# Drug control and public health: getting beyond stalemate

Robin Room is a member of a drugs policy modelling group that uses data to project what would happen to the harm caused by illicit drugs if policies or conditions changed. He talks to Fiona Fleck about alternative scenarios to today's illicit trade in drugs and the implications of different scenarios for public health.

Courtesy of Robin Room

Robin Room

Robin Room is professor of Population Health and Chair of Social Research in Alcohol in the School of Population Health at the University of Melbourne and he directs the Centre for Alcohol Policy Research at Turning Point Alcohol and Drug Centre in Melbourne, Australia; posts he has held since 2006. He is also a professor at the Centre for Social Research on Alcohol and Drugs at Stockholm University, Sweden, and has been since 1999. His work researching the harm wrought by addictive substances – particularly alcohol – spans three continents and five decades. He started his career as a researcher in California, where he earned his PhD in sociology in 1978.

*Q: Six former presidents and other prominent figures have called repeatedly over the last couple of years for an end to "the failed war on drugs". The group, which calls itself the Global Commission on Drug Policy, believes that the global drug prohibition regime needs to be reformed. Last October, the London School of Economics released a report also arguing that the global war on drugs had failed. Do you agree with this assessment?*

A: Looking at the evidence about the period since the United Nations' 1961 Single Convention on Narcotic Drugs, most scholars agree that forbidding a legal market for nonmedical use has not worked. While nations differ in their demand for particular drugs, there is a substantial demand nearly everywhere for nonmedical use of psychoactive substances. The system has failed to channel that demand exclusively into legal alternatives – which in most places, ironically, would include alcohol and tobacco.

*Q: How did we end up with this state of affairs?*

A: Current international drug control policies are derived from the original drug treaties starting in 1912, which were a by-product of the international temperance movement against alcohol. Today's situation reflects a political settlement made in the middle of the 20th century and the treaties are worded so inflexibly that they cannot readily be adjusted to current conditions.

*Q: Given these international agreements, are evidence-based drug policies feasible?*

A: There are examples of evidence-based policy in many high-income countries and a few middle and low-income countries, particularly in treatment. Maintenance on methadone or buprenorphine to substitute for heroin and other opiates has a considerable evidence base documenting effectiveness in reducing HIV transmission, illicit drug use and criminal behaviour, and facilitating reintegration. The provision of opioid substitution treatment reflects pragmatic policy decisions based on evidence, often in the face of considerable resistance on moral or ideological grounds. In the areas of prevention of drug use and the resulting harms associated with it and drug control, evidence-based policy is much less common.

*Q: What has been the outcome of prohibiting drugs?*

A: In the decades after the Second World War, the drug control treaties were greatly extended in scope. Criminalizing the trade in prohibited substances has made the black market highly profitable. Yet research in biomedicine, epidemiology and psychopharmacology shows that alcohol and tobacco are among the most harmful of the psychoactive substances, so that the mid-20$^{th}$-century decision to permit the trade in alcohol and tobacco but prohibit trade in other drugs has turned out to be a disastrous choice in terms of public health.

*Q: Should countries return to international prohibition for alcohol and tobacco?*

A: No. Although alcohol and tobacco are two of the three main risk factors for many noncommunicable diseases, prohibition of them would reproduce the problem of the illicit markets we already have for drugs. International conventions on drug control need to be revised to take account of the evidence on the harm caused by alcohol and tobacco that has emerged in recent decades. These products need to be brought under stricter international controls. Political resistance to including alcohol and tobacco in international drug conventions is inevitable, as there are substantial economic interests in their sale and promotion.

*Q: How free are countries to formulate their own drug control policy and drug dependence treatment programmes, given the terms of international treaties?*

A: The drug treaties are unusual among international agreements in the extent to which countries have signed away any right to make their own decisions about domestic matters. For instance, the 1998 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances requires countries, subject to their constitutional principles, to make possession of the drugs for personal use a criminal offence.

*Q: What are the problems with such provisions?*

A: Countries are restricted in what they can do to formulate their own drug policies, although some push at these boundaries, by decriminalizing personal possession and use. One area where countries have considerable choice is with regard to treatment programmes as any references to these in the treaties are generally in terms of encouragement. Even here, however, the international

control system has tried to limit options, for instance by arguing that medically supervised injection facilities are not allowed under the Conventions.

