effective: while in 1985 only between 2% and 6% of Americans identified drug use as the country's most pressing issue, by 1989 that figure had soared to 64% (Tarricone 2020). Many states responded with stringent legislation, the enforcement of which mirrored the racial biases embedded in the media narratives (see, for instance, Mosher & Akins 2014, pp. 431–433). With the midterm elections approaching, the Democratic-controlled House of Representatives and the Republican-controlled Senate competed to adopt increasingly punitive measures in an effort to appeal to an anxious electorate. On October 27, 1986, President Ronald Reagan signed the Anti-Drug Abuse Act, followed by its 1988 amendment. Commonly referred to as the Len Bias Law, the legislation dramatically expanded the list of offenses subject to mandatory minimum sentencing and reinstated the death penalty for major drug traffickers engaged in ongoing criminal enterprises, as well as for those whose drug-related offenses resulted in the death of another person (Musto 1999, pp. 277–278).

One of the most controversial features of the Act was the introduction of a stark sentencing disparity between crack and powder cocaine: possession of five grams of crack triggered a mandatory minimum sentence of five years without parole—the same penalty applied to possession of five hundred grams of powder cocaine. This 1:100 ratio lacked any scientific basis in the pharmacological properties of the substances involved.

Under Reagan's two terms, incarceration rates for non-violent offenses rose sharply, particularly for drug-related crimes. In 1980—the final year of President Jimmy Carter's administration—there were an estimated 581,000 arrests for drug possession and trafficking. By 1988, Reagan's last full year in office, that number had risen to over 1.15 million (Benson 2009, p. 296). Arrests for simple possession or use increased from approximately 200 to 350 per 100,000 residents, representing a rise of nearly 75% (U.S.

Department of Justice 2012, p. 12). Over the same period, the population incarcerated under state and federal jurisdiction nearly doubled, from 329,000 at the end of 1980 to 627,000 by the end of 1988 (U.S. Department of Justice 1982, p. 1; 1989, p. 1).

Simultaneously, the United States witnessed a rise in overdose deaths, from approximately 6,000 in 1980 (or 2.7 per 100,000 residents) to 9,000 in 1988 (3.7 per 100,000 residents) (CDC/NCHS 2011, p. 1). Despite the scale of this emerging public health crisis, it was the specter of criminality—rather than the mounting toll of drug-related deaths—that prompted a vigorous federal response. Meanwhile, another public health emergency had begun to unfold even before the emergence of crack cocaine.

The AIDS epidemic

AIDS was first identified in 1981, when physicians in Los Angeles and New York observed a cluster of rare conditions—Kaposi's sarcoma and Pneumocystis jirovecii pneumonia—among sexually active gay men, illnesses usually associated with severely immunocompromised individuals (Gottlieb 2006). Initially, the syndrome was labeled GRID (Gay-Related Immune Deficiency), and was subsequently referred to by the Centers for Disease Control and Prevention (CDC) as the "4H disease," referencing four groups perceived to be at risk: homosexuals, heroin users, hemophiliacs, and Haitians (Gilman 1987, p. 87). It was not until September 24, 1982, that the CDC formally adopted the term Acquired Immunodeficiency Syndrome (AIDS; CDC 1982), marking a critical shift in medical terminology, though not yet in public perception. AIDS refers to the most advanced stage of Human Immunodeficiency Virus (HIV) infection, typically characterized by a severe decline in CD4 lymphocytes, a subset of white blood cells critical to the body's immune response, and the onset of infections or malignancies that

the body can no longer combat effectively; this stage can occur several years after initial exposure to the virus.

Just three weeks later the adoption of the new term, on October 15, 1982, the White House made its first public mention of AIDS—albeit indirectly and dismissively. During a press briefing, journalist Lester Kinsolving asked Press Secretary Larry Speakes about President Reagan's response to the CDC's recent update on the epidemic, which had by then resulted in over 600 diagnosed cases and more than 200 deaths. The exchange was met with laughter from the press corps and Speakes himself, who made light of the question and implied that AIDS was not a matter of concern within the administration. Despite the official renaming of the disease, it remained widely stigmatized as the "gay plague" in public discourse. Speakes's remark—«There's been no personal experience here, Lester»—carried an implicit message: the epidemic was seen as distant, affecting others, and thus not warranting immediate attention or empathy from those in power.

After several unsuccessful legislative attempts, the U.S. Congress in May 1983 passed a bill that, for the first time, allocated federal funding specifically for AIDS research. The sum—$2.6 million—was discreetly embedded within broader appropriations for research on Legionnaires' disease and toxic shock syndrome (Green 2011). Between June and August of that year, President Reagan participated in two meetings during which AIDS was discussed. The first included representatives from the Department of Health and Human Services and two delegates from the National Gay Task Force. By contrast, the second meeting excluded LGBT representatives, replacing them with conservative activists. The evidence-based, public health-oriented recommendations presented by physicians and epidemiologists found little resonance with the administration or its new interlocutors. No concrete policy measures were adopted, and there is no record of further

governmental deliberation on the issue for the subsequent two years (Brier 2009, pp. 83–84).

Remarkably, AIDS did not feature among the topics addressed during the 1984 presidential campaign, in which Reagan secured re-election against Democratic candidate Walter Mondale. By the end of that year, the Centers for Disease Control and Prevention (CDC) had reported 7,699 diagnosed cases and 3,665 confirmed deaths in the United States (CDC 1984). Globally, the number of reported infections stood at 11,965 (CDC 1988). The following year saw a dramatic 110% increase in global infections (ibid.), yet it was not government action but rather a single high-profile case—that of actor Rock Hudson—that significantly raised public awareness of the epidemic.

One of the most prominent film stars of his era, Rock Hudson had long concealed his homosexuality from the public, aided by the protective strategies of Hollywood studios. Celebrated as a heterosexual sex symbol, both Hudson and his professional associates understood that any disclosure regarding his sexual orientation could severely damage his popularity—and with it, his career. In June 1984, Hudson was diagnosed with Kaposi's sarcoma and tested positive for HIV. Over the subsequent year, growing concerns about his deteriorating health circulated in the press, until, in late July 1985—nearly fourteen months after his diagnosis—it was publicly confirmed that Hudson had AIDS.

Hudson's illness and subsequent death marked a pivotal moment in the shifting public perception of AIDS, and influenced the stance of President Reagan, who had known Hudson personally. The day prior to the public announcement of Hudson's condition, Reagan wrote in his diary:

> *Called Rock Hudson in a Paris Hospital where press said he had inoperable cancer. We never knew him too well but did know him & I*

thought under the circumstances I might be a reassurance. Now I learn from T.V. there is question as to his illness & rumors he is there for treatment of AIDS. (Reagan 1985)

Hudson passed away on October 2, 1985, at the age of 59. That same month, both the House and the Senate approved a substantial increase in federal funding for AIDS research and treatment (Secter 1985).

In February 1986, Reagan commissioned Surgeon General C. Everett Koop to prepare a comprehensive report on the AIDS crisis. A conservative Presbyterian, Koop nevertheless demonstrated a notable degree of independence and openness to dialogue, qualities that likely placed him at odds with elements within the administration. He engaged with stakeholders across a wide ideological spectrum—from fundamentalist Christian organizations to the National Coalition of Black Lesbians and Gays—while also consulting medical experts and people living with HIV/AIDS. Among the advisors he enlisted was Dr. Anthony Fauci, then head of the AIDS research team at the National Institutes of Health.

Anticipating potential political interference, Koop wrote the report himself with the assistance of a small team of trusted collaborators, and released it without prior review or approval by the administration. The final document stressed the necessity of straightforward, accessible public information. In keeping with this objective, Koop employed plain language, deliberately avoiding euphemisms or technical obfuscation, to ensure the report's reach extended to the broadest possible audience.

In plain language the 36-page report discussed the nature of AIDS, its modes of transmission, risk factors for contracting the disease, and ways in which people could protect themselves, including use of condoms. It projected that in 1991, 270,000 cases of AIDS would have occurred. The prediction

> *was too pessimistic, as the total reported cases of AIDS in the U.S. through 1991 turned out to be 206,000, a measure of the effectiveness of Koop's AIDS education campaign. In his remarks Koop emphasized that since education was the best and only strategy of prevention against AIDS, and since AIDS was spread primarily through sex, school children from grade three onward should receive sex education.* (NIH 2019)

Koop's report contended that public education campaigns should include information regarding homosexual intercourse and drug use (U.S. Department of Health and Human Services 1986, pp. 29, 31). It also endorsed the implementation of voluntary and confidential blood testing for individuals considered at risk, thereby rejecting proposals—favored by some figures within the administration—for mandatory testing and the establishment of a national AIDS registry (ibid., pp. 30, 33; Tumulty 2021, p. 419).

The Surgeon General faced sharp criticism from those who had expected a document that would merely affirm the moral stance of the government's most conservative factions (NIH 2019), and his recommendations were largely disregarded. The following year, the Presidential Commission on the Human Immunodeficiency Virus Epidemic was created, comprising numerous critics of Koop's report. Following the resignation of the respected physician and academic Eugene Mayberry, the commission was chaired by retired Admiral James D. Watkins, former Chief of Naval Operations of the U.S. Navy. Years later, Watkins' wife would recount a telling anecdote regarding his appointment:

> *He told the president, "I'm a sailor and a submariner, and I know nothing about medicine" (…). But Reagan told him, "You're exactly who we're looking for".* (Shapiro 2012)

This exchange might be easily interpreted as indicative of an effort by President Reagan and his advisers to assemble a compliant commission—one likely to produce findings that conformed ideologically with the administration's position. However, if that was indeed the intent, the outcome did not fully align with expectations. In its report, issued on June 27, 1988, the commission identified the principal barriers hindering progress in the fight against HIV/AIDS. It issued a pointed critique of national and federal institutions for their inadequate commitment and lack of coordination and put forward 579 recommendations. Many of these closely mirrored those found in the earlier, more succinct report authored by Surgeon General C. Everett Koop.

These recommendations included: significantly increased funding for research at the local, national, and federal levels; enhanced support for treatment programs to reduce or eliminate waiting lists; rigorous protection of patient privacy and measures to combat discrimination and stigma; the implementation of widespread information, education, and prevention campaigns beginning in early childhood; targeted interventions for high-risk populations such as minorities and intravenous drug users; a nationwide call for all individuals who had received blood transfusions after 1977 to undergo testing; low-threshold outreach strategies designed to reach as many patients and at-risk individuals as possible—such as mobile units and clinics operating 24 hours a day; and the integrated provision of services for patients and their families, including access to medical professionals, psychologists, and social workers (Presidential Commission on the HIV Epidemic 1988).

In August 1988, with fewer than six months remaining in his second and final term, President Reagan announced a ten-point action plan grounded in select recommendations from the Presidential Commission. On November 4 of the same year, he signed into law the Health Omnibus Programs

Extension (HOPE) Act, which allocated increased federal funding for education, prevention, research, and diagnostics related to HIV/AIDS. Nevertheless, the legislation did not completely eschew ideological considerations: federally funded programs were mandated to include information on the consequences of sexual promiscuity and the benefits of abstinence, and were explicitly prohibited from "encouraging or promoting" either heterosexual or homosexual activity. While such programs were permitted to disseminate accurate information on reducing the risk of infection, all educational materials had to avoid content deemed "obscene".

Most notably, Title II, Subtitle E of the HOPE Act prohibited the use of federal funds for needle exchange programs (NEPs), unless the Surgeon General officially determined that such programs effectively reduced both drug abuse and the transmission of infections. By that time, substantial evidence already existed supporting the efficacy of NEPs in curbing the spread of AIDS and hepatitis. These programs had been successfully implemented in countries such as the Netherlands (Buning 1991), the United Kingdom (Stimson 1995), Australia (National Research Council 1994), and Switzerland (Somaini & Grob 2012); in the United States, similar initiatives had also begun to emerge, though often without institutional backing and, in many instances, in defiance of existing laws (Lambert 1989) [see the following section].

Since the 1970s, numerous U.S. states had criminalized the possession and distribution of needles, syringes, and other paraphernalia used to detect or analyze controlled substances. Although the federal Controlled Substances Act of 1970 did not itself criminalize such items, in 1979 the Drug Enforcement Administration (DEA) drafted the Model Drug Paraphernalia Act to assist states in standardizing legislation in this domain. The Act made it illegal to use, possess, manufacture, or distribute needles, syringes, and

other devices intended for the consumption or analysis of controlled substances. By December 1987, thirty-eight states and the District of Columbia had adopted this model legislation (Legislative Analysis and Public Policy Association 2022, pp. 3–4). As a result, individuals involved in the grassroots organization of needle exchange programs to protect both individual and public health faced the serious risk of prosecution under state law.

The crucial importance of providing sterile needles to safeguard the health of those unwilling or unable to "just say no to drugs" (as advocated by the First Lady's campaign) was also emphasized by Surgeon General C. Everett Koop in his final report:

> *(…) many drug users are addicted to drugs and for one reason or another have not changed their behavior. For these people, the only way not to get AIDS is to use a clean, previously unused needle, syringe or any other implement necessary for the injection of the drug solution.* (U.S. Department of Health and Human Services 1986, p. 19)

Ensuring access to sterile needles would not only protect the health of individuals who inject drugs but would also serve the broader public interest. By 1988, it was estimated that injection drug users accounted for approximately 25% of all AIDS cases in the United States. Furthermore, 70% of heterosexual transmission cases were linked to contact with drug users, and 70% of pediatric HIV cases—arising from perinatal transmission—occurred in children born to mothers who injected drugs. As the epidemic continued to spread within this population, the situation was rapidly deteriorating (Presidential Commission on the HIV Epidemic 1988, p. 94).

According to some perspectives—which ultimately influenced federal policy—funding needle exchange programs would send a dangerous message, suggesting that the immorality and illegality of drug use were negotiable or even tacitly condoned by the federal government (Weinmeyer 2016, p. 253).

Despite the growing public health emergency, President Ronald Reagan's response to the AIDS crisis amounted to little more than a vague action plan and limited, ideologically constrained legislation. His interventions were widely regarded as too little, too late. In January 1989, Reagan was succeeded by his vice president, George H. W. Bush, who would largely maintain the same policy stance toward both AIDS and drug use as his predecessor.

Yet while federal policy remained constrained by abstentionist and moralistic frameworks, new approaches to drug-related harms—particularly among people who inject drugs—were already emerging from below.

The emergence of Harm reduction

The growing evidence of policy failure during the AIDS epidemic—especially in its impact on people who inject drugs—played a crucial role in shifting global drug governance. As noted in the previous section, the failure of punitive strategies to contain the spread of HIV/AIDS in Western urban centers prompted the emergence of a new paradigm in Europe, Australia, and eventually also in the United States: harm reduction. This approach acknowledged not only the structural drivers of drug-related harms but also the agency and dignity of those most affected. More than a policy shift, it was—and remains—a bottom-up movement driven by users themselves, demanding recognition, health, and justice.

The origins of harm reduction are inseparable from the activism of drug user unions. In 1977, Nico Adriaans founded the Rotterdam Junkie Union

(RJB), the first user-led organization of its kind. Similar groups soon spread across the Netherlands, culminating in the Federation Netherlands Junkie Unions (FNJB). These collectives advocated for social acceptance of drugs and users, decriminalization, and the rejection of psychiatric-medical approaches to drug dependence (van Dam 2008, pp. 4-5). The MDHG, a medical-social service founded by users, families, and social workers, further challenged dominant paradigms by promoting policies based on dignity and pragmatic care (Ibidem).

This grassroots infrastructure was crucial in launching what is generally considered the first formal needle exchange program (NEP) in 1984, even though informal or ad hoc initiatives had already appeared in various parts of the world (EMCDDA 2010, p. 38). The initiative originated in 1983, when Amsterdam's Junky Union raised concerns that the end of syringe sales by a central pharmacy—prompted by complaints that the concentration of drug users had become a nuisance for other customers—would lead to increased equipment sharing and a hepatitis B outbreak (Buning 1991; Coutinho 1995, p. 1490). Initially opposed by health authorities, a compromise was reached: the Junky Union established a formal NEP with municipal support. The program quickly evolved into a model of low-threshold, anonymous, user-centered care (Lane et al. 2000, pp. 49-50).

The Dutch approach, which emphasized pragmatic health interventions over moralism, soon gained international traction. In 1986, British health authorities visited Amsterdam and, recognizing the model's value, launched pilot NEPs across the UK. These were later expanded nationwide after favorable evaluations (Coutinho 1995, p. 1490; Inciardi & Harrison 1999, pp. viii–ix). Similar programs followed in other European countries, often amid political resistance. However, the development and implementation of harm reduction measures have historically varied across Europe, with Southern

and Eastern countries often lagging behind in terms of policy adoption and civil society engagement. Yet a common feature remained: grassroots mobilization by PWID (van Dam 2008).

While early resistance persisted, the magnitude of the HIV epidemic and the limitations of prohibitionist strategies forced a shift that obviously could not only concern the European continent. Australia began implementing a national NEP network as early as 1985. That same year, the Australian Commonwealth Government adopted a harm minimisation policy framework as part of the National Campaign Against Drug Abuse (NCADA). Unlike prohibitionist models, this strategy explicitly aimed to prioritize AIDS prevention over criminal enforcement, and to reduce the harms associated with both licit and illicit drug use—even if use itself persisted. This commitment legitimised a broad array of programs including needle and syringe distribution, safer sex education, and expanded methadone programs. It also facilitated greater research, surveillance, and intersectoral cooperation, and allowed for more pragmatic, negotiated treatment goals that did not necessarily require abstinence (Wellbourne-Wood 1999, pp. 403-405).

In the United States, harm reduction advanced more slowly. Abstentionist orthodoxy and federal opposition curbed early reform. Although European and Australian models were well known among U.S. researchers by the mid-1980s, political resistance was widespread. Nonetheless, the rapid escalation of HIV cases in cities like New York catalyzed grassroots initiatives. Activists launched street outreach projects—distributing bleach, condoms, and health referrals—in what became known as the "bleach and teach" strategy (Newmeyer 1988).

Civil disobedience soon followed. Activists like Jon Parker and Dave Purchase began distributing syringes in defiance of local laws. These early

NEPs, often led by former users, laid the foundation for broader reforms. Over time, newer NEPs benefited from increasing institutional support and legitimacy, reflecting evolving legal frameworks and public health priorities (Lane et al. 2000).

The success of NEPs was evident: they reduced HIV, hepatitis, and overdose rates without increasing drug use. More profoundly, they shifted the discourse: from repression to care, from stigma to inclusion.

Parallel to NEPs, methadone maintenance emerged as another cornerstone of harm reduction. Pioneered in the 1960s by Marie Nyswander and Vincent Dole, and influenced by earlier British models, methadone treatment prioritized stability over abstinence. Despite initial resistance, methadone became a key public health strategy during the AIDS crisis (Drucker 2000).

Methadone's pharmacological profile plays a crucial role in its effectiveness as a harm reduction tool. Administered orally, methadone has a high bioavailability and a long elimination half-life—typically ranging from 24 to 36 hours—which allows for once-daily dosing. This pharmacokinetic stability reduces the oscillations in plasma opioid levels that are commonly associated with the chaotic cycles of intoxication and withdrawal in heroin use. By mitigating these fluctuations, methadone maintenance therapy (MMT) provides physiological stabilization, diminishes cravings, and prevents the onset of withdrawal symptoms, thereby reducing the compulsion to engage in risky behaviors such as injecting or criminal activity to procure drugs. A substantial body of evidence has confirmed methadone's efficacy in decreasing illicit opioid use, criminal involvement, and the incidence of blood-borne infections (Ball & Ross 1991). Moreover, methadone reframed opioid dependence not as a moral failing but as a chronic, manageable condition—one that could be addressed through sustained pharmacological and psychosocial support. Although institutional constraints and regulatory

frameworks have, over time, contributed to the bureaucratization of MMT, its foundational logic endures: maintenance treatment enables individuals to regain autonomy, engage in daily life, and access care, even in the continued presence of opioid use (Drucker 2000).

Riley and O'Hare (2000) identify a set of normative and operational principles that define harm reduction as both a policy orientation and a public health ethos. First, pragmatism: drug use is recognized as a near-universal human phenomenon, and the goal is not to eradicate it entirely but to manage its risks and consequences. Second, humanistic values: interventions must respect the dignity, autonomy, and lived experiences of people who use drugs, avoiding coercion and moral judgment. Third, a focus on harms: the primary objective is not necessarily to reduce consumption per se, but to minimize the negative health and social outcomes associated with use—such as overdose, infectious disease, and marginalization. Fourth, cost-benefit analysis: policies and programs should be evaluated on the basis of their real-world effectiveness, including their unintended consequences, rather than ideological purity. Finally, a hierarchy of goals: harm reduction emphasizes incremental improvements in health and wellbeing, recognizing that abstinence, while a legitimate aim for some, is neither realistic nor desirable for all individuals at all times. These principles collectively inform a flexible, user-centered approach that contrasts sharply with punitive or abstentionist models.

This paradigm is further supported by longitudinal and ethnographic research on the natural history of addiction. Studies have shown that drug dependence, particularly on substances such as heroin or cocaine, often follows a non-linear trajectory characterized by phases of escalation, stabilization, and decline. Importantly, many individuals eventually reduce or cease their drug use, frequently in the absence of formal treatment or

coercive intervention (Waldorf & Biernacki 1984; Courtwright, Des Jarlais & Joseph 1989; Reinarman & Levine 1997; Waldorf, Reinarman & Murphy 1991). This evidence challenges the dominant notion of addiction as a fixed and irreversible condition, suggesting instead that it can be a temporally bounded phase shaped by personal circumstances, social environment, and structural constraints. Within this framework, harm reduction offers a realistic and humane strategy for supporting individuals throughout the course of their drug use—not by insisting on immediate abstinence, but by fostering safer practices, enhancing health, and creating the conditions for voluntary change.

Harm reduction marked a decisive break from punitive models. It embraced grassroots activism, medical pragmatism, and social solidarity. Where prohibition marginalized and criminalized, harm reduction sought to include, care, and empower. Though unevenly implemented and at times co-opted, its legacy remains a testament to the transformative potential of user-led reform.

It is within this context—of resistance, crisis, and reimagining—that the international community would soon confront its own contradictions. As the next section explores, the 1988 UN Convention Against Illicit Traffic codified a new phase in global drug policy—one increasingly at odds with the harm reduction ethos taking root across the world.

The international agenda

Meanwhile in 1981—the year Ronald Reagan succeeded Jimmy Carter as president, the year AIDS was first clinically identified, and the year a refrigerated truck was rented to manage a morgue overflow in Miami—the Commission on Narcotic Drugs had introduced the International Drug Abuse Control Strategy.

In response to the rising rates of drug consumption and the increasing reach of international drug trafficking networks, the strategy urged cooperation among nation-states, international agencies, and organizations. The Economic and Social Council was assigned the task of annually reviewing progress. The Strategy's goals included strengthening the drug control system; maintaining the balance between the legitimate demand, production, and manufacture of controlled substances; eradicating illicit production and manufacture; and reducing both illicit trafficking and demand. This was to be achieved in part through enhanced prevention efforts, treatment programs, rehabilitation services, and the social reintegration of individuals with substance use disorders (UNODC 2009b, p. 66).

In 1984—the year Colombian Justice Minister Rodrigo Lara Bonilla was assassinated, and shortly after large-scale joint raids by the DEA and Mexican authorities in Chihuahua led to the seizure of several thousand tons of cannabis valued at billions of dollars (Brinkley 1984; Lamar Jr. 1984)—the United Nations General Assembly adopted the Declaration on the Control of Drug Trafficking and Drug Abuse. This declaration acknowledged the collective responsibility of all States in combating both the supply and demand sides of the illicit drug trade. It formally moved beyond the historical division between consumer, producer, and manufacturing countries and emphasized the intrinsic link between drug trafficking and abuse, security, and broader socioeconomic development (UNODC 2009b, p. 66).

Despite an unprecedented alignment of purpose among national governments and international institutions in the field of drug policy, the results of these concerted efforts remained increasingly ambivalent. On the one hand, enhanced controls on the legal production and distribution of narcotics had succeeded in substantially minimizing the diversion of

substances from legitimate to illicit channels. On the other hand, the proliferation of illegal production, processing, and trafficking persisted unabated. Powerful, well-financed, increasingly sophisticated, and often extraordinarily violent criminal organizations continued to traffic massive quantities of cannabis, cocaine, heroin, amphetamines, and methamphetamines across global markets (UNODC 2009b, p. 67).

To these substances were added so-called "designer drugs"—novel psychoactive compounds manufactured in clandestine laboratories and marketed with little concern for public safety. These synthetic substances often mimicked the effects of drugs already regulated under international conventions, but their slightly altered chemical compositions allowed them to temporarily evade legal classification, at least until the Commission on Narcotic Drugs moved to ban them (Division of Narcotic Drugs of the UN Secretariat 1987).

The enormous profits generated by the illicit drug trade empowered criminal organizations to infiltrate legitimate sectors of the global economy, corrupt public institutions, and exert political influence. When bribery proved insufficient, these groups resorted to arming paramilitary units, financing coups d'état, forging violent alliances with other criminal enterprises, and perpetrating acts of extreme brutality to intimidate politicians, judges, law enforcement officials, and rival factions. Even when coordinated international efforts succeeded in dismantling a trafficking network, rival organizations were quick to occupy the resulting power vacuum. They would compete—by legal manipulation or outright violence—for control of the remaining market, devise new operational strategies to circumvent regulatory enforcement, and exploit geopolitical instability to establish new trafficking routes (UNODC 2009b, p. 67; CND 1985, pp. 37–39).

In June 1987, the International Conference on Drug Abuse and Illicit Trafficking convened in Vienna, bringing together delegates from 138 countries. The conference expressed strong support for the drafting of a new international convention to replace the 1936 Geneva Convention—an instrument rendered largely obsolete by the *Single Convention on Narcotic Drugs* but technically still in effect. Furthermore, the conference adopted the *Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control* (CMO). Not conceived as a binding legal document, the CMO instead functioned as a set of flexible guidelines aimed at assisting national authorities and relevant organizations in crafting and implementing more effective policies to curb both the supply and demand for illicit drugs. The document was deliberately pragmatic in tone and content, emphasizing practical applicability across diverse legal, political, and social contexts (Division of Narcotic Drugs of the UN Secretariat 1988, p. 5).

Structured into four main chapters—prevention and reduction of illicit demand; control of supply; action against illicit trafficking; treatment and rehabilitation—the *Comprehensive Multidisciplinary Outline* articulated thirty-five objectives and proposed a range of potential strategies for their achievement. Its principal contribution lay in its endorsement—albeit primarily at the rhetorical level—of a balanced approach to drug policy, one that accorded prevention, treatment, and rehabilitation the same weight as had traditionally been granted to the suppression of supply (Division of Narcotic Drugs of the UN Secretariat 1988, p. iii; UNODC 2009, p. 67).

Among its key recommendations, the CMO advocated for the systematic and timely collection of statistical, medical, legal, and demographic data, highlighting the importance of rigorous methodological evaluation. It urged member states to establish early warning systems to monitor trends in drug consumption prevalence and emphasized the development of targeted

educational programs, particularly for youth and other high-risk populations. The CMO also promoted the implementation of rural development plans and called for technical, economic, and financial assistance to support the agricultural transition in regions engaged in the cultivation of opium poppy, coca, and cannabis.

Moreover, the document underscored the necessity of institutional cooperation at the local, regional, and international levels, particularly in relation to extradition and offenses linked to drug trafficking. Notably, it addressed the growing concern over health conditions associated not with drug use per se, but with the socio-environmental context and modes of administration, especially intravenous drug use. In this regard, the CMO encouraged policymakers to move beyond the all-or-nothing paradigm and to adopt a more pragmatic, public health-oriented approach. This included the consideration of prophylactic interventions aimed at mitigating the spread of communicable diseases such as HIV/AIDS and hepatitis, provided that such measures did not promote or facilitate drug abuse (Division of Narcotic Drugs of the UN Secretariat 1988, p. 82).

Yet, perhaps due to the political compromises inherent in a document designed to gain consensus among governments with widely divergent ideological frameworks, the CMO avoided explicitly naming specific harm reduction strategies as «possible means to halting the transmission of disease» (Ibid.). As a result, the dissonance between the pragmatic tone of the CMO and the prevailing legal frameworks—particularly those criminalizing the possession of needles, syringes, and analytical equipment, and thereby impeding harm reduction initiatives such as needle exchange programs and drug checking—was, and remains, stark.

The UN Convention Against Illicit Traffic of 1988

The process that would culminate in the drafting and adoption of the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* was formally initiated on 14 December 1984, when the United Nations General Assembly adopted Resolution 39/141. This resolution instructed the Economic and Social Council to mandate the Commission on Narcotic Drugs to prepare a draft convention addressing illicit trafficking in narcotic drugs, with particular attention to aspects of the problem that were not adequately covered by existing international agreements (UN General Assembly 1984).

By February 1985, the CND had commenced substantive discussions on the proposed text. The draft convention was not intended to duplicate or derogate from the obligations set forth in the *Single Convention on Narcotic Drugs* (1961) and the *Convention on Psychotropic Substances* (1971), but rather to supplement and strengthen them. Moreover, the convention needed to be crafted in a manner that would be compatible with the diverse legal and constitutional systems of member states, in order to maximize participation and ratification.

Given these complexities, the CND decided from the outset to engage national governments in the drafting process by soliciting feedback and proposals on both the preliminary draft and the provisions deemed necessary for inclusion in the final instrument. Several contentious issues were raised during this consultative phase. These included objections to the classification of drug trafficking as a crime against humanity, proposals for the creation of an international criminal tribunal dedicated to prosecuting illicit trafficking offenses, and the suggestion of establishing an additional assistance fund alongside the United Nations Fund for Drug Abuse Control (UNFDAC) (UN 1998, p. 5). In terms of format, some states expressed a preference for

an amending protocol to existing conventions, rather than the creation of a wholly new international treaty (ibid.).

Nevertheless, compared to previous efforts at international treaty-making in the field of drug control, the path to the 1988 convention proved relatively smooth. Several factors help explain this convergence. First, drug consumption had by this point become a truly global concern—affecting all countries, albeit with varying degrees of severity—thereby reinforcing the consensus that international cooperation was essential. Second, unlike earlier debates surrounding the regulation of the licit production and trade of narcotics and psychotropics—which had often divided producing, manufacturing, and consuming nations—the 1988 convention focused squarely on *illicit* trafficking. This narrower scope, concerning a universally recognized threat, helped to depoliticize negotiations. Despite the occasional complicity between criminal organizations and certain institutional actors, no state could credibly regard illicit drug trafficking as a national asset—whether as a producer, a manufacturer, or a consumer.

The work progressed with relatively few obstacles, though not with particular urgency. The priority was to secure the broadest possible participation, facilitated by an unprecedented alliance among the United States, the Soviet Union, China, Japan, and various Islamic countries—an alignment forged around one of the rare common causes of that era (Jelsma 2011, p. 7). While this consensus increased the likelihood of reaching the final objective, it also required that each provision be meticulously crafted to accommodate diverse constitutional frameworks, social contexts, and legal cultures.

On 25 November 1988, nearly four years after the adoption of Resolution 39/141, delegates from 106 countries convened in Vienna. Also in attendance were representatives from national liberation movements,

relevant United Nations bodies and specialized agencies, as well as observers from non-governmental organizations (ibid., p. 10). On 19 December, the Plenipotentiary Conference adopted the final text of the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances*. The Convention consisted of a preamble, thirty-four articles, and an annex listing chemical substances frequently used in the manufacture of illicit drugs—substances that, from that point forward, would be subject to international control.

The next day, the accession process officially began with forty-two states signing the Convention. These included countries historically central to "drug diplomacy," such as the United States, China, the United Kingdom, Turkey, and Iran (the Soviet Union would sign the following month), as well as several countries involved in cocaine production and trafficking, including Colombia, Bolivia, and Nicaragua (Mexico signed on 16 February 1989).

The distinct purpose of this third convention, as compared to the two earlier treaties it was designed to complement, is immediately evident in its preamble. Although it references «the health and welfare of human beings», its primary focus lies in the relationship between illicit drug trafficking and the stability, security, and sovereignty of states, as well as the drug trade's impact on economic and social development. Unlike the *Single Convention on Narcotic Drugs* and the *Convention on Psychotropic Substances*, where the protection of public health constituted the central concern, this new treaty was primarily driven by considerations of international security and state integrity:

> *The Parties to this Convention,*
>
> *Deeply concerned by the magnitude of and rising trend in the illicit production of, demand for and traffic in narcotic drugs and psychotropic substances, which pose a serious threat to the health and welfare of human*

> *beings and adversely affect the economic, cultural and political foundations of society, (…)*
>
> *Recognizing the links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States, (…)* (UN 1988)

The fact that the primary focus is not on public health also becomes evident in the more strictly normative sections of the Convention, which dedicate only limited attention to the issue.

Paragraph 4 of Article 3 (*Offences and Sanctions*) permits Parties to adopt, either as additional measures to criminal sanctions or as alternatives in the case of minor offences, provisions for treatment, education, aftercare, rehabilitation, or social reintegration. Similar clauses had already been included in the *Protocol amending the Single Convention* and in the *Convention on Psychotropic Substances*.

Article 14 obliges signatory countries to implement measures aimed at reducing illicit demand and invites them to follow the recommendations of specialized UN agencies such as the WHO and the guidelines set out in the 1987 *Comprehensive Multidisciplinary Outline* (CMO) in their efforts related to prevention, treatment, and rehabilitation. With this reference, the *Convention Against Illicit Traffic* formally incorporates the "balanced approach" that the CMO advocates and articulates.

