Cannabis and the Psychedelics: Reviewing the UN Drug Conventions

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Psychoactive Substances and the Origins of Regulation

The three United Nations drug conventions of 1961, 1971, and 1988 oblige almost every country in the world[1] to criminalize the production, trade, and possession of psychoactive substances originating from three plants—the opium poppy, cannabis and coca leaf—as well as from other sources. The unintended consequences of these conventions have been devastating worldwide. They have resulted in millions of otherwise innocent people being criminalized and imprisoned, ruining their career prospects and life chances; facilitated the spread of AIDS and hepatitis C; fostered an illegal market which is estimated to be the world's third-biggest industry (after food and oil, worth around $350 billion per year), empowered ruthless, transnational criminal organizations; destabilized nation states through violence and corruption; enabled the widespread curtailment of basic human rights; caused tens of thousands of deaths each year in an unending "War on Drugs"; required the expenditure of hundreds of billions of dollars of taxpayers' money on enforcement; and created a regulatory regime so draconian that 80 % of the world's population now lack access to the pain-killing medicines they need (World Health Organization [WHO] 2009).

Prohibitionism is a relatively new phenomenon, but the practices it seeks to proscribe and regulate are as old as human culture itself. The human mind underwent an extraordinary change between around 70,000 and 50,000 years ago.

[1] The only countries which are not parties to the 1961 Convention and/or the 1971 Convention are South Sudan (which became a nation only in July 2011 and still has no stable institutions of state), Equatorial Guinea (with a population of well under a million), and a handful of tiny Pacific island nations. Countries outside the 1988 Convention include many of the above, plus the significantly larger countries of Somalia and Papua New Guinea.

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We developed language, an aesthetic sense, and a spiritual propensity. After a hundred thousand years of making flint arrowheads, we rapidly progressed to producing beautiful and inspired art.

Cave paintings, dating back 35,000 years or more, show evidence that artists had experienced the psychedelic state. In historical times, the religions and spiritual practices of Ancient Egypt, India, Mesoamerica, and others included changing states of consciousness. The Eleusinian Mysteries of the cult of Demeter, one of the foundation stones of Greco-Roman culture, and hence of modern Western civilization, had at its core the ingestion of a psychedelic potion, most probably based on ergot. In modern times, too, psychoactive substances play a central role in the traditions of many indigenous and religious groups: the *ayahuasqueros* of the Amazon basin, the bhang drinkers of Hindu tradition, the Aymara coca chewers of the Andes, the peyote-gathering Wixáritari, the khat users of East Africa and Arabia, the ganja-smoking adherents of Ras Tafari, the iboga-eating Bwiti of West Africa, and many others. (For more information on ayahuasca, see: Feeney and Labate, this volume.) These and other users have found that the altered state of consciousness induced by these drugs is conducive to spiritual engagement and development, and to the creation of social bonds.

Over the past 3,000 years, the consumption of cannabis in particular has spread across Asia, the Arab world and Africa, reaching Europe and the USA only in modern times. By the mid-nineteenth century cannabis, apart from its role as a popular medicine, was used by small groups of intellectuals, particularly in France, where a hashish-eating club was established in Paris, patronized by writers and artists such as Baudelaire, Dumas, and Delacroix. However, apart from the activities of this bohemian minority, cannabis use remained largely the preserve of traditional peoples. The recreational use of cannabis in the West did not take flight until the 1960s, when it became identified with the anti-Vietnam war movement and the emergence of the counter-culture. Nowadays, it is prevalent, particularly among the youth in many developed countries. The adoption of cannabis and psychedelics by the youth of the West set in motion a violent official reaction against these drugs and the people who used them.

The prohibition of psychoactive substances, initiated by the Opium Convention of 1912, had started as an attack on the habits of minority groups such as Chinese-Americans, African-Americans, and Hispanics. In the following years, other treaties followed, culminating in the consolidating UN Single Convention on Narcotic Drug*s* in 1961, later expanded and strengthened by the 1971 UN Convention on Psychotropic Substances and the 1988 UN Convention Against Illicit Traffic in Narcotic Drugs.

The aims of these three conventions, expressed in their preambles, are noble and lofty. Declaring themselves "concerned with the health and welfare of mankind," the parties set about formulating an international regime of control which would ensure access to medication "indispensable for the relief of pain and suffering," and would combat the "evil" of addiction to narcotic drugs and the concomitant dangers to society. As recently as 1998, the 20th UN General Assembly Special Session

restated the conviction that prohibition would eliminate the problem, under the slogan "A drug-free world: We can do it!"

Fifty years after the Single Convention came into force, it is evident that the war against "controlled" psychoactive substances, and the people who use them, has been a catastrophic failure. It has not succeeded in its aim of eliminating drug use, and has caused devastating collateral damage resulting in human misery and death. It is time for world leaders to review this issue from the perspective of scientific evidence and common sense.