*Q: What are the implications of Bolivia's withdrawal from and subsequent re-admission to the 1961 United Nations' Single Convention on Narcotic Drugs over whether chewing coca leaves should be criminalized?*

A: When it announced its withdrawal, Bolivia said it would seek to re-accede with a reservation with respect to coca leaves, and its re-accession on this basis has recently been accepted. While such a path seems complicated and dramatic, it was the only legal way for Bolivia to get the small tweak it was seeking in its relation to the international drug treaties. This is one path to change, another would be for like-minded countries to adopt a new treaty.

*Q: Is legalization of illicit drugs feasible?*

A: Not under the current treaties, except for medical use. But, of course, it is feasible, as the USA proved, for instance, when it ended alcohol prohibition. Legalization does not mean removing all controls on the market. A total lack of control would not exist for any commodity in a modern state. One approach would be through a drug control system in parallel to the alcohol control system, which exists in many countries. At a minimum, this usually includes specific licenses to produce, distribute and sell the products, and conditions on time, quantity, formulation and other aspects of sale. Or the state itself might take on the role of retail sales, as is true in several countries for retail sales of alcohol. There is more than a century of detailed experience with a variety of such arrangements, from highly restrictive to highly permissive environments.

*Q: Would this solve the public health problems of illicit drug use?*

A: No, no policy choice will remove all the public health problems. But, in my view, a highly controlled legalized market would reduce the overall burden of health problems caused by these drugs. There is no question that such controlled market arrangements can be made to work, and that they can provide effective competition which, over time, reduces any competing illicit market to inconsequential size. In addition, it would be wise to forbid any advertising or other promotion of the products. The lessons of alcohol and tobacco are that restrictions and other controls on the market can indeed limit drug consumption and reduce harm, but that drugs should be exempted from any free-trade treaties and provisions, and that the commercial interest in increased sales and, in turn, increased use should be neutralized as far as possible.

*Q: What are the obstacles to a legal domestic market for nonmedical use of these drugs?*

A: Such a drug control system would not be in compliance with the current drug conventions. Its existence would depend on either substantial amendment of the treaties; the country involved leaving the treaties, perhaps re-acceding with reservations if allowed by other treaty parties; or turning a blind eye to the treaties. Given the wider network of international obligations, this last option would be most easily implemented in a powerful country.

> "…the policy window can open. When it does, research suddenly becomes the basis for policy change."

*Q: If a country were to go that way, how would it deal with an inevitable thriving black market in these drugs?*

A: Past experience with prohibitions of alcohol shows that a legal drug market would not immediately eliminate a parallel black market, but it would offer effective competition to it unless the taxes on the legal product are set too high. The alcohol experience was that parallel black markets declined over time and are inconsequential in most high-income countries today. The main threat to effective control in a legal market is not from black market interests but of the legal industry influencing politics over time to increase availability and, in turn, profitability.

*Q: Do governments heed the advice of groups such as the Drugs Policy Modelling Group in Sydney, of which you are a member?*

A: There are examples of research that has influenced policy. Studies of the effects of decriminalizing illicit drug possession and use, for instance in the Czech Republic and Portugal, have been influential in current policy discussions in many countries. The modelling by researchers at Sheffield University of changing alcohol prices or taxes has been crucial to moves in the United Kingdom of Great Britain and Northern Ireland to set minimum prices for alcoholic drinks. However, evidence-based advice can be solicited by governments and then rejected. This happened with the Shafer Commission's advice on cannabis to President [Richard] Nixon in the USA, and the Roques panel's advice on alcohol and cannabis to the state secretariat for health in France in 1999. But the policy window can open. When it does, research suddenly becomes the basis for policy change. It seems we are in such a moment now for the international drug control system. Particularly in Latin America, from Guatemala to Uruguay, governments are calling the current system into question, and coming to researchers for evidence and advice on alternatives.

*Q: Why do many politicians continue to resist considering alternatives to the war on drugs?*

A: Never underestimate the power of the status quo and the vested interests in it. For more than 100 years, an international drug control system has been built up with increasing emphasis on criminalization and law enforcement. Those within the system understandably fear change. Moreover, drugs have been an instrument of foreign policy for powerful countries in recent decades, and poorer countries have often manoeuvred to get international aid given as part of the war on drugs. No matter how badly things are going, one can always argue that any alternative to the current international system of drugs control would be worse. And we are dealing with what are sometimes called wicked problems, where all policy options have downsides. Yet, it is hard these days to find a serious scholar contending that the global war on drugs has been a success. ■



*Bull World Health Organ* 2013;91:91–92 | doi:10.2471/BLT.13.040213