William C. Gilmore, Professor of International Criminal Law and co-author—along with Henri Mazaud, John F. Scott, and David McClean—of the official commentary on the Convention, explains:

> *Although in various of its provisions there is to be found a recognition of the multifaceted nature of the drugs problem and the consequent need for appropriate measures to be taken to reduce demand, promote treatment,*

> *education, aftercare, rehabilitation and social reintegration of drug offenders, and to eradicate illicit cultivation, this is in the main a law enforcement treaty.* (Gilmore 1991, p. 3)

Gilmore's interpretation is consistent with Article 2, which defines the purpose of the Convention as the promotion of cooperation among Parties to more effectively combat international drug trafficking. At the same time, the article introduces specific limitations designed to safeguard national sovereignty. In particular, Article 2 requires Parties to fulfill their obligations in a manner that is compatible «with the fundamental provisions of their respective domestic legislative systems» (paragraph 1), «with the principles of sovereign equality and territorial integrity of States and that of non-intervention in the domestic affairs of other States» (paragraph 2), and by refraining from undertaking «in the territory of another Party the exercise of jurisdiction and performance of functions which are exclusively reserved to the authorities of that other Party by its domestic law» (paragraph 3). The clause in paragraph 3, Gilmore himself points out, was the reformulation of a principle already consolidated in international doctrine, but:

> *(…) [its] specific reaffirmation was, however, thought to be of value given the emergence in recent years of unorthodox enforcement practice which have in turn been justified on the basis of alleged exceptions to this fundamental general rule. As the UK Home Office has pointedly noted, such treaty provisions may be "helpful in countering the exorbitant claims to jurisdiction often made by the United States".* (*Ibid.*)

This apparent excess of caution thus served to avoid potentially harmful misinterpretations. Together with paragraphs 1 and 2, it was also meant to temper the perhaps inevitable tension between the binding nature of international treaties and the authority of domestic legal systems—a tension

all the more pronounced when the treaty intervenes, as in this case, in areas traditionally governed by national criminal law (Boister 1997, p. 19). The four years of preparatory work leading up to the plenipotentiary conference had, in this sense, also helped to fine-tune these sensitive legal mechanisms.

The following article, which enumerates prohibited conduct, introduces two significant innovations. The first concerns the classification of offences: whereas the previous conventions stipulated that conduct violating drug legislation should be treated as *punishable* offences under Article 36 of the *Single Convention* and Article 22 of the *Convention on Psychotropic Substances*, Article 3 of the *Convention Against Illicit Traffic* establishes that the acts listed therein, if committed intentionally, must be treated as *criminal* offences.

These acts include the production, manufacture, offering, distribution, delivery, dispatch, and transportation of any substance listed in the schedules; the cultivation of cannabis, opium poppy, and coca bush; the organization, management, or financing of any of the aforementioned crimes; and the conversion, transfer, concealment, or falsification of the origin of goods derived from such crimes. Most notably, and this constitutes the second major innovation, the Convention includes the possession, purchase, and cultivation for personal consumption within its scope.

Earlier treaties had focused primarily on producers and traffickers of prohibited substances, while the criminalization of drug users remained a matter of national discretion. The 1961 Convention, for instance, does list the cultivation, possession, and purchase of controlled substances among the prohibited acts. However, some States interpreted these provisions as not necessarily implying penal sanctions when the conduct was for personal use. A clue supporting this interpretation is found in Adolf Lande's official commentary on the *Single Convention* (UN 1973, p. 112): in the third draft of the Convention, the article that included possession among the punishable

offences was located in Chapter IX, titled *Measures Against Illicit Traffickers*. Although the final version of the Convention eliminated chapter divisions, the relevant article (Article 36, *Penal Provisions*) remained situated between Article 35 (*Action Against the Illicit Traffic*) and Article 37 (*Seizure and Confiscation*), reinforcing the impression that it pertained primarily to trafficking-related offences.

Similar considerations apply to the criminalization—or lack thereof—of possession under the *Convention on Psychotropic Substances*. The outcome of protracted negotiations, the 1971 Convention was shaped by a figure closely aligned with the interests of pharmaceutical companies and finalized by a plenipotentiary conference composed largely of industry lobbyists. As such, it bears little resemblance to the 1961 *Single Convention*. Its primary emphasis lies in the regulation of production, manufacturing, and distribution through a system of authorizations and licenses, rather than in the criminalization of these activities. The prevailing interpretation holds that, even in this case, the limitations imposed on the use and possession of scheduled substances do not entail a mandatory obligation to prosecute users (UN 1998, pp. 80–81).

According to David Bewley-Taylor, Cindy Fazey, and Tim Boekhout van Solinge, the explicit extension of criminal liability to drug users, introduced by the 1988 Convention, was driven by the need to strike a political balance between producer and consumer countries. This compromise reflects the principle of shared responsibility enshrined in the 1984 *Declaration on the Control of Drug Trafficking and Drug Abuse*, and reiterated in the preamble of the 1988 Convention:

> *(…) it was not only the duty of producing countries (e.g. the developing countries of Asia and South America) to suppress illicit supply, but also the duty of consumer countries (e.g. the industrialized countries of Europe and*

North America) to suppress the demand for drugs. (Bewley-Taylor et al. 2003)

However, the Convention includes mechanisms that temper this punitive stance toward users. Article 3, paragraph 4(c), allows parties to adopt alternatives to conviction or criminal penalties in cases of minor offenses, including educational, rehabilitative, and social reintegration measures, as well as therapeutic treatment and healthcare interventions for individuals with drug dependence. Furthermore, paragraph 2 of the same article provides significant latitude to states with respect to the criminalization of possession, purchase, and cultivation for personal use. Such conduct is to be treated as a criminal offense only «subject to its constitutional principles and the basic concepts of each party's] legal system» and if committed « contrary to the provisions of the 1961 Convention, the 1961 Convention as amended or the 1971 Convention». According to the authors of the official commentary, this latter clause may be interpreted as allowing states to uphold their own understanding of the earlier treaties concerning the non-punishability of drug users (UN 1998, p. 81).

It is also noteworthy that the criminalization of possession, purchase, and cultivation for personal use is addressed in paragraph 2 rather than paragraph 1 of Article 3. The latter focuses on more serious offenses and triggers a series of consequential legal mechanisms, including provisions on extraterritorial jurisdiction, asset forfeiture, extradition, mutual legal assistance (UN 1998, pp. 81–82), and the aggravating circumstances listed in paragraph 5. These aggravating factors require courts and competent authorities to consider elements such as the offender's involvement in organized criminal activities, the use of violence or weapons, the involvement of minors, recidivism, the abuse of a public office in connection

with the offense, and the commission of the crime near prisons, educational institutions, or areas frequented by students.

Beyond the contested clause concerning personal use, the primary objective of the *United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* is to enhance international cooperation in the prosecution of drug trafficking. This objective is pursued through the harmonization of national legal frameworks, the simplification of procedural requirements, and the introduction of new investigative tools and enforcement mechanisms.

Article 5 obliges each State Party to take measures to identify, trace, freeze, or seize proceeds, property, and instrumentalities derived from the offenses listed in Article 3, paragraph 1, with a view to their eventual confiscation. It further empowers domestic courts or other competent authorities to compel the production or seizure of banking, financial, or commercial records, and prohibits the invocation of bank secrecy in such proceedings. The same article addresses the confiscation of income and other benefits derived from criminal offenses and allows States to reverse the burden of proof regarding the lawful origin of assets subject to seizure.

Article 6 incorporates all offenses enumerated in Article 3, paragraph 1, into any existing extradition treaties between State Parties, and mandates the facilitation of extradition procedures and the reduction of evidentiary barriers in prosecuting these crimes.

Articles 7 through 10 require State Parties to provide each other with «the widest measure of mutual legal assistance» in criminal investigations and proceedings concerning offenses under Article 3, paragraph 1. These provisions encourage the transfer of proceedings to promote effective administration of justice, the adoption of new forms of cooperation and legal

assistance, and the strengthening of communication channels between authorities.

Article 11 introduces the technique of controlled delivery, an investigative tool permitting law enforcement authorities to allow a shipment of illicit drugs to proceed under surveillance, with the aim of identifying and apprehending the individuals involved in the trafficking network.

Finally, Article 12 recognizes the existence of precursor chemicals commonly used in the illicit manufacture of narcotic and psychotropic substances—those listed in Schedules I and II—and places their monitoring under the authority of the International Narcotics Control Board.

The Convention Against Illicit Traffic entered into force on 11 November 1990, ninety days after the deposit of the twentieth instrument of ratification—less than two years after its initial signing. In its Preamble, the contracting parties expressed their intention to adopt «a comprehensive, effective and operative international convention» (para. 15), aimed at eliminating «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» (para. 7).

There is little doubt that the 1988 Convention Against Illicit Traffic overcame many of the operational shortcomings of earlier treaties. It serves as a robust instrument for national law enforcement and judicial systems, as well as for international agencies and organizations, by articulating in detail the obligations of States Parties and establishing mechanisms for monitoring the implementation of relevant measures (UN 1998, p. 24). The widespread adherence to the Convention—perhaps facilitated by its less ideologically divisive focus compared to its predecessors—attests to the quality of the work conducted by the commissions, subcommissions, and the plenipotentiary conference involved in its drafting. Most importantly, it

contributes to the realization of the Convention's stated goals by enhancing its global reach and practical effectiveness.

Nevertheless, the entry into force of a comprehensive, effective and operative international instrument should not be regarded as an end in itself. Rather, the Convention must be understood as a means toward the attainment of a broader and more ambitious objective, namely that articulated in paragraph 7 of the Preamble: the eradication of illicit drug demand, the resolution of drug abuse problems, the suppression of trafficking, and the dismantling of the disproportionate profits it generates. The next chapter will examine this objective in greater depth, along with the tools—both regulatory and otherwise—envisioned to support its realization.

The crisis of consensus

A drug-free world?

With the entry into force of the Convention Against Illicit Traffic, the construction of the contemporary prohibitionist regime reached its completion. This system rests on two ideological foundations: first, that certain substances—commonly referred to as "drugs"—may possess significant medical utility, but their non-therapeutic use is inherently harmful to both individuals and society at large; and second, that the most effective means of minimizing the consumption and trafficking of these substances is to strictly regulate their production and sale for medical purposes while categorically prohibiting all other uses.

This stage corresponds to the fourth phase of the model proposed by Nadelmann, in which the prohibited activity is criminalized and actively prosecuted across much of the world, with international institutions assuming a key role in coordinating global policy responses. However, as previously noted, prohibition is a means to an end—not an end in itself. The ultimate goal remains the eradication or substantial reduction of the proscribed activity. As Nadelmann observes:

> *In some cases, a fifth stage is attained, during which the incidence of the proscribed activity is greatly reduced, persisting only on a small scale and in obscure locations.* (Nadelmann 1990, p. 485)

The attainment of this fifth stage—the marker of a successful international prohibitionist regime—depends on a range of factors. Foremost among

them is the existence of broad and genuine international consensus, which translates into a shared commitment by the majority of states to implement the rules negotiated at the international level. While some degree of non-compliance is to be expected, excessive deviation—particularly by strategically significant states—undermines the stability and efficacy of the regime.

After decades in which entrenched economic interests and abrupt political shifts consistently thwarted the emergence of such consensus, a more cooperative climate began to take shape between the 1980s and the early 2000s. One striking indication of this shift is the record of the United Nations Commission on Narcotic Drugs (CND), which, from 1985 until 2024, reportedly adopted all of its resolutions by unanimous consensus, without a single vote in the Plenary Assembly (IDPC 2024, pp. 14, 23). Based in Vienna, the CND came to embody what has been termed the *Vienna consensus*, or *Vienna spirit*—expressions evoking the collaborative ethos and shared commitment of member states in pursuit of agreed drug control objectives.

However, consensus is only the first among several factors that determine the success or failure of an international prohibitionist regime. The second is the actual capacity of states and international institutions to enforce the agreed rules. It is only since the nineteenth century—and more evidently throughout the twentieth and twenty-first centuries—that states have progressively filled longstanding gaps in sovereignty over vast areas of their territory and adjacent waters, which had previously functioned as de facto lawless zones where enforcement was virtually nonexistent.

While full territorial sovereignty and a willingness to adhere to internationally agreed norms are necessary preconditions, they are far from sufficient to guarantee effective enforcement. A range of operational,

economic, and social obstacles often stands between authorities and their intended outcomes, and there is no certainty that authorities possess the means to overcome them. Much depends on the direct and indirect costs associated with enforcement; the technologies available to both law enforcement and offenders; and, crucially, the nature of the proscribed activity itself. Activities that generate substantial profits—thus enabling the recruitment of new participants and the corruption of institutions—activities that require minimal resources or expertise to initiate, that are easily concealed, that benefit from relatively inelastic demand, or that do not produce direct victims likely to report wrongdoing, all pose formidable challenges. In such cases, international law and, in particular, criminal sanctions risk proving largely ineffective (ibid., p. 486).

It is therefore unsurprising that, despite the significant efforts undertaken and the billions invested in drug prohibition, the desired outcomes have remained elusive. Nor is it surprising that, following decades of cautious optimism, a persistent lack of results has gradually eroded the foundational consensus. What was once a banner of unity—the Vienna consensus—has come to symbolize a cumbersome and increasingly ossified system, impervious to meaningful reform due to entrenched vetoes and paralyzed by an ongoing, fruitless search for common ground between divergent political philosophies. While this dynamic has occasionally produced incremental progress, in the context of an increasingly polarized debate it now primarily serves to reinforce the status quo.

Nearly forty years on, the fetishization of consensus has collapsed. It has collapsed because, despite goodwill, commitment, and careful diplomacy, the attainment of the fifth stage in Nadelmann's model—the effective disappearance of the prohibited activity—appears increasingly utopian with each passing year.

Fast forward

The 1980s ended not with fireworks, but with dynamite. On December 6, a truck bomb loaded with approximately five hundred kilograms of dynamite exploded in Bogotá, near the headquarters of the Departamento Administrativo de Seguridad (DAS), Colombia's intelligence agency, killing fifty-seven people and injuring more than two thousand. Just nine days earlier, on November 27, another bomb had detonated on Avianca Flight 203, which had departed from Bogotá en route to Cali, killing all 110 people on board. It was widely believed that César Gaviria Trujillo, then a presidential candidate and future president of Colombia, would be among the passengers. Gaviria had replaced Luis Carlos Galán Sarmiento, founder and leader of the *Nuevo Liberalismo* party, who was assassinated on August 18 moments before stepping onstage for a campaign rally. That same day, Colombian President Virgilio Barco Vargas declared martial law and expedited the extradition procedure for drug traffickers to the United States. In response, the leaders of the Medellín cartel expressed their discontent by igniting a wave of terror across the country.

Mexico, too, was in turmoil. On April 8, Miguel Ángel Félix Gallardo—*El Jefe de Jefes*—was arrested. A founding figure and central leader of the Guadalajara cartel, Félix Gallardo had controlled significant portions of the drug routes along the U.S.-Mexico border (Bowden 2002, p. 136). In addition to trafficking charges, he was accused of participating in the abduction, torture, and murder of DEA agent Enrique Camarena, who disappeared on February 7, 1985, and was found dead a month later, his body wrapped in a plastic bag (Orme Jr. 1985). In the days following his arrest, key cartel members gathered in Acapulco to determine how to manage future operations and avoid internecine violence. The meeting, orchestrated by Félix Gallardo from behind bars, resulted in the proposal to divide the

territory into *plazas*—zones of influence assigned to individual members. Each would have the exclusive right to traffic within their designated territory and could levy a tax on others using their corridors. While initially perceived as the most pragmatic solution, the agreement soon unraveled. The power vacuum created by Félix Gallardo's arrest and subsequent transfer to a maximum-security prison, combined with the eventual dissolution of the Guadalajara cartel, paved the way for the rise of new, heavily armed and ambitious cartels. These groups, eager to expand their territorial control, would not hesitate to escalate even the smallest disputes into open warfare

In the United States, meanwhile, as the AIDS epidemic continued to claim lives, the war on drugs pressed forward at full throttle. On September 5, President George H.W. Bush addressed the American people live from the Oval Office, presenting the *National Drug Control Strategy*. At the time, the media narrative around drugs in the United States was still dominated by crack cocaine. Bush's message, like that of his predecessor, rested on a particular ideological foundation: the root causes and structural responsibilities of a systemic problem were not to be found within the economic, political, or social systems in which it had emerged, but rather in the personal, autonomous choices of individual deviants. As Bush stated:

> *All of us agree that the gravest domestic threat facing our nation today is drugs. Drugs have strained our faith in our system of justice. Our courts, our prisons, our legal system, are stretched to the breaking point. The social costs of drugs are mounting. (…) Our most serious problem today is cocaine, and in particular, crack. Who's responsible? Let me tell you straight out: everyone who uses drugs, everyone who sells drugs, and everyone who looks the other way.* (Bush 1989)

Moments later, Bush held up a sealed transparent bag marked *Evidence*, containing large crystals of crack cocaine. According to the president, the DEA had seized the crack just days earlier in a park adjacent to the White House. If dealers could operate within sight of the very heart of Washington, D.C., then, he warned, «none of us is safe»—not schoolchildren, not infants, not even unborn children (ibid.).

Despite having full editorial control over the framing of the speech and the ability to select supportive data and studies, the president's speechwriters—and possibly Bush himself—chose to lie to the American people on live television. In reality, the bag of crack had been seized by the DEA for the express purpose of allowing the president to display it during the televised address. That deception had tangible consequences. Keith Jackson was eighteen years old when an undercover DEA agent contacted him with an offer to buy crack, requesting a meeting near the White House.

> *(...) the undercover DEA agent called the suspect and attempted to set up a meeting to buy crack in Lafayette Park. But making arrangements proved difficult. At first, the suspect seemed not to know what or where the White House was (…). When finally told it was the residence of the president, he replied, "Oh, you mean where Reagan lives."* (Isikoff 1989)

Jackson was lured to Lafayette Park, arrested immediately after the transaction, and sentenced to ten years in prison. For the sake of spectacle and a theatrical flourish, Bush and his aides did not hesitate to entrap a teenager and deliver him into the carceral system. One might assume that Keith Jackson would eventually have ended up in the justice system regardless; likewise, it is reasonable to suggest that selling crack cocaine as a high school senior is not a fully free choice in the way Reagan and Bush portrayed it. And for an eighteen-year-old who had committed no violent

offense, a decade behind bars is hardly a promising foundation for a future as a law-abiding citizen.

Keith Jackson's fate caused no public outcry. He was a small fish, with nothing to offer but the drugs he sold: a harsh punishment, and for a few years he could simply be forgotten. The Contras, however, were another matter entirely.

On April 14, the Subcommittee on Terrorism, Narcotics and International Operations, chaired by Senator John Kerry, published a report detailing the state of drug trafficking in various South and Central American countries, as well as the links between narcotics, foreign policy, and governmental institutions. Chapter Five (U.S. Senate Committee on Foreign Relations 1989, pp. 36–61) was devoted to the activities of the Contras, a far-right paramilitary group that, with the backing of the Reagan administration, had sought to overthrow the Sandinista government in Nicaragua. Despite Congressional opposition (Fisher 1989, pp. 758–761), both the State Department and the CIA had secretly provided the rebels with weapons, financial assistance, and operational support, turning a blind eye to the substantial evidence of their involvement in drug trafficking. The report stated:

> *The State Department selected four companies owned and operated by narcotics traffickers to supply humanitarian assistance to the Contras. The companies were:*
>
> - *SETCO Air, a company established by Honduran drug trafficker Ramon Matta Ballesteros;*
> - *DIACSA, a Miami-based air company operated as the head-quarters of a drug trafficker enterprise for convicted drug traffickers Floyd Carlton and Alfredo Caballero;*

- *Frigorificos de Puntaremas, a firm owned and operated by Cuban-American drug traffickers;*
- *Vortex, an air service and supply company partly owned by admitted drug trafficker Michael Palmer.*

In each case, prior to the time that the State Department entered into contracts with the company, federal law enforcement had received information that the individuals controlling these companies were involved in narcotics. (*Ibid.*)

Between January and August 1986, the State Department had allocated over $800,000 to these companies. When asked to explain this, Robert Duemling—then U.S. Ambassador and Director of the Nicaraguan Humanitarian Assistance Office—stated that he could not recall how the companies had been selected for funding. The report continued:

> *At best, these incidents represent negligence on the part of U.S. government officials responsible for providing support to the Contras. At worst it was a matter of turning a blind eye to the activities of companies who use legitimate activities as a cover for their narcotics trafficking.* (*Ibid.*)

This was neither the first nor the last time a government had chosen to overlook the illicit actions of a valuable—albeit potentially temporary—ally. Limiting the focus to U.S. foreign policy alone, a similar realpolitik approach had previously been adopted in Southeast Asia and in Panama.

Panama had also been investigated by the Subcommittee (U.S. Senate Committee on Foreign Relations 1989, pp. 79–97). In January 1988, General Manuel Antonio Noriega, the de facto head of state of the Central American nation, was indicted by grand juries in Miami and Tampa on drug trafficking charges. The symbiotic relationship between the cartels and Panama, and between the traffickers and Noriega himself, had been known for some time.

However, other geopolitical interests—judged to be of greater strategic importance—had led the U.S. government to look the other way.

Noriega's predecessor, Omar Torrijos, had come to power in 1968. One of Torrijos's strategies for consolidating the national economy was to transform Panama into a tax haven:

> *(…) Panama could become a tax haven by eliminating income taxes and a bank haven by developing strict bank secrecy laws along the lines of Switzerland. By using the U.S. dollar as its official currency (…), Panama could become an ideal site for people and institutions from around the world to deposit their money without having to worry about convertibility, taxation and disclosure.*
>
> *During the late 1970's and early 1980's, illegal dollars began to enter Panama via private planes, by private couriers, in passenger suitcases on commercial flights, and as air freight. Eventually, this activity was facilitated by the Panamian military, who supervised the off-loading of cash into armored cars.* (*Ibid.*)

During the late 1970s and early 1980s, illicit dollars began pouring into Panama—transported via private planes, couriers, suitcases on commercial flights, and air freight. Eventually, the Panamanian military itself facilitated this flow, overseeing the off-loading of cash into armored vehicles (Ibid.).

It did not take long for the cartels to take advantage of the Panamanian government's favorable conditions. With Torrijos's death in 1981, leadership passed to Manuel Noriega, who had previously served as the head of the intelligence services and had been on the CIA's payroll since 1971 (Johnston 1991). Noriega had already cultivated strong ties with Colombian drug traffickers: with his intervention, the Panamanian military assisted the Medellín cartel in laundering billions of dollars, welcoming flights filled with

cash from Miami and supervising the funds' transfer and deposit into the Banco Nacional de Panamá. He also allowed traffickers to establish laboratories in the town of La Palma, near the Colombian border. According to the DEA, Noriega's name appeared in at least eighty drug trafficking case files between 1970 and 1987 (Ibid.).

That these leaks and clues did not lead to further investigations by the federal government or law enforcement agencies was no coincidence. Unlike Keith Jackson, Noriega had much to offer in exchange for his operational freedom. The United States was reluctant to compromise its relationship with the Panamanian government, with whom it jointly managed the Panama Canal. According to the Torrijos–Carter Treaties signed in 1977, Panama was set to take full control of the Canal on December 31, 1999. Furthermore, Noriega—ever pragmatic and unbound by ideological loyalties—had sold weapons to the Sandinistas, aiding in the overthrow of Anastasio Somoza, only to later traffic arms to the Contras, staunch allies of the U.S. and the Reagan administration in their fight against the Nicaraguan revolutionary government.

Noriega's ability to make himself indispensable—to eschew moral or ideological constraints, to forge alliances with traffickers and the very agencies meant to pursue them, with governments and their enemies alike—brought him both wealth and power. It also led him to commit the fatal error of believing himself untouchable.

In September 1985, Manuel Noriega ordered the torture and assassination of Hugo Spadafora, a prominent member of the Panamanian parliament who had publicly denounced his ties to Colombian drug cartels. The murder failed to provoke any official reaction from the U.S. government. However, this stance became untenable when, on June 13, 1986, a front-page article in *The New York Times* detailed the accusations against Noriega, which included

charges of murder and direct involvement in drug trafficking (Engelberg 1986). In 1988, Noriega was formally indicted, and the U.S. government began to exert increasing pressure on him to step down, especially in the wake of the electoral defeat of Carlos Duque, the candidate supported by Noriega's coalition, against Guillermo Endara—a result Noriega refused to acknowledge.

Tensions escalated until, on December 15, 1989, Noriega declared a state of war with the United States. The following day, an American soldier stationed at the Panama Canal, Robert Paz, was killed at a Panamanian army checkpoint while en route to dinner with other soldiers, unarmed and dressed in civilian clothes (Freed 1990). It was the spark that would ignite a full-scale conflict.

On December 20, the United States launched *Operation Just Cause*. More than 27,000 U.S. troops, backed by an aerial fleet of over three hundred aircraft, invaded Panama and targeted key strategic sites. The operation resulted in the deaths of twenty-three American soldiers and approximately one thousand Panamanians (Glass 2018). The United Nations condemned the invasion as a «flagrant violation of international law» (UN General Assembly 1989). The United States, however, pressed on, determined to capture Noriega, who had taken refuge in the Vatican Embassy. Even the ousted general recognized that the end had come: he surrendered on January 3, 1990.

United Nations Decade Against Drug Abuse

From February 20 to 23, 1990, a Special Session of the United Nations General Assembly convened in New York to address the issue of drug abuse. In the Political Declaration that concluded the session, UN Member States reiterated their concern over the scale of the problem and the violence and

corruption fostered by the illicit drug trade. They emphasized the need for international cooperation, acknowledged the link between drug supply and demand and the economic, social, and cultural conditions in affected countries, and recognized the connection between drug abuse and the spread of HIV and AIDS.

The session concluded with the adoption of thirty action points, the twenty-ninth of which proclaimed the decade 1991–2000 as the United Nations Decade Against Drug Abuse. During this period, Member States committed to intensify and sustain «international, regional and national efforts in the fight against drug abuse on the basis of the measures contained in the Global Programme of Action» (UN General Assembly Special Session 1991, p. 11). The Global Programme of Action, which supplemented the Political Declaration, reaffirmed the centrality of the *Comprehensive Multidisciplinary Outline of Future Activities in Drug Abuse Control* as a guiding framework for the development of policies and interventions. These ranged from demand reduction and supply control, to treatment, rehabilitation, and social reintegration, as well as mechanisms for monitoring and evaluating the effectiveness of implemented measures.

The Decade Against Drug Abuse also began with a streamlining of the international control bodies. With Resolution 45/179 of 21 December 1990, the General Assembly tasked the Secretary-General with establishing a single programme to which the administrative structures of the UNFDAC, the DND, and the INCB could be aligned. Thus, the United Nations International Drug Control Programme (UNDCP) was created, mandated to ensure coordination, complementarity, and the avoidance of duplication within the UN's drug control framework (McAllister 1999, p. 245; ECOSOC 1991).

As one might expect, expectations among the main architects of the increasingly structured conventional regime were high. Contributing to this climate of optimism were the fall of the Berlin Wall and the end of the Cold War, which were widely assumed to pave the way for compromise and cooperation among states that had previously been distrustful, if not openly antagonistic. However, this optimistic outlook soon collided with a persistent and unresolved fault line: the divide between the Global South and Global North. Moreover, the decriminalization and harm reduction policies adopted by some European countries began to cast doubt on the effectiveness and sustainability of the prohibitionist model.

In 1993, the General Assembly convened a three-day High-Level Meeting «to examine urgently the status of international cooperation» in drug control. In the months leading up to the meeting, Mexico emerged as a spokesperson for Latin American countries, sending a letter to the Secretary-General urging the international community to focus its attention on the problem of drug demand. This, Mexico argued, was the main driver of production and trafficking and was primarily the responsibility of wealthier nations. These same nations, by virtue of their economic and political hegemony, had succeeded in shifting much of the burden of control and enforcement onto producing countries. The letter also criticized the aggressive posture of the United States, whose anti-drug operations had repeatedly violated Mexican territorial sovereignty (Jelsma 2003, p. 182).

Meanwhile, the INCB, in its 1992 annual report, expressed disapproval of the tolerance policies implemented in the Netherlands. Since 1976, Dutch legislation had imposed a less punitive framework for cannabis, refraining from penalizing possession, use, and retail sales of up to thirty grams through licensed establishments (the so-called coffee shops). In October, INCB delegates conducted an official visit to the Netherlands. While the report

acknowledged that national health authorities had not observed any significant deterioration in public health and recognized the law's widespread support among citizens and policymakers—some of whom viewed regulation of cultivation and a legal market as the next logical step—it also reiterated that Dutch law amounted to decriminalization rather than, as commonly misunderstood, full legalization.

Nonetheless, the INCB argued that this approach contravened the provisions of the *Single Convention* and risked producing harmful repercussions for both European and global markets (INCB 1992, pp. 36–37). Detecting increasing dissatisfaction with the limited results achieved thus far in curbing drug supply and demand, the report also addressed the question of legalization, firmly rejecting it on the grounds that it would have "a substantial and irreversible adverse impact on public health, social welfare and the international drug control system" (ibid., pp. 3–7). The Board's conclusions were subsequently endorsed by the Commission on Narcotic Drugs during its next session (CND 1993, pp. 37–39).

This polarization was evident at the High-Level Meeting, where calls for renewed collective commitment and the purported need to reinforce the current system were counterbalanced by those voices—often accused of defeatism or surrender—that called for a critical review of the results achieved so far. These voices defended the decision not to criminalize users and to implement harm reduction measures that had proven effective in curbing certain health conditions related to drug use, measures that by then had also gained the support of the World Health Organization (Jelsma 2003, pp. 183–184; WHO 1993, pp. 35–36).

Unlike in the past, the debate was no longer between advocates and opponents of international control—by this point, the necessity of a global drug control framework was largely accepted. Rather, the discussion revolved

around the interpretive leeway afforded by the three drug control conventions, their flexibility, and ultimately, the extent to which States could choose not to criminalize "punishable" behaviors considered less serious. It was also about whether they could implement measures to help users avoid some of the risks associated with drug consumption, thereby protecting individual and public health—though this would also mean relinquishing the clearly utopian goal of eradicating drug demand. The confrontation was thus between proponents of a more pragmatic approach and advocates of zero tolerance, who feared that any concession could weaken the international control regime, both ideologically and in practice.

At the end of the three-day meeting, the General Assembly adopted Resolution 48/12, the content of which did not differ significantly from previous resolutions. However, it did instruct the Commission on Narcotic Drugs to monitor control instruments and identify shortcomings, and the Economic and Social Council to assess the state of international cooperation to identify potential improvements. Both bodies, supported by the UNDCP and the INCB, were also tasked with making recommendations on a number of issues, the first of which was the strengthening of policies and strategies for the prevention, reduction, and elimination of illicit drug demand—with particular emphasis on ensuring that treatment, rehabilitation, and public information and education campaigns be given the highest priority (UN General Assembly 1993).

Despite the growing doubts about the limited progress made and the frustration of those on the frontlines of the war on drug trafficking, no substantial shifts appeared on the horizon. In its 1994 report, the INCB wrote:

> *The international community has expressed a desire not to reopen all debates but to build on those commonly defined strategies and broad principles and to*

> *seek ways to further strengthen measures for drug control at both national and international levels.* (INCB 1994, p. 8)

The following year, the Uruguayan delegate to the CND was even more forthright:

> *The UN from its high position must be clear. Any doubt, hesitation, or unjustified review of the validity of goals will only undermine our commitment… Our goals are noble and inflexible. We cannot be successful if there are discordant voices. We cannot retreat, we must be steadfast in our goals.* (Room 1999)

This position was formalized by the Commission on Narcotic Drugs in its report on the session held in April 1996: any move toward the legalization of non-medical drug use was to be considered out of the question, and even research on the subject was discouraged, as it might «send wrong signals» (CND 1996, p. 25).

Not even the positive results or the endorsement of the World Health Organization could shield harm reduction strategies from controversy. The then-president of the INCB, Oskar Schroeder, argued that such measures might be interpreted as a form of legitimizing drug use, and were therefore unjustifiable (Jelsma 2003, p. 187). On this point, however, the dissenting countries were unwilling to compromise: Australia and the Netherlands, in particular, defended their pragmatic approach and the results it had achieved. They found allies in countries such as Portugal and Switzerland, which were not entirely convinced of the effectiveness or obligatory nature of international norms and favored a more open debate and experimentation with alternative policies (Ibid.).

By now accustomed to asserting themselves through majority vote, the advocates of zero tolerance were caught off guard by the tone and content of

the first *World Drug Report*, published by the UNDCP in 1997. The report devoted an entire chapter to the legalization debate, doing so without the usual caveats. It openly acknowledged the limitations of the prohibitionist model and presented legalization advocates as an eclectic group composed of academics, politicians, physicians, scientists, economists, and opinion leaders, many of whom were «motivated by serious and well-founded concerns». The report criticized the polarization of the legalization debate, noting that the excessive focus on opposing extremes had obscured the spectrum of regulatory alternatives that diverged—more or less radically—from these poles: «Laws—and even the international Conventions—are not written in stone; they can be changed when the democratic will of nations so wishes it», the authors concluded (UNDCP 1997).

The report also tackled the issue of cannabis, stating that it was less addictive than tobacco, that no mortality could be attributed to its cumulative effects, and that «for a variety of reasons, perhaps linked to its status as a prohibited drug, the social and health costs resulting from use have been less harmful to date than those of cigarettes or alcohol» (Ibid.; Jelsma 2003, pp. 190–191). Just four years earlier, similar statements by the World Health Organization had stirred major controversy and forced the agency into an unconvincing retraction. Yet in 1997, the UNDCP's *World Drug Report* reiterated them in black and white.