The UN Drug Conventions: An Impediment to Progress

Two areas in which the possession and use of "controlled" drugs are expressly permitted by the UN Conventions are medicine and science. Nevertheless, in practice, the conventions severely obstruct progress in both fields. In the medical arena, narcotic and opioid medications are indispensable, for example, in the treatment of pain, epilepsy, opioid dependence, and in emergency obstetric care. Because of their status as essential medicines, access is a human right as defined in the International Covenant on Economic, Social, and Cultural Rights (UN 1966). Yet in 2003, six developed countries accounted for 79 % of the total global consumption of morphine (for severe pain), while developing countries, representing 80 % of the world's population, accounted for just 6 %. Around 75 % of people with epilepsy in developing countries, and around 90 % in Africa, do not receive the treatment they need. In developing countries, only about 2 % of injecting drug users, with opioid dependence, receive treatment with methadone or buprenorphine (WHO 2010).

The World Health Organization identifies three key barriers blocking access to these essential medications:

- Limited medical knowledge, including a fear of abuse and dependence;
- Overly restrictive regulations and lack of enabling policies. This category includes the criminalization of injecting drug users, and the imposition of undue controls on the storage and distribution of "controlled" drugs for fear that they will be diverted into the illicit market;
- Supply challenges, including the difficulty of providing accurate estimates of need to the International Narcotics Control Board (INCB), and the complexity of licensing.

It is apparent that all three barriers identified by the WHO are caused by or exacerbated by the prohibitionist system of international control.

In the scientific arena, too, the prohibitionist approach of the conventions acts as a severe impediment. Ethical approval for work with these substances is rarely forthcoming. Indeed, the expectation that approval will be refused deters most of the few scientists who are willing, in principle, to undertake this work from even applying. This is particularly so in the case of LSD which, due to its negative

reputation left over from the 1960s, has yet to be investigated in a modern neuroscientific research setting.[2] Research is further hampered by the cost and complication of obtaining the licenses needed to handle "controlled" chemicals. Similarly, the burdensome regulatory requirements imposed on manufacturers mean that there are very few legal suppliers of clinical-grade psychoactives such as psilocybin or LSD, so that even those scientists who have, exceptionally, obtained permission to use them find them difficult and very expensive to procure. Furthermore, the power of the taboo means that academic institutions are often reluctant to become involved in research involving "controlled" substances, fearing a backlash in the popular press. Funders, too, are wary of becoming associated with such research.

This deficit in scientific research is an enormous problem. Without scientific investigation, there can be no understanding of how psychoactive drugs work and of what they can tell us about consciousness; no sound evidence on which to base harm-reduction strategies and other policy decisions; and no exploration of the potential medical and therapeutic benefits that many "controlled" drugs may provide. It was to overcome these problems that in 1998, the Beckley Foundation Scientific Programme was established.

Psychoactive Drugs in Science and Medicine

Despite the difficulties placed in the path of scientific research by the combination of the conventions and the effects of the societal taboo, there have, in the past few years, been some important developments in the study of cannabis and the psychedelics, initiated and sponsored by organizations including the Beckley Foundation, the Heffter Research Institute, the Multidisciplinary Association for Psychedelic Science (MAPS), and others.

A review of the findings is beyond the scope of this chapter, but detailed below are a few highlights of the recent studies in which the Beckley Foundation has been involved. In 2012, the Beckley Foundation/Imperial College Psychedelic Research Programme published results from a series of studies that used the latest fMRI and MEG brain-imaging technology to investigate changes in cerebral blood supply and brain function following the injection of a dose of psilocybin in comparison with a placebo. Contrary to expectations, the findings showed for the first time that psilocybin acts by decreasing the flow of blood to the brain, and especially to the "default mode network" (DMN), a system of interconnected brain regions responsible for coordinating and filtering the flow of information through the brain

[2] In 2007, The Beckley Foundation, working in collaboration with University of California, Berkeley, obtained the first approvals in modern times to use LSD with human participants. However, due to unforeseen difficulties involving the principal investigator, the study was not completed.

(Carhart-Harris et al. 2012a). The research provides a neuroscientific underpinning for the metaphor, popularized by Aldous Huxley, of the brain as a "reducing valve" whose censoring activity is limited by psychedelics, which constrict the blood supply to those brain hubs involved in censorship (Huxley 1954).

The DMN is shown to be active when people are not performing any specific task, and particularly when they are engaging in self-reflection. Certain centers of the DMN are chronically over-active in depression, an illness characterized by excessively rigid ruminative thought patterns. The fact that psilocybin reduces the activity of these centers by throttling back their blood supply, raises the possibility that it may be a valuable new avenue of treatment for chronic depression that would allow dysfunctional thought patterns to be reset. The program has now received a large government grant from the UK's Medical Research Council to study this possibility. Other regions of the DMN are overactive in cluster headache, a particularly agonizing condition that is notoriously hard to treat. Our findings reinforce the anecdotal evidence that LSD and psilocybin are among the few treatments to provide effective relief.

The brain imaging results complemented subjective reports of vivid and lifelike memories under psilocybin by showing that psilocybin, but not placebo, activates areas of the brain responsible for visual and other sensory processing. This finding also points to the potential value of psilocybin as an aid to psychotherapy, showing how it may help patients to access, vividly relive, and process painful memories (Carhart-Harris et al. 2012b).