That same year marked a change in leadership at the UNDCP: following the expiration of Giorgio Giacomelli's term, another Italian, Pino Arlacchi, took over as director. It was also a philosophical shift. As early as 1994, Giacomelli had voiced the need to re-examine the principles underpinning existing international legislation, noting that:

> *[It is] increasingly difficult to justify the continued distinction among substances solely according to their legal status and social acceptability. Insofar*

> *as nicotine-addiction, alcoholism, and the abuse of solvents and inhalants may represent greater threats to health than the abuse of some substances presently under international control, pragmatism would lead to the conclusion that pursuing disparate strategies to minimise their impact is ultimately artificial, irrational and uneconomical.* (UNDCP 1994)

Arlacchi's debut marked a sharp departure from the pragmatism advocated by his predecessor, Giacomelli. In preparation for the 1998 United Nations General Assembly Special Session (UNGASS) on the world drug problem, the UNDCP launched a sixty-second television commercial aptly described by Tom Blickman:

> *A cleaner enters a empty hall at the United Nations building in New York to prepare the room for an important meeting. A voice-over explains: "Here in this room, on the 8th, 9th and 10th of June, world leaders will join forces to confront the drugs problem". As the cleaner sprays cleaning liquid onto a globe, the scene cuts to a roaring helicopter spraying herbicides. There follow images of burning drugs crops, heavily armed soldiers and a farmer processing coffee. At the end, the voice concludes: "A drug free world - We can do it."* (Blickman 1998)

Arlacchi adopted this slogan to promote the SCOPE plan—*Strategy for Coca and Opium Poppy Elimination*—which aimed to eradicate coca and opium poppy cultivation by 2008 in the principal producing countries: Colombia, Bolivia, Peru, Afghanistan, Pakistan, Myanmar, Laos, and Vietnam. According to Arlacchi, the war on drugs was not lost—it had simply not yet been truly fought (Ibid.).

Had it been fully implemented, Arlacchi's plan would have effectively set aside the so-called balanced approach that had been introduced—at least rhetorically—by the *Comprehensive Multidisciplinary Outline* of 1987 and

reaffirmed in every subsequent international document. However, many countries had grown weary of being blamed for what they saw as a global issue. In particular, Mexico and Colombia rejected the reiteration of the traditional dichotomy between producing and consuming states and insisted on the concept of shared responsibility, calling attention to the role of the global North. It was the insatiable demand from wealthier nations, they argued, that drove supply and generated turmoil on the other side of the world.

Backed by the Latin American and Caribbean bloc, Mexico also attempted to obtain the presidency of the Special Session, but the move was thwarted by the United States, which disapproved of the increasingly critical stance Mexico had taken toward U.S. foreign policy and the prevailing conventional regime (Jelsma 2003, pp. 191–192). After prolonged behind-the-scenes negotiations, the Assembly presidency was ultimately awarded to Portugal. However, Mexico secured the presidency of the intergovernmental group responsible for drafting the *Guiding Principles of Demand Reduction*, one of the cornerstones of the UNGASS 1998 program and a document directly addressing the demand side—precisely the area in which Mexico and its allies were calling for stronger international commitment.

Somewhat unexpectedly, among these allies stood Raymond Kendall, then Secretary General of Interpol, who supported an approach grounded in harm reduction and public health. «Although law enforcement is the *raison d'être* of Interpol,» he explained, «we do not consider it as a panacea for all ills associated with the drug problem» (Ibid.).

The UNGASS closing document also reflected the renewed emphasis on measures to address drug demand, later elaborated in the *Guiding Principles of Demand Reduction*. Introduced by an appeal to the principles enshrined in the Universal Declaration of Human Rights, these principles did not limit their

objective to combating drug abuse alone, but also included the reduction of its adverse consequences—thus implicitly, almost quietly, acknowledging the need to implement harm reduction measures.

For proponents of zero tolerance, however, this was far from a surrender: beyond a few formal advances, the regulatory framework and its practical application emerged unscathed and, in fact, despite the failure to adopt the SCOPE plan, the rhetoric of a *Drug-Free World* promoted by the UNDCP successfully permeated the final document. It established two objectives to be achieved within ten years. The first—already unsuccessfully pursued in the past—was the elimination or significant reduction of the illicit cultivation of coca, cannabis and opium poppy. The second, the result of a long and this time more balanced debate between producing and manufacturing countries, was the elimination or significant reduction of the illicit manufacture, marketing and trafficking of psychotropic substances, including synthetic drugs, and the diversion of precursors (UN General Assembly Special Session 1998).

The urgency for change

Ten years passed quickly. In the preface to the *World Drug Report* 2008, Antonio Maria Costa, then Executive Director of UNODC (the successor to UNDCP), while sharply criticizing the idea of legalization, acknowledged that changes were necessary. First and foremost, repressive policies should focus on traffickers rather than on consumers, who require medical assistance rather than criminal sanctions. Particular attention should be paid to problematic users, who, though a minority, consume a large share of the drug supply, thereby generating profits for criminal organizations while harming themselves and society. Greater investment was needed in marginalized urban areas and in services for young people and at-risk groups. Finally,

enhanced international cooperation was essential to combat organized crime, corruption, and the trafficking of arms and human beings (UNODC 2009c, pp. 1–2).

None of these recommendations were novel: rather, they served as confirmation that, twenty years after the adoption of the *Convention against Illicit Traffic* and a decade after the 1998 UNGASS, the problems remained largely the same—as did the proposed solutions, which had yet to be fully implemented.

In March 2009, the High-Level Segment of the Commission on Narcotic Drugs convened in Vienna. The *Political Declaration* opened with an acknowledgment that, «notwithstanding the ever-increasing efforts and progress made by States, relevant international organizations and civil society», the objectives originally set for 2008 had not been met. The global drug problem continued to pose a grave threat to the health, safety, and well-being of humanity, undermining sustainable development, political stability, democratic institutions, poverty reduction efforts, national security, and the rule of law (UNODC 2009d, p. 7). In particular, United Nations Member States recognized that:

> *(D)espite our past efforts, illicit crop cultivation and illicit drug production, manufacturing, distribution and trafficking have been increasingly consolidated into a criminally organized industry generating enormous amounts of money, laundered through the financial and non-financial sectors (...).* (*ibid.*, p. 13)

Despite these stark admissions, the Declaration—aside from a few minor notes on the need for improved indicators and tools for more accurate data collection and analysis—essentially reaffirmed the strategy previously adopted and simply extended the deadline for achieving the 2008 targets to the year 2019 (ibid., p. 14). Some Member States lobbied for the document

to explicitly reference harm reduction for the first time, initially within the main text, and then at least in a footnote. However, after prolonged and ultimately inconclusive negotiations, the term «harm reduction» was replaced with the euphemistic phrase «related support services».

The compromise failed to satisfy all parties. Twenty-six countries issued a joint statement affirming that they would interpret the vague expression «related support services» as synonymous with harm reduction measures. While formal consensus was preserved, the underlying tensions were becoming increasingly difficult to ignore.

More promising, however, was the *Plan of Action* that accompanied the Political Declaration. Each section was introduced by the identification of a specific problem, followed by the recommended actions to mitigate it. Among the challenges cited were: «insufficient emphasis on human rights and dignity», prevention and treatment interventions «not based entirely on scientific evidence and a multidisciplinary approach», «the increasing level of harm and violence».

Despite various attempts to acknowledge and address the shortcomings and unintended consequences of the conventional drug control regime, trust in the system was increasingly eroded. In Mexico, violence between drug cartels—and between the State and drug trafficking organizations—had escalated into full-scale conflict. Alarmed by intensified U.S. law enforcement efforts and the growing threat of extradition, Colombian traffickers had, since the 1990s, opted to outsource most cocaine distribution operations to their Mexican counterparts. Formerly limited to courier roles, Mexican cartels had by then become dominant stakeholders in the international cocaine trade (Grillo 2011, pp. 55ff.).

This growing control over the market generated unprecedented profits, which in turn emboldened the Mexican cartels, making them more ambitious

and ruthlessly violent. The situation became so critical that the newly elected President Felipe Calderón launched an unprecedented military campaign against the cartels. On December 11, 2006, Calderón deployed 6,500 soldiers as part of a broader national offensive, resulting in the arrest of 10,000 individuals by August 2007 (Calderón 2007). In the following year, the scale of the operation increased substantially, with the number of army and police personnel engaged in the campaign rising to 45,000 (Ramos & Gómez 2008).

However, as with any war, the campaign produced significant casualties. In addition to confrontations with government forces, the growing instability triggered violent conflicts among rival criminal organizations competing for territorial control and dominance. Bloodshed swept across Mexico, claiming the lives of both small- and large-scale traffickers, as well as military personnel and civilians. During Calderón's presidency, the country recorded over 122,000 homicides—more than double the number reported during the term of his predecessor, Vicente Fox (2001–2006). The spiral of violence did not abate with subsequent administrations: over 440,000 homicides were recorded in Mexico between 2007 and 2022 (Statista 2024).

In Colombia, the situation was equally dire—though far more complex. In addition to the persistent challenge posed by drug trafficking, which remained unresolved despite the dismantling of the Medellín and Cali cartels in 1993 and 1995 respectively, the Colombian state had been engaged for decades in a protracted conflict with various insurgent groups. Inspired by the decolonization movements in Africa and Asia, and by the revolutionary ideologies emanating from the Soviet Union, China, Cuba, and Vietnam, Marxist-inspired social movements across Latin America took up arms in the 1960s in response to state repression, rapid urbanization, and entrenched socioeconomic inequality. Colombia was no exception (Gutiérrez Sanín 2015).

Unlike insurgent movements in other parts of Latin America, Colombian guerrillas did not need to study guerrilla warfare through Vietnamese or Chinese manuals—they had inherited firsthand experience from the period known as *La Violencia*. Between 1948 and 1958, Colombia endured an undeclared civil war between Liberals and Conservatives, during which an estimated 113,000 to 300,000 people were killed in a wave of assassinations, persecution, massacres, and terrorism (Romero-Prieto & Meisel-Roca 2019). This brutal period left a legacy of resentment among the rural population and, crucially, endowed them with practical knowledge of insurgent tactics.

From the 1960s onward, Colombia entered a new phase of conflict, marked by confrontations between the central government, leftist guerrilla organizations, and far-right paramilitary groups. The emergence of the cocaine trade, with its immense financial rewards, added further complexity and violence to the conflict, deepened institutional fragility, and obscured the boundaries between political and criminal agendas.

By the late 1990s, the United States and Colombia launched *Plan Colombia*. Originally envisioned by then-President Andrés Pastrana as a form of Marshall Plan, its aim was to bring an end to the armed conflict and foster peace through economic development, social investment, and the promotion of alternative livelihoods supported by reductions in cocaine production and trafficking (Pastrana & Gómez 2005, pp. 48–51). However, between its initial drafting and final implementation, *Plan Colombia* was significantly transformed. The original peace-oriented framework was subordinated to the dual objective of suppressing insurgent movements and militarizing the fight against narcotics. Funds initially intended for agricultural and socio-economic development were redirected to military and law enforcement initiatives. The European Union, which Pastrana had invited to participate in the initiative, ultimately declined involvement (De Lombaerde et al. 2006, p. 8).

Following the September 11, 2001 attacks and the subsequent increase in U.S. military spending, *Plan Colombia* underwent a further shift away from its original developmental focus. The election of Álvaro Uribe as President of Colombia in 2002 accelerated this transformation, as the initiative came to prioritize military repression of Marxist guerrilla movements—most notably the FARC (Franz 2016; Rosen 2014). In contrast, the *Autodefensas Unidas de Colombia* (AUC), a coalition of far-right paramilitary groups heavily implicated in drug trafficking, were treated with relative leniency. In 2006, the group's leaders formally agreed to a demobilization process that entailed serving reduced prison sentences in exchange for participation in state-sponsored reintegration programs. Despite the formal dissolution of the AUC, Uribe's administration continued to provide financial and operational support to many of its former members who remained active in combatting the FARC (Romero 2007).

This support was not without long-term consequences. When, in 2008, the *Norte del Valle* cartel—an offshoot of the Cali cartel and the last major Colombian drug trafficking organization—collapsed, its territory and operations were swiftly divided among former AUC operatives. To avoid tarnishing the reputation of groups that had, for some time, served as de facto allies of the state (and perhaps always had been, as Forero [2018] suggests), the Uribe government coined a new term: *BaCrim*, a portmanteau of *bandas criminales*, to describe these emerging criminal actors (McDermott 2017).

Unlike the highly centralized and militarized Medellín and Cali cartels, the BaCrim lacked comparable organizational sophistication and were largely subordinate to Mexican cartels, who purchased the cocaine and managed its distribution across the U.S. border (ibid.). However, this loss of strategic autonomy did not diminish their brutality. Acts of extortion, kidnapping, and

murder remained rampant. The *Clan del Golfo*, led by Daniel Rendón Herrera, was emblematic of this trend. When Herrera was captured on April 15, 2009, Colombian authorities held his organization responsible for some 3,000 murders in the preceding eighteen months (Adams 2009). Between January 2001 and December 2010, Colombia recorded approximately 200,000 homicides (Chaparro-Narváez et al. 2016, p. 575). While not all of these deaths can be directly attributed to criminal competition over the cocaine trade—especially in a country mired in a decades-long internal armed conflict—the illicit drug economy undoubtedly played a significant role in perpetuating the violence.

The upheaval in Colombia, and especially the escalation of violence in Mexico, reverberated across the wider cocaine trafficking corridor, particularly affecting Guatemala. With its 870-kilometer border with Mexico and ports on both the Atlantic and Pacific coasts, Guatemala emerged as a strategic logistical hub for northbound drug shipments. After the rupture of the alliance between the Gulf Cartel and Los Zetas, the latter sought to establish new routes through Central America by forging alliances with local Guatemalan criminal organizations (Transnational Institute 2014).

Notoriously violent and technologically advanced, Los Zetas were among the most sophisticated paramilitary actors involved in drug trafficking (National Drug Intelligence Center 2007). Their entry into Guatemala did not occur in a vacuum; rather, it involved a violent contestation for territory previously dominated by the Sinaloa and Gulf cartels. The effects were quickly visible in national crime statistics: between 2000 and 2010, Guatemala's annual homicide count nearly doubled, rising from 2,904 to 5,963, with a peak of 6,505 murders recorded in 2009 (Diálogos 2022).

On 1 October 2012, the governments of Mexico, Colombia, and Guatemala issued a Joint Declaration urging the United Nations to convene,

without delay, an international conference aimed at revisiting and renegotiating global drug policies. While such a review had already been scheduled for 2019—originally intended to assess the achievement of targets first set for 2008 and then postponed for over a decade—the three countries emphasized the urgency of addressing the issue well before that date. Crucially, their demand was not limited to a reaffirmation of existing commitments or a new set of technical recommendations to mitigate the unintended consequences of the current regime. Rather, they called for a fundamental revision of the international drug control framework:

> *(D)espite the efforts of the international community over decades, the use of these substances continues to increase globally, generating substantial income for criminal organizations worldwide. (…)*
>
> *(I)t is urgent to review the approach so far maintained by the international community on drugs, in order to stop the flow of money from the illicit drug market. (…)*
>
> *(T)his review should be conducted with rigor and responsibility, on a scientific basis, in order to establish effective public policies in this area. (…)*
>
> *(T)he United Nations should exercise its leadership, as is its mandate, in this effort and conduct deep reflection to analyze all available options, including regulatory or market measures, in order to establish a new paradigm that prevents the flow of resources to organized crime organizations.* (Governments of Colombia, Guatemala and Mexico 2012)

By this time, the American continent had become the epicenter of the political and institutional tremors challenging the conventional drug control regime. In 2009, Bolivia had submitted a formal request to amend the 1961 Single Convention on Narcotic Drugs, seeking to remove the obligation imposed on State Parties to prohibit the traditional practice of coca leaf

chewing. This indigenous practice had recently been enshrined in Article 384 of Bolivia's new constitution and was recognized as part of the country's cultural heritage (Estado Plurinacional de Bolivia 2009). The Bolivian government further argued:

> *Several international legal instruments and obligations are at odds with the current scheduling and related prohibition of coca leaf usage, including the traditional practice of coca chewing. The use of coca leaf as an expression of cultural norms and as a fundamental part of the traditional nutritional and medical practices of indigenous people, is clearly protected by dispositions in human rights treaties. (…) When there is a collision between legal systems, in this case the drug treaties and the international system for the protection of human rights,* jus cogens *norms prevail (…). [T]he administrative procedure for the inclusion of the coca leaf in List I of the 1961 Single Convention has resulted in a severe and permanent infringement of the rights of peoples who use coca leaf.* (Estado Plurinacional de Bolivia 2023, p. 13)

Bolivia's amendment, however, was blocked by the objection of seventeen countries. As a result, on June 29, 2011, Bolivia formally notified the UN Secretary-General of its intention to withdraw from the *Single Convention*, effective January 1, 2012. The following year, Bolivia re-acceded to the Convention, but with a reservation that recognized the legality—within its national territory—of coca leaf chewing, its consumption for medicinal purposes, and the cultivation, trade, and possession of coca for such uses. Simultaneously, the Bolivian government reaffirmed its commitment to prevent the illicit cultivation of coca and the production of cocaine (ibid., pp. 8–9). Despite the opposition of fourteen States, Bolivia was officially readmitted to the Convention on February 10, 2013.

Ten months later, the Single Convention suffered yet another significant setback. On 10 December 2013, Uruguay became the first signatory to the Convention to fully legalize cannabis. While other States Parties had long tolerated the emergence of a cannabis market by decriminalizing possession or authorizing cultivation and sale under specific conditions, Uruguay was the first to establish a comprehensive regulatory framework governing all stages of cannabis production and distribution [see pp. 361 ff.], thereby openly contravening the provisions of the Convention.

The day after the law was enacted, the President of the INCB, Raymond Yans, condemned Uruguay's decision, not only denouncing the violation of the Convention but also criticizing the scientific basis of the reform. He claimed that the Uruguayan government had relied on «precarious and unsubstantiated assumptions» rather than rigorous scientific evidence, predicting that legalization would lower the average age of initiation, increase the prevalence of developmental disorders and addiction, and fail to reduce crime. These statements were subsequently endorsed in a brief and unequivocal communiqué by the United Nations Office on Drugs and Crime (INCB 2013a; UNODC 2013).

Soon thereafter, Yans escalated his rhetoric, accusing Uruguay of adopting a «pirate attitude» and lamenting the government's unwillingness to engage in dialogue (Jelsma 2013). This provoked a sharp response from Uruguayan President José Mujica, who publicly called the INCB President a liar and invited him to Montevideo for direct talks—suggesting that Yans should also «explain what is happening in many North American states, each of which has a capital city with a population exceeding that of Uruguay. Or does he have one discourse for Uruguay and another for the powerful countries?».

Mujica was alluding to the fact that, in 2012—one year before Uruguay's reform—the U.S. states of Colorado and Washington had also legalized the

entire cannabis production and distribution chain. In those instances, however, Yans adopted a noticeably more restrained tone (INCB 2013b). Yet those state-level reforms in the United States initiated a broader process of change that, within a few years, would see many other states moving toward the decriminalization or outright legalization of cannabis for medical and even recreational use, through both referenda and legislative action.

Following Uruguay's reform, the United States, unlike in previous cases—most notably Bolivia's withdrawal and re-accession to the Single Convention—chose not to mount a strong protest. The proactive steps taken by Colorado and Washington would have rendered any appeal to treaty compliance less persuasive. Moreover, since President Obama's election in 2008, the federal government's approach to cannabis policy had already begun to shift, even in the absence of formal legislative reform (Ingraham 2016). For U.S. drug diplomacy, this marked the end of one era and the beginning of another—one in which the country's position on harm reduction policies was also poised to evolve (Office of National Drug Control Policy 2013). This shift was all but inevitable, as the United States was by then grappling with a humanitarian crisis that could only be addressed through a fundamental rethinking of drug control paradigms

The opioid epidemic

In 2022, the United States recorded 111,029 drug overdose deaths, of which 84,181 were attributable to opioids. Since 1999, overdose fatalities have surpassed one million, with opioid-related deaths increasing more than tenfold. This trend has continued unabated, with the sole exceptions of a modest decline in 2018 and a still-unconfirmed decrease in 2023—an encouraging but tentative sign of a possible reversal (CDC/NCHS 2024a; 2024b). It is estimated that, in 2022, 3.7% of the adult population in the

United States—approximately 9.37 million individuals—suffered from an opioid use disorder (Dowell et al. 2024, p. 568).

The opioid crisis has spurred the publication of numerous investigative works, including *The Empire of Pain* by Patrick Radden Keefe (2021), *Pain Killer* by Barry Meier (2018), and *Dreamland: The True Tale of America's Opiate Epidemic* by Sam Quinones (2015), as well as documentaries such as *The Crime of the Century* by Alex Gibney and *All the Beauty and the Bloodshed* by Laura Poitras, and dramatized television series such as *Dopesick* (Hulu) and *Painkiller* (Netflix). The books by Keefe, Meier, and Quinones, in particular, form the basis of the brief historical reconstruction that follows, which seeks to answer a central question: how did this hecatomb come to pass?

A direct answer would point to the introduction of OxyContin—an oxycodone-based medication manufactured by Purdue Pharma and approved for market release by the Food and Drug Administration (FDA) in December 1995. OxyContin differed from other oxycodone-containing drugs such as Percocet, Percodan, and Tylox, which combined lower doses (up to 5 milligrams) of oxycodone with over-the-counter analgesics such as aspirin or acetaminophen. While these combination drugs produced rapid but short-lived effects, OxyContin consisted of pure oxycodone in doses ranging from 10 to 160 milligrams, formulated for extended release (hence the suffix «Contin», indicating continuous action), with an effect intended to last approximately twelve hours.

OxyContin presented what was perceived as a significant advantage: its extended-release formulation was believed to reduce the potential for misuse. In addition to potency, one of the key factors contributing to a drug's abuse liability is the rapidity of its onset (Allain et al. 2015). Purdue Pharma thus argued that OxyContin was safer than other opioid analgesics, as it was presumed to be less prone to misuse by patients and less likely to be diverted

for non-medical use. This purported advantage was explicitly endorsed in the official FDA-approved package insert, which stated: «Delayed absorption, as provided by OxyContin tablets, is believed to reduce the abuse liability of a drug».

Why, then, is the marketing of OxyContin widely regarded as the catalyst for the opioid epidemic that swept across the United States and severely impacted Canada in the subsequent decades? One principal reason is that the claim regarding OxyContin's low abuse liability was merely a supposition—a hypothesis based on reasoning that, while not entirely implausible, was neither grounded in empirical evidence nor supported by any specific clinical studies on OxyContin itself. Moreover, this assumption failed to consider the possibility that the tablets could be crushed, thus bypassing the time-release mechanism and delivering the full dose of the active ingredient immediately.

Despite the absence of substantiating data, the statement proposed by Purdue was approved by the FDA. In an internal company report, Purdue executives expressed elation over the FDA-approved package insert, which they described as «so valuable and promotional that it could have easily served as [OxiContin's] principal selling tool» (Meier 2018, p. 75). Such was their enthusiasm that, less than three years later, Curtis Wright IV—the FDA official who had overseen the drug's evaluation and approved the labeling—was hired by Purdue as its Medical Director, with an initial annual salary approaching $400,000.

In truth, the history of the opioid epidemic is, before being a story of a public health crisis, a tale of the pursuit of profit, opaque relationships, institutional cynicism, and a chilling illustration of how law can be shaped and applied. It is, therefore, a story that began decades before the introduction of OxyContin.

In 1952, the Sackler brothers acquired a small pharmaceutical firm, the Purdue Frederick Company. The company's management was assigned to Mortimer and Raymond Sackler, though the purchase had been orchestrated with the involvement of their elder brother, Arthur Sackler. By the early 1940s, Arthur had become a partner at the pharmaceutical advertising agency William Douglas McAdams Inc., and rapidly contributed to transforming the field. In 1998, the Medical Advertising Hall of Fame noted:

> *No single individual did more to shape the character of medical advertising than the multi-talented Dr. Arthur Sackler. His seminal contribution was bringing the full power of advertising and promotion to pharmaceutical marketing.* (Podolsky et al. 2019)

In addition to supervising advertising campaigns for prescription drugs, Arthur Sackler also exerted influence over a number of scientific journals that regularly published articles on emerging pharmaceuticals—especially those manufactured by his clients. Among these journals was *Medical Tribune*, a biweekly publication distributed free of charge to 168,000 physicians, whose articles were effectively designed to lend a scientific veneer to the advertisements purchased by pharmaceutical companies.

Arthur Sackler was also a pioneer of the so-called *infomercial* format, which enabled pharmaceutical firms to communicate more directly and persuasively with both physicians and the general public. This strategy laid the groundwork for what would become continuing medical education (CME) programs—conferences, seminars, and meetings ostensibly devoted to medical topics, but in practice often employed as platforms for promoting the products of their corporate sponsors.

Complementing these efforts was the widespread distribution of gifts to physicians and the financial support of health-related advocacy organizations

that presented themselves as independent actors. Collectively, these practices produced a web of interdependent interests that placed the commercial imperatives of pharmaceutical companies, industry publications, distributors, and complicit or misled healthcare professionals above the imperative of protecting public health.

After years of enriching his clients, Arthur Sackler eventually decided to enter the pharmaceutical business himself, albeit from behind the scenes: he financed his brothers' acquisition of Purdue Frederick and collaborated with them in devising its commercial strategy. This strategy transformed a company that, in 1952, had an annual turnover of $22,000 (equivalent to approximately $260,000 today) and specialized in products such as laxatives and earwax removal solutions (Senokot and Cerumenex), into a pharmaceutical powerhouse. Between 1996 and 2019, Purdue generated approximately $34 billion in revenue—most of it from OxyContin sales (U.S. Supreme Court 2024).

As Barry Meier notes:

> *On the basis of his experience in the pharmaceutical industry, Arthur Sackler, who likely had a role in acquiring Senokot and Cerumenex, knew that a small, privately held operation such as Purdue would prosper only if it found opportunities or created niches unclaimed by big manufacturers. Decades later, this idea led his brothers to see opportunity in another overlooked area – the treament of pain.* (Meier 2018, p. 56)

For a long time, pain remained peripheral to mainstream medical research. Prior to the advent of modern neuroimaging techniques, pain was considered a subjective and unverifiable experience—its existence could be attested to only by the individual suffering from it. Research on pain began to gather momentum in the 1960s, and gained further traction in the 1970s with the

founding of a specialized journal (*Pain*) and the establishment of the International Association for the Study of Pain. These developments helped to place pain at the center of biomedical inquiry (Collier 2018). A decisive shift occurred in the following decade, when a growing number of pain specialists began to advocate for broader use of opioids, including in the treatment of chronic non-cancer pain (Ibidem).

To pursue this objective, nearly any means were considered acceptable. On January 10, 1980, a letter to the editor by Dr. Jane Porter and Dr. Hershel Jick of the Boston University Medical Center was published in the *New England Journal of Medicine*. Porter and Jick wrote:

> To the Editor: *Recently, we examined our current files to determine the incidence of narcotic addiction in 39,946 hospitalized medical patients' who were monitored consecutively. Although there were 11,882 patients who received at least one narcotic preparation, there were only four cases of reasonably well documented addiction in patients who had a history of addiction. The addiction was considered major in only one instance. (…) We conclude that despite widespread use of narcotic drugs in hospitals, the development of addiction is rare in medical patients with no history of addiction.* (Porter, Jick 1980, p. 123)

Dr. Jick would later clarify that he and his colleague had submitted the letter to the *New England Journal of Medicine*'s correspondence section because the data were not sufficiently robust to justify a formal study, and that no conclusions could be drawn regarding the long-term risks of opioid use. Indeed, the analysis included dozens of different narcotic substances—not exclusively opioids—and was limited to the period of hospitalization, with no follow-up data after patient discharge (Meier 2018, p. 37).

Nevertheless, Porter and Jick's eleven-line letter to the editor became a foundational text for advocates of expanded pain management. In their self-serving yet flawed interpretation, opioid addiction occurred in «less than 1 percent of cases»—a claim they would repeat for decades in seminars and conferences sponsored by pharmaceutical companies. Purdue Pharma adopted this statistic as a key element in the training of its sales representatives tasked with promoting OxyContin to physicians. If any doctor expressed doubts about prescribing OxyContin for conditions such as lower back pain, arthritis, dental pain, fibromyalgia, or trauma, the sales personnel were instructed to reassure them that fewer than 1% of patients who used opioids became addicted. They also emphasized that, according to the product label approved by an FDA official who would later join Purdue's payroll, OxyContin's extended-release formulation reduced its abuse potential.

The company's objective was to make OxyContin the first potent narcotic suitable for mass consumption—to move it beyond oncology departments and into general medical practice. In pursuit of this goal, Purdue Pharma doubled its sales force within just a few years of OxyContin's release and systematically implemented all the strategies that Arthur Sackler had once helped develop with calculated cynicism.

As was common practice among pharmaceutical companies, Purdue partnered with IMS Health—a data analytics firm in which Arthur Sackler had previously been a silent partner. IMS Health collected and shared detailed information on physicians' prescribing habits. Through this partnership, Purdue gained access to granular data that allowed it to identify doctors most likely to prescribe opioids and strategically deploy sales representatives to their practices.

Following the launch of OxyContin, Purdue representatives—unable to distribute free samples of a controlled substance—distributed thousands of coupons to physicians, which entitled patients to trial supplies of the drug. Purdue allocated approximately four million dollars annually to fund the distribution of these promotional vouchers (Meier 2018, p. 129).

Another significant expenditure was allocated to organizing educational conferences on pain management, frequently held in desirable tourist destinations such as Boca Raton (Florida) or Scottsdale (Arizona). Between 1996 and 2001, more than 5,000 healthcare professionals—including physicians, pharmacists, and nurses—attended these events at Purdue's expense (Government Accountability Office 2003, p. 22). These conferences also served as recruitment grounds for future collaborators: between 1996 and 2002, Purdue hired approximately 2,500 of the attending professionals as paid speakers for subsequent company-sponsored events (Ibidem).

While cultivating close relationships with physicians, Purdue certainly did not overlook those it intended to make the final consumers of its product. The company was among the funders of organizations and associations such as the American Pain Foundation, the American Pain Society, the American Academy of Pain Medicine, and Partners Against Pain. These entities actively promoted greater use of potent narcotics by physicians, provided patients with referrals to pain specialists, and distributed brochures in waiting rooms encouraging individuals to discuss pain management options with their doctors (ibid., pp. 42, 81). The American healthcare system proved particularly fertile ground for such strategies: non-pharmacological approaches to chronic pain treatment and the rehabilitation programs offered by multidisciplinary centers were significantly more expensive than supplies of oxycodone, morphine, and other narcotic pills, which soon became the preferred option for insurance companies (ibid., p. 43).

OxyContin was launched in 1996. By 1997, dozens of internal emails, recordings, and documents reveal that Purdue executives were already aware that the drug was being misused. However, this information was withheld from the company's sales force, physicians, patients, and regulatory authorities. In the ensuing years, reports of abuse surged, and studies showed that both MS Contin (Sajan et al. 1998) and OxyContin were appearing on the black market and becoming targets for theft and armed robbery. Purdue had at its disposal all the necessary tools to investigate the situation—thanks in part to IMS Health's data services. It would have been straightforward to identify which physicians were prescribing opioids in excessive quantities and to report suspected «pill mill» operators, that is, doctors prescribing painkillers regularly and in volumes that defied medical rationale. Yet OxyContin was generating unprecedented profits, with sales rising steadily: by 2000, annual revenues from OxyContin alone had reached approximately one billion dollars.

Despite knowing the extent of the problem, Purdue executives chose not to compromise their commercial interests. The company maintained its aggressive marketing campaign unchanged—an approach that soon became a model for other pharmaceutical firms, such as Insys Therapeutics. Insys adopted Purdue's tactics to market Subsys, a fentanyl-based drug approved by the FDA exclusively for cancer patients, but which was often prescribed far beyond its intended use by complicit physicians.

Purdue's aggressiveness extended well beyond marketing: anyone who dared to voice criticism or raise allegations risked becoming a target of the company's lobbyists, legal teams, or allied media outlets. Even officials from the Drug Enforcement Administration (DEA) were not immune. In 2000, Laura Nagel was appointed director of the Office of Diversion Control, the division responsible for investigating the diversion of legal pharmaceuticals

to illicit markets. Nagel and her team focused on OxyContin and concluded that neither Purdue nor the FDA was doing enough to educate physicians and patients about the drug's risks or to contain its proliferation.

Unlike the DEA's criminal division, the Office of Diversion Control lacked significant resources: its agents were unarmed, could not conduct undercover operations, and were forced to manually examine paper prescription records stored in pharmacies when investigating suspected pill mills. They did not have access to IMS Health data and operated without the support of a national electronic prescription monitoring system, which had failed to gain Congressional approval in the mid-1990s due to resistance from pharmaceutical companies and the American Medical Association (Meier 2018, p. 41). Despite these obstacles, Nagel and her team were undeterred by the scale of the crisis. In March 2001, as OxyContin abuse and illicit distribution spread across the country, a DEA official—speaking anonymously to the *New York Times*—declared that it would take years to undo the damage caused by OxyContin (Meier, Petersen 2001).

Outraged by the mounting media scrutiny, Purdue executives requested and were granted a meeting with Laura Nagel. The subsequent correspondence made it increasingly evident that Purdue had no intention of altering its production or sales practices. As tensions escalated, Purdue mobilized its top executives to pressure the DEA into marginalizing Nagel. Following the advice of its public relations consultants and crisis communication experts, the company launched a counteroffensive in the media. It framed the controversy around the defense of patients' rights: the right to live free from pain was under threat not from OxyContin or Purdue, but from drug abusers, from a DEA engaged in an ideologically driven crusade, and from media outlets whose coverage was, paradoxically, exacerbating the problem

In the meantime, within four months, Purdue initiated negotiations and reached an agreement with the Food and Drug Administration (FDA). The company pledged to monitor OxyContin usage data more rigorously and, «proud to be the first drug manufacturer to voluntarily review prescribing information», amended the package insert. This revision removed the statement suggesting that the extended-release formulation reduced the risk of abuse and introduced the indication that OxyContin should be used for the treatment of long-term or chronic pain, rather than for intermittent or acute episodes. Nevertheless, even amidst mounting controversy, Purdue's revenues—driven by the OxyContin product line—continued to climb, reaching three billion dollars by 2010 (Ryan et al. 2016).

In parallel with Purdue's soaring profits, the social costs escalated as well:

> *(T)he number of people who admitted to using OxyContin for non-medical purposes increased dramatically from approximately 400,000 in 1999 to 1.9 million in 2002 and to 2.8 million in 2003.*
>
> *By 2009, about 1.2 million emergency department (ED) visits were related to misuse or abuse of pharmaceuticals, an increase of more than 98% since 2004 and more than the number of ED visits related to use of illicit drugs such as heroin and cocaine. Most prominent among these prescription drug-related deaths and ED visits were opioid pain relievers (OPR), especially OxyContin.* (FDA 2024)

In 2002, the U.S. Attorney for the Western District of Virginia, John L. Brownlee, assigned Assistant U.S. Attorneys Randy Ramseyer and Rick Mountcastle to investigate Purdue. After four years of inquiry, Ramseyer and Mountcastle submitted a comprehensive 120-page memorandum, which—drawing upon internal emails, recordings, corporate documents, and witness testimonies—reconstructed the criminal scheme devised by the company's

senior leadership. These executives had instructed their sales representatives to mislead physicians regarding OxyContin's potential for addiction and abuse, and they continued this conduct even after becoming aware of widespread misuse of the drug across the United States.

Members of the Sackler family, Purdue's owners, sat on the company's board of directors and continued to profit from OxyContin's sales, transferring millions of dollars from Purdue's accounts into a complex web of shell companies and private accounts. However, having formally relinquished any operational role within the company years earlier, they were spared from prosecution. Executives Howard Udell, Michael Friedman, and Paul Goldenheim were less fortunate: they faced serious charges, including conspiracy to defraud the United States—offenses that could have resulted in prison sentences upon conviction.

Nonetheless, securing a conviction would have required a public trial. Despite the overwhelming evidence implicating Udell, Friedman, and Goldenheim (and others), senior officials within the U.S. Department of Justice opted to resolve the matter through a plea agreement. Purdue and the three executives pleaded guilty to the lesser charge of misbranding. The company agreed to pay fines and penalties totaling six hundred million dollars—a figure significantly lower than the cumulative profits generated by OxyContin up to that point. The executives were ordered to pay a combined fine of thirty-four million five hundred thousand dollars and were sentenced to three years of probation and four hundred hours of community service in drug rehabilitation or substance abuse treatment programs.

By avoiding trial, Purdue successfully prevented the public release of investigative documents and a potentially devastating impact on its business. The company's operations continued uninterrupted, in large part due to a key agreement brokered by one of Purdue's consultants, Rudy Giuliani, former

mayor of New York. Since companies with criminal convictions are typically prohibited from conducting business with the federal government, only Purdue Frederick—the parent company—was formally convicted. Its subsidiary, Purdue Pharma, was thus able to continue manufacturing and selling OxyContin without restriction, including within public health programs such as Medicaid, Medicare, and the Veterans Administration health system (McGreal 2018).

For Purdue Pharma, this marked the beginning of the end. In the years that followed, lawsuits and damage awards multiplied—compensations that, paradoxically, the company could only fulfill by selling millions more OxyContin tablets. In 2019, one year before reaching an agreement with the federal government to pay an additional fine of eight billion three hundred million dollars, Purdue Pharma filed for bankruptcy—a petition that, as of yet, has been denied by the U.S. Supreme Court (U.S. Supreme Court 2024).

As Purdue sinks, the white-collar criminals who orchestrated every facet of its operations—and whose greed and cynicism devastated millions of lives—have walked away without serving a single day behind bars or even receiving a criminal conviction. Meanwhile, other companies complicit in the crisis have continued to thrive, and in some cases, actively worked to undermine public oversight mechanisms.

Under the Controlled Substances Act, pharmaceutical manufacturers are prohibited from selling their products directly to pharmacies; all transactions must be routed through licensed distribution companies. McKesson, Cencora (formerly known as AmerisourceBergen until 2023), and Cardinal Health constitute the three primary pharmaceutical distributors in the United States, each generating annual revenues between two hundred and three hundred billion dollars. According to the same statute, distributors are mandated to log all incoming orders into a centralized computer database

and are required to refrain from fulfilling—and to report—any orders deemed suspicious to the Drug Enforcement Administration (DEA). Failure to comply enables the DEA to issue an Order to Show Cause and an Immediate Suspension of Registration. This administrative action entails the temporary shutdown of the offending distribution center until a hearing is held, which may either lift the suspension, determine its duration, or permanently revoke the distributor's authorization to handle controlled substances.

In 2007, the DEA issued Immediate Suspension Orders against seven Cardinal Health distribution centers that had fulfilled hundreds of suspicious orders, thereby facilitating the diversion of millions of hydrocodone pills (U.S. Attorney's Office 2008). Only two years earlier, the DEA had already warned Cardinal Health executives about these irregularities, but the alert had evidently gone unheeded.

> *"Despite DEA's repeated attempts to educate Cardinal Health on diversion awareness and prevention, Cardinal engaged in a pattern of failing to report blatantly suspicious orders for controlled substances filled by its distribution facilities located throughout the United States," said DEA Acting Administrator Michele M. Leonhart. "Cardinal's negligent conduct contributed to our nation's serious pharmaceutical abuse problem. This substantial civil penalty underscores DEA's determination to prevent pharmaceutical diversion and protect the public health and safety by continuing to hold companies responsible if they fail to fulfill their obligations under the Controlled Substance Act."* (*Ibid.*)

The substantial civil penalty to which Leonhart referred resulted from a plea agreement between the Department of Justice and Cardinal Health: a fine of thirty-four million dollars. For a company whose revenues in 2008,

according to the *Fortune 500*, approached ninety billion dollars, a thirty-four-million-dollar fine was merely a slap on the wrist. Indeed, Cardinal Health, McKesson, and AmerisourceBergen continued to flood the country with narcotics: between 2007 and 2012, they shipped approximately 780 million oxycodone and hydrocodone pills to West Virginia—an amount equivalent to 433 pills for every man, woman, and child in the state (Meier 2018, p. 163).

In 2012, the DEA intervened again. Investigators sought to bring charges against the companies and their executives in criminal court (Bernstein, Higham 2016; 2017), but the leadership at the DEA and the Department of Justice opted instead for negotiation. The distributors agreed to pay fines and temporarily close certain facilities, but they also began lobbying to erode the DEA's enforcement authority.

Between March and April 2016, Congress passed and President Barack Obama signed the *Ensuring Patient Access and Effective Drug Enforcement Act*. Beneath its reassuring title, the law significantly weakened the DEA's ability to suspend the activities of major distributors even in the face of blatant legal violations. The new legislation required the DEA to obtain a hearing before issuing a suspension order and redefined the standard for action from «imminent danger» to «substantial likelihood of an immediate threat»—a threshold far more difficult to meet.

Meanwhile, fatal overdoses continued to escalate: from nearly 30,000 in 2005 to over 52,000 in 2015, from 70,000 in 2019 to 91,000 in 2020, and from 106,000 in 2021 to more than 111,000 in 2022 (CDC/NCHS 2024a; 2024b).

The catastrophe unfolded in distinct waves. The first, beginning in the late 1990s, was driven by a surge in prescriptions for opioid analgesics, particularly OxyContin, which led to hundreds of thousands of deaths and

cases of addiction. Stricter state laws, enhanced monitoring of clinics, the closure of numerous pill mills, and growing physician reluctance to prescribe opioids curtailed the first wave, but simultaneously laid the groundwork for the second.

The second wave began in 2010, when many individuals who had lost access to prescription opioids—or sought cheaper and more potent alternatives—turned to heroin, often with fatal consequences (Mars et al. 2014).

The third wave emerged in 2013, marked by the explosive proliferation of fentanyl. According to the DEA's National Forensic Laboratory Information System, in 2013, fentanyl was identified in 1,041 forensic analyses of seized substances; by 2016, this figure had soared to 28,751 (U.S. Department of Justice 2017, p. 2). Fentanyl, a synthetic opioid significantly more potent and cheaper to produce than heroin, offered traffickers extraordinary profit margins: in 2017, one kilogram of fentanyl purchased in China for $3,000 could yield over $1.5 million on the American black market (Ibidem). To maximize profits, traffickers increasingly mixed fentanyl—or its even more potent analogues, such as carfentanil—into heroin, cocaine (D'Errico 2018), and counterfeit pills. Many users ingested fentanyl unknowingly, though some sought it deliberately (NDEWS Coordinating Center 2016). The motivations varied: fentanyl could be more accessible, cheaper, or necessary for users who, after prolonged opioid consumption, required higher doses to achieve the desired effects. Nevertheless, fentanyl represented a deadly gamble: the estimated lethal dose is approximately two milligrams (EMCDDA 2015). Overdose deaths involving synthetic opioids have risen dramatically each year (CDC 2022).

The situation worsened further with the onset of the fourth wave, characterized by increased poly-substance use and, in particular, a rise in

stimulant abuse (Ciccarone 2021). Overdoses involving cocaine and methamphetamines tripled and quintupled respectively between 2012 and 2018. Two factors may have aggravated the toll. First, the 2016 CDC guidelines recommending opioid dosage reductions below 90 morphine milligram equivalents (MME) per day were at times implemented too aggressively, leading to rapid tapers or discontinuations without patient consent, thereby increasing risks of mental health crises and overdose (Manchikanti et al. 2022). Second, the COVID-19 pandemic, which triggered spikes in overdose deaths at local, regional, and national levels (Ghose et al. 2022, p. 316), exacerbated vulnerabilities through reduced treatment access, heightened social isolation, and disruptions to drug markets.

Preliminary data suggest that 2023 may have witnessed a slight decline in overdose deaths—107,543 compared to 111,029 in 2022, a 3% decrease (CDC/NCHS 2024b). If confirmed, it would mark only the second annual decline since the opioid epidemic began. Nonetheless, the fourth wave is far from over: while deaths from opioid overdoses (natural, semi-synthetic, and synthetic; legal and illicit) have slightly decreased, fatal overdoses involving stimulants such as cocaine and methamphetamine have continued to rise (Ibidem).

Pandora's Box

Let us take a step back. While the situation in the United States was rapidly deteriorating, two major international events related to drug policy loomed on the horizon. The second would be the United Nations General Assembly Special Session (UNGASS) scheduled for 2016, convened following the Joint Declaration of Colombia, Guatemala, and Mexico. The first was the 57th session of the Commission on Narcotic Drugs (CND), held in March 2014, formally convened to conduct a High-Level Mid-Term Review of the

Political Declaration and Plan of Action adopted in 2009. Instead of delivering a balanced assessment of progress and setbacks, the summit devolved into a forum for conflict between increasingly irreconcilable visions and prolonged negotiations aimed at producing a consensus-based document.

While Russia emerged as the most vocal defender of the conventional regime, dissenting voices multiplied. Ecuador, in particular, distinguished itself as the first Member State to call for a profound reconsideration of the system and the replacement of the existing conventions with a new Single Convention (Ecuador 2014, p. 4). The ensuing debate revealed deep fractures: in just a few years, numerous countries had decriminalized or legalized, either de jure or de facto, the medical and recreational use of cannabis, with others in the process of considering similar reforms. Other contentious issues included the use of the death penalty for drug-related offences, growing human rights violations associated with enforcement practices, and the spread of HIV/AIDS among people who inject drugs (PWID). In 2011, the UN General Assembly had adopted the target of halving new infections among PWID by 2015 (United Nations General Assembly 2011, p. 9), a goal that remained far from being met (IDPC 2018, p. 19).

These divisions were superficially resolved in the form of a diluted Joint Ministerial Statement, which offered little more than a reiteration of previously established goals and a reaffirmation of shared commitments to combating drug abuse and illicit trafficking (Commission on Narcotic Drugs 2014). The statement's final draft was the product of nine months of protracted negotiations (Ibidem).

By the time UNGASS 2016 approached, the international drug control regime found itself on increasingly unstable ground. In Canada, legalization

of cannabis had not yet begun, but the Liberal Party under Justin Trudeau, elected in October 2015, had pledged to move swiftly in that direction (Lemon 2019). In the United States, cannabis reform was advancing rapidly at both state and municipal levels. While many of these laws focused exclusively on medical use, the growing recognition of cannabis's therapeutic potential cast doubt on its continued inclusion in Schedule IV of the Single Convention—reserved for substances whose risk of abuse is deemed not offset by any significant therapeutic benefit.

At the federal level, a significant development occurred in December 2015, when Congress repealed the longstanding ban on the use of federal funds for needle exchange programs. While the amendment technically continued to prohibit federal dollars from being used to purchase sterile syringes, it permitted funding for other aspects of NEP operations—staff salaries, vehicles, fuel, and general operational costs—thus facilitating the effective functioning of these programs (Weinmeyer 2016, pp. 254–255).

Meanwhile, on 25 September 2015, the UN General Assembly adopted Resolution A/RES/70/1, establishing the Sustainable Development Goals (SDGs): seventeen goals and 169 associated targets to be achieved by 2030 (UN General Assembly 2015). Only one target, 3.5, made direct reference to substance abuse, aiming to strengthen prevention and treatment for drug and alcohol dependence. However, numerous other SDGs—such as the eradication of poverty, food security, access to health, reduction of violence, environmental protection, and the promotion of inclusive institutions—were clearly entangled with the broader dynamics of drug production, trafficking, and use. As such, the SDGs provided additional justification for those calling for an overhaul of current drug policies (Health Poverty Action 2015).

On 19 April 2016, delegates gathered in New York for the 20th UN General Assembly Special Session on the world drug problem—the third in

UN history, following those held in 1990 and 1998. For those countries and international organizations advocating for reform, the session was a sobering experience. The entrenched practice of seeking consensus through the so-called «Vienna spirit» proved once again to be a barrier to formalizing changes that were already being implemented de facto by many Member States. The Outcome Document failed to conduct a meaningful review of the past decades' results or harms and reiterated the objective of a society free from drug abuse. Despite debates over human rights, capital punishment, and harm reduction, the document offered no structural departure from the punitive paradigm.

Nonetheless, the reformist bloc continued to expand. During the session, only two countries—China and Singapore—explicitly opposed harm reduction measures, while forty-six expressed support, joined by several UN agencies including the World Health Organization, the Office of the High Commissioner for Human Rights, the United Nations Development Programme (UNDP), UNAIDS, and the UNODC (IDPC 2017, p. 5). Although the term «harm reduction» once again did not appear in the final document, paragraph 1(o) of the Outcome Document introduced a periphrastic yet unmistakable endorsement of such strategies:

> *We (…) invite relevant national authorities to consider (…) effective measures aimed at minimizing the adverse public health and social consequences of drug abuse, including appropriate medication-assisted therapy programmes, injecting equipment programmes, as well as antiretroviral therapy and other relevant interventions that prevent the transmission of HIV, viral hepatitis and other blood-borne diseases associated with drug use (...).* (United Nations General Assembly Special Session 2016)

The death penalty, in contrast, was neither condemned nor mentioned. More encouragingly, human rights—children's rights, women's rights, the right to health, and the right to proportionate sanctions—featured more prominently than in any previous international drug control document. The extent to which these affirmations translate into practice remains debatable. Still, paragraph 4 of the 2016 Outcome Document marked a turning point in formally elevating human rights to the forefront of international drug control diplomacy.

From 14 to 22 March 2019, the CND convened in Vienna for its 62nd session, marking ten years since the 2009 Political Declaration and Plan of Action had postponed the 2008 goals to 2019. Civil society played a major role, with hundreds of delegates participating—many within national delegations—and contributing to over forty side events (IDPC 2019, p. 1). The session was tasked with reviewing the global situation and considering recommendations from the WHO Expert Committee on Drug Dependence (ECDD) and the INCB on proposed scheduling changes.

The most recent World Drug Report painted a grim picture. In his preface, UNODC Executive Director Yury Fedotov warned:

> *Both the range of drugs and drug markets are expanding and diversifying as never before. (…)*
>
> *We are facing a potential supply-driven expansion of drug markets, with production of opium and manufacture of cocaine at the highest levels ever recorded. Markets for cocaine and methamphetamine are extending beyond their usual regions (…), drug trafficking online using the darknet (…) continues to grow rapidly (…).*
>
> *Non-medical use of prescription drugs has reached epidemic proportions in parts of the world. (…)*

> *[M]ore new psychoactive substances are being synthesized and more are available than ever, with increasing reports of associated harm and fatalities.*
>
> *Drug treatment and health services continue to fall short: the number of people suffering from drug use disorders who are receiving treatment has remained low, just one in six.* (UNODC 2018, p. 1)

The loss of faith in the control regime led many states to circumvent restrictions on cannabis, which remained listed in the most restrictive schedule (Schedule IV) of the Single Convention. In 2018, the Canadian government under Trudeau implemented a comprehensive legal framework for cannabis, disregarding warnings from the INCB. Russia responded aggressively. After the adoption of Canada's Cannabis Act in June 2018, Mikhail Ulyanov, Russia's permanent representative to the UN in Vienna, accused Canada of violating the treaties and of undermining the system's integrity, warning that such selective application of treaty obligations risked «opening Pandora's box» (IDPC 2019, pp. 12–13).

Nine months later, Russia submitted Resolution L3, «Supporting the INCB», urging the Board to actively enforce compliance using all mechanisms available under the treaties. Though vague, the phrase «various means» was widely interpreted as a veiled reference to Article 14 of the Single Convention, which allows the INCB to recommend sanctions if a party fails to comply with its treaty obligations. The resolution triggered tense negotiations. Thanks to mediation by Canada, the United States, and European allies, the final version omitted references to Article 14 and adopted a more conciliatory tone.

Meanwhile, other resolutions adopted at the session reflected a more progressive stance. Resolution L6 promoted alternative development in line with the SDGs, Resolution L9 advocated for measures to prevent HIV transmission among women who use drugs, and Resolution L4—«Promoting

measures to prevent and treat viral hepatitis C attributable to drug use»—emphasized public health responses. Although the phrase «harm reduction» was again omitted, the resolution endorsed the WHO's Global Health Sector Strategy on Viral Hepatitis 2016–2021, which explicitly supported harm reduction and public health alternatives to criminalization, and encouraged provision of 300 sterile syringes annually per PWID by 2030 (WHO 2016).

The time then came to consider scheduling changes. The ECDD recommended placing several synthetic cannabinoids and fentanyl analogues under international control. More controversially, it proposed removing cannabis and cannabis resin from Schedule IV of the Single Convention (WHO 2019, pp. 37–41). The Committee emphasized that cannabis was neither especially prone to abuse nor lethal, and that its therapeutic potential was increasingly recognized. Although it did not recommend transferring cannabis to Schedule II, this decision stemmed more from its widespread use than from any evidence of harm.

Once again, Russia reacted sharply. Its delegation condemned countries legalizing cannabis and criticized the ECDD for reversing nearly sixty years of established policy. Despite the backlash, the CND postponed a decision until 2020, giving Member States more time to assess the recommendation (IDPC 2019, p. 19).

The fateful moment arrived on 2 December 2020, when the sixty-third session of the Commission on Narcotic Drugs reconvened to vote on the recommendations made by the World Health Organization's Expert Committee on Drug Dependence (ECDD) regarding cannabis and cannabinoids. In addition to recommending the removal of cannabis from Schedule IV (it would remain in Schedule I, of which Schedule IV is a subset), the ECDD proposed several additional changes: the transfer of THC, its psychoactive component, and its isomers from Schedule II of the

Convention on Psychotropic Substances to Schedule I of the Single Convention; the deletion of cannabis extracts and tinctures from the same schedule; the placement of THC-based preparations in Schedule III of the Single Convention; and the inclusion of a footnote specifying that preparations containing CBD and no more than 0.2% THC are not subject to international control.

Of these recommendations, only the removal of cannabis from Schedule IV was approved, with twenty-seven countries voting in favour, twenty-five against, and one abstention. Unlike political documents that have traditionally required unanimity, amending the schedules of the Single Convention requires only a simple majority (UNODC 2020a, p. 2). With decision 63/17, cannabis was officially removed from Schedule IV as of 2021, and its therapeutic utility was implicitly acknowledged at the international level.

From a strictly legal perspective, the reform did not constitute a dramatic shift: the Single Convention already allowed States a degree of flexibility in regulating the medical use of controlled substances. Article 2(5)(b) provides that any Party may prohibit the production, distribution, and use of cannabis for medical purposes «if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare» (United Nations 1972). Symbolically, however, this decision marked the end of an era. It constituted an explicit acknowledgement that the original placement of cannabis in Schedule IV had been informed more by ideology than by science, and that a substantial rethinking of the international drug control system was both necessary and inevitable— a fact that would be confirmed by developments that followed shortly thereafter.

The end of the Vienna consensus

In March 2024, the CND convened what would become the most widely attended session in its history: 2,500 delegates, including over 600 representatives from 141 non-governmental organizations (IDPC 2024, p. 2). The High-Level Segment was tasked with conducting the Midterm Review of the 2019 Ministerial Declaration, and there was a palpable sense of a long-overdue reckoning. Months of exhaustive negotiations had laid bare the fact that the pursuit of consensus at all costs had rendered the Commission inefficient, capable only of recycling previous decisions and appending minor amendments that generally avoided naming contentious issues directly, so as not to provoke resistance from status quo-oriented States. Statements made by delegates in the Plenary Assembly suggested that compromise would be more difficult than ever to achieve: cannabis regulation, human rights, and harm reduction had come to deeply polarise the debate.

Volker Türk, the first United Nations High Commissioner for Human Rights to attend a CND session, stated unequivocally: «after decades of following a largely punitive approach, we see that it is simply not working» (IDPC 2024, p. 5). The previous August, the Office of the High Commissioner for Human Rights (OHCHR) had published a report detailing the human rights challenges posed by current drug policies. The report, conceived as a contribution to the Midterm Review, marked the first time that a UN agency had explicitly called on Member States to consider the responsible regulation of all drugs—a paradigm shift grounded in principles of equality, non-discrimination, and human rights.

The findings of that report were echoed in the remarks of Colombian President Gustavo Petro, who in his address to the Plenary Assembly openly declared the failure of the current system (ibid.). At the High-Level Segment, Colombia's Foreign Affairs Minister Álvaro Leyva Durán presented a joint

declaration endorsed by sixty-two countries, calling for a comprehensive re-evaluation of the international drug control framework, grounded in empirical evidence. The United States also expressed support, calling for a creative and innovative interpretation of the conventions that would prioritise the well-being of populations (ibid.).

This rationale—placing public health above rigid legal interpretation—was precisely what had been invoked by those States that had already regulated or were in the process of regulating cannabis. Although such reforms inevitably constituted violations of the treaties, States justified their actions through a flexible reading of the conventions and an appeal to the overarching aim declared in their preambles: the protection of public health and welfare.

Meanwhile, Bolivia and its allies continued to denounce the prohibition of coca leaf, which they characterised as an unjust vestige of an international drug control regime rooted in Western colonialism. In 2023, they secured an initial victory: the World Health Organization mandated its Expert Committee to undertake a critical review of coca and its classification in Schedule I of the Single Convention.

The opposing bloc, no less assertive, delivered its position through Russia, whose delegation read out a joint statement signed by forty-six countries reaffirming their commitment to the international control system and their aspiration for a society free from drug abuse. However, their determination to stay the course was forced to confront the grim reality of 115,000 annual overdose deaths in the United States and Canada, alongside early signs of similar trends emerging in other parts of the world (ibid., p. 7). This unprecedented public health emergency prompted the U.S. administration to adopt a dual-track strategy: on the one hand, bolstering international law enforcement cooperation; on the other, embracing—albeit belatedly—a harm reduction approach.

Introducing resolution 67/4, the U.S. delegate employed unambiguous language:

> *[W]e are proud to sponsor a resolution focusing on overdose prevention, in which we have utilized the term "harm reduction", albeit recognizing its contentious nature among many Member States. We urge you to move beyond semantics and join us in exploring compassionate approaches that do not rely solely on criminal justice responses to drug use.* (*Ibid.*)

During the week of debate in the Committee of the Whole, sixteen Member States and the European Union issued statements in favour of harm reduction and its explicit inclusion in the final text, firmly rejecting the paraphrased formulations that had been reluctantly accepted in the past. This principled stance did not, however, imply an abandonment of diplomacy. On the contrary, these delegations worked toward a compromise text that would allow for a large number of reservations. They reduced the nine references to harm reduction in the original draft to a single mention in the version submitted to the Plenary Assembly, eliminated references to specific interventions such as drug checking and supervised consumption sites, and proposed a footnote acknowledging that such measures were prohibited in certain jurisdictions. Yet even these concessions were insufficient to overcome the deadlock.

Once the impasse had been confirmed, the United States requested that the Committee Chair forward the resolution to the Plenary Assembly, indicating the paragraphs on which consensus had not been reached. The Plenary Assembly subsequently adopted, without a vote, resolutions 67/1, on the promotion of rehabilitation and care services for individuals with drug use disorders, and 67/2, on access to medicines—both of which had already secured unanimous support within the Committee of the Whole.

The discussion then moved to resolutions 67/3—on alternative development, ten years after the adoption of the UN Guiding Principles—and 67/4, both of which would expose deep political and geopolitical divisions.

When Thailand proposed that resolution 67/3 be adopted «by consensus», Iran objected. The underlying tensions reflected a broader fault line between the Global North and the Global South. Central to the disagreement were references to unilateral coercive measures and the transfer of technology. The former were viewed by many countries in the Global South as arbitrarily applied instruments of foreign policy, targeting geopolitical adversaries such as Russia after the invasion of Ukraine, while sparing allies such as Israel—whose military campaign in Gaza, from October to March (when the CND was held), had already resulted in over 30,000 civilian deaths (IDPC 2024, p. 11). Meanwhile, the issue of technology transfer was seen as essential by countries of the Global South in order to guarantee their populations access to life-saving medications, currently monopolised by Western pharmaceutical companies under stringent patent protections that inflated prices and restricted availability.

For the first time since 1985, a CND resolution would be adopted by vote rather than consensus. Although Iran had disrupted the consensus mechanism, it did not destroy it entirely: when the time came for the Plenary vote, Iran abstained, as did Armenia and Tanzania, and resolution 67/3 was adopted with forty-five votes in favour and none against.

After a brief intermission, discussion resumed on resolution 67/4. When the Chair inquired whether the Plenary Assembly wished to adopt the resolution «by consensus», it was Russia that objected. With thirty-eight votes in favour, six abstentions, and two votes against (Russia and China), the

CND adopted its first-ever resolution to explicitly refer to the term «harm reduction».

The post-vote statements revealed that the underlying tensions remained unresolved. The United States delegate accused Russia and its allies of pushing the spirit of Vienna to the brink, using the consensus-based decision-making process to hold the Commission hostage. The European Union delegate echoed this sentiment, arguing that the consensus mechanism should not be equated with a unilateral veto, but should instead be exercised with openness, flexibility, and good faith. This remark was a direct response to the Russian delegate's accusation of bad faith and disregard for the established traditions of the CND (IDPC 2024, p. 17).

These frictions laid bare the extent to which the consensus mechanism had become a source of paralysis rather than cohesion—setting the stage for the even deeper ruptures to come.

In March 2025, at the 68th session of the Commission on Narcotic Drugs, consensus failed on all six resolutions tabled—including on topics that, in the past, had typically garnered swift agreement, such as prevention and the dismantling of drug laboratories. The proceedings took place in a markedly altered political climate: for the first time, the United States participated under the new administration of President Trump, whose return to power brought a sharp shift in tone and priorities. Just a year earlier, at the 67th session, the U.S. had co-sponsored a resolution explicitly endorsing harm reduction. In 2025, by contrast, its delegation rejected all mention of gender and gender-sensitive policies, openly challenged the role of the World Health Organization and denounced the Sustainable Development Goals as a «program of soft global governance (…) inconsistent with U.S. sovereignty and adverse to the rights and interests of Americans» (U.S. Mission to International Organizations in Vienna, 2025). This marked not just a

rhetorical change, but a substantive repositioning: the United States, long perceived as cautiously reform-oriented, now stood at the forefront of a renewed conservative bloc.

Alienating many of its traditional allies, the U.S. paralysed negotiations across the board and called for a vote on all six resolutions, but found itself repeatedly and visibly isolated. In most cases, its position was supported only by Argentina, while Russia—despite its traditionally conservative stance—voted in favour of several resolutions and aligned with the U.S. only once, on the Colombian initiative. That vote—30 in favour, 18 abstentions, and 3 against (Argentina, Russia, and the United States)—marked a historic break: for the first time, the Commission formally adopted a resolution establishing a panel of independent experts tasked with assessing whether the current machinery of the international drug control system remains adequate for contemporary challenges.

This constituted a major institutional departure. The panel—composed of twenty experts appointed by the CND, the UN Secretary-General, the INCB, and the WHO—is explicitly mandated to formulate concrete and actionable recommendations to enhance the implementation of international drug policy commitments. Crucially, its scope extends beyond the drug control treaties themselves, encompassing all relevant international instruments—a formulation widely interpreted as including international human rights law.

The collapse of consensus at the 68th CND marked a turning point with both immediate effects and longer-term institutional consequences. It signalled not only a break with long-standing institutional routines but also revealed a deeper structural transformation within the Commission. For decades, the CND's reliance on consensus had rendered formal membership largely symbolic: all UN Member States—regardless of whether they belonged to the 53-member body—could participate in negotiations and

influence outcomes. With the normalisation of voting procedures, however, official membership has acquired newfound weight.

This procedural transformation has triggered a notable surge in interest among governments seeking a seat at the table. For the first time in many years, more countries applied than there were seats available, prompting ECOSOC to hold secret ballots to determine the new composition of the Commission. In several regional groups—Asia, Eastern Europe, and Western Europe and Others—longstanding members were voted out, and new alignments took shape. What was once a bureaucratic formality has become a politically charged process, with the makeup of the Commission increasingly reflecting broader ideological and geopolitical fault lines over the future of drug policy.

Nowhere was this realignment more apparent than in the outcome of the April 2025 elections, when two of the most staunchly prohibitionist countries—the Russian Federation and the Islamic Republic of Iran—lost their seats on the CND. While their exclusion might suggest a shift away from prohibitionist orthodoxy, in Russia's case the decisive factor was not its stance on drug policy, but its ongoing war in Ukraine. For the first time since the Commission's founding in 1946, Russia was no longer represented in any capacity, its seat taken by Ukraine, the very country it had invaded.

Although the presence and engagement of both Russia and Iran within the CND are unlikely to diminish, their exclusion from any future vote—for the next few years at least—marks a turning point in the institution's trajectory. This growing competition for CND seats reflects not only the erosion of the Vienna consensus, but also a profound reconfiguration of who gets to shape global drug policy. The Commission, long characterised by inertia and diplomatic stagnation, is becoming a more politicised—and potentially more

consequential—forum, where decisions no longer rest on unanimity but on dynamic and evolving coalitions of interests and values.

Looking ahead, the path forward is unlikely to be smooth. The ongoing liquidity crisis affecting the United Nations may be exploited to slow the work of the expert panel; and the appointment of UNODC as the panel's secretariat could raise concerns about impartiality. Nonetheless, the direction of travel is clear: the era of consensus-based paralysis at the CND is over. In its place, a more pluralistic, contested, but ultimately more responsive form of multilateralism is beginning to take root. How far this process will go will depend on the ability of reform-minded States, UN agencies, and civil society actors to consolidate these gains—and to resist the forces that seek to preserve a status quo that is increasingly difficult to justify.

Unfit for purpose

We have thus far reconstructed two centuries of drug policies, composing a historical mosaic and offering an overview that seeks to trace the principal normative vectors shaping the current control regime. We shall examine the production dynamics of drug law in greater depth later. For now, it is sufficient to note that this process has deep roots in racist and colonial societies; that geopolitical, economic, and corporate interests have influenced both national and international legislation; and that ideology has frequently prevailed—not only over the ideal of a more just and democratic society, but even over basic political pragmatism.

The key question posed in this section is: despite its ontological distortions, has the control regime—here defined as prohibitionist—yielded tangible results? Considering its stated objective, as articulated in the preambles to international conventions—namely, to protect public health by preventing the abuse of controlled substances while ensuring their availability for medical and scientific use—is the prohibitionist model effective? Is access to essential medicines guaranteed on a global scale? Is the licit and illicit consumption of drugs effectively controlled?

Access to essential medicines is a fundamental component of the right to health (OHCHR 2008, p. 3), enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights and Article 25 of the Universal Declaration of Human Rights. It is also included in Target 3.8 of Sustainable Development Goal 3 (Good Health and Well-Being) under the 2030 Agenda.

The 2024 World Drug Report (UNODC 2024c, p. 135), under the section *Contemporary Issues on Drugs*, affirms:

> *One of the key dimensions for promoting the right to health of people is ensuring access to internationally controlled drugs for medical purposes, including for the treatment of drug use disorders, other mental health disorders, pain management and palliative care.*
>
> *Pain can substantially affect an individual's health, with serious negative consequences including slower or partial healing from injury, surgery or disease, as well as impact quality of life and activities of daily living.* (UNODC 2024c, p. 135)

Pain has a profound impact on individual health, with serious consequences such as delayed or incomplete recovery from injury, surgery, or illness. It also affects quality of life and daily functioning.