The Beckley/Imperial program is continuing with a broadly similar series of studies into the effects of MDMA. At the time of writing, the results have not been published;[3] however, preliminary results show that, in response to positive memory cues, MDMA increases the activation of brain regions involved in visual and other sensory processing. In response to negative memory cues, it decreases the activation of brain regions involved in anxiety and fear response, enabling the subject to more easily access these memories and to work through them, thereby releasing the negative charge left by trauma.

These findings complement previous MAPS-supported work on MDMA-assisted psychotherapy as a potential treatment for post-traumatic stress disorder (PTSD) (Mithoefer et al. 2011). At the time of writing, a Phase 2 pilot study is under way in the USA with veterans from the Armed Forces, firefighters, and police officers as subjects. The brain-imaging results mirror the subjective experience of particularly vivid recollections under MDMA, and provide a neuroscientific rationale for the psychotherapeutic studies by showing that MDMA can allow people to access painful memories without the overwhelming emotional response characteristic of PTSD.

The Beckley Foundation's brain-imaging studies at Imperial College also complement their collaboration with Johns Hopkins University, where the Beckley and Heffter Foundations are working with Dr. Roland Griffiths and his team on a pilot study investigating psilocybin-assisted psychotherapy in overcoming

[3] This research was recently featured live on UK television (Murdoch 2012).

treatment-resistant addiction; in this case, to nicotine. This is a small pilot study, but so far, the results have been extraordinary, with an unprecedented success rate of almost 100 %.[4] This initial study is in need of government funding in order to carry out a much more extended double blind clinical trial.

An earlier series of studies, in collaboration with Dr. Paul Morrison at the Institute of Psychiatry at King's College, London, highlights the important protective effects of CBD (cannabidiol) against short-term psychotic symptoms and memory impairment caused by THC (Englund et al. 2013). Modern breeds of street cannabis are bred to be high in THC, with little or no CBD; a composition that we would expect to carry a particularly high risk of harm. This state of affairs cannot be avoided under the present prohibitionist regime. An inevitable consequence of prohibition is that it creates illicit supply channels; and an illegal market is a completely unregulated market. This theme will be revisited later in the chapter.

Cannabis: The Elephant in the Room

Over the course of many years' work in drug policy at national and international levels, we reached the conclusion that the treatment of cannabis (and the psychedelics, considered below) is highly anomalous. Cannabis accounts for three-quarters of illicit drug use, according to UN estimates (United Nations Office on Drugs and Crime 2012), and is thus the mainstay of the War on Drugs, supporting huge interdiction and enforcement efforts. In the USA, for instance, some 800,000 people are arrested each year for cannabis offenses, and worldwide there are many millions of people in prison for personal possession. Cannabis is listed in Schedule IV of the UN Single Convention. Although the convention does not formally define what that listing means, the European Union characterizes drugs in Schedule IV as "the most dangerous substances, already listed in Schedule I (i.e., addictive drugs with a high risk of abuse), which are particularly harmful and of extremely limited medical or therapeutic value" (European Monitoring Centre on Drugs and Drug Addiction [EMCDDA] 2012a).

Yet, despite the severity of this classification, cannabis attracts barely a mention in the meetings and publications of the UN and other international bodies. Without cannabis, the War on Drugs would collapse: since only around 1–1½ % of the world's population use all the other illicit drugs combined, the expenditure of hundreds of billions of dollars would be impossible to justify.

[4] Typically only about 4–7 % of those aiming to quit smoking are successful. Most medical intervention studies report success rates of around 25 % (source: The American Cancer Society website. Retrieved February 13, 2013 from http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/guide-to-quitting-smoking-success-rates.

The work of the Beckley Foundation's Global Cannabis Commission highlighted this anomaly and explored how it could be resolved. The commission brought together five of the world's leading scholars to examine the legal position of cannabis in jurisdictions around the world, as well as at UN level, to review the latest scientific evidence surrounding cannabis and the policies that control its use, and to develop proposals for policy reform.

The Commission's Report (Room et al. 2008) was presented and discussed at the Beckley Foundation's international meeting at the House of Lords in 2008, and its findings were re-published in book form (Room et al. 2010) in collaboration with Oxford University Press, with an endorsement by President Fernando Henrique Cardoso of Brazil, whose thinking was influenced by the report's findings. The commission's conclusions included the following:

- The probability and scale of harm among heavy cannabis users is modest compared with that caused by many other psychoactive substances, both legal and illegal, in common use; namely, alcohol, tobacco, amphetamines, cocaine, and heroin.
- Variations in the rates of cannabis use within and between countries do not seem to be much affected by the probability of arrest or by the penalties for use or sale, however draconian. The widespread pattern of cannabis use indicates that many people gain pleasure and therapeutic or other benefits from use.

The Commission's analysis led to a series of recommendations, which are discussed later.