The need to ensure access to essential medicines was already evident to the drafters of the international conventions. In the preambles to both the *Single Convention on Narcotic Drugs* and the *Convention on Psychotropic Substances*, we find the following affirmations:

> *Recognizing that the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering and that adequate provision must be made to ensure the availability of narcotic drugs for such purposes (…)* (United Nations 1972)

> *Recognizing that the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should not be unduly restricted (…)* (United Nations 1971)

Nevertheless, according to the *World Drug Report 2024*, decades after the ratification of the treaties—and despite various amendments and adjustments—approximately 75% of the global population still lacks access, or has insufficient or inadequate access, to essential medicines for managing

acute and chronic pain. This includes medications required for palliative care and childbirth. As a result, millions of individuals continue to endure avoidable suffering.

Although the past two decades have seen some progress in the distribution of methadone and buprenorphine—both used as analgesics and as opioid agonist therapies for opioid use disorder—major disparities in medical access to opioids persist. In 2022, per capita availability of opioids for pain management and palliative care in high-income countries was 46 times greater than in low- and middle-income countries. The disparity was even more dramatic when comparing North America and Africa (a ratio of 250:1), and North America and West and Central Africa (a staggering 1,700:1) (UNODC 2024c).

Legal consumption of morphine—a WHO Model Essential Medicine, alongside methadone and buprenorphine—is also heavily skewed toward high-income countries, with middle- and low-income countries accounting for just 17% of global production (Human Rights Council 2024, p. 12).

Where these essential medicines are unavailable, the risk of counterfeit and substandard drugs increases significantly. Recent research indicates that in middle- and low-income countries, approximately 13.6% of medicines (including those not subject to international control) are counterfeit or substandard (Ozawa et al. 2018), negatively impacting patient health.

Meanwhile, in the Global North—particularly in the United States—the opposite problem has emerged. As noted by the Special Rapporteur of the Human Rights Council, Tlaleng Mofokeng:

> *Pharmaceutical companies, driven by profit motives, have played a major role in fuelling the proliferation of prescription opioids and the opioid crisis. Private-sector activities, which prioritize corporate interests over patient*

interests, have shaped individuals' access to pain management care. (Human Rights Council 2024, p. 3)

This stark polarization in the availability and use—both licit and illicit—of controlled drugs underscores the systemic limitations of a regime that has thus far failed to achieve its declared objective: ensuring the global production and distribution of drugs sufficient to meet medical and scientific needs.

The other principal objective of the international control regime, as we have seen, is the containment of drug consumption.

According to the *World Drug Report 2024*, in 2022— the most recent year for which comprehensive data are available—almost 292 million people, approximately one in eighteen individuals aged between 15 and 64, reported having used drugs in the past twelve months. This figure represents an increase of 20% compared to a decade earlier, a rise attributable not only to global population growth but also to an increase in the relative prevalence of drug use.

At the same time, an estimated 64 million people suffered from substance use disorders, marking a 3% increase compared to 2018. Moreover, the number of substances available on the illicit market has continued to grow, making polydrug use increasingly common (UNODC 2024a, p. 22).

Cannabis remains the most widely consumed controlled substance, with approximately 228 million users reported in 2022, followed by opium derivatives (60 million) and stimulants such as amphetamines and cocaine (30 million and 23.5 million users, respectively; ibid., p. 3). Among individuals who used drugs in the past year, approximately three out of four were men, although gender distributions vary considerably depending on the substance and region: for instance, in North America, women account for 45% of cannabis users, whereas in Asia the figure falls to approximately 9%.

Conversely, in several countries, the non-medical use of sedatives, tranquilizers, stimulants, and opioids by women is equal to or exceeds that of men (ibid., p. 23).

Both the demand for and supply of cocaine reached record levels in 2022. Cocaine production hit 2,700 tons, representing annual growth of 20% and a threefold increase compared to eight years earlier. Hospitalizations, treatment requests, and fatal overdoses related to cocaine use have also risen markedly (ibid., p. 13).

Meanwhile, the Taliban government's ban on opium cultivation in Afghanistan resulted in a sharp contraction in global opium production, only partially offset by increased cultivation in other countries. This abrupt shift has had serious consequences for Afghanistan's already vulnerable rural communities, exacerbating economic hardship and likely affecting the global heroin market. Higher heroin prices could, on the one hand, encourage some users to reduce consumption or seek treatment; on the other hand, they could also push users toward more dangerous consumption practices or drive a shift toward synthetic opioids that are more potent and hazardous (ibid., p. 14). Among the emerging synthetic opioids, particular concern has been raised about nitazenes—a group of compounds significantly more potent than fentanyl. These substances are increasingly reported in North and South America, Western Europe, and Oceania. Although no definitive causal link has yet been established, nitazenes are suspected of contributing to the recent rise in fatal overdoses (UNODC 2024a, p. 16).

The original flaw of the international drug control conventions—their emphasis on supply-side control while neglecting demand reduction—has never been fully corrected, despite decades of scientific evidence and various legislative adjustments. Globally, only one in eleven individuals with a substance use disorder has access to treatment services.

Treatment coverage remains uneven, both geographically and by gender. In Asia, only one in twenty people with a substance use disorder receives treatment; in Africa, fewer than one in thirty-five. Due to stigma, economic hardship, and the scarcity of gender-specific treatment facilities, women everywhere face greater barriers to access: only one in eighteen women with a substance use disorder receives treatment, compared to one in seven men (UNODC 2024a, p. 31).

Among the nearly fourteen million people who inject drugs, as of 2022, approximately 6.8 million were infected with hepatitis C. Unsafe injection practices account for about 23% of new hepatitis C infections. Furthermore, approximately 1.6 million individuals were living with HIV, and around 1.4 million were co-infected with both hepatitis C and HIV (UNODC 2024a, p. 22).

At least 160,000 people die each year as a direct result of drug use. Several indicators suggest that since the last consolidated global data from 2019, the number has increased. The total annual number of deaths—both direct and indirect—attributable to drug use is now estimated to be close to, or exceeding, 500,000. Liver disease remains the leading cause of drug-related mortality, accounting for approximately 57% of drug-related deaths in 2019, as well as for the largest share of years of healthy life lost due to premature death or disability (UNODC 2024d; WHO 2024, p. 294).

Given this general picture, can we, in good conscience, assert that drug consumption is under control? Probably not. The increasing prevalence of drug use and the adoption of high-risk methods of consumption—practices that result in consumer deaths and the spread of serious communicable diseases among both PWUD and the wider population—demand critical reflection on whether the means provided by the current system are consistent with the goals it claims to pursue.

Expected and unintended consequences

In 2008, the Executive Director of UNODC, Antonio Maria Costa, published a report entitled *Making Drug Control "Fit for Purpose": Building on the UNGASS Decade*. Ten years had passed since the 1998 UNGASS and the 51st session of the Commission on Narcotic Drugs was approaching. That session would evaluate global drug control efforts and, once again, postpone the achievement of targets that had initially been set for that very decade.

In his report, Costa resisted calls to "throw the baby out with the bathwater". While openly acknowledging the clear limitations of drug diplomacy and the failure to achieve many of its stated objectives, he maintained that, over the course of its now century-long history, the international control system had played a crucial role in containing both the production and use of drugs. Costa wrote:

> *The drug control system has succeeded in containing the drugs problem to less than 5% of the adult population (aged 15-64) of the world. This refers to annual prevalence: those who have used drugs at least once in the year prior to the survey. Problem drug users are limited to less than one tenth of this already low percentage (…). In other words, occasional statements such as "there are drugs everywhere" or that "everybody takes drugs" are just plain nonsense.* (Costa 2008, pp. 3-4)

At the same time, Costa acknowledged that the drug problem was far from resolved and identified a series of unintended consequences resulting from the prohibitionist model. Every legal norm, regardless of its intended aim, carries the risk of producing unintended consequences. These outcomes are not always unforeseen: for instance, when the trade of a particular good is

prohibited, the emergence of an illegal market is often an undesirable—but not unexpected—result.

Indeed, such markets can arise in response to any form of regulation, even those less severe than outright prohibition. The fact that alcohol and tobacco are legal in most countries has not led to the elimination of their smuggling. In highly regulated societies, almost any product—drugs, food, clothing, toys—can be subject to illicit trade. Of course, a legal market provides guarantees for producers, suppliers, consumers, and third parties that illicit traders cannot offer. Their competitive edge often lies in reducing costs (and therefore prices), usually through tax evasion and non-compliance with quality standards, or by targeting consumers excluded from the legal market—such as minors in the case of alcohol and tobacco.

Thus, in the shadow of many legal markets, pockets of illegality persist. These may continue to generate significant profits for the "entrepreneurs" involved, but they are unlikely to capture substantial market share from the legal economy.

Prohibition, more than any other regulatory model, pursues control while simultaneously relinquishing it—relegating the entire market (or most of it) to illegality, where it becomes governed by the rules, risks, and power dynamics of the individuals and criminal organizations operating within it. However, the prohibitionist choice is not, in itself, irrational or ineffective. In certain cases, it is the only legitimate option. Consider, for example, the prohibition of slavery: a legal slave market could theoretically offer greater protection to sellers and buyers, and perhaps even to the enslaved individuals themselves. But would this be a politically viable or morally acceptable strategy? Obviously not—at least not if one believes in human rights and the dignity of the individual.

Fundamental principles enshrined in the Universal Declaration of Human Rights—such as the right to life, liberty, and security of person, the prohibition of slavery and servitude, and the prohibition of torture or cruel, inhuman, and degrading treatment (Articles 3, 4, and 5)—render any legal regulation of slavery inconceivable.

According to the International Labour Organization (2022, pp. 2–5), approximately 50 million people worldwide remain subjected to conditions of modern slavery, highlighting serious shortcomings in the enforcement of national and international prohibitions. Yet this failure of implementation does not undermine the normative necessity of abolition: no alternative to the absolute prohibition of slavery could be contemplated without fundamentally betraying human rights and the principles underpinning the international legal order. In contrast to drug prohibition, the ban on slavery does not fuel clandestine markets, exacerbate violence, or intensify the suffering of those it seeks to protect. Rather, it stands as an unequivocal repudiation of an inherently unjust system. By comparison, drug prohibition has often reproduced and amplified harm, fostering illicit economies that thrive precisely because of the illegality they are meant to suppress.

Nevertheless, an analogy between drug use and slavery, albeit imperfect, retains some conceptual relevance. If slavery involves the subjugation of one individual by another, certain psychoactive substances can, through the mechanism of addiction, exert a form of internal domination over the user. The very term *addiction* in English—referring to the compulsive use of drugs, distinct from mere physical dependence (Szalavitz et al. 2021, p. 1990)—derives from the Latin *addictio*, a legal concept describing the submission of a debtor to the authority of a creditor by judicial decree. That said, important distinctions must be drawn. Unlike human beings, psychoactive substances can be concealed, transported, and consumed with relative ease. Moreover,

few individuals involved in illicit drug markets have an interest in reporting their victimization to the authorities, as they are often complicit in the criminal transaction itself (Nadelmann 1990, p. 512).

These factors, among others, help to explain why prohibitionist policies in the field of drug control have often proven ineffective. Yet inefficacy may not be the sole—nor even the principal—shortcoming of the current system. The criminalization of the market generates both expected and unexpected, desired and undesired consequences. In an illicit market, price inflation is an anticipated effect: consumers are not merely paying for the good itself but also for the significant risk borne by those involved in its production and distribution. A higher price is also a desired outcome, insofar as it is intended to deter purchase and reduce consumption. However, as will be discussed, price inflation may, in turn, produce unintended adverse effects.

Some of these consequences affect only those who violate the prohibition, while others extend their impact to society at large. Given that unintended effects can never be wholly eliminated, it becomes crucial to identify, manage, and account for them within the broader cost-benefit analysis of the regulatory framework that engenders them.

Over the years, numerous scholars, organizations, and international institutions have examined the costs and consequences of drug control policies. What follows is a brief overview of this collective body of research, intended to illuminate the chain of effects produced by regulatory strategies whose stated goal is the protection of public health and safety but which, paradoxically, may have undermined both.

Public spending

Among the unintended consequences highlighted by Costa in his 2008 paper is what the then-Executive Director of UNODC defined as *policy*

displacement: the systematic misallocation of resources toward activities that are politically expedient but often contrary to evidence-based public health priorities. In the field of drug control, this phenomenon manifests in the diversion of limited public funds across sectors such as health, justice, security and public order, education, and social protection. An accurate estimation of these expenditures forms the foundation for a cost-benefit analysis of drug policies, aimed first at understanding the financial burden they impose on public budgets, and then at evaluating which investments are effective, which could be improved, and which add significant social costs to economic ones.

Although indispensable, the evaluation of drug policies presents considerable complexity. Drug control programs involve international and intergovernmental organizations, multiple ministries and departments, and different levels of public administration. Many related expenditures are embedded within general budgets, making it difficult to isolate clean data specific to drug policy interventions. Consider, for instance, prison systems, where the costs of detaining and treating individuals incarcerated for drug-related offenses are combined with those for other prisoners; moreover, individuals convicted under drug laws may also face charges for unrelated crimes, further obscuring the ability to calculate the net costs attributable to specific legal frameworks. Similar challenges arise in assessing costs borne by police forces, judicial systems, and healthcare facilities. Consequently, while timely and systematic data collection is crucial, the resulting estimates are necessarily approximate.

Perhaps due to these methodological and practical challenges, there is currently no international instrument capable of systematically collecting and comparing national estimates of expenditures related to the enforcement of drug legislation. One of the few institutions to have attempted this task was

the EMCDDA (European Monitoring Centre for Drugs and Drug Addiction, now the European Union Drugs Agency, or EUDA), which for a period collected and published expenditure estimates shared by a limited number of European countries (Prieto 2010). However, due to gaps and inconsistencies in the data, as well as differences in definitions and methodologies across countries, the initiative had limited utility (Council of Europe, Groupe Pompidou 2017, p. 20) and failed to gain the collective commitment and scientific rigor it deserved. To date, no comparable analysis appears either in the European Drug Report of the EUDA or in the World Drug Report of the UNODC.

The limited and outdated information available suggests that, although the historical emphasis on supply control has been gradually tempered by greater attention to the demand side, the security-centered approach based on criminalization has consistently prevailed over a public health-centered approach (ibid., p. 21). This tendency can be partly explained by the dynamics of political visibility: repressive measures produce immediate, tangible results—such as arrests and seizures—that attract media attention and political capital, whereas public health interventions, such as street outreach programs aimed at supporting detoxification or harm reduction, yield long-term benefits that are less visible and less sensational (Costa 2008, p. 10). In this context, drug control policies suffer from a visibility bias that structurally favors repression over health-based approaches.

Political calculations that prioritize image and rhetoric over a rational assessment of costs and benefits offer a textbook illustration of *policy displacement*: funds and resources that, according to available evidence, could have been invested in more useful, efficient, and equitable measures are instead redirected toward repressive interventions whose societal costs often

outweigh any demonstrable benefits. This dynamic is not an occasional deviation but a structural feature of contemporary prohibitionist regimes.

Public health and scientific research

International conventions impose a structural tension on contracting parties: they are simultaneously obligated to prevent the illicit production, trafficking, and abuse of scheduled substances, while also ensuring their adequate availability for medical and scientific purposes. In practice, however, the global prohibition regime has resulted in widespread shortages of essential medicines in many countries—drugs critical for the treatment of chronic and acute pain, for palliative care, and for opioid dependence therapy. This constitutes one of the most immediate, unwanted, and perhaps initially unforeseen consequences of the current control system, which we will not further examine here, having already discussed it earlier [see pp. …-…].

A second consequence, closely related to the first, is the damage inflicted on scientific research. It is difficult to determine whether, and to what extent, this consequence was unexpected, given that the conventions formally guarantee contracting parties the right to produce, purchase, and use scheduled substances for medical and scientific purposes. Nevertheless, in practice—particularly regarding substances listed in Schedules I and IV of the Single Convention and Schedule I of the Convention on Psychotropic Substances—such activities have been extremely limited.

We have already discussed the therapeutic potential of cannabis, long ignored or denied at the international level and only officially recognized in December 2020. Another major development of recent years is the rediscovery of the therapeutic value of psychedelics, an area that scientific research has returned to explore after decades of enforced embargo.

Rediscovery is the appropriate term, as the therapeutic potential of psychedelics was already under investigation during the 1950s and 1960s, before these substances became emblematic of countercultural movements and before national legislation—and later the Convention on Psychotropic Substances—effectively prohibited their production and sale. With their inclusion in Schedule I, psychedelics were officially categorized as substances with a high potential for abuse and no, or very limited, therapeutic value. As a result, medical and scientific research on psychedelics, already severely restricted, came to a complete halt in 1976, the year the Convention on Psychotropic Substances entered into force.

The first permission to conduct psychedelic research was not granted until 1988, when the Swiss Federal Office for Public Health authorized psychiatrist Peter Gasser to conduct trials with LSD and MDMA. Despite promising results (Gasser 1995), these studies were interrupted by Swiss authorities in 1993. A true turning point came only in 2006, with the initiation of a new Swiss trial exploring the potential of MDMA in treating post-traumatic stress disorder. In the following year, Gasser obtained permission to commence another trial on LSD-assisted psychotherapy aimed at helping terminally ill patients manage anxiety and fear of death.

In recent years, research on psychedelics has proliferated in both the United States and Europe, giving rise to what has been termed the *Psychedelic Renaissance* (Sessa 2012)—a resurgence of scientific interest marked by rigorous clinical protocols, stringent ethical standards, and advanced methodological tools. LSD, psilocybin, mescaline, dimethyltryptamine (DMT), alongside substances whose primary action is not psychedelic—such as ketamine, ibogaine, phencyclidine (dissociative hallucinogens), and MDMA (an empathogen-entactogen)—are demonstrating significant therapeutic potential in addressing conditions such as anxiety, depression,

post-traumatic stress disorder, addiction, obsessive-compulsive disorder, and eating disorders (Carhart-Harris, Goodwin 2017; Calder et al. 2023).

Contemporary research is progressing rapidly, which is a promising development. Nevertheless, the decades lost to ideological prohibition have exacted a heavy toll. How many lives might have been improved—or even saved—if psychedelics had not been prematurely dismissed as having «little or no therapeutic value» and if this promising line of inquiry had not been ignored for more than thirty years? It is a question that, regrettably—or perhaps fortunately—is destined to remain unanswered. What is certain, however, is that the case of psychedelics offers a paradigmatic example of how drug policies driven by ideological imperatives rather than empirical evidence can stifle scientific progress and, ultimately, fail the very populations they are intended to protect.

A third consequence of prohibition is the development of an illegal market that meets the needs, vices, and curiosities of drug users. Even the most optimistic prohibitionists have never believed that a global market could disappear solely as a result of a ban; what they believe, rather, is that the illicit market represents the lesser of two evils—one that can be fought, contained, and perhaps even eradicated in the long term. Thus, the emergence of an illegal market is an unwanted but expected consequence. However, the illegality of the market produces further consequences—some expected, others not—affecting supply, pricing, product quality, and consumer behavior, and thereby impacting both individual and public health. The criminalization of supply chains often exacerbates risks for users, not only by making drugs more dangerous but also by pushing markets toward the production of adulterated, more hazardous substances. Some of these dynamics merit closer examination.

One unintended consequence of the illicit status of substances is the phenomenon known as substance displacement. When control mechanisms prove at least partially effective in restricting the production, trafficking, and/or use of a particular substance—or in increasing the risks associated with these activities—traffickers and consumers may adapt by shifting supply and demand toward substances with similar effects that are either less strictly regulated or technically legal, having been newly synthesized and not yet scheduled (i.e., New Psychoactive Substances, or NPSs, also known as designer drugs). This dynamic, widely recognized in drug policy scholarship, is referred to as the "balloon effect": when one squeezes a balloon, the air inside does not disappear or diminish but simply moves to an area offering less resistance.

For a medium- to long-term example, one can consider the case of cocaine and amphetamines. After its criminalization and its association—whether accurate or not—with dock workers, farm laborers, sex workers, and particularly African Americans, cocaine lost much of the social appeal it once held (Musto 1992). According to Edward M. Brecher (1972, pp. 276–277) and later Franklin E. Zimring and Gordon Hawkins (1992, p. 60), two additional factors contributed to the collapse of cocaine consumption: first, the Great Depression, which rendered the cost of cocaine unsustainable for many users; and second, the emergence of a new family of synthetic drugs—amphetamines—that were legal and far cheaper than cocaine.

Marketed in the early 1930s by Bayer—the first amphetamine-based product being Benzedrine, sold as a decongestant—amphetamines quickly gained popularity among young people and students, and later proved useful for soldiers engaged in arduous military operations during World War II. In the postwar period, amphetamine production and consumption, initially unregulated internationally and sometimes not even requiring a prescription,

expanded rapidly. This was the era of the so-called *amphetamine democracy*, in which amphetamines were marketed as a panacea for an ever-increasing number of physical and psychological ailments, from fatigue to obesity, from hypotension to seasickness (Courtwright 2002, pp. 78–79). Despite mounting evidence of abuse, pharmaceutical companies long denied the addictive potential of amphetamines and other psychotropic substances. It was only in 1971 that the industry had to acknowledge reality with the adoption of a new international control instrument—the Convention on Psychotropic Substances—which, however, was much less stringent than the Single Convention of 1961, partly due to intense and overt lobbying efforts [see pp. …–…].

Over the following years, thanks to the collaboration of certain states favoring strict regulation and to accumulating scientific evidence on the addictive properties of psychotropic substances, international institutions succeeded in extending control measures and imposing stricter limits on amphetamines. In the United States, for instance, the Bureau of Narcotics and Dangerous Drugs and the Food and Drug Administration set a production quota for 1972 equivalent to one-fifth of the previous year's production; by the late 1970s, amphetamine consumption had declined significantly (Rasmussen 2008, p. 981). During the same period, cocaine—still illegal but no longer a top priority for legislators and law enforcement—began the ascent that would culminate in the cocaine boom of the 1980s.

While the case of cocaine and amphetamines can cautiously be regarded as a long-term example of substance displacement, there are also examples of short-term shifts affecting not only substances but also their precursors. Safrole, a key precursor in the production of MDMA, illustrates this dynamic. In the early 2000s, following effective crackdowns in China and Cambodia that resulted in the seizure of tons of safrole, global MDMA

production collapsed for several years (Barron 2015). This gap in the market was filled by NPSs with similar effects to MDMA but with little or no MDMA content; among these were paramethoxyamphetamine (PMA) and paramethoxymethamphetamine (PMMA), whose use carries significantly higher risks than MDMA.

Compared to MDMA, PMA and PMMA take roughly twice as long to produce noticeable effects, leading some users to redose prematurely under the mistaken belief that the initial dose was insufficient. This behavior greatly increases the risk of hospitalization and fatal overdose. Data from England and Wales demonstrate a correlation between the collapse of MDMA production and a rise in deaths linked to PMA/PMMA use—a trend that reversed only when a new MDMA synthesis process was developed that did not require safrole (Transform Drug Policy Foundation 2020, pp. 114–115).

These examples illustrate a broader dynamic: substance displacement is a well-established, and perhaps inevitable, feature of the illicit drug market. Technological innovation makes this dynamic increasingly difficult to control for both regulatory and health authorities. The rapid proliferation of NPSs not only complicates enforcement efforts but also represents a growing public health crisis, challenging the effectiveness and legitimacy of the current international drug control regime. As noted in the World Drug Report 2024, the number of NPSs identified on the global market rose from 162 in 2010 to 566 in 2022, with 44 newly identified substances appearing in the twelve months preceding the survey (UNODC 2024a, p. 7). The acute and chronic effects of many of these substances remain largely unknown.

A further consequence of prohibition, both expected and desired, is the increase in the price of illicit goods. It is expected because, in an illegal market, producers and traffickers demand financial compensation not only for the work and costs incurred but also for the significant risks they bear,

including arrest, prosecution, conviction, and threats to their physical safety from rival groups. It is desired because a higher price is assumed to contain demand, discouraging individuals from initiating drug use or prompting current consumers to reduce or cease consumption. According to basic economic theory on the price elasticity of demand, higher prices should correlate with lower levels of consumption; however, the practical translation of this principle within the drug market context is neither immediate nor linear. The effect of price increases varies significantly depending on the specific drug in question and the subpopulation of consumers considered (Transform Drug Policy Foundation 2020, p. 59). Thus, rather than uniformly reducing demand, elevated prices may negatively influence consumer behavior, further endangering individual and public health.

Where consumers are unable or unwilling to significantly reduce their consumption, they may instead curtail spending on basic necessities such as hygiene products, food, clothing, housing, and healthcare. Such economic displacement can exacerbate existing vulnerabilities, deepen cycles of poverty, and intensify marginalization, with serious implications for social cohesion and public health outcomes. Furthermore, higher drug prices may incentivize consumers to adopt more potent and riskier methods of consumption. For instance, heroin can be smoked or snorted, but the most "efficient" method—one that maximizes the psychoactive effect while minimizing the quantity required—is intravenous injection, a practice that significantly elevates the risk of fatal overdose and the transmission of infectious diseases when needles and syringes are shared (Council of Europe, Groupe Pompidou 2017, p. 29).

Price inflation may also drive consumers toward cheaper alternatives, such as certain synthetic designer drugs that mimic the effects of more established substances but whose immediate and long-term health consequences can be

even more severe (ibid.). Small-scale dealers may similarly seek to maximize profits by adulterating products with potent and low-cost substances like fentanyl—a strategy that dramatically increases the risk of fatal overdoses (Drug Enforcement Administration 2020). The phenomenon observed here is yet another manifestation of substance displacement: prohibition not only reshapes demand and supply but also generates a cascade of unintended and undesirable effects that ultimately jeopardize the very good—health—that regulatory frameworks purport to protect.

An illegal market is a market almost entirely devoid of quality controls. While it is plausible that, for certain substances, some quality control measures are applied during the initial stages of production—particularly when wealthy criminal organizations purchase products wholesale and require suppliers to meet specific standards—by the time these substances reach the retail level, they are often significantly altered compared to the original product, and to what the consumer believes he or she is purchasing. Variations in purity represent another expected but undesirable consequence of prohibition.

We have already discussed the case of MDMA, PMA, and PMMA; another relevant example is provided by the N-BOMe compounds, psychedelic phenethylamines often sold as LSD or mescaline but considerably more dangerous, with neurotoxic and cardiotoxic effects that can prove fatal (Zawilska et al. 2020; Lawn et al. 2014). However, when discussing variations in purity, the most emblematic cases involve cocaine and heroin, two of the most widely consumed illicit substances globally. Due to their physical form as soluble powders, they can be easily adulterated with low-cost additives (e.g., paracetamol, caffeine, diltiazem, hydroxyzine, levamisole, lidocaine, phenacetin; Broséus et al. 2016) to increase profits, moderate the (non-purity-adjusted) price of single doses, or enhance psychoactive effects.

According to data collected by UNODC and published in its Statistical Annex, in 2022 the average purity of retail cocaine seized across twenty-four countries (mostly European) and the Hong Kong Special Administrative Region ranged from 17.8% to 88.8%. The average purity of retail heroin seized across twenty-two countries (also mostly European) and Hong Kong ranged from 3% to 81%, although, excluding rare outliers, typical purity levels ranged between 15% and 20% (UNODC 2024e).

Cutting agents can themselves be toxic, thereby increasing the risk of morbidity and premature mortality. A dramatic example is fentanyl, increasingly used in the United States to cut heroin in order to enhance potency and reduce costs, even though as little as two milligrams can be sufficient to cause a fatal overdose (Drug Enforcement Administration 2020). However, even when cutting agents are relatively harmless (e.g., bicarbonate, sugar, lactose), the significant fluctuations in the concentration of the active substance within individual doses represent a constant danger. Unless a consumer carefully resorts to drug-checking services [see pp. …-…], it is practically impossible to determine the degree of purity and anticipate the effects of a given dose, thereby increasing the risk of unintentional overdose with potentially fatal outcomes.

At the intersection of criminal and social dimensions, criminalization translates into the stigmatization of individuals who fail to conform to legal norms—a stigmatization that often leads to marginalization and social exclusion. Although expected and, to some extent, not entirely unintended, stigmatization generates significant adverse effects on the self-esteem, mental well-being, and physical health of the affected individuals, with broader repercussions on public health.

Drug users are frequently perceived by the general population as dangerous, unpredictable, incapable of rational decision-making, and

ultimately responsible for their own condition (Peretti-Watel et al. 2014; Schomerus et al. 2011; Yang et al. 2017). The internalization of such negative stereotypes weakens self-esteem, fosters social isolation, and complicates access to health and social services, including mental health care (Clement et al. 2015). This dynamic is often referred to as the *Why Try effect*, whereby individuals internalize stigma to the point of giving up on recovery or rehabilitation efforts (Corrigan et al. 2009).

Importantly, stigmatization does not operate solely at the interpersonal level but is frequently embedded within institutional practices, particularly in healthcare settings. Healthcare personnel may develop prejudices against drug users, viewing them as abusers of scarce public resources, as individuals who fail to invest in their own health, or as non-compliant with therapeutic protocols and medical advice. Such biases—whether conscious or unconscious—constitute a form of structural stigma, creating additional barriers to care and exacerbating existing health inequalities (Zarei et al. 2015). This can hinder not only access to addiction treatment but also to healthcare services addressing conditions such as hepatitis, HIV, and other illnesses not necessarily related to drug use.

The consequences of stigmatization thus extend beyond the individual level. Marginalization can affect users' immediate family members, partners, and friends, discouraging them from seeking health services even when needed. Moreover, communicable diseases affecting people who use drugs can spread within marginalized communities and beyond, reaching non-users through routes such as unprotected sexual contact or occupational exposure among healthcare workers.

While the unintended consequences discussed thus far stem primarily from the legal frameworks themselves, others arise from the practices and systemic modalities through which these laws are enforced, as well as from the

concrete outcomes they produce. The involvement of law enforcement agencies and the adoption of a rigidly prohibitionist and often militarized approach can, in turn, generate effects that, if the objective is the protection of public health, cannot be considered desirable.

One of the most evident examples of such unintended consequences is provided by a recent study funded by the Centers for Disease Control and Prevention (CDC), which analyzed two years of data from Marion County, Indiana (population approximately one million). The study identified a correlation between large seizures of stimulants and opioids and subsequent increases in overdoses and overdose deaths (Ray et al. 2023).

Over the years, several studies have examined the impact of police presence on PWUD's (People Who Use Drugs) access to health services, consistently finding an inverse relationship. Fear of arrest discourages PWUD from seeking medical care, participating in voluntary treatment programs, and utilizing needle exchange services. It also deters the safe disposal of needles and syringes and may prompt the adoption of riskier, more rapid methods of consumption intended to avoid detection (Council of Europe, Groupe Pompidou 2017, pp. 32–33).

Another serious risk associated with criminalization is the potential for physical confrontations between law enforcement officers and individuals suspected of violating drug laws. Such encounters may result in the excessive use of force, violations of suspects' rights, and the deterioration of both physical and mental health (ibid., p. 34).

Although abuses of authority might be dismissed as dystopian exceptions, they are, regrettably, far from rare. Such risks are often exacerbated by broader patterns of systemic discrimination, particularly racism. In some contexts, these dynamics have escalated to horrifying extremes. In the Philippines, for example, President Duterte's anti-drug campaign (2016–

2024) resulted in the extrajudicial killing of thousands of individuals accused or suspected of drug-related offenses, often carried out with impunity by government forces and civilian militias (Schlein 2022). The scale and brutality of these operations have provoked widespread international condemnation. In particular, the International Criminal Court (ICC) has opened an investigation into alleged crimes against humanity committed in the context of Duterte's war on drugs, underscoring how drug enforcement policies, when unbound by the rule of law, can become instruments of systematic human rights violations.

The pragmatic approach underlying harm reduction policies and practices often struggles to reconcile with the moral and ideological perspective of those who seek to eradicate drug use entirely. From this latter standpoint, any initiative aimed at mitigating the risks associated with drug use is interpreted not as a public health strategy, but as an endorsement of consumption and a form of complicity with those who refuse to conform to societal norms and persist in their "vice".

According to this view, harm reduction practices are inherently problematic, but they become utterly unacceptable in the prison context, where authority is—or is presumed to be—omnipresent, regulating space, marking time, and, by virtue of its walls and guarded entrances, enforcing a prohibitionist regime more rigorously than is possible outside its perimeter. Accepting harm reduction measures within prisons would be tantamount to acknowledging that drug use can infiltrate even the most controlled environments; in other words, it would mean admitting the reality of the facts, thereby conceding ground to those advocating for more pragmatic alternatives.

In many countries, a substantial proportion of the prison population either has a drug use disorder or is incarcerated for drug-related offenses. While

some individuals cease or reduce their drug use after entering prison, many others begin using drugs or adopt riskier methods of consumption as a result of the environment (Council of Europe, Groupe Pompidou 2017, p. 35). As the Human Rights Council's Special Rapporteur, Tlaleng Mofokeng, observes:

> *Within prison settings, high rates of drug use by injection, a lack of access to harm reduction services and a lack of prevention and treatment services lead to a high prevalence of HIV, hepatitis C and tuberculosis. Many prisons fail to provide appropriate medical care, including evidence-based treatment for drug use disorders, or deny people who use drugs the opportunity to provide informed consent before being tested or treated.* (Human Rights Council 2024, pp. 8-9)

The relationship between prisons and drugs (including pharmaceuticals) is deeply ambivalent. While illicit substances circulate within prison settings, this reality is often systematically ignored or denied. Compared to the general population, prisoners exhibit a higher prevalence of substance use disorders, mental illnesses, hepatitis, and HIV infections (Favril et al. 2024). Nonetheless, treatment options are scarce, collaboration between general health services and prison health systems is frequently inadequate—jeopardizing therapeutic continuity—and the implementation of harm reduction policies is systematically hindered. The right to health, enshrined in international human rights law, does not cease to apply upon incarceration; yet, in many prison systems, this right is systematically neglected.

At the same time, prisons are characterized by the extensive use of psychotropic medications (Hassan et al. 2016; Princivalli, Sbraccia 2021). The use (or abuse) of such medications serves multiple purposes: it allows many prisoners to sleep for prolonged periods, thereby accelerating their subjective

experience of time, and it addresses the management needs of prison staff through the chemical containment of anxiety, depression, and insomnia—pathologies that are widespread and exacerbated by incarceration—and, ultimately, internal conflict (ibid.). The pervasive reliance on psychotropic substances, alongside the denial of illicit drug use, reflects an institutionalized hypocrisy that undermines the credibility of the penitentiary system and hampers efforts to address the actual health needs of incarcerated populations. Legal and illegal drugs thus constitute an unavoidable element of daily prison life, and the refusal to adopt even a minimal degree of pragmatism risks causing far greater harm than it prevents.

The lack of adequate healthcare services within prisons, coupled with the aforementioned disruption of therapeutic continuity due to the disconnect between general and prison health systems, generates consequences that extend well beyond the period of incarceration. Deterioration in health may hinder the social reintegration of individuals upon release and contribute to the spread of communicable diseases both inside and outside prison walls. For individuals suffering from heroin or other opioid use disorders, the lack of access to Opioid Substitution Treatment (OST) during incarceration leads to a decrease in opioid tolerance, thereby exposing them to a heightened risk of overdose—potentially fatal—in the weeks immediately following release (Merrall et al. 2010). Such preventable deaths are not merely individual tragedies, but clear indicators of a broader failure in public health policies and reintegration strategies.

Security

Among the unintended but expected consequences of prohibition, as we have seen, is the development of an illegal drug market—a market that suffers neither from a shortage of funds nor of personnel and that can reach

levels of violence with few precedents in human history. Although no country is immune from such violence, it is most heavily concentrated in areas of cultivation, production, manufacturing, and transit, often exacerbating existing political instability or capitalizing on it to the advantage of traffickers.

In this section, the unintended consequences of prohibition will be intertwined with an analysis of the reasons for its ineffectiveness, exposing the vicious cycle through which anti-drug legislation often generates effects that are diametrically opposed to its intended purposes.

According to the *World Drug Report 2024*, in 2022 approximately seven million individuals worldwide were in formal contact with authorities for violations of drug laws; 2.7 million were on trial, and over 1.6 million had been convicted—nearly 700,000 of whom were convicted for trafficking-related offenses (UNODC 2024b, pp. 68–69).

The association between drugs and crime, like that between drugs and incarceration, is one of the most widely propagated narratives of our time. However, these figures tell us little about any inherent relationship between drugs and crime; rather, they suggest that violations of drug laws constitute one of the most common categories of criminal offenses and that the prohibitionist system, through its associated policing, judicial, and prison costs, consumes vast public resources annually. More arrests, more trials, and more convictions do not necessarily translate into greater safety, less crime, or reduced danger. Indeed, the relationship is often inverse. We must therefore ask whether prohibition genuinely contributes to societal safety or whether it instead fosters disorder, benefits organized crime, and acts as a contributory factor to petty criminality.

Paul J. Goldstein (1985), in his seminal work *The Drugs/Violence Nexus: A Tripartite Conceptual Framework*, explored the complex relationship between

drugs and violence. Goldstein distinguished three types of drug-related violence: psychopharmacological violence, compulsive economic violence, and systemic violence. However, as not all the phenomena discussed involve violence per se, it is preferable here to speak more broadly of psychopharmacological crimes, compulsive economic crimes, and systemic crimes.

Psychopharmacological crimes are those directly caused by the psychoactive effects of substances, whereby altered consciousness may provoke violent and/or unpredictable behavior or impair a victim's ability to defend themselves, thus facilitating victimization. Yet if one seeks scientific rigor, it is problematic to speak generically of "drugs." Different substances produce vastly different effects: cocaine and cannabis, amphetamines and heroin, for instance, have divergent pharmacological profiles, and the causal link between their use and the commission of crimes is sometimes very weak, if not entirely absent (EMCDDA 2007, p. 2). A stronger correlation has been observed with withdrawal syndromes (ibid.) and with the consumption of legal substances such as alcohol (Sontate et al. 2021).

The incidence of psychopharmacological crimes is difficult to quantify, as many cases go unreported (e.g., domestic violence incidents or offenses where the victim voluntarily consumed substances), and because the state of intoxication may have subsided by the time authorities intervene, rendering the causal link between substance use and criminal behavior difficult to establish.

Estimating the impact of current drug regulation on the prevalence of psychopharmacological crimes is even more complex. While prohibition may reduce overall drug consumption, it is not clear that it reduces *problematic* use. Indeed, by criminalizing users, fostering stigmatization, and limiting access to

information and services, prohibition may paradoxically increase problematic consumption—and with it, psychopharmacological crimes.

In any case, from the perspective of arrests, trials, convictions, and public concern, psychopharmacological crimes constitute a minority compared to the other two categories. Most crimes committed by individuals with substance use disorders are not committed under the influence of substances, but rather to obtain them—or to secure the financial means necessary to purchase them. Such offenses fall into the category of compulsive economic crimes, encompassing theft, robbery, prostitution, prescription fraud, and, more rarely, fraud, embezzlement, and other crimes requiring specialized skills. Of course, not all individuals with substance use disorders engage in economic crimes: many are able to sustain their consumption through legitimate income. However, a substantial number resort to illicit means, depending on factors such as the type of drug used, patterns of consumption, socioeconomic conditions, and the degree of deviation from conventional lifestyles (EMCDDA 2007, pp. 2–3).

How does prohibition influence the prevalence of such crimes? Again, definitive conclusions are elusive. As discussed earlier, prohibition inevitably fosters the emergence of an illegal market, whose illegality leads to another expected—and indeed desired—consequence: higher drug prices. From a prohibitionist perspective, significantly elevated prices should deter consumption, preventing potential consumers from starting and encouraging existing users to reduce or cease their use. Ideally, prices would be driven so high as to render drugs unaffordable for most. In practice, however, the higher the prices, the greater the profits—and the greater the profits, the more attractive the market becomes for producers, traffickers, and dealers, thus maintaining prices at a consistently high, but not prohibitive, level. This

phenomenon, known as the *profit paradox*, ensures that drug prices remain elevated but never wholly inaccessible (Bertram et al. 1996, p. 13).

Other compensatory mechanisms, such as adulterating drugs with cheaper substances or adopting more efficient methods of consumption, can also mitigate price increases. Nevertheless, artificially inflated prices can stimulate an increase in compulsive economic crimes and may also drive consumers toward dealing—a form of systemic crime—to offset their costs:

> *Required funds are frequently obtained through various forms of acquisitive crime, prostitution and drug dealing, such as small-scale dealing as a means of obtaining drugs as payment-in-kind. Fraud, property crime, and robbery are commonly mentioned as income sources by drug users and some studies suggest that robberies increase as a consequence of price hikes in illegal drug markets.* (Council of Europe, Groupe Pompidou 2017, p. 38)

Can we therefore conclude that prohibition, by causing drug prices to soar, also leads to an increase in compulsive economic crimes? The correlation is not so direct. First, we must consider the potential alternatives to prohibition, how they might influence drug prices, and the desirability of their related consequences.

A decriminalization of use and possession for personal use would likely have limited impact on prices but could promote greater contact between consumers and health and social services, reducing stigmatization and facilitating access to treatment and employment opportunities. A free market in drugs could potentially lower prices but, faithful to the logic of profit, would risk significantly increasing consumption—including problematic consumption—which could, in turn, elevate the incidence of psychopharmacological and compulsive economic crimes.

A different model of legalization, based on strict regulation of the production and sale of scheduled substances and designed to exclude or severely limit profit motives, could aim to maintain prices not far from those prevailing in the illicit market it seeks to supplant. Prices that are too low could encourage broader consumption, while prices that are too high would fail to compete effectively against illicit markets (Transform Drug Policy Foundation 2009, pp. 41–45). At comparable prices, however, a legal market would ensure higher quality standards—greater product safety, reduced marginalization of consumers, and easier, more consistent access to information and services.

Therefore, except in the hypothetical case of a completely deregulated free market (a scenario we hope remains confined to academic speculation), a significant reduction in drug prices appears unlikely.

Can we then deduce that prohibition does not significantly affect the incidence of compulsive economic crimes? Again, the answer is not straightforward.

Alongside price increases, prohibition reinforces the labeling of drug users as deviants, fostering stigmatization that affects public perception, individual identity, self-esteem, access to services, legal entanglements, stable employment, and social relationships. The status of deviant carries a general symbolic weight, overshadowing other personal attributes and leading to the attribution of a host of undesirable traits (Hughes 1945). The treatment of deviants often deprives them of what might be termed "the ordinary means for an ordinary life", producing a self-fulfilling prophecy: the labeled individual conforms to the deviant identity, ultimately violating additional social norms that they might not otherwise have considered (Becker 1966, pp. 34-35; Lemert 1967, pp. 40–60).

An interdependent relationship thus develops between problematic drug use, unemployment, economic hardship, anxiety, and stress—factors that themselves constitute risks for the initiation, perpetuation, intensification, or resumption of drug use (a dynamic known as cumulative disadvantage; Sampson, Laub 1997; EMCDDA, Brotherhood, Sumnall 2012). Aware of their status and weary of repeated failures, individuals with substance use disorders may abandon efforts to find employment (Spencer et al. 2008), withdraw from conventional society and their communities, and, free from the commitments required of functional citizens, find alternative forms of belonging within criminal environments.

The prison system represents the culmination of this process of selection and labeling. Among prisoners, the prevalence of serious mental health problems—such as major depression, post-traumatic stress disorder, psychosis, and personality disorders—is significantly higher than in the general population (Fazel, Baillargeon 2011). Incarcerated individuals are more likely to have a history of substance use, to use substances regularly, and to develop substance-related problems (Fazel et al. 2017), often entering the criminal justice system precisely through the commission of compulsive economic and systemic crimes (Chandler et al. 2009).

Prisoners also experience exposure to serious trauma at rates approximately ten times higher than the general population (Fazel et al. 2017), and such trauma is strongly associated with antisocial and criminal behavior (Krischer, Sevecke 2008). Moreover, incarceration has a demonstrably negative impact on both physical and mental health, and it further impairs the prospects for social reintegration (Associazione Antigone 2023).

Considering these interrelated factors, it becomes easier to understand how prohibition impacts public safety, particularly in relation to compulsive economic crimes. Far from being the sole or even primary cause of

marginalization—a process often rooted in socioeconomic and ethnic disparities—prohibition erects an additional barrier between vulnerable individuals and the community. Policies centered on harm reduction, decriminalization of personal use and possession, and carefully regulated legalization models free from profit-driven incentives could help to repair this divide, generating mutual benefits for society and individuals alike. In certain contexts, these approaches are already demonstrating efficacy, implementing recommendations long supported by international resolutions, guidelines, and reports.

The so-called systemic crimes are those associated with the production, trafficking, and, above all, the control of the drug market. In the proliferation of such crimes, the illegality of the market and the consequent inflation of drug prices play a direct and decisive role.

Price increases are not primarily driven by production costs. While a legal market might reduce production and transportation expenses, an illegal market can minimize these costs as well, avoiding taxation altogether. Elevated prices largely serve to compensate for the risks associated with the punitive apparatus of the state and the violent competition among rival organizations. High profit margins, more than high costs, make the illicit drug market attractive for investment and manpower—especially in regions where legitimate economic opportunities are scarce.

Moreover, high profits incentivize ruthless competition, which, unlike legal market competition, does not manifest through marketing strategies or lawsuits, but through violence: between criminal organizations, within them, and between criminal groups and institutions, communities, and citizens.

Between 2006—when President Felipe Calderón's government declared war on the cartels—and 2022, Mexico recorded over 400,000 homicides (UNODC 2023c). During the same period, Colombia recorded

approximately 230,000 (ibid.). Between 2019 and 2022, both cocaine seizures and homicides increased fivefold in Ecuador, with similar trends observed in the Caribbean (UNODC 2024b, p. 20). A substantial proportion of these homicides, often brutal, can be attributed to systemic crimes linked to competition for drug market control (Hardaway 2003, p. 107; Husak, De Marneffe 2005, p. 120).

Beyond cultivation, production, and sales, systemic crimes also encompass homicides, assaults, threats, extortion, robbery, money laundering, and corruption, all tied to the dynamics of the drug market. Due to its extraordinary profits, drug trafficking has become a cornerstone of organized crime's expansion and globalization strategy, fostering both vertical integration of the production-distribution chain and transnational alliances among criminal groups (Becchi, Turvani 1993, pp. 108–111).

Drug trafficking organizations often reinvest their profits in other illicit operations—such as clandestine mining, terrorist activities, human trafficking—and notably, arms trafficking. Drugs are among the most frequently seized commodities alongside firearms, ammunition, and explosives (UNODC 2020b, p. 78).

Not all proceeds from drug trafficking are reinvested in other illegal activities; a significant portion is laundered and reintroduced into the legal economy, sometimes with the complicity of corporations, financial institutions, or even governments [see the case of Panama; pp. 242–245]. Additionally, part of these proceeds is used to corrupt public officials at every level—from police officers to judges, administrative staff, legislators, and even jury members and witnesses.

The impact of illicit financial flows (IFFs)—funds originating from illegal activities such as drug trafficking and corruption, transferred through money laundering, or destined to finance further illicit activities—has been

extensively analyzed by international organizations. As noted in a recent paper by the International Monetary Fund:

> *The fundamental impact of IFF is undermining the productivity and growth of the economy, as IFF and underlying criminality distort market prices and balance of payments, inhibit genuine investment and effective allocation of resources, erode the incentive structure of voluntary exchange, embezzle public resources, create volatility not linked to economic fundamentals, as well as weaken cooperation and fair market competition. (...) Furthermore, organized crime, drug trafficking, environmental crimes, and their proceeds could deepen the informality of the economy, distort markets, weaken trust in the government and institutions and rule of law, and affect climate change.* (International Monetary Fund 2023, p. 8)

In a now somewhat dated report, the UNODC estimated that the illicit drug market alone accounted for between 17% and 25% of the total proceeds of global crime, or approximately 0.6–0.9% of the global gross domestic product at the time (UNODC 2011, p. 7). Since then, the market has continued to evolve, adapting to changing contexts, emerging trends, and technological innovations such as the consolidation of the so-called darknet and the opportunities offered by cryptocurrencies and blockchain technologies, which make it increasingly difficult for authorities to identify and locate online sellers and buyers.

In April 2022, German and American authorities succeeded in dismantling Hydra, the largest and longest-running illegal online marketplace, which alone managed between 80% and 90% of darknet drug sales, while also offering services such as the production of forged documents and money laundering. Over its seven years of activity, Hydra grossed approximately 5.2 billion U.S. dollars in cryptocurrencies (UNODC 2024b, p. 36; U.S.

Department of Justice 2022). However, true to its mythological name, cutting off Hydra's head was not enough to destroy the monster: new marketplaces such as Mega, Kraken, Blacksprut, and OMG are now competing, both commercially and technologically, to claim the market shares once dominated by Hydra—and, before that, by Silk Road, which was shut down by the FBI in 2013.

A similar dynamic occurs, with far bloodier consequences, when a criminal organization involved in drug trafficking is heavily targeted by authorities, attacked by rival groups, or collapses due to internal conflicts. In a market characterized by extremely high profit margins, any vacuum created is rapidly filled by new criminal entrepreneurs, who will not hesitate to use violence, intimidation, and corruption to assert dominance over competitors.

This recurring pattern exemplifies what is known as the balloon effect: a systemic feature of illicit economies, not merely a side effect. Attempts to suppress one node of the network merely displace activity to another, often generating greater instability and violence.

A notable example illustrating these dimensions of the balloon effect is provided by the efforts of the Reagan and Bush administrations (1981–1993) to curtail cocaine trafficking from Colombia. The crackdown launched by the South Florida Task Force laid the groundwork for an alliance between Colombian cartels—suppliers of the product—and Mexican cartels, who transitioned from being mere couriers to majority shareholders in the distribution phase. Alarmed by the U.S. government's determination and the threat of extradition, Colombian traffickers increasingly outsourced distribution to their Mexican counterparts. Rather than dismantling trafficking networks, enforcement efforts merely reshaped them, empowering new and often more violent actors.

This transformation made the Mexican cartels—previously specializing mainly in low-grade opiates and cannabis—far wealthier and, following the arrest of Miguel Ángel Félix Gallardo (known as "El Jefe de Jefes") and the fragmentation of the Guadalajara cartel, far more violent. Meanwhile, the U.S. government launched the Andean Initiative, aimed at providing economic and military support to Colombia, Peru, and Bolivia to eradicate coca crops. Despite an investment of 2.2 billion U.S. dollars over five years, the plan proved largely ineffective: destroyed crops were simply replaced by new ones in more remote areas, keeping overall production levels stable (Rouse, Arce 2006, pp. 545–548).

Thus, while the interdiction effort temporarily achieved success in Florida, it ultimately led to a reconfiguration of trafficking routes and a transfer of power from Colombian to Mexican organizations. The effort succeeded in shifting geography, but failed in its ultimate objective: reducing supply and violence. The capture of Mexico's leading trafficker triggered infighting among his former associates, unleashing a brutal war that has already resulted in hundreds of thousands of deaths and shows no sign of abating. Meanwhile, the flow of cocaine to the United States has remained uninterrupted. More than three decades later—and despite additional cross-border interventions such as Plan Colombia and the Andean Regional Initiative, at a further cost of billions to U.S. taxpayers—cocaine production has reached record levels, and global demand continues to grow at an alarming pace, particularly in new markets (UNODC 2023d, p. 32).

Every interdiction effort, even those initially deemed successful, ultimately proves in vain: if a substance is effectively interdicted, it is either adulterated with or replaced by other, often riskier, substances; if a criminal organization is dismantled, its rivals will move to occupy the uncovered market; if a trafficking route is disrupted, alternative routes will emerge; if a production

area is eradicated, others will be ready to inherit its crops, laboratories, and logistical networks. This is the balloon effect, a phenomenon that systematically perpetuates and globalizes the very problems it purports to solve, at enormous economic, human, and environmental costs. These impacts will be further discussed in the following section.

Human rights and the environment

Article 14, paragraph 2, of the 1988 *Convention Against Illicit Traffic*, which requires contracting parties to adopt appropriate measures to prevent and eradicate the illicit cultivation of controlled plants, is the only passage in the three conventions that explicitly refers to human rights and environmental protection. In particular, the article stipulates that «the measures adopted shall respect fundamental human rights and shall take due account of traditional licit uses, where there is historic evidence of such use, as well as the protection of the environment».

However, it is crucial to ask whether, in practice, not only the eradication measures outlined in Article 14 but the entire current control system can be considered consistent with these parameters, or whether it instead moves in the opposite direction.

In 2023, in preparation for the mid-term review of the 2019 Ministerial Declaration scheduled for the following year, the Office of the United Nations High Commissioner for Human Rights (OHCHR) prepared and published a report addressing the challenges posed by the global drug problem and the current control regime (OHCHR 2023). The report highlights, among other issues, the difficulty individuals with substance use disorders face in accessing treatment and services for abuse-related health conditions such as AIDS and HIV, the lack of harm reduction services and social support, and the imposition of coercive treatments in certain countries

that violate the rights and dignity of those subjected to them. According to the OHCHR, criminalization has also led to an escalation in the use of force, resulting in arbitrary detentions, disappearances, ill-treatment, torture, and extrajudicial killings, predominantly affecting the poorest and most marginalized segments of the population. The intensive reliance on the criminal justice system for violations of anti-drug laws, combined with penalties often disproportionate to the severity of the offenses, has led to a significant increase in the prison population and the overcrowding of judicial systems, further exacerbating the backlog of pending cases. The OHCHR also reports that in over thirty countries, possession and trafficking of drugs remain punishable by death. In the conclusion of the report, it states:

> *Shifting away from punitive models is critical to addressing all human rights challenges that arise from or are facilitated by the implementation of punitive drug control policies. Drug control policies should be understood as a way of achieving broader objectives, including the protection of human rights, in particular the right to health, ensuring equality and non-discrimination.* (OHCHR 2023, p. 18)

Human rights are inextricably linked to environmental protection: a healthy, clean, and sustainable environment is essential for safeguarding other fundamental human rights, including the right to health and an adequate standard of living (UNDP 2019, p. 9). A growing number of documents, declarations, and international conventions are dedicated to environmental protection and the fight against climate change, such as the Declaration on the Human Environment (1972), the Convention concerning the Protection of the World Cultural and Natural Heritage (1972), the Convention on Biological Diversity (1992), the Rio Declaration on Environment and Development (1992), the Framework Convention on

Climate Change (1992), which includes the Kyoto Protocols (1997) and the Paris Agreement (2016), and the UN Climate Summit New York Declaration on Forests (2014). Goals 13, 14, and 15 of the 2030 Agenda for Sustainable Development specifically address the fight against climate change, the protection of life on land, and the protection of life in the oceans.

Despite the global urgency, environmental concerns have consistently received marginal attention in the international discourse on drug policies, with discussions typically limited to crop eradication measures. However, a comprehensive assessment of the ecological impact of the conventional drug control system has yet to be seriously incorporated into the global policy agenda.

While the area of agricultural land designated for the cultivation of opium, coca, and cannabis is relatively small, it plays a disproportionately significant role in deforestation and biodiversity loss, often exacerbated by crop eradication efforts (McSweeney 2015, p. 2).

Illicit plantations, unable to emerge in the open, are often established in remote, ecologically valuable areas—rich in resources and biodiversity, yet inherently fragile. The chosen location will inevitably suffer from deforestation and pollution: native plants will give way to crops, laboratories, and roads needed for transport and logistics; chemicals will be used to accelerate crop growth and process the product; traffickers, in their desire to maximize profits and minimize the risk of detection, adopt intensive cultivation methods that exacerbate environmental damage. Millions of hectares of Amazon rainforest have been destroyed solely for the cultivation of coca (OAS 2013, p. 33). Toxic waste is absorbed by the soil or poured into waterways, with annual estimates of millions of barrels (McSweeney 2015, p. 8), while fossil fuels are used to power the operations needed to keep the plants running and provide transportation.

Beyond the environmental impact, the clandestine nature of the production process poses a serious threat to the health, freedom, and lives of the many individuals who, willingly or unwillingly, find employment in the sector. The presence and influence of criminal organizations in the territories where they operate, combined with the absence of viable alternatives for subsistence, compel many farmers to engage in the cultivation of coca, opium, or cannabis. Such decisions are rarely motivated by the prospect of wealth: sales occur under a monopsony regime, where a single buyer—the criminal organization—sets prices well below what would be attainable in a competitive market (UNODC 2014, p. 56). Moreover, exposure to chemical agents and the absence of any safety standards severely jeopardize workers' health, further diminishing their quality of life.

The environmental and human toll is compounded by the effects of interdiction measures. Numerous studies have highlighted the negative impact of herbicide use on ecosystems and public health (OAS 2013, p. 33). A report prepared for the Commission on Narcotic Drugs session in March 2015, which contributed to the preparations for UNGASS 2016, denounced the consequences of fumigation and eradication campaigns on legal crops, forests, rare plant species, water sources, livestock, and even areas not directly targeted by such operations (UNDP 2015, p. 9). In the same document, the United Nations Development Program also addressed a fourth dimension of the balloon effect previously mentioned: geographical displacement. As Kendra McSweeney explains:

> *Drug crop eradication drives deforestation by progressively displacing drug farmers into new, more remote environments. Policies to disrupt and intercept drug shipments drive forest loss and habitat destruction by incentivizing traffickers to seek out more new routes, which they often carve through biodiverse frontier regions.* (McSweeney 2015, p. 2)

Geographical displacement can occur over both long and short distances. For example, the success of control measures targeting opium cultivation in China during the 20th century led to increased production in the Golden Triangle; the crackdown in Thailand shifted cultivation to Myanmar; and the efforts of Turkey, Iran, and Pakistan ultimately allowed Afghanistan to inherit their role in global production (Costa 2008, pp. 10–11). The recent collapse of opium production in Afghanistan, following the Taliban's crackdown, has not yet been offset by increased cultivation in Myanmar (+36%; UNODC 2024b, p. 16) or other countries, but such developments are likely imminent, and there are indications that Afghanistan's production may already be rebounding, albeit at levels still well below those recorded in 2021 (ibid.).

In the case of coca, displacement is more geographically constrained, as cultivation is almost exclusively concentrated in Peru, Bolivia, and particularly Colombia, due to climatic and topographical factors (UNODC 2023d, pp. 12, 15). Even here, interdiction measures and repeated fumigation campaigns have failed to eradicate coca crops, instead pushing cultivation into environmentally sensitive areas. It is estimated that, in 2021, 52% of Colombia's coca crops were located within protected areas, including natural parks, forest reserves, and indigenous territories (UNODC 2022, p. 17).

The prohibitionist framework and the measures deployed to enforce it ultimately contravene the United Nations Declaration on the Rights of Indigenous Peoples, which in Article 8 requires States to take effective measures to prevent and redress «any action which has the aim or effect of

dispossessing them of their lands, territories or resources» and «any form of forced population transfer which has the aim or effect of violating or undermining any of their rights». Article 32 further guarantees indigenous peoples the right to «determine and develop priorities and strategies for the

development or use of their lands or territories and other resources», and obliges States to «consult and cooperate in good faith with the indigenous peoples concerned through their own representative institutions in order to obtain their free and informed consent prior to the approval of any project affecting their lands or territories and other resources» (UN General Assembly 2007). While the text of international conventions may have only marginally acknowledged the traditional and medicinal value of certain plants, their enforcement in practice displaces violent and unscrupulous criminal actors into indigenous territories, exposing these lands to pollution, expropriation, destruction, and endangering the freedom and lives of their inhabitants.

Similarly, the remote areas selected by criminal organizations as trafficking hubs suffer extensive environmental degradation. To avoid detection, traffickers often operate in regions far removed from native vegetation. Once established, their activities expand beyond drug trafficking to include illegal logging, hunting, poaching, and resource extraction. As previously noted, drug trafficking provides criminal organizations with opportunities for operational integration and cost rationalization, but it does not reduce environmental harm; rather, it intensifies it. Since 1850, deforestation has been responsible for approximately 30% of human-induced CO2 emissions (Le Quéré et al. 2018) and about 10% of emissions over the past decade (Friedlingstein et al. 2022), contributing significantly to global warming. The first territories to suffer the consequences of climate change are often those impacted by deforestation, where hydrogeological instability increases vulnerability to floods, tropical storms, and droughts. In this context, international drug conventions and the supply-side measures adopted to enforce them inadvertently undermine the broader efforts of the United Nations and individual states to address climate change and promote

sustainable development. Only by integrating human rights protection, environmental sustainability, and public health strategies into a coherent and coordinated framework will it be possible to address the complexity of the drug phenomenon and its far-reaching impacts. Fragmented approaches that isolate these dimensions risk perpetuating, rather than resolving, the very crises they seek to remedy.

The long dawn of a sixth stage?

Ethan A. Nadelmann outlined his five-stage model of the evolution of the global prohibitionist regime in an article published in the journal *International Organization* in the fall of 1990, shortly after the entry into force of the Convention Against Illicit Traffic and a few months after the launch of the United Nations Decade Against Drug Abuse. By then, the fourth stage—marked by the final development and concrete application of the global prohibitionist regime—had been completed, and there was already growing anticipation for the drug-free world that the UNDCP would later present as the slogan and objective of UNGASS 1998.

The prohibitionist movement was at the height of its strength and optimism, yet Nadelmann had no doubts: for the drug prohibition regime, the fifth stage—the disappearance or significant contraction of the prohibited phenomenon—was simply not (and still is not) within the order of things. He therefore hypothesized, in broad terms, four possible evolutionary scenarios for the regime, one of which bears a striking resemblance to the current international context and points toward a future that is much more plausible today than it was at that time:

> *It is possible that increasing frustration with the limitations and costs of drug prohibition will lead to widespread drug decriminalization, in which case the drug regime may follow in the footsteps of the stillborn alcohol prohibition regime and the global market in drugs may well come to resemble today's global markets in alcohol, tobacco, coffee, and tea.* (Nadelmann 1990, p. 513)

We might recognize in this phase the emergence of a sixth stage in the evolution of the prohibitionist regime—a regime that, having failed to reach the fifth stage, moves beyond prohibition to experiment with alternative regulatory approaches. This sixth stage would not represent a natural

progression of prohibitionism, but rather the acknowledgment of its structural crisis and the attempt to redefine the terms of control. This sixth stage could be encapsulated in a single key term: remission.

Despite the growing experiences of decriminalization and legalization of cannabis, despite the breakdown of the Vienna consensus and the increasing difficulty in finding common ground, the transition to the stage of remission may have already begun but, if it is ever fully realized, it remains far from completion. Although the creative interpretation or blatant violation of existing norms has weakened the regime's cogency, from a formal standpoint, the global prohibitionist framework has yet to be structurally altered. In this perspective, "remission" should not be understood as the disappearance of control, but as a profound transformation of its objectives, methods, and symbolic legitimacy. In order to speak meaningfully of remission, change cannot be limited to partial non-compliance or flexible treaty interpretations; it must also involve a transformation of the written legal framework—through repeal or, more plausibly, substantial reform that abandons the prohibitionist paradigm without relinquishing the principle of control. Until such change materializes, the regime will remain suspended between the fourth and sixth stages, condemned to continue consuming resources in pursuit of the probably unrealistic goal of achieving the fifth.

Meanwhile, at the national level, practical reforms are proliferating that reflect—often in uneven and fragmented ways—the early contours of remission. Even within the conventional framework, these reforms signal the abandonment of the now obsolete war on drugs in favor of approaches centered on the protection of public health and, in some cases, on opportunities for direct or indirect profit. These approaches often share common principles and strategies, but they can also exhibit significant regulatory and operational differences:

> *Alternative responses include various decriminalization, diversion, and depenalization schemes (…). The features include the reform architecture (objectives, decriminalization options,* de jure *or* de facto *approach), eligibility criteria (person-, place-, and drugbased criteria), and the actions taken (deterrence, therapeutic, and enforcement strategies). (…) (T)he notion of 'decriminalization' is not a simple, unified framework. Rather, there are meaningful differences in policies and options available within a non-criminal response.* (Greer et al. 2022)

We shall now examine the alternatives to total criminalization of drug use—and, in some cases, of cultivation, production, and sale—that are already in place or gaining ground. We will consider their objectives, principles, and differences, as well as their limitations—limitations that have led some countries to take a step beyond even the most flexible interpretation of conventional norms: legalization.

Harm reduction

The non-governmental organization Harm Reduction International defines harm reduction measures as those «policies, programmes and practices that aim to minimise the negative health, social and legal impacts associated with drug use, drug policies and drug laws» (International Harm Reduction Association 2023, p. 6).

Although still controversial in the political arena (Hunt 2016), harm reduction is transversal to drug trafficking regulation policies, can be implemented even within a solidly prohibitionist paradigm, and constitutes a valid approach for all types of narcotic substances, including legal and controlled drugs such as alcohol, tobacco, and certain medicines (Ibidem).

As previously discussed [see section: *The emergence of Harm reduction*], Harm reduction advocates assume that not all drug users wish or are able to quit,

and it is therefore crucial to help them manage the spectrum of consumption-related harms that impact both their psychophysical health and social stability. This is achieved through proximity services—easily accessible and designed with the needs of users in mind—which we will briefly overview. By prioritizing evidence-based interventions, harm reduction not only improves the immediate well-being of individuals but also contributes to the overall strengthening of public health systems at the global level.

Needle and syringe exchange programs (NEPs): these programs provide sterile needles and syringes for injection, ensuring proper disposal of used ones. In addition to needles and syringes, kits may include sterile materials for preparing the substance, disinfectants, filters, condoms, lubricants, informational brochures on drugs, methods of consumption, and other services available to consumers, such as testing and treatment for infectious diseases, treatment options for drug abuse disorders, vaccinations, and social and legal support.

Crack pipe distribution programs (safe inhalation pipe provision): the use of improvised materials such as bottles, cans, or damaged pipes, or non-heat-resistant pipes, can cause burns and injuries to the mouth, nose, and hands, increasing the risk of transmitting diseases when such equipment is shared, and causing inhalation of toxins, which can damage the lungs (Harris 2020). Safe inhalation kits typically include heat-resistant Pyrex and/or borosilicate glass pipes, metal filters, rubber mouthpieces, and pipe cleaners. Several studies have highlighted the correlation between the distribution of these kits and a reduction in the use and sharing of improvised and unsafe materials for crack consumption, greater awareness of health risks, more frequent access to services that provide the kits, and a transition from injection to inhalation (Ibidem).

Drug consumption rooms and supervised injection facilities: often located in strategic places within cities, near areas of dealing and consumption, these sites allow people who inject drugs to self-administer substances purchased elsewhere under hygienic conditions, without the fear of criminal sanctions, and under the supervision of qualified personnel, such as harm reduction operators, social workers, nurses, and other health professionals.

Drug checking: in an illegal market, products do not have to meet quality standards; street drugs can exhibit substantial variations in purity, may be entirely different from the intended product, and can be adulterated with toxic substances. Without the fear of criminal sanctions or seizures, drug checking services allow users to submit a sample of the substance they intend to consume to laboratories (including mobile ones) for chemical analysis. This service not only increases users' awareness of the risks associated with drug use but also helps prevent fatal overdoses and is useful for collecting data on substances available on the illegal market.