Psychedelics and the Trap of Insufficient Harm

If cannabis is the elephant in the room, hugely important in policy terms but barely discussed at international meetings, then psychedelics are the mouse, ignored simply because they are barely noticed. This may seem a strange statement to make about a class of drugs with such potency and profound effects as the psychedelics. Indeed, it cannot be denied that LSD and other psychedelics carry a risk of harm when inappropriately used without a proper context. The most serious risk is the possibility that, in a small fraction of cases, use may trigger a psychotic episode.

On the other hand, psychedelics such as LSD and psilocybin are not addictive, which, among other things, means that there is no social problem from crime because of dependent users. They lack the acute toxicity of, say, alcohol, heroin, and cocaine, all of which, from time to time, cause death by overdose. And long-term use does not give rise to the chronic toxic effects of, say, tobacco or alcohol. For all these reasons, it is fair to characterize the psychedelics as presenting a low risk of problem use, which partly accounts for the fact that they are so overlooked in policy discussions.

This insufficiency of harm, I would argue, has created a regulatory trap in which the psychedelics are caught. They are classed alongside the most harmful drugs: for example, in the UK, LSD, psilocybin, and MDMA are in Class A of the Misuse of Drugs Act 1971, along with heroin and cocaine.[5] Indeed, the controls on legal possession for science or medicine are more stringent for psychedelics (in Schedule 1 of the Misuse of Drugs Regulations 2001) than for heroin and cocaine (Schedule 2),[6] as it is claimed that they have no medical application. Yet, it is precisely because psychedelics do not figure in crime or health statistics that there is no compelling reason to re-examine their status. And so they languish in the most restrictive class, with all the consequences that this implies for the advancement of scientific and medical knowledge.

The "Legal Highs"

The newer synthetic psychoactives—the so-called "legal highs"—present particular problems for regulators. New substances emerge onto the market at an ever-increasing rate: 150 were identified by the EU in the whole of the period 1997–2010, but 24 of these appeared in 2009, and 41 in 2010 (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA] 2011a); in 2011, 49 new substances were reported (EMCDDA 2012b). These substances are frequently sold online, and there is evidence of a rapidly expanding marketplace. The number of online shops offering "legal highs" for sale in Europe more than doubled from 314 to 631 between January 2011 and July of the same year (EMCDDA 2011b).

Many such substances appear to carry a low risk of harm, although for a government to safety-test them all would be prohibitively expensive. On the other hand, it is not justifiable to ban them simply because they are used recreationally. Since November 2011, the UK Home Secretary has had the power to make a "temporary drug class order," effective for up to 12 months, while consideration is given to classifying the substance under the Misuse of Drugs Act. So far, the power has been used only once (for methoxetamine), and the classification procedure means that, in principle, a drug should not be assigned to the temporary class unless there is genuine concern about its safety.

The recent proposal by New Zealand's Associate Health Minister Peter Dunne concerning the regulation of "legal highs" represents an attempt to balance, on the one hand, the right to produce and use psychoactive substances with, on the other hand, the need to protect public safety. Under the proposal, manufacturers would

[5] The US Classification system takes a similar route, with psychedelics classified as Schedule 1. Drugs in this classification have a high potential for abuse, no currently accepted medical use, and are unsafe for use under medical supervision.

[6] For the Home Office list of substances controlled under the Misuse of Drugs Act and the Misuse of Drugs Regulations, see http://www.homeoffice.gov.uk/publications/alcohol-drugs/drugs/drug-licences/controlled-drugs-list?view=Binary.

have to conduct safety testing at their own expense before a drug could be brought to market. If testing revealed no significant safety concerns, then a license could be given for sale of the drug. The suggestion has the merit that it closely resembles the routine procedure for licensing prescription medicines: This familiarity should lend the proposal public acceptability.

Such a regime would free governments from the impossible burden of safety-testing every new substance as it appears on the market, while at the same time allowing drugs to enter legal circulation if they are shown to pose a low risk. A procedure that would provide for the regulated supply of, say, an MDMA analogue once it had been proven safe, would surely give better protection to the youth than the current system. A recent UK/USA survey found that one-fifth of respondents aged between 18 and 25 had, in the previous year, taken a mystery white powder without knowing what it was or what it was originally sold as (Global Drug Survey 2012). In an unregulated market, when an individual has a bad reaction to an unlabeled substance they have ingested, the medical professionals have no idea how to treat the symptoms, thereby increasing the risks of serious harm or even death. (For more information on salvia, see O. Hayden Griffin III, *Salvia divinorum*: Hallucinogens and the Determination of Medical Utility, this volume.)

Reforming the UN Drug Conventions

I have argued that the present prohibitionist system of international control has both stifled access to medicines and scientific research into "controlled" drugs, and has also trampled on the traditional spiritual practices of many groups, and therefore indirectly on Article 18 of the Universal Declaration of Human Rights (UN 1948). Moreover, Prohibitionism has ensured that markets in many psychoactive drugs are completely unregulated.

Some steps towards reform are possible within the latitude, or "wriggle room," allowed under the conventions as they stand. However, such reforms often operate within a legal grey area. For example, the Netherlands makes a plausible legal argument to justify its policy of tolerating the sale, purchase, and consumption of cannabis in "coffee shops" by according it the lowest judicial priority, although it remains an offense. On the other hand, because of the requirements of the conventions, there is no legal avenue to regulate the wholesale supply of cannabis to coffee shops. Thus, for over 30 years, the Netherlands has been caught in the "back door" syndrome, where retail sale of small amounts is *de facto* legal, but the provision of the cannabis for sale is illegal. This puts the police in an impossible position, as Jan Wiarda, former Head of Police in the Hague and Chair of the European Chiefs of Police, pointed out in two Beckley Foundation seminars (Wiarda 2002, 2004).

A number of European countries provide clean injection facilities where users may inject themselves using sterile needles without fear of prosecution. Countries adopting this policy argue strongly that it is permissible under the conventions on

public health grounds. The INCB, on the other hand, argues equally vociferously that the policy, and other moves towards liberalization, are not:

> A number of States parties are shifting towards more lenient national drug policies that are not in line with the international drug control treaties. For example, some States parties have permitted the use of "safer crack kits," the existence of so-called "coffee shops" and the establishment and operation of so-called "drug injection rooms." The Board has warned that such policies promote social and legal tolerance of drug abuse and drug trafficking and therefore contravene the international drug control treaties. (INCB 2011a)

The recommendations of the Global Cannabis Commission included the following, which can be implemented without modifying the Conventions:

- In response to the evidence that more than minimal enforcement of prohibition does little to reduce cannabis use, the primary concern of any policy should be to mitigate the harms that have been produced by the prohibitionist approach.
- The enforcement of laws against cannabis use and possession should be a very low priority for the police.
- Violations should be processed administratively outside the criminal justice system.

However, the conventions are a serious impediment to more thoroughgoing policy reform, such as the creation of a legal, regulated, and taxed market for, say, cannabis. By mandating a series of legislative provisions that must be adopted by all signatories, they prevent policy experimentation and thereby stifle the creation of an evidence-base. Moreover, the cumbersome amendment mechanism and the effective need for unanimity before amendments are adopted make it difficult, if not impossible, to respond to changing circumstances which, since 1961, have included the emergence and spread of AIDS and the discovery of multiple medicinal uses for cannabis and its constituents, as well as the insights from the above-mentioned brain-imaging into the effects and possible therapeutic uses of psychedelics. Whatever the original intention of the conventions, it is therefore clear that their current operation is ideologically, rather than empirically, driven. Even allowing for the most liberal interpretations of the conventions, and the most expansive view of the allowable room for maneuvering, it is clear that certain reforms would go well beyond the available latitude. Among the recommendations of the Global Cannabis Commission's Report in 2008, was that the international drug control regime should be amended in order to allow a state to adopt, implement, and evaluate its own cannabis policy within its borders.

The commission explored in detail the changes in treaty wording that would be required in order to effect two policy reforms: (1) clear and explicit decriminalization of the personal cultivation, possession, and use of cannabis; and (2) the creation of a legal, regulated market. As a contribution to the discussion and implementation of policy reform, the commission proposed a new *Draft Framework Convention on Cannabis Control* (Room et al. 2008), based upon the WHO's *Framework Convention for Tobacco Control* (WHO 2003). The Commission also examined the process by which the reforms that it suggested could be brought about.

More recently, the Beckley Foundation has commissioned *Roadmaps to Reforming the UN Drug Conventions* (Room and Mackay 2012), which expands

the Global Cannabis Commission's work by showing how the conventions could be amended in order to permit countries to (1) clearly and explicitly decriminalize the possession and use of small quantities of one or more "controlled" drugs for personal consumption; and (2) create legal, regulated, non-medical markets in one or more "controlled" drugs. The obvious starting point for reform would be cannabis, but similar principles apply to other substances as well.

The conventions lay down the mechanisms that must be followed when a party wishes to amend them. However, the process is so lengthy and cumbersome that no country has yet managed to have an amendment proposal accepted. After a party proposes an amendment, all other parties have up to 24 months (depending on which convention is under consideration) to object. If there are objections, the Economic and Social Council of the UN may choose to call a conference to debate the proposal (in the case of the 1988 Convention, a conference will not be called unless requested by a majority of parties). An amendment takes effect only if there is unanimous assent or if a conference of parties votes in favor.

The effective requirement for unanimity presents an almost insurmountable barrier to reform, and it is not surprising that there has only ever been one successful amendment, to the conventions: namely, the 1972 Protocol to the 1961 Convention, which strengthened some of its provisions. Other than this, the only attempt to amend the treaties has been by Bolivia, which in 2009, filed a proposal to amend the 1961 treaty by removing coca leaf chewing from its scope. Coca chewing has been traditional among indigenous peoples in Bolivia for millennia. For nearly 20 years, including the date of Bolivia's accession to the convention, the country was governed by a military dictatorship. In 2009, following a referendum, Bolivia adopted a new constitution protecting the rights of indigenous peoples and affirming the status of coca as part of the country's cultural heritage and biodiversity. (For more information, see: P. Metaal, "Coca in Debate," this volume.) In the wake of the amendment proposal, a group of powerful nations, including all members of the G-8, filed objections by the deadline of January 2011.