Substitution therapies: methadone and buprenorphine are two opioids included in the WHO's Model List of Essential Medicines. Substitution therapies with methadone or buprenorphine, which target the same receptors as heroin and morphine to alleviate withdrawal symptoms, have proven effective in treating addiction and ensuring users' continuous access to services, halving the risk of fatal overdoses (UK Government 2021). These therapies, often administered through mobile clinics that also distribute syringes, condoms, and offer medical assistance, are part of the harm reduction paradigm when they do not raise the threshold for access, do not impose abstinence on users, but rather grant them greater autonomy, encouraging a virtuous path toward detoxification, reduced consumption, or

even increased awareness of consumption-related risks and more frequent contact with health services.

Overdose treatment and prevention: nearly 40 percent of opioid overdose deaths (including prescription opioids) occur in the presence of another person. Consequently, the availability of life-saving drugs can prevent a significant number of fatal overdoses (WHO 2014a). Naloxone is the life-saving drug in question: when administered promptly, naloxone blocks the effects of opioids and restores normal breathing within minutes, which is why the WHO has included it in the list of essential medicines and recommends that it be made available to those likely to witness an overdose.

Social and legal support: although no single variable or set of variables can provide certainty about the choice to use drugs or the development of a drug use disorder, several studies have shown a correlation between the deterioration of social and economic well-being, drug abuse, and overdose deaths (Human Rights Council 2024, p. 15). Access to health, social, housing, education, and training services, including legal support, can help users abandon problematic consumption patterns and reintegrate into society. By reducing barriers to social services and fostering inclusion, harm reduction also addresses underlying social inequalities that contribute to health disparities and marginalization.

After having been incorporated into the vocabulary of the United Nations and numerous national and international institutions, harm reduction, albeit cautiously («as appropriate, in accordance with domestic law and pursuant to the aims of the international drug control conventions, if permitted by domestic law and included in national drug policies»), made its debut in a resolution of the Commission on Narcotic Drugs, which since March 2024 «encourages» the adoption of such measures (CND 2024a, p. 22).

Obviously, harm reduction has costs: materials, infrastructure, and personnel require an adequate budget, which not all countries can guarantee. At the global level, funding allocated for this purpose has decreased in recent years (Human Rights Council 2024, p. 15). After all, criminalization also carries costs—both economic and social—often far higher, without yielding any benefits in terms of health and safety. Decisions to allocate funds to police operations rather than health programs, courts rather than harm reduction, and prisons rather than housing services, are all examples of what we have referred to as *policy displacement*.

We read in the Human Rights Council report:

> *Divesting from the "war on drugs" can also free up resources to reinvest in health and harm reduction services – creating a pathway for an approach grounded in public health and human rights that is also based on the best available scientific evidence.* (*ibid.*, p. 13)

Criminalization, as we have seen, brings with it a series of undesirable consequences that result in avoidable damage to public health, safety, the environment, and violations of human rights. Reinvesting in harm reduction thus represents not only a health-oriented shift but also an opportunity to advance a more just, inclusive, and sustainable public policy framework for the future. Let us now examine the options available for those countries that wish, or have already chosen, to manage the issue differently, moving beyond the darkest phase of the war on drugs.

Depenalization and decriminalization

The Single Convention, the Convention on Psychotropic Substances, and the Convention Against Illicit Traffic require that the cultivation, use, and possession of drugs for purposes other than medical and scientific ones be

punishable offenses. However, this obligation is subject to additional clauses that introduce a degree of flexibility: the conventions also require States to offer drug users measures for prompt diagnosis, treatment, education, aftercare, rehabilitation, and social reintegration, and allow these measures to be used as an alternative or complement to a conviction or criminal sanction. Unlike legalization, therefore, depenalization and decriminalization are compatible with the conventional regime.

But what exactly do depenalization and decriminalization entail? Which countries have adopted these policies, and with what differences?

Depenalization, as can be inferred from the etymology of the word itself, consists in the removal of the penalty for a conduct that remains prohibited and technically classified as a crime; in other words, a depenalized conduct remains a criminal offense, but one that the authorities choose not to punish. This distinction is crucial: depenalization is essentially a policy of enforcement discretion, where certain offenses remain criminal but are not prosecuted due to practical considerations or shifting priorities.

The best-known example of depenalization is probably the *gedoogbeleid* (tolerance policy) implemented by the Dutch Ministry of Justice for certain drugs, primarily cannabinoids. According to Dutch law, the possession, cultivation, and sale of cannabis are all punishable acts (EMCDDA 2018, p. 15), but they are not prosecuted as long as they remain within specified tolerance thresholds. Adults are permitted to cultivate up to five plants for personal use and carry up to five grams of cannabis without incurring penalties. To operate, coffeeshops must obtain a license and comply with specific regulations, which municipalities may further tighten: they cannot sell to minors, cannot sell alcohol or so-called hard drugs, cannot sell more than five grams to a customer per day, and cannot possess more than five hundred grams on site. Promotional activities are prohibited, coffeeshops

must be located at least 250 meters away from the nearest school, and customers must not cause public disturbances.

Unlike depenalization, decriminalization does not merely remove the penalty *de facto*, but intervenes *de jure* on the legal status of the act, which ceases to be classified as a criminal offense (Stevens et al. 2022, p. 31). It thus constitutes a formal legal modification that removes the act from the sphere of criminal justice, redirecting it to administrative or civil regulatory frameworks. Measures such as administrative sanctions or referrals to health, social, or educational services may still be imposed. Decriminalization can concern the use and possession of all controlled substances, or be selectively applied to certain substances designated by the legislator, allowing for highly diverse regulatory models.

To provide an illustration of the practical flexibility inherent in these policies, we will briefly review the approaches adopted in four European countries where the use, possession, and cultivation for personal use have long been decriminalized: Italy, Portugal, Spain, and Belgium. These examples show the practical flexibility of decriminalization policies, with countries adopting different regulatory systems that reflect national priorities and legal cultures, while remaining aligned with international drug control frameworks.

In Italy, the decriminalization of use and possession for personal use is a long-standing development: as early as 1975, such conduct had been decriminalized for all drugs. The so-called Iervolino-Vassalli law reversed this trend in 1990, but a popular referendum three years later restored the previous approach, followed by the so-called Fini-Giovanardi law of 2006, which, although formally reinstating criminal sanctions, was declared unconstitutional in 2014. Today, in Italy, anyone who «illegally imports, exports, purchases, receives for any reason, or in any case possesses narcotic

or psychotropic substances for personal use» is subject only to administrative sanctions, such as the suspension or prohibition of obtaining a driving license, firearm license, passport, or residence permit, among others, and may be invited to participate in a therapeutic and social rehabilitation program. Although a public health approach is contemplated, data indicate that the sanctioning and stigmatizing aspects of the procedure prevail, with requests for therapeutic programs accounting for less than 1% of total reports (Cianchella 2024, p. 20).

In Portugal, decriminalization is a more recent but now well-established phenomenon, with characteristics that have made it unique and internationally studied as a model. Initially perceived as radical, it later proved effective. To understand how Law 30/2000 came into being, it is important to contextualize its emergence. During the period of the *Estado Novo*, one of the longest-lived authoritarian regimes in twentieth-century Europe (1933–1974), even Coca-Cola was banned in Portugal, and a license was required to own a lighter (Ferreira 2017). When the Carnation Revolution ended the dictatorship, the country remained isolated, with weak institutions, widespread poverty, and low educational attainment. With its borders reopened, Portugal faced a challenge for which it was entirely unprepared: a massive influx of drugs.

> *(…) by the mid-1990s 1% of the population was addicted to heroin (…). In 10 years (1989–99), deaths by overdose quadrupled (…). Rates of infectious diseases, including HIV, tuberculosis, and hepatitis B and C, soared (…). In 1999, one in every 200 people aged between 15 and 49 years was HIV-positive—the highest incidence rate in Europe. Drug use also became increasingly visible with the open-air drug markets (…). Finally, the number of presumed drug law offenders almost doubled between 1995 and*

> *1999, and it was estimated that in 1999 up to 75% of prisoners were consuming heroin daily.* (Moury, Escada 2023, p. 971)

In the Portuguese case, the spread of drug use was so sudden and widespread that it transcended the usual geographical and social barriers that often protect the wealthier classes, relegating drug-related problems primarily to urban peripheries and economically disadvantaged populations. The unusually «democratic» nature of the crisis not only revealed the systemic vulnerabilities of Portuguese society but also catalyzed an urgent political consensus across different sectors, overcoming ideological divides and fostering support for a fundamental paradigm shift in drug policy. Meanwhile, in 1993, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was established in Lisbon, whose first president, Vitor Feytor Pinto, was a Portuguese Catholic bishop and long-time advocate of decriminalization and harm reduction measures. The time was ripe, and the situation desperate enough, for alternative approaches to be attempted. Beginning in 1996, in the Casal Ventoso neighborhood of Lisbon—particularly affected by the epidemic—needle and syringe exchange programs were launched, followed by other social and health support initiatives, such as methadone maintenance treatment. Positive outcomes convinced the Socialist government to continue in this direction: a special commission composed mainly of doctors, psychiatrists, and psychologists already active in the field was established and tasked with developing a national strategy on drugs, with the sole constraint of maintaining compliance with international conventions (ibid., pp. 971–972).

The outcome of this process was Law 30/2000, which decriminalized the use and possession for personal use of all drugs, as had already been done in Italy, but also introduced a diversion system (Stevens et al. 2022, p. 31) that transferred jurisdiction from the Ministry of Justice to the Ministry of Health.

Individuals reported for drug use or possession are referred to a *Comissão para a Dissuasão da Toxicodependência* (Commission for the Dissuasion of Drug Addiction), composed of one legal expert and two professionals selected from among doctors, psychologists, sociologists, and social workers specializing in addiction issues. The commission is tasked with assessing whether the individual's drug use is problematic, a process conducted in collaboration with the person concerned, who may also involve a therapist of their choosing. The approach is multidisciplinary and case-specific, evaluating factors such as social and family context, employment status, and economic conditions that could exacerbate substance dependence. If the use is deemed non-problematic, or if problematic but the individual agrees to a therapeutic plan, the procedure is suspended. Otherwise, the commission may issue a warning, impose a fine, or apply non-pecuniary sanctions, such as prohibitions on practicing certain licensed professions, restrictions on access to particular places or associations, travel bans without permission, and the revocation or denial of firearm licenses.

The Portuguese government did not limit itself to regulatory reform. In the following year, under pressure from the *Bloco de Esquerda*, additional funds were allocated, and further harm reduction measures were implemented. Decree-Law 183/2001 promoted collaboration between public and private sectors by involving associations and non-governmental organizations in implementing new policies. Flexibility, field experience, and greater trust among users—often wary of official authorities—allowed for more efficient and effective resource management (Moury, Escada 2023, p. 973).

The immediate positive results were insufficient to prevent the censure of the INCB, which, adhering to a strict interpretation of the treaties, in its 2001 Annual Report criticized both the decriminalization of drug use and possession and the establishment of drug consumption rooms as contrary to

the conventions (INCB 2001, p. 74). However, the success of the reform was sufficient to persuade the newly elected center-right government in 2002—initially opposed to the policy shift—not to reverse course. In the long run, the INCB itself acknowledged the validity of the Portuguese model: it gradually adopted a more balanced stance, recognizing the compatibility of decriminalization with international conventions (INCB 2005, p. 80), a position reiterated in 2013 (INCB 2013c, p. 16), and again in 2015, when the then INCB President Werner Sipp, during a side event of the 58th Session of the CND, defined the Portuguese approach as an example of best practice (IDPC 2016).

A different decriminalization model from that of Portugal has been adopted in Spain, which, like Italy, does not provide for diversion mechanisms but applies a more permissive policy regarding cultivation, use, and possession for personal use. Unlike Portugal's model, which prioritizes public health interventions within a formalized framework, Spain's approach is characterized by a pragmatic tolerance that leaves broader margins of informal regulation. According to Ley Orgánica 4/2015, these conducts are sanctioned with a fine and additional penalties, but only when they occur in public places or are visible to the public (Article 36); thus, cultivation, use, and possession for personal use that occur in private spaces and are not visible to the public have no criminal or administrative relevance (Decorte et al. 2017, p. 46).

At the jurisprudential level, the Tribunal Supremo has affirmed the so-called doctrine of shared consumption, which extends the notion of personal consumption to cases where a person, without seeking profit, shares drugs in their possession with third parties—a conduct that would otherwise fall under Article 368 of the Código Penal, which criminalizes «those who (...) promote, encourage, or facilitate the illegal consumption of drugs».

Based on these legal norms and their interpretation, since 1991 (Marín 2008) the so-called Cannabis Social Clubs (CSCs) have proliferated in Spain. These are non-profit associations that cultivate cannabis for their members and distribute it without profit, thereby seeking to avoid prosecution under Article 368 of the Código Penal. However, CSCs operate in a legal "gray area", where practices accepted by local authorities can nonetheless be subject to criminal prosecution depending on interpretations of national law and judicial discretion.

Unless they intend to openly challenge the criminal system, CSCs must typically comply with three almost inevitable requirements: maintaining non-profit association status (which requires a minimum of three members and registration in the national registry of associations), imposing a minimum age for membership (generally eighteen, but in some clubs twenty-one), and refraining from any promotional activities. In the absence of a national regulatory framework, some autonomous communities and municipalities have introduced additional restrictions: these may concern the minimum distance between clubs and/or between clubs and schools, impose caps on the number of members, raise the minimum age requirement, or permit the use of club facilities solely for distribution purposes, excluding on-site consumption.

Generally, to become a member of a CSC, an individual must be introduced by an existing member and must declare on the registration form that they are already a regular cannabis user. There is no legal prohibition on being a member of multiple clubs. While many CSCs restrict membership to residents, many others—particularly in Barcelona—adopt a more permissive approach, actively seeking to attract tourists (Decorte et al. 2017, p. 48). This phenomenon of "cannabis tourism" has led to the exponential growth of some clubs and has reignited political and judicial debates about the risks of

commercialization and the potential erosion of the original harm reduction goals. These clubs easily reach hundreds or even thousands of members, and when profits are not fully reinvested into the association, they risk exposure to charges of drug trafficking. Similarly, CSCs face legal risks if they fail to establish maximum limits on the quantities that each member can acquire. Following recommendations from their federations, many clubs in 2016 (at the time of the Decorte et al. study) had set these limits between 60 and 90 grams per month (ibid., p. 52).

As in Spain, cannabis social clubs (CSCs) also emerged and developed in Belgium—albeit at different rates—within a legal grey area. However, the Belgian context presents an even greater degree of legal uncertainty, as there is no local or regional regulatory framework offering formal recognition or specific operational guidelines for CSCs. The regulatory foundations are similarly structured: in Belgium, drug use has no criminal or administrative relevance, while possession remains punishable. However, since 2005, ministerial guidelines have accorded the prosecution of cannabis possession—specifically possession of a cannabis plant or up to three grams of product, offenses subject to a fine—the lowest priority; such conduct is tolerated provided that it does not disturb public order and no aggravating circumstances are present (ibid., p. 46). Moreover, since 2003, shared consumption without profit has not been considered a criminal offense (EMCDDA 2023, p. 29).

Unable to rely on de jure recognition, Belgian CSCs have sought to legitimize their existence by adhering—at least in their interpretation—to the applicable laws, jurisprudence, and ministerial guidelines. For this reason, the clubs limit each cultivation cycle to a maximum of one plant per member (the maximum tolerated for an individual under the ministerial guidelines) and, just as in Spain, operate under the guise of non-profit associations,

refrain from any advertising, and admit only adults (in some cases, individuals over the age of twenty-one) who declare themselves to be regular cannabis users (Decorte et al. 2017, p. 52).

There is no statutory limit on the number of members in Belgian CSCs; however, on average, they are smaller than their Spanish counterparts (ibid.), perhaps because they enforce the residency requirement more strictly, and also because individuals may be members of only one CSC at a time. Nonetheless, compliance with this rule faces practical challenges, as the protection of user privacy—while safeguarding personal rights—hinders any system of centralized membership control and complicates internal regulation efforts. In 2016, the maximum amount of cannabis that a member could purchase varied across clubs, ranging between 10 and 30 grams per month, although higher limits could be authorized for therapeutic users (ibid., p. 51).

Far from exhausting the possible models of implementation of policies for the decriminalization of use, possession, and cultivation for personal use, the cases discussed demonstrate how States, along with their legislative, executive, judicial, and health institutions and civil society organizations, have worked over the decades to blunt and weaken conventional norms that, if applied with the rigor demanded by their heralds, would have further exacerbated the situation.

Decriminalization has been supported, among others, by Amnesty International (2024), Human Rights Watch, the National Association for the Advancement of Colored People, the International Federation of Red Cross and Red Crescent Societies (Drug Policy Alliance 2015), the World Health Organization (2014b), the Human Rights Council (2024), UNDP and UNAIDS (2024), and the UN System Chief Executives Board for Coordination (UN CEB 2018).

We have already discussed the unintended consequences of criminalization; reversing the perspective, and without delving into excessive detail, let us briefly review the benefits of decriminalization: its immediate impact would be a reduction in arrests, detentions, trials, and police operations, with consequent savings for public finances that could be reinvested in harm reduction policies, in the care, treatment, and rehabilitation of people who use drugs, and in social support measures. Furthermore, these resources could strengthen the prevention and repression of violent crimes and offenses that generate widespread social harm—crimes often treated leniently because they are committed by so-called white-collar offenders [see pp. …-…]. Decriminalization would also attenuate the consequences of stigmatization, encouraging and facilitating access to treatment and halting the social exclusion that, like the experience of incarceration, constitutes a risk factor for the onset, worsening, or resumption of problematic drug use, for the deterioration of physical and mental health, and for the adoption of a criminal lifestyle. Additionally, decriminalization would contribute to reducing abuses of authority and racial disparities, which tend to flourish under law-and-order paradigms (Drug Policy Alliance 2015).

Data collected in countries that have opted for decriminalization suggest that, despite these benefits, there is no significant increase in drug consumption or drug-related crimes (Drug Policy Alliance 2015; Human Rights Council 2024, p. 13).

But what happens when the decriminalization of use, possession, and cultivation for personal use, combined with other factors (ministerial guidelines, judicial rulings, etc.), gives rise to phenomena such as coffee shops and cannabis social clubs? What is the impact on consumption? Why do authorities decide not to intervene?

The decision to abstain from or engage in substance use, and the patterns of consumption adopted, are influenced by numerous social and individual, physical and psychological variables, which complicate any attempt to draw direct causal links. Scholars from various disciplines have developed dozens of theories attempting to explain the reasons that lead an individual to use drugs, often complementary but differing in focus, ambition, and methodology (Mosher, Akins 2014, p. 71). According to the COM-B model (Michie et al. 2011), an individual engages in a given behavior (Behaviour, B—whether legal or illegal) because they possess the capability, opportunity, and motivation (Capability, Opportunity, Motivation, COM) to do so. In this model (and not only in this one), exposure to a behavior is thus a significant factor in the decision to perform it, as it can facilitate access to the materials and environments necessary for the behavior and influence motivational dynamics.

A tragic illustration of the role of exposure is provided by David Courtwright:

> *Between 1960 and 2015 the resident population of Clark County, home to Las Vegas, grew by two million. The gambling industry cashed in. By 1991 gambling ranked as the locals' fourth most popular commercial recreation, trailing only eating out, movies, and shopping. By 1999 some 6 percent of the county's residents were compulsive gamblers, a rate over four times the national average. Exposure mattered, as did novelty and social class.* (Courtwright 2021, p. 194)

Can exposure to coffee shops and cannabis social clubs have an equally deleterious effect on those who live in or frequent cities where such activities are tolerated? Much depends on the regulatory framework in place, which can affect the capability, opportunity, and motivation to use cannabis, and on

the level of exposure itself. In this sense, Las Vegas represents an example of what not to do when seeking to contain a social phenomenon such as gambling—or, by analogy, drug use. In Las Vegas, giant neon signs, water and light shows, sponsored limousines, bouncers, labyrinthine corridors, the absence of clocks, unlimited alcohol, and 24/7 accessibility are all designed to foster disorientation and maximize profit. Public order problems generated by these strategies are viewed as a public issue, but not as a problem for Las Vegas itself.

The Netherlands, Spain, and Belgium have regulated cannabis consumption in various ways. In none of these countries are promotional activities permitted, and minimum distances are often imposed between coffee shops or CSCs and sensitive sites such as schools and clinics. It is well known that, unlike other Dutch municipalities, Amsterdam allows coffee shops to serve non-residents, and similar practices are observed in some Spanish CSCs, especially in Barcelona. This choice has contributed to cannabis-related tourism and, potentially, to public order issues. Over the years, authorities have repeatedly considered stricter regulations (Boztas 2022; Sabaghi 2024), but these efforts have met with limited success, possibly because of the economic benefits generated by this type of tourism.

Does the presence of coffee shops and CSCs cause an increase in consumption? Where access is not restricted to residents—and if one aggregates residents' and tourists' consumption—this is likely. A recent Dutch study calculated that, without the influx of tourists, only sixty-six of Amsterdam's 166 coffee shops would suffice to meet local demand (Snippe et al. 2020, p. 31). If, however, the focus is limited to residents, there appears to be little cause for concern: consumption rates in the Netherlands, Spain, and Belgium remain broadly comparable to those of other European

countries, both in the general population and among young people aged 15–34 (EUDA 2024).

The emergence and persistence of coffee shops and CSCs have pragmatic and strategic motivations. One reason is financial: repression is costly, while tolerance generates tax revenues. Even non-profit associations generate more fiscal activity than the black market, where profits are hidden or laundered. Cannabis tourism similarly contributes to public finances, although a comprehensive cost-benefit analysis should also take into account the opinions of local residents, who may experience deteriorations in security, housing affordability, and quality of life. Thus, while financial benefits are an important driver of tolerance, they must be carefully weighed against potential social costs, especially in terms of urban livability and public safety.

Another reason underpinning tolerance policies is strategic: as envisioned by the architects of the 1976 Dutch reform, one objective was to separate the tolerated cannabis market from the illegal hard drug market, thereby minimizing users' exposure to harder substances (Wouters, Korf 2009, pp. 630–631). Coffee shops and CSCs contribute to this objective by offering an alternative to the black market and potentially weakening criminal organizations' control over cannabis sales.

However, important distinctions must be made. CSCs are non-profit associations that cultivate cannabis collectively for their members, managing the entire production and distribution cycle internally. If properly regulated and monitored, CSCs effectively sever the connection between cannabis distribution and the black market.

By contrast, the situation of coffee shops is more complex. Although retail cannabis sales are tolerated under certain conditions, the supply side—known as the back-door problem—remains outside the bounds of legality. Cultivation is tolerated only for personal use and in quantities insufficient to

supply coffee shops. As a result, shops have historically relied either on illegal cultivation or on illicit suppliers.

Only recently have Dutch authorities taken steps to address this paradox. In 2019, legislation was passed authorizing a pilot program for a regulated cannabis supply chain. This experiment represents a potentially historic turning point: for the first time, the Netherlands is testing a comprehensive model in which both the retail and supply sides of cannabis distribution are subject to legal regulation and quality control. As of June 2024, coffee shops in ten municipalities can legally source cannabis from three of the ten licensed growers who have met the requirements for controlled cultivation and production (Government of the Netherlands 2024). The experimental phase will last four years, with a possible extension of eighteen months. During this period, authorities will collect data from growers, retailers, and consumers to determine whether to adopt a fully regulated model or revert to previous arrangements. The new regime would also permit more stringent quality controls, including monitoring THC and CBD levels and detecting contaminants such as metals and aflatoxins.

Coffee shops, cannabis social clubs, and other retail distribution channels are not the inevitable outcome of decriminalization policies. Several countries, such as the aforementioned Portugal and Italy, do not criminalize personal use or cultivation and possession for personal use, yet they do not permit any form of collective self-cultivation or distribution. The objective is merely to avoid the detrimental consequences of comprehensive criminalization, while remaining within the boundaries—both legal and ideological—established by international conventions.

Despite the benefits already analyzed, decriminalization has a clear limitation: except in cases of access to certain substances (including cannabis) for therapeutic purposes, and except for cannabis social clubs, coffee shops,

and similar establishments (such as smartshops or headshops) that offer their members or customers cannabis, hashish, and occasionally mushrooms or truffles containing psilocybin, salvia divinorum, LSA, or other niche controlled substances, even in countries where use, cultivation, and possession for personal use have been decriminalized, the drug market remains under the control of criminal organizations. These organizations manage every phase of the production and distribution chain, with all the consequences for public expenditure, health, safety, human rights, and the environment that we have previously discussed extensively [see pp. …-…].

To prevent this, legalization would be necessary. Yet, in a period when substances already integrated into the culture of many societies, such as alcohol and tobacco, are facing increasingly stringent regulations, is it truly conceivable—and above all desirable—to legalize substances that, for many, carry a much more threatening aura, such as cannabis itself, but even more so stimulants (e.g., cocaine, MDMA), narcotics (e.g., heroin), and psychedelics (e.g., LSD, psilocybin, DMT)? What principles should guide the regulation of the production, sale, and access to these substances? Who should assume control of the production and distribution chain?

We will explore the possible, slippery future of drug policies in the final chapter. For now, let us focus on the present, on the cannabis legalization models that have emerged in recent years, and on the preliminary indications we can begin to draw from these experiences.

The legalization of soft drugs

On December 10, 2013, the Uruguayan Senate approved Law 19.172, which was promulgated two weeks later by President José Mujica. Although it would take more than three years to achieve full implementation, with its publication in the official gazette Uruguay became the first country that had

signed the three international drug control conventions to legalize the production and distribution chain of cannabis for recreational purposes. Uruguay was the first among the signatories, but not the first overall: on November 6, 2012, Colorado and the State of Washington had already approved, by popular vote, Amendment 64 and Initiative 502, respectively—two laws that authorized the regulation of the recreational cannabis market, directly contradicting U.S. federal law, which remained aligned with the conventions.

The regulatory frameworks adopted by the two American states are, in practical effect, partly similar to the system implemented in the Netherlands: individuals over the age of twenty-one (the legal drinking age in the United States) may purchase cannabis at licensed dispensaries; promotional activities are restricted, and public consumption is prohibited. Possession for personal use is permitted—up to one ounce (approximately 28 grams) in Washington, and up to two ounces in Colorado—and sharing small quantities with others over twenty-one years old is not criminalized. In Colorado, but not in Washington, home cultivation is also permitted, with a limit of six plants per household, three of which may be flowering at any given time. Unlike in the Netherlands, or perhaps ahead of it, the cultivation of cannabis intended for sale to dispensaries has also been regulated through a licensing system.

However, while Colorado and Washington pioneered a more commercialized approach to legalization, Uruguay pursued a markedly different path, seeking to maintain tight public control over production and distribution rather than handing them over to market forces. In Uruguay, Law 19.172 authorizes only citizens and permanent residents of legal age to access cannabis through one of three mutually exclusive options: personal cultivation of up to six plants per year or a maximum of 480 grams of product; purchase of up to ten grams per week from authorized pharmacies;

or membership in *clubes de membresía* (the equivalent of cannabis social clubs), which are non-profit associations with between fifteen and forty-five members, collectively cultivating up to ninety-nine plants and distributing no more than 480 grams per member per year. A key innovation of the Uruguayan model is the creation of the *Instituto de Regulación y Control de Cannabis* (IRCCA), an autonomous public authority responsible for licensing, oversight, scientific research coordination, and the management of the entire legal cannabis framework—a centralization of powers unprecedented in previous models.

The Uruguayan legislation introduced a series of measures aimed at limiting demand and minimizing the impact on public health and society at large. Among these measures: the registration of consumers in the IRCCA's *Registro de Adquirentes de Cannabis* to prevent individuals from accessing multiple sources and exceeding legal purchase limits; the imposition of THC limits in cannabis products; the prohibition of all advertising by pharmacies and clubs; the organization of public information campaigns on the risks of consumption; and, of course, the reinforcement of prohibitions on driving under the influence of cannabis.

Although there are many similarities between the models adopted in the American states (despite some differences between Colorado and Washington) and the one adopted in Uruguay—such as education measures, protections for minors and third parties, limits on possession, restrictions on promotional activities, and licensing systems—there is a fundamental difference that revolves around one of the key concepts of our time: profit.

In Uruguay, individuals can cultivate cannabis at home, participate in non-profit clubs limited in size and scope, or purchase cannabis at authorized pharmacies that offer only a few IRCCA-approved varieties, at fixed prices and in standardized, non-branded packaging containing health warnings.

Supply chains are also regulated: authorized growers may sell only limited quantities of approved strains to pharmacies at fixed prices. Legalization in Uruguay does not include the sale of hashish, concentrates, or cannabis-infused edible products.

In contrast, the regulatory systems in Colorado and Washington are far more liberal and commercially oriented. Here, the primary objective is not public health management but the establishment of a functioning, profit-driven cannabis industry, where economic expansion and consumer market growth are key driving forces. While a licensing system exists and there are restrictions on advertising, business hours, and sales limits, growers and retailers operate in a competitive market environment with profit as their primary goal, along with its corollaries: attracting and retaining customers, diversifying products (concentrates, edibles, etc.), and resisting regulations that might limit business expansion—even when such regulations aim to protect public health and safety.

It is no coincidence that Colorado and Washington were the first U.S. states to legalize cannabis for recreational purposes. Both had previously adopted relatively relaxed frameworks for medical cannabis sales and, consequently, already possessed a burgeoning cannabis industry poised to invest millions of dollars both in the sector itself and in lobbying efforts aimed at resisting the adoption of stricter public health regulations (EMCDDA 2016; Rotering et al. 2023).

In the following years, another twenty-two American states (for a total of twenty-four as of October 31, 2024) and several countries that have signed the conventions have legalized the sale and/or cultivation, possession, and use of cannabis for recreational purposes: the first after Uruguay was Canada in 2018, the last (so far) was Germany in April 2024.

Discussing in detail the measures adopted in each of these countries would go beyond the scope of this thesis. For now, it is enough to state the obvious: the concept of legalization is a vague concept, which indicates the process through which something that was previously illegal becomes legal, but which is only embodied in the criminal, administrative, fiscal, commercial, etc. rules (or lack thereof), which will actually regulate the sector. These rules may arise in different political, economic, and social contexts, reflect different worldviews, and therefore pursue (at least partially) different objectives. But if there is anything that the last almost two hundred years of drug policies have taught us, it is that, with all its pitfalls, its delays, its subterfuges, the international arena is the inescapable center of gravity of the legislation on the matter. It is there then that we must return if we want to imagine, outline, program an alternative and effective model, consistent with itself and compatible with human rights.

The legal regulation of the recreational cannabis supply chain is a violation of conventions, but it could become something more than a banal act of insubordination. Rather than a marginal deviation, it signals a broader systemic shift: a growing recognition of the need to reframe global drug policy along more rational, scientific, and human rights-based lines. The legalization of cannabis is rooted, above all, in the irrationality of its prohibition and exposes the historical and political nature of the conventional regime, its arbitrariness, and ultimately, its obsolescence.

This rupture, still in its early stages, may soon widen into a decisive breach, capable of undermining the very foundations of the international drug control system and forcing its transformation.

Conclusions

New perspectives

In 1997, ten years after the release of the first iconic commercial, the Partnership for a Drug-Free America produced a new version: the then eighteen-year-old Rachael Leigh Cook presents an egg («This is your brain...») and a frying pan («...and this is heroin»); she places the egg on a counter and warns: «This is what happens to your brain after snorting heroin.» She then smashes it with the frying pan, destroying it, and in a fit of rage, proceeds to demolish the entire kitchen: «This is what your family goes through! And your friends! And your money! And your job! And your self-respect! And your future!» Finally, standing amidst the wreckage, she concludes: «And your life... Any questions?»

Twenty years later, in 2017, Cook filmed a new commercial, this time sponsored by the Drug Policy Alliance: the frying pan now serves as a metaphor for the war on drugs, while the eggs represent African-American citizens, their dreams, and their futures. «The war on drugs is ruining people's lives,» Cook states. «It fuels mass incarceration. It targets people of color in greater numbers than their white counterparts. It cripples communities. It costs billions and it doesn't work. Any questions?» (Blistein 2017).

On November 8 of the previous year, California held a referendum on the legalization of cannabis: Proposition 64 (Control, Regulate and Tax Adult Use of Marijuana Act) was approved with 57.13% of the vote. Among those in favor was John Roselius, the handsome middle-class white man who had starred in the 1987 anti-drug commercial. In an interview with Canadian

radio CBC, Roselius explained that he considered drug policies a failure and revealed that, at the time of filming «This is your brain on drugs,» he himself was struggling with alcohol abuse (Lopez 2016b)—a psychoactive substance which, according to the definition of Zimring and Hawkins, qualifies as a drug, yet remains legal, taxed, and advertised. Roselius stated that his views changed after his in-laws, who wished to avoid opioids, found relief from arthritis and chronic pain through cannabis; when the referendum was held in Washington State, both had voted in favor of legalization, as he himself would later do.

The stories of John Roselius and Rachael Leigh Cook are emblematic of a broader cultural shift: the growing awareness of the contradictions and failures of prohibition has fueled political mobilization and normative change across diverse social sectors. This social shift has been translated into normative change: numerous countries have decriminalized or depenalized the use, cultivation, and possession for personal use of certain or all drugs; some have legalized cannabis; many others have implemented or expanded harm reduction measures.

At the international level, change is also evident: over the past ten sessions of the Commission on Narcotic Drugs (CND), from 2015 to 2024, «progressive» resolutions—concerning harm reduction measures, treatment and health services, access to essential medicines, alternative development, civil society participation, alternatives to incarceration, and gender issues—have prevailed over resolutions focused on organized crime, supply reduction, and demand prevention (IDPC 2024, p. 12).

Over the past decades, the CND, the United Nations Office on Drugs and Crime, and the International Narcotics Control Board have also revised their positions regarding depenalization and decriminalization, recognizing their compatibility with the conventions. Hostility towards any form of

legalization, however, remains—and indeed, it could not be otherwise: their institutional mandate is to develop and monitor the application of the conventional framework, with which legalization is evidently incompatible.