The *Roadmaps to Reforming the UN Drug Conventions* propose two kinds of mechanism by which a country unable to achieve unanimous agreement for an amendment might nevertheless pursue policy reform. The first is the path of denunciation and re-accession with a reservation, which Bolivia initiated after its attempt to secure an amendment had failed. Parties wishing to make a reservation in respect of certain treaty clauses usually do so at the time of accession, and over 160 such reservations were made in this way to the three drug conventions, by countries including the USA, Brazil, Russia, India, China, Mexico, South Africa, Germany, the UK and many others. Indeed, the principle that reservations should be made at the point of accession is so established that the status of a late reservation, declared *after* accession, is not settled in international law.

A legally less problematic route than a late reservation, is for a country to "denounce" (withdraw from) a treaty and then immediately to re-accede with a reservation. There are a number of precedents from other treaties for this procedure, as discussed in Room (2012). Having failed to secure assent for its proposed amendment, Bolivia therefore denounced the 1961 Single Convention, at the same time expressing its intention to *re*-accede immediately with a reservation on

coca leaf. Bolivia's denunciation took effect on January 1, 2012. Although a handful of countries objected to the reservation, the number of objections received before the deadline fell far short of the one-third of parties (i.e., around 60 countries) that would have been needed to block the re-accession. Accordingly, Bolivia successfully re-acceded, with its reservation on coca leaf, in January 2013.

Although Bolivia ultimately succeeded in achieving its reservation on coca leaf, its decision to denounce the Single Convention drew a vigorous reaction from the INCB, which declared:

> The Board is of the opinion that, while this step by Bolivia may be in line with the letter of the Convention, such action is contrary to the Convention's spirit. The international community should not accept any approach whereby Governments use the mechanism of denunciation and re-accession with reservation, in order to free themselves from the obligation to implement certain treaty provisions. Such an approach would undermine the integrity of the global drug control system, undoing the good work of Governments over many years. (INCB 2011b)

The INCB's view seems surprising given that, upon acceding to the 1971 Convention, the USA, Canada, Mexico and Peru declared reservations for plants traditionally used in "magical or religious rites." These reservations are rather similar to Bolivia's; indeed, more permissive because they are less narrowly delineated. There was no objection to them, and they can hardly be said to have compromised the international drug control system. Moreover, it is hard to understand how the remit of the INCB, which is charged with monitoring compliance with the conventions, can extend to condemning an action that, by its own admission, follows the conventions to the letter.

The backlash against Bolivia was not confined to the drug policy arena: on March 19, 2012, the European Commission decided to "initiate an investigation in order to establish whether the denunciation of the UN Single Convention on Narcotic Drugs justifies a temporary withdrawal of the special incentive arrangement for sustainable development and good governance for products originating in Bolivia" (European Commission 2012). The threat of aid, trade, and financial sanctions by developed countries against poorer countries can seriously inhibit their freedom of action to devise policies better suited to their special circumstances.

A reservation specifies the treaty provisions that a party refuses to accept; the party is still bound by the remaining provisions. For that reason, reservations can only *subtract* treaty wording. *Changes* and *additions* to wording require a different mechanism, which is also outlined in the *Roadmaps to Reforming the UN Drug Conventions*. This second avenue, which provides some safety in numbers, is for a group of like-minded countries to negotiate a new treaty among themselves. Such a treaty, drawn up by a consortium of states with broadly similar views on reform, would clearly be more recent than any of the conventions. For this reason, according to the legal principle of "last in time," the amended treaty would supersede the conventions in those countries that signed it.

The supplementary treaty would also be more specific in its ambit than the UN Conventions, inasmuch as it would cover only certain areas of policy or certain

substances. The legal norm is that a law dealing with the specific case at hand takes precedence over a more general law. For this reason, too, it can be persuasively argued that the new amended treaty would supersede the conventions.

Provision would, of course, need to be made for those countries wishing to remain within the conventions as they stand. States that did not become parties to the new treaty could be accommodated through the usual principles of comity (reciprocity) that govern international relations, so that, for example, no country would export a drug to a country unwilling to import it. For a much fuller development of the arguments and a detailed discussion of specific treaty wording, see Room and MacKay (2012).

Steps Towards Reform

The "legal highs" proposal from New Zealand described above is among several recent reforming developments from around the world. Particularly notable at the time of writing are the initiatives emerging from several Latin American countries, including Guatemala, Uruguay, Colombia, and Mexico. Uruguay never criminalized the possession of drugs for personal consumption, giving the state something of a head start towards the social acceptance of drug use and the liberal reform of its cannabis policies. Decriminalization was formally introduced in 1974, and legislation was updated in 1998 with Law 17.016, in order to clarify some ambiguities. According to Article 31: "Whoever is found in possession of a reasonable amount of drugs meant exclusively for personal consumption, as determined in good faith by a judge, will be exempt from punishment; the judge must substantiate the reasoning behind his/her ruling" (Transnational Institute 2012).

In August 2012, President José Mujica sent a proposal to Congress that would establish a state-run cannabis monopoly, allowing the government to assume control over the production, acquisition, and distribution of marijuana. Under the proposals, marijuana would be sold only to users who register on a government database, allowing the authorities to keep track of purchases made by an individual and, for example, divert particularly heavy users into rehabilitation. The main aims of the bill are to create a divide between the legal and illegal markets, take profits away from the criminal cartels and put them into the hands of the government, and to strengthen the treatment options available for problem drug users. As the Minister of Defense Eleuterio Fernandez Huidobro said some months before the proposal was formally taken to Congress, "It's a fight on both fronts: against corruption and drug trafficking. We think the prohibition of some drugs is creating more problems to society than the drug itself" (Associated Press 2012). If the law passes, government-licensed cannabis cultivation could begin shortly. In order to serve the country's 70,000 cannabis consumers, of whom 18,000 are regular users, the government will need to produce approximately 5,000 pounds of the drug a month, requiring around 150 hectares of land.

The case of Guatemala has been more unexpected, but has the potential to be more far-reaching. President Otto Pérez Molina, a retired general and former head of military intelligence, took office in January 2012 after a tough "iron fist" election campaign. Within days of coming to power, he surprised commentators by calling for a rethink of the country's drug policies and for an examination of all possible avenues for reform, including regulation. Two months earlier, the Beckley Foundation had launched its *Global Initiative for Drug Policy Reform* at a meeting at the House of Lords in London, which brought together high-level representatives of 14 countries interested in reform, and countries where reform had already been successfully implemented, together with members of the *Global Commission on Drug Policy*. To coincide with the launch, the foundation published a public letter in leading British newspapers (Beckley Foundation 2011). Signed by 7 former presidents, 12 Nobel laureates and over 60 distinguished figures from the worlds of politics and diplomacy, academia, business, and the arts, the letter declared the "War on Drugs" a failure and called for a new health-oriented, evidence-based approach to drug policy.

The *Global Initiative for Drug Policy Reform* is a declaration of intent to drive the process of reform internationally as well as nationally. Recognizing a confluence of interests in both national and global change, President Pérez Molina invited the Beckley Foundation to set up a Latin American Chapter in Guatemala. He launched the chapter, and signed the Beckley Public Letter, at a ceremony at the Presidential Palace on July 3, 2012.

The *Beckley Foundation Latin American Chapter* will produce a series of detailed, evidence-based drug policy reports for President Pérez Molina and his government. The first will analyze the effects of the current prohibitionist regime on Guatemala which, as a transit country sandwiched between the large producers in the south and the world's largest consumer in the north, is particularly hard hit by the violence and corruption which has destabilized large swathes of the region. Subsequent reports will make concrete and rigorously evaluated proposals for a range of policy alternatives, including regulation. The Beckley Foundation has convened an international advisory board representing leading scholars in the fields of economics and development, law, health, and drug policy, who will assist in the preparation of these reports.

Reform in Guatemala and the wider region will require a change in public perception as well as legislative change. Consumer countries must accept a share of the responsibility for the devastation that the illicit drug trade leaves in its wake. As the Colombian Ambassador to London, Mauricio Rodríguez Múnera, eloquently phrased it: "For so many years it has been easy for politicians to blame drug-producing nations like Colombia for poisoning their lovely kids. And the result has been a stigma on Colombia. But that game—that farce—is now over" (Vulliamy 2012).

The Ambassador's words underline the leading role being taken by Colombia in bringing drug policy issues to international attention. As early as February 2011, President Juan Manuel Santos said in an interview that decriminalization was one of the options that should be considered (Preferiría no reelegirme 2011). As host of the Sixth Summit of the Americas in Cartagena in April 2012, he announced that

the delegates had mandated the Organization of American States (OAS) to prepare reports that will "examine the results of current policy in the Hemisphere and explore new approaches for responding more effectively to the problem" (Inter-American Drug Abuse Control Commission 2012). Referring to the OAS project at the 67th Session of the UN General Assembly in September 2012, he declared:

> This is only a first step, but one of great importance as it is the beginning of a discussion that the world has avoided for many years and one we hope will produce concrete results. The debate on drugs must be frank, and without a doubt, global. (UN 2012a)

The statement is typical of Colombia's stance under President Santos, that reform requires international action.