Thus, the process of regulatory change has not affected the letter of the conventions but has been limited to a partial revision of their interpretation and application. Why?

According to William Thomas and Florian Znaniecki, «order-and-forbid» is the oldest, yet also the most persistent, form of social technique: through an act of will and the use (or threat) of force against offenders, authority decrees the disappearance of an undesirable phenomenon or the appearance of a desirable one; if the objective is not achieved, rather than investigating the causes of failure, authority often introduces «a new act of will and new accessory physical elements» to pursue it [The oldest but most persistent form of social technique is that of "ordering-and-forbidding"—that is, meeting a crisis by an arbitrary act of will decreeing the disappearance of the undesirable or the appearance of the desirable phenomena, and using arbitrary physical action to enforce the decree. This method corresponds exactly to the magical phase of natural technique. In both, the essential means of bringing a determined effect is more or less consciously thought to reside in the act of will itself by which the effect is decreed as desirable and of which the action is merely an indispensable vehicle or instrument; in both, the process by which the cause (act of will and physical action) is supposed to bring its effect to realization remains out of reach of investigation; in both, finally, if the result is not attained, some new act of will with new material accessories is introduced, instead of trying to find and remove the perturbing causes. A good instance of this in the social field is the typical legislative procedure of today.] (Thomas, Znaniecki 1918-1920, p. 3).

The fact that, in drug policy, the coherence between objectives and means has long remained—and in some respects still remains—outside the field of investigation is one of the reasons for normative stasis. Even when, in recent years, a less ideological approach and greater reliance on data have been adopted, the evaluation of drug policies has remained narrowly circumscribed:

> *The official take on assessing the impact of drug control strategies is that the 'right' policy framework already exists (…). The principal aim of evaluating drug policies is seen as part of the response to 'implementation failure', not to employ impact evaluation to prepare the ground for policy change.* (Schultze-Kraft, Befani 2014)

The belief that prohibition is the only viable strategy and that problems arise merely from its imperfect application has increasingly been called into question. Awareness is growing of the intrinsic limits of the prohibitionist paradigm, whose exorbitant social costs are borne primarily by producing and transit countries of the Global South—countries that are not coincidentally among its harshest critics. After decades of apparent regulatory stability, characterized by slow and partial adjustments in implementation, the visible cracks in the conventional edifice suggest that a turning point may no longer be merely possible, but increasingly inevitable.

AGGIUNGI:

As Ethan Nadelmann has observed, what distinguishes these regimes from other areas of international law is their normative and emotional foundation: violations are not only matters of legal infraction, but also triggers for moral condemnation and political pressure, both domestically and internationally (Nadelmann 1990, p. 479). This moral underpinning, though potentially a

source of strength, may also contribute to rigidity, resistance to reform, and political polarization.

In the evolution of global society, the centrality of Western Europe initially and of the United States during this century cannot be overemphasized. Virtually all of the norms that are now identified as essential ingredients of international law and global society have their roots in the jurisprudence of European scholars of international law and in the notions and patterns of acceptable behavior established by the more powerful Western European states. This is particularly true of many of the norms reflected in global prohibition regimes. Their emergence within Europe reflected the needs and impositions of the most powerful states as well as the influence of the Enlightenment and contemporaneous religious and moral notions. The globalization of these norms, manifested by the emergence of global prohibition regimes, reflected the dominance of Europe over much of the world from approximately the seventeenth century to recent decades. (Nadelmann 1990, p. 484)

Nadelmann 1990, pp. 524 e ss. (lessons)

While some global prohibition regimes have achieved significant results—such as those targeting piracy, slavery, or human trafficking—others have proven less effective in curbing the prohibited conduct. In many cases, however, these shortcomings can be attributed to flaws in implementation, insufficient coordination, or limited resources, rather than to the normative foundations of the regimes themselves. With strategic adjustments and more consistent enforcement, these regimes continue to serve legitimate and

broadly shared purposes, such as the protection of human dignity, financial integrity, or biodiversity.

The global drug prohibition regime, by contrast, stands out for the scale and persistence of its unintended and often harmful consequences. Far from eradicating the illicit production, trade, and consumption of psychoactive substances, the regime has contributed to the expansion of transnational criminal markets, the militarization of law enforcement, the stigmatization and mass incarceration of people who use drugs (PWUD), and the obstruction of scientific research on the therapeutic uses of controlled substances. Entire communities—particularly in the Global South—have been devastated by policies aimed at forced eradication and interdiction, often pursued with disregard for basic human rights and public health.

Furthermore, the regime has entrenched a rigid classification system that is frequently at odds with scientific evidence. For decades, cannabis remained in the most restrictive schedules of the 1961 Single Convention, despite mounting evidence of its medical potential. Likewise, substances such as LSD and psilocybin—now at the center of a renewed interest in psychedelic-assisted therapy—continue to be treated as among the most dangerous, based on outdated and ideologically charged criteria.

Unlike other global prohibition regimes, which allow room for recalibration while preserving their normative legitimacy, the drug control system has become emblematic of what happens when prohibition becomes an end in itself. Its punitive orientation has proven largely ineffective in achieving its stated goals, while generating a host of collateral harms that undermine public health, social justice, and human rights. This regime, therefore, requires not just reform but a profound rethinking of its objectives, instruments, and underlying assumptions.

→ Il primo regime proibizionista internazionale che potrebbe raggiungere il sesto stadio, un inedito

Age of addiction; addiction by design; Courtwright, p. 9

Drug, set, setting; feticismo della sostanza

Sesto stadio è in realtà alternativo al quinto!

the dynamics of how capitalism, structural inequalities, and social marginalization interact to shape regulatory frameworks.

Pacta sunt servanda

The preamble to the Charter of the United Nations outlines the four pillars of what was then the new international system: alongside peace and security, human rights, and social progress, there was also a place for the rule of law:

> *We the Peoples of the United Nations determined (…)*
> *to establish conditions under which justice and respect for the obligations arising from treaties and other sources of international law can be maintained (…)* (UN 1945)

This principle is reaffirmed by the so-called "Treaty of Treaties," the Vienna Convention on the Law of Treaties of 1969, which in Article 26, entitled *Pacta sunt servanda*, establishes that: «Every treaty in force is binding upon the parties to it and must be performed by them in good faith.»

From a logical perspective and in terms of the hierarchy of sources, the first problem posed by the international drug control conventions is their conflict—or at least their difficult coexistence—with the maintenance of peace and security, the protection of human rights, and the promotion of social progress, three of the four pillars of the United Nations. A growing number of scholars (see, among others: Bewley-Taylor 2005; Elliott et al. 2005; Barrett 2010; McSweeney 2015), non-governmental organizations [see p. …-…], and institutional representatives, including the United Nations High Commissioner for Human Rights Volker Türk (IDPC 2024, p. 9), have highlighted the incompatibility of the drug control regime with norms deriving from other treaties and resolutions, such as the Universal Declaration of Human Rights, the 2030 Agenda (Sustainable Development Goals), the UN Declaration on the Rights of Indigenous Peoples, the Rio Declaration on Environment and Development, and the International Covenant on Economic, Social and Cultural Rights. These instruments

represent the implementation of the other three pillars and the purposes and principles enshrined in the UN Charter.

How can this antinomy be resolved? Given that, as intuition would suggest, peace and security, human rights, and social progress must prevail over the binding force of the drug control conventions and their norms, can the non-application of the latter be left to the discretion of individual states? An affirmative answer would imply chaos: the conflict between norms of equal rank (whether between pillars or between conventions) would lack objective resolution and would instead fall into the realm of interpretation, filtered by differing sensitivities, legal cultures, and national constitutional frameworks. This would give rise to a phenomenon of "multilateral erosion" of the three drug conventions, depriving them of any claim to universality.

Thus, the antinomy should be resolved at its source, either by profoundly amending the texts of the conventions or by drafting, signing, and ratifying a new single convention to replace the existing ones and reform the system from its foundations. In other words, the logical conflict reveals the structural necessity of intervention: without a formal reconfiguration, the legitimacy of the international drug control regime will continue to erode, exposing its internal contradictions ever more clearly. But what would be the pathway, and how realistic is it to envision such a development?

Article 47 of the Single Convention on Narcotic Drugs and Article 31 of both the Convention on Psychotropic Substances and the Convention Against Illicit Traffic regulate the procedure for amending each convention. Although there are minor formal differences between the Single Convention and the other two, the processes are broadly similar: any party may propose and motivate an amendment; within the following eighteen or twenty-four months, the other parties may object. If no objections are raised, the amendment is deemed accepted and, in the case of the Single Convention,

enters into force immediately; otherwise, for the other two conventions, it enters into force for each party upon express consent. If a party rejects an amendment—or *motu proprio* in the case of the Single Convention—the United Nations Economic and Social Council, after consulting the parties, may convene an international conference to discuss the proposed amendment.

At present, and for the foreseeable future, the idea that a significant amendment could be accepted by all contracting parties or emerge intact from the ordeal of an international conference remains a pious illusion—or, as the saying goes, the dream of an opium smoker. This is not merely a reflection of contingent political divisions, but a structural impasse rooted in the foundational asymmetries of the international system itself. The polarization witnessed at the Plenary Assembly of the 67th Commission on Narcotic Drugs, particularly during the High-Level Segment, offers clear proof: in a joint statement, sixty-two countries emphasized the shortcomings of the current system and expressed support for its reform.

> *If we want to impact the lives of individuals, households, and communities around the globe, we need a transformation in our vision of the world drug policy, based on a realistic evidence-based assessment and a pragmatic response. Therefore, we resolve to jointly review and reassess the international drug control system to ensure weaknesses in implementation are addressed, and that we are appropriately focused on achieving our common goals and objectives to protect the health and well-being of humankind.* (CND 2024b)

Among the signatories—alongside Colombia and most Latin American countries—are the United States, the United Kingdom, France, Italy, Poland, and many others that clearly have no intention of fundamentally questioning, let alone abandoning, the current regime. Their criticisms, far from radical,

are thus limited to specific aspects of implementation. Even if the drafting of a new drug control convention were entrusted exclusively to these countries, the negotiations would hardly be harmonious; while it might be possible to achieve consensus on certain (sometimes significant) adjustments, a reversal of the prohibitionist paradigm would be out of reach.

Moreover, the debate would inevitably involve the forty-six countries, led by Russia, that responded to the call for reform at the Plenary Assembly with a joint declaration urging the international community not to «surrender to the scourge of drug proliferation» and reaffirming their commitment to a «society free from drug abuse» (IDPC 2024, p. 5).

At present, amending the conventions is not a credible option. In March 2009, Bolivia attempted to do so by requesting the deletion of Article 49, paragraphs 1(c) and 2(e) of the Single Convention, which required that the practice of coca leaf chewing be abolished within twenty-five years of the Convention's entry into force. In its proposed amendment, the Bolivian authorities emphasized the socio-cultural prejudices and scientific inconsistencies underlying the ban, as well as its problematic relationship with other international instruments protecting indigenous peoples and their cultures (ECOSOC 2009, p. 5) [see also pp. 261–262].

When the amendment was rejected and no conference was convened to discuss it in greater depth, Bolivia opted to resort to the procedure outlined in Article 46 of the Single Convention, which, in the case of the Convention on Psychotropic Substances and the Convention Against Illicit Traffic, is regulated instead by Article 30: denunciation.

A formal notification to the Secretary-General and the expiration of the prescribed timeframes—one year for the 1971 and 1988 conventions, between six and eighteen months for the Single Convention—are sufficient for a contracting party to withdraw from the convention. This is precisely

what Bolivia did: it denounced the Single Convention in 2012 and rejoined in 2013, reserving the right to permit the use of coca leaves for cultural and medicinal purposes and to authorize their possession, cultivation, and trade to the extent necessary for lawful uses.

If the amendment procedure offers no real prospect of success, could denunciation followed by re-accession with reservations concerning the contested provisions represent a viable strategy for countries critical of the system? Certainly not.

From a purely formal standpoint, the right to formulate reservations is tightly regulated: if at least one-third of the contracting parties raise objections, the reservation is invalidated. In Bolivia's case, only fifteen countries objected—well short of the sixty-one required to block the reservation. However, reservations that are less legitimate or less narrowly framed would likely encounter greater resistance.

From a substantive perspective, if a sufficient number of countries were willing to pursue this route, it would signify that the conventional regime was already in a state of collapse. In such a scenario, withdrawal would serve not merely as an individual act of protest, but as a strategic lever of political pressure aimed at precipitating the demise of the existing conventions and catalyzing the negotiation of a new international treaty. Even in isolated cases, however, denunciation carries a significant symbolic weight: it signals the erosion of the consensus that has historically underpinned the regime and highlights the growing dissonance between international norms and national priorities.

At least three additional factors must be considered.

The first is that, far from regulating only the substances commonly defined as drugs, the three conventions also govern the supply chain for medicines and the precursors needed to produce them. Exiting the conventions would

therefore immediately create significant difficulties in accessing essential medicines, particularly for countries without a cutting-edge chemical and pharmaceutical industry capable of compensating for this shortfall in the short term.

The second factor is that a political move of such magnitude would have repercussions far beyond the specific subject matter of the conventions. Countries that chose to leave could face embargoes not only on medicines and precursors but also on other goods and services of various kinds, the economic and broader consequences of which would be difficult to predict.

The third factor is that politics does not operate in watertight compartments. In the current context of acute international tensions, withdrawal from or breach of a treaty staunchly defended by countries such as Russia, China, India, Pakistan, Iran, Turkey, Saudi Arabia, and the United Arab Emirates could represent a point of no return from a diplomatic and geopolitical standpoint. Such a precedent could trigger unilateral withdrawals from other crucial treaties, such as the Nuclear Non-Proliferation Treaty, the Chemical Weapons Convention, or the Paris Agreements—failures that would shake the entire United Nations system and threaten human survival itself.

To date, therefore, despite its proven failure, the global prohibitionist paradigm does not appear capable of being dethroned, and the conventions seem unlikely to be undermined except in their application.

From this perspective, another potentially incisive move deserves consideration—one we have not yet examined: direct intervention on the control schedules, for which a simple majority within the CND would be sufficient in the case of the Single Convention, and a two-thirds majority for the Convention on Psychotropic Substances and the Convention Against Illicit Traffic.

There are at least two obstacles, however.The first is that a significant modification or emptying of the schedules would produce effects equivalent, in practice, to a breach of the treaties, potentially triggering the political and diplomatic consequences outlined above. The second is that, in the case of the Single Convention, opium, coca, and cannabis are not only listed in the control schedules but are explicitly mentioned in the text of the articles themselves, thus severely limiting the scope for reform through simple rescheduling measures.

If, at the international level, there appears to be no room for anything beyond minor adjustments in application, at the national level regulatory change can proceed in two ways.

First, it can occur within the existing conventional framework, which permits decriminalization, depenalization, and harm reduction measures and, owing to the vague language employed in the conventions—language crafted through exhaustive diplomatic negotiations aimed at reconciling divergent interests—offers a considerable degree of flexibility in implementation. Alternatively, change can develop in direct contravention of the conventions, as exemplified by the legalization of the recreational cannabis supply chain. Such developments have provoked criticisms from the UNODC and harsher reactions from the INCB and certain contracting states, yet have not resulted in any countermeasures capable of forcing legalized countries to reverse course or deterring others from pursuing similar reforms.

The latter path—incremental, fragmented, and diplomatically fraught—appears to be the main route toward a gradual erosion of the prohibitionist paradigm, despite the numerous diplomatic, commercial, and even legal risks involved, particularly for countries whose constitutions bind the exercise of legislative authority to compliance with international obligations. The choice

between internal compliance and external challenge thus entails not only legal interpretation but strategic geopolitical calculation.

Let us suppose that a country decides not to withdraw from the conventions, continues to cooperate in combating illicit trafficking and to share information with other contracting parties, but also intends to create a space of legality not only for cannabis but for the cultivation, production, distribution, and consumption of other controlled substances.

The consequences it would face are difficult to predict, and—as is often the case in both domestic and international law—would depend primarily on the balance of power and other geopolitical considerations. If the United States were to take such a step, the countermeasures it would encounter would likely be far less severe than those faced by Colombia, Mexico, or any other country of the Global South under similar circumstances.

The repercussions would also depend on the boldness of the regulatory reform: the establishment of a full-fledged legal market would likely provoke greater indignation—and therefore more serious consequences—than a cautious relaxation of therapeutic frameworks, such as permitting certain doctors, under specific conditions, to prescribe substances like cocaine, MDMA, or LSD.

One issue that undoubtedly warrants consideration is that not all drugs are the same—not only in terms of their effects, addictive potential, or long-term harms, but also in terms of their production and distribution requirements.

This distinction suggests that different regulatory strategies would be necessary: while relatively simple substances could be integrated into models based on collective self-cultivation and non-profit associations, more complex substances would require the creation of tightly regulated commercial supply chains, involving higher technical standards and greater oversight.

Substances such as cannabis, hallucinogenic mushrooms, and San Pedro (a cactus containing mescaline) are amenable to home cultivation and to non-profit association models. By contrast, drugs such as cocaine, MDMA, and LSD require technical expertise and specialized equipment beyond the reach of individual consumers, necessitating a different production and distribution chain—one that would inevitably involve chemical and pharmaceutical companies, entities for which profit, while perhaps not the sole objective, remains central. The inevitable industrialization of production raises additional regulatory challenges, as it risks amplifying commercialization dynamics and reshaping the relationship between consumers, markets, and public health.

The Stone Guest

In the previous chapters, by retracing the entire history of drug policies, we have identified multiple vectors of regulatory change.

The explicit ones, stated in the preambles of the conventions, are the legitimate concerns of numerous public authorities committed to safeguarding fundamental rights: the protection of the health and well-being of humanity, and the defense of the legitimate economy as well as the stability, security, and sovereignty of states, threatened by criminal organizations and drug trafficking. We have already dedicated extensive analysis to the gulf between these stated objectives and the results actually achieved.

Another vector was the moral one—driven by religious, ideological, paternalistic, and sometimes sincerely humanitarian motives. This vector, highly influential during the golden age of the temperance movements, has lost momentum in contemporary debates but has never disappeared entirely. Even today, for many, the belief that «drugs are bad» suffices to justify prohibition, irrespective of distinctions between substances or pragmatic evaluations of policy outcomes.

A third important vector was the pursuit of prestige, power, and sometimes mere sustenance by private individuals, corporations, and associations: from doctors and pharmacists who, between the nineteenth and twentieth centuries, campaigned for the establishment of professional orders and exclusive control over the sale of certain substances, to the bureaucratic apparatus whose members found secure employment, authority, and endless funding in the implementation and expansion of the prohibitionist regime; to the white labor unions in the United States who, particularly after the 1929 economic crisis, endorsed criminalization policies aimed at Black, Mexican,

and Asian populations—targeting, among other aspects, the consumption of substances less socially integrated than alcohol and tobacco.

The fourth vector concerns the pursuit of power and control by the state, its political class, and its top leaders. This dynamic has unfolded both externally, through the ongoing effort to expand military, commercial, and cultural influence, and internally, through drug policies that have functioned as instruments for the penal control of minorities, political opponents, and subaltern classes.

Over the past forty years, the dismantling of the welfare state across much of Europe and the United States has been accompanied by the phenomenon of mass incarceration, driven in large part by detentions for violations of anti-drug laws. In parallel, the U.S. government has turned the «war on drugs» into a tool of political and military hegemony in Central and South America. More recently, the Chinese government, in reaction to the open hostility and tariffs imposed by the Trump administration, loosened controls on the production and export of fentanyl and its precursors, which have subsequently been acquired and processed by Mexican cartels distributing the finished product in the United States (Congressional Research Service 2024). It was only following the talks between President Biden and President Xi Jinping in November 2023 that China launched a renewed crackdown on fentanyl and its precursors, and the two countries resumed bilateral cooperation in the fight against drug trafficking (U.S. White House 2024).

It is rare for any of these vectors to present itself in pure form, without intertwining with at least one of the others. Governments' thirst for control has often found political support both in communities with certain ideological or religious orientations—communities fearful of, or in conflict with, cultures and individuals perceived as alien—and within their own bureaucratic apparatuses and professional orders, eager to make themselves

indispensable, to consolidate their positions, and to extend their spheres of competence.

All these vectors are linked, directly or indirectly, to what has arguably been the principal vector of regulatory change in drug policies since their inception: profit.

As William McAllister notes:

> *(…) [T]he primary goal of the international drug control regime has never been to eliminate illicit drug use. The most important objective of the delegates to the 1961 and 1971 conventions was to protect sundry economic, social, cultural, religious, and/or geopolitical interests. The amount of time actually spent at the conferences discussing the problems of addicted individuals, how to help them, and how to prevent more people from joining their ranks was minimal. Until these priorities change, problems with widespread drug abuse, and the attendant cost in human and material capital, will continue.* (McAllister 1992, p. 162)

From the Opium Wars to the Shanghai Commission, from the role played by pharmaceutical company representatives in drafting the Convention on Psychotropic Substances, to the approval of the Ensuring Patient Access and Effective Drug Enforcement Act of 2016 by the U.S. Congress during the height of the opioid crisis, the historical trajectory reveals a consistent pattern: economic power has not merely adapted to regulatory frameworks but has actively shaped them to protect or expand profitable interests. Profit has consistently proven to be the gravitational center of drug policies at both the national and international levels.

Recent experiences of legalization have been no exception. Lobbyists for the cannabis industry immediately mobilized to weaken or eliminate regulations on THC limits, pesticide use (Johnson 2024), and, more generally,

any regulation that—while safeguarding public health, especially that of young people—might constrain their pursuit of profit (INCB 2023, pp. 2, 16–17). Several multinational alcohol and tobacco corporations have already invested heavily in the cannabis sector, deploying the same commercial and political tactics historically used to expand and monopolize markets (Ibidem).

Rotering and Apollonio observe:

> *Tobacco, alcohol, and gambling companies, (…) hire lobbyists to influence policy, connect with front groups and allied industries to oppose regulation, and build relationships with policymakers through political donations. Tobacco, alcohol, and food interests orchestrate lobbying across industries and transnationally to promote policies favorable to consumption. The cannabis industry has a similar interest in maximizing profits by creating a favorable regulatory environment.* (Rotering, Apollonius 2022)

Similar conflicts between public and private interests have also shaped the regulation and marketing of pharmaceutical products, with tragic consequences whenever private interests prevailed. In his book *Marijuana, The Forbidden Medicine*, the American psychiatrist Lester Grinspoon recalls the day he was called to testify before the Bureau of Narcotics and Dangerous Drugs regarding the therapeutic value of cannabis. While awaiting his turn, Grinspoon attended another hearing, in which the future of Talwin—a drug based on pentazocine, known to cause addiction and overdose—was being decided. The pharmaceutical company holding the patent appeared with six attorneys tasked with preventing the drug from being included in the schedules, or at least ensuring it was placed in one of the less restrictive categories. Ultimately, Talwin was classified in Schedule IV, the least restrictive.

Shortly thereafter, during the cannabis hearing, Grinspoon was joined by numerous physicians and patients who testified to the therapeutic benefits of cannabis—a substance for which no fatal overdoses or patterns of addiction comparable to those associated with Talwin had been recorded. Their request to move cannabis from Schedule I, reserved by the Controlled Substances Act for drugs with no therapeutic value and high potential for abuse, to the slightly less restrictive Schedule II, was denied. Grinspoon poignantly asks: «Would the outcome have been different if a large pharmaceutical company with enormous resources had a commercial interest in cannabis?» (Grinspoon, Bakalar 1993, p. 14).

In 2024, more than half a century after that BNDD hearing, proceedings to move cannabis from Schedule I to Schedule III were initiated. This is a decision that, while cautiously welcomed as a partial correction of an obsolete and unscientific classification, raises doubts about whether, absent a billion-dollar industry already invested in cannabis, such a development would have been delayed much longer. The DEA has scheduled public hearings to discuss the transfer of cannabis to Schedule III for December 2, 2024; the list of experts and stakeholders permitted to participate has not yet been disclosed. However, it is certain that this time, many white-collar representatives will occupy the witness stand—bringing with them the solid and convincing arguments that Grinspoon, his colleagues, and their patients, despite the strength of their testimonies, evidently lacked at the time.

Will profit, therefore, be the most formidable vector of regulatory change in drug policies—the «stone guest» at every contemporary discussion on reform—that undermines the prohibitionist paradigm first at the national and then at the international level? It is a plausible scenario. But is it a desirable one? Given historical precedents, probably not. Overcoming prohibition through the ascendancy of poorly regulated markets risks simply

replacing one form of injustice—criminalization—with another: a commodification of substances that prioritizes profits over public health, human rights, and social equity. Entrusting the production and distribution of certain substances to a poorly regulated market and its dominant players would indeed mean overcoming prohibition, but it would also risk betraying the very rationale for doing so: not to boost corporate stock prices, but to reduce the social harms exacerbated by criminalization, to deprive criminal organizations of a major source of profit, to safeguard human rights, and to advance the objectives set out in numerous international conventions and in the 2030 Agenda for Sustainable Development.

Beyond prohibition

Legalization—like prohibition, decriminalization, and depenalization—is not a monolith. Legalization is, in itself, the process through which an act or behavior previously deemed illegal becomes legal. However, legality does not imply the absence of regulation: in the vast majority of countries, alcohol is legal, yet its production, sale, and even consumption are subject to regulation; the same applies to tobacco.

Both alcohol and tobacco possess psychoactive effects, can lead to abuse, pose significant risks to public health, and lack therapeutic utility. By any reasonable definition of «drug», alcohol qualifies as a drug—and so does tobacco, albeit with a milder psychoactive effect, particularly for individuals who are not already addicted. Their exclusion from the schedules of international drug control conventions is not attributable to their intrinsic characteristics, but rather to the temporal, geographical, economic, and social circumstances surrounding their adoption and diffusion.

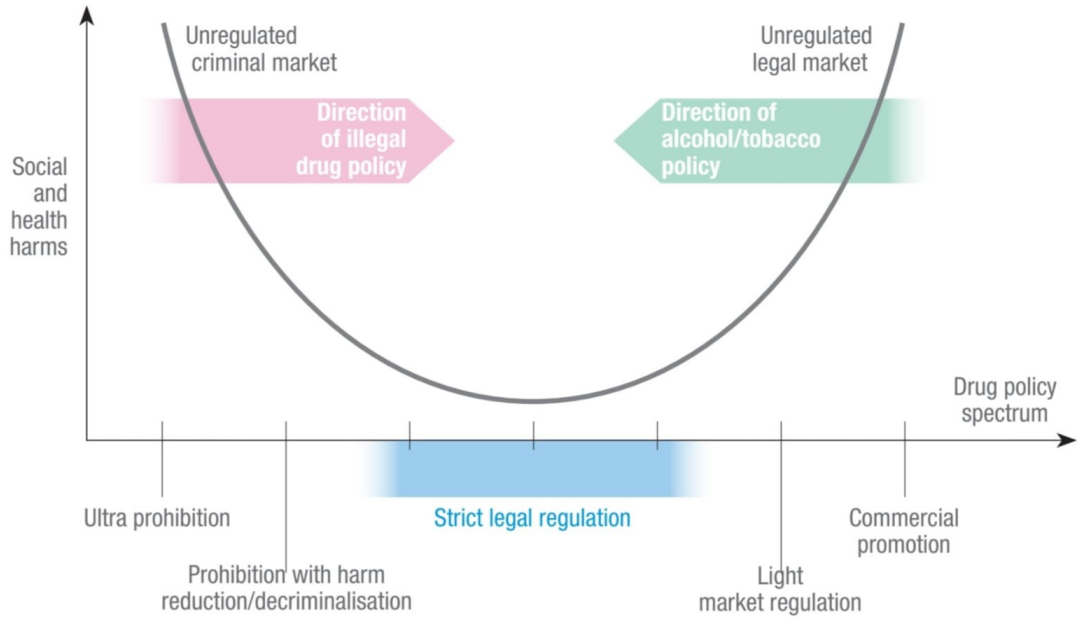
Those same circumstances shaped the divergent regulatory paths of alcohol and tobacco consumption (and subsequently their respective industries) compared to other psychoactive substances.

The anti-vice campaigns of the temperance movements, which reached their peak between the late nineteenth and early twentieth centuries, succeeded in imposing strict controls on newly introduced or culturally «alien» substances but failed—except for limited and transient episodes—to restrict socially integrated substances such as alcohol, long known in Europe, and tobacco, originally from the Americas but highly valued in Europe since the sixteenth century and, by the eighteenth century, already the focus of a thriving global industry.

Thus, alcohol and tobacco «escaped» the fate of criminalization and remain legal in most countries today. Can the regulatory models governing these

substances serve as templates for the future regulation of currently illicit drugs? The answer is: yes—and no.

Both alcohol and tobacco, as well as other substances, foremost among them cannabis, have been subject to increasingly stringent regulation in recent years—but from opposite starting points: a legal yet poorly regulated market for alcohol and tobacco, versus an illegal and therefore inherently unregulated market for cannabis and other drugs.



Source: Transform Drug Policy Foundation 2020, p. 23.

Today's legislators enjoy a twofold advantage.

The first is that of having the cautionary example of two legal yet poorly regulated markets—and their consequences. For decades, the alcohol and tobacco industries commissioned spurious scientific studies denying the harmful effects of their products on health; financed politicians and political parties to forestall more stringent regulations on sales, taxation, and packaging; and carried out marketing campaigns specifically targeting young people. Lobbying activities are, of course, not exclusive to the alcohol,

tobacco, or pharmaceutical industries, but represent an intrinsic flaw of the capitalist production system, in which the ruling class owns and/or controls the means of production and mass media, and exerts an influence on governments, parliaments, and international institutions far greater than it would in a truly democratic system. If countermeasures against these oligarchic tendencies are always necessary, they are even more so when we propose to regulate a sector as sensitive as the production and sale of substances capable of generating addiction and negatively impacting consumer health. The failures of the past leave today's policymakers with no excuse for inaction or negligence: they can and must learn from history. The history of the alcohol and tobacco industries, purchased at a high social cost, offers an essential lesson.

And this leads to the second advantage: the legal drug supply chain, at the regulatory level, must be built from scratch. While stricter regulations on alcohol and tobacco have encountered resistance from powerful industries unwilling to sacrifice profits, the regulation of drugs offers the opportunity to prevent similar problems by excluding, or at least strongly limiting, profit motives from the outset. We can establish stringent regulations from the beginning—starting with a level of caution that some may view as excessive—and only gradually introduce greater freedom as circumstances permit, always maintaining robust safeguards, continuous policy evaluation, and a prudent distance from the commercial model adopted in some U.S. states for cannabis. Yet this will require maintaining an exceptionally delicate balance: regulation must be rigorous enough to protect public health and disincentivize problematic consumption, while remaining sufficiently pragmatic to outcompete illicit markets.

Regulation should be substance-specific, or at least tailored to groups of substances. For naturally occurring drugs such as cannabis, mushrooms,

truffles, and hallucinogenic cacti, the Uruguayan model already in force for cannabis could serve as a blueprint, allowing three mutually exclusive sources of supply: home cultivation, associated cultivation, and purchase in authorized pharmacies.

Various restrictions could be imposed: on the varieties and quantities that can be cultivated and purchased; on the quantity that can be kept at home and in public; on wholesale and retail prices (from authorized growers to pharmacies, and from pharmacies to customers); on the non-profit nature of cannabis clubs; on membership numbers; on age of access; on pesticide use; on distribution methods; on minimum distances from schools and rehabilitation centers; on mandatory information provided to members or consumers; and on the prohibition of promotional activities.

The legislation must be clear and stringent, and prices must be adequate: legislation that is too lax risks fueling increased consumption—including problematic use and use among young people—whereas legislation that is too harsh may fail to compete effectively with the black market. A delicate balance will therefore be essential to ensure the success of reform efforts.

However, regulating synthetic drugs such as MDMA, amphetamines, and cocaine poses even greater challenges. This is not only because of the higher risks associated with the use of these substances compared to natural cannabinoids and hallucinogens, but also because their production and distribution would necessarily involve private companies, whose statutes prioritize profit-making.

Production and sales should be restricted to authorized companies and pharmacies; production volumes and prices should be strictly fixed; promotional activities should be completely prohibited; packaging and product quality should be subject to rigorous standards. These would be only some of the safeguards the public authority would need to impose if it truly

wished to pursue a legalization pathway without repeating the mistakes of the past.

Further elaborating the legalization proposal would go beyond the scope of this thesis. Authors such as MacCoun, Reuter, Rolles, and the Transform Drug Policy Foundation (2009, 2020, 2022, 2023) have already developed sophisticated and detailed proposals for the regulation of cannabis, stimulants, psychedelics, narcotics, benzodiazepines, and barbiturates—certainly in a more comprehensive manner than could be achieved within the few pages or lines available here.

What is certain, however, is that for many proponents of legalization, the fall of the prohibitionist paradigm would by no means imply the end of control. Rather, their foundational premise is not that drugs are harmless to public health, society, or individuals, but that, despite the risks and despite the stigma of criminalization, millions of people around the world continue to use them. Legalization, therefore, would not signify the abandonment of governance, but the redefinition of governance in rational, evidence-based terms.

The objective of legalization would thus be the achievement of the very control that prohibition has failed to deliver: an extensive public regulation of the production and distribution chain—currently dominated by criminal enterprises—and an approach to consumption centered on the physical and mental health of people who use drugs, rather than on their moral or criminal condemnation.

In this perspective, legalization is not the negation of control, but the necessary reorientation of it: away from punitive ideologies and towards health, human rights, social justice, and sustainable development. Such a model today appears to be the only path consistent with the principles enshrined in the Charter of the United Nations, in the preambles (if not all

the operative articles) of its international drug control conventions, and in the 2030 Agenda for Sustainable Development.

«Any questions?»

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