The outgoing President of Mexico, Felipe Calderón, is equally clear that the reform of drug policy must transcend national boundaries. As he told the 67th General Assembly:

> drug consumption in many developed countries is causing violence and thousands of deaths in producer and transit countries. . .the nations suffering most acutely from the devastating effects of this situation are those countries positioned between the Andean zone of production and the principal drugs market: the USA. (UN 2012b)

At the same meeting, President Pérez Molina also characterized drug control as "a transnational phenomenon," noting that:

> it is for this reason that I raise it in the universal forum of the United Nations. . .We believe that the basic premise of our war against drugs has proved to have serious shortcomings. . .I call on the member states of the United Nations to review the international norms that currently govern our global policies regarding drugs. (UN 2012c)

President Pérez Molina has consistently gone further than other leaders in spelling out the need for a new approach, but also in drawing attention to the opportunities that reform could generate by freeing resources currently consumed by the fight against drug trafficking. At the 67th General Assembly, he noted that his country's efforts in respect of

> . . .lowering chronic malnutrition in children, reducing violence and insecurity, and promoting employment and fiscal reform are partially challenged by a scourge represented by the trafficking of narcotics. . .The most affected group of the population from drug consumption, our youth, demands more effective responses from us. Let us address the problem for what it is: largely a public health issue, more than a problem of criminal justice. . .I invite the members of the General Assembly to jointly seek avenues that allow us to offer our youth a more promising future [and] a lowering of violence and poverty. (UN 2012c)

Where to from Here?

In my view, reform should begin immediately with the decriminalization of personal drug use, and of acts preparatory to that use (for example the growing and possession of small amounts of cannabis). Use without crime should not be a crime. Explicit decriminalization would enable drug users to more easily access treatment,

both for health problems directly related to drug use, such as the toxic effects of heroin, and for those arising indirectly from drug use, such as infections transmitted by shared needles. It would reduce the strain on over-burdened criminal justice systems, allowing funds currently spent on interdiction and incarceration to be reallocated for education and treatment facilities. And it would protect users who commit no other crime from the devastating effects of a criminal record, which stigmatizes their life thereafter. We should also note that minorities bear a vastly disproportionate burden of convictions and incarcerations.

A further step would be to experiment with the creation of legal non-medical markets; as I have stated, there is no other way to bring about *regulated* markets. While harms cannot be eliminated through regulation, they can surely be more effectively reduced by strict regulation than by no regulation. One must presume that governments, aided by experts, can do a better job of managing the potential harms associated with the use of psychoactive substances than criminal cartels whose only motivation is profit.

In addition to reducing harms, effective regulation could foster important societal changes. As we have seen, psychoactives have been used since the dawn of human culture—and continue to be used—for spiritual growth. Psychedelics in particular can help to bring about profound and lasting personal change. However, in order to do so, they must be treated with a high degree of respect. The current prohibitionist climate tends to shift the emphasis away from the more spiritual and creative uses of psychedelics towards the more purely hedonistic.

An important aspect of any well-designed regulatory regime should be that it would effectively differentiate between the various drugs and drug classes. The status quo, which restricts scientific research into LSD more severely than into heroin and cocaine, is scientifically untenable. Indeed, the current classification system of drugs as a whole, which has been in place for many years, has a very poor alignment with scientific reality. In 2003 and 2004, Dr. Colin Blakemore, Waynflete Professor of Physiology at Oxford University and one of the UK's most eminent neuroscientists, gave presentations at the Beckley Foundation's Seminar Series entitled "Drugs and Society: A Rational Perspective," on the development of a scientifically based scale of harms for all social drugs (Blakemore 2003, 2004). These presentations were later elaborated by Dr. David Nutt, then Professor of Psychopharmacology at Bristol University, Dr. Blakemore, and others, and published in the medical journal the *Lancet* in 2007 (Nutt et al. 2007).

The details governing regulated markets would need to be formulated by states in the same way as any other national policy. However, the recommendations of the *Global Cannabis Commission* (Room et al. 2008), the *Roadmap to Reforming the UN Drug Conventions* (Room and MacKay 2012), and the work a few of other organizations (e.g., Transform Drug Policy Foundation 2009) provide some pointers and would suggest, for example, that the following points should be included:

- Any regime that makes a currently "controlled" drug legally available should involve state licensing or state operation of entities producing, wholesaling, and retailing the drug (as is true in many jurisdictions for alcoholic beverages).

- A possible model for regulation of cannabis would be to permit, alongside government-licensed production, the establishment of members-only clubs, along the lines of the existing Spanish cannabis-growing clubs. This is a particularly interesting model because unlike existing markets in alcohol, tobacco, and prescription medicines—it operates on a not-for-profit basis (Barriuso Alonso 2011).
- The state should impose regulations that would be appropriate to the specific drug. They would include, for example: mandatory labeling of potency; controls on the product's quality and purity; age limits for purchase and use; minimum pricing; a ban on advertising; licensing of outlets; training and licensing of vendors (e.g., by permitting sale only by qualified pharmacists or other expert professionals); restrictions on the density and location of outlets; rationing; a ban on sale to or for intoxicated people; restrictions or bans on public consumption; bans on driving or operating machinery after using certain drugs; and, for certain substances, a mandatory time delay between order and collection of the product.
- The state should ensure that appropriate information is available and actively conveyed to users about the harms associated with drug use. Education should highlight *inter alia* the dangers of combining alcohol with certain other drugs, and of poly-drug use more generally.
- The impacts of any changes, including any unintended adverse effects, should be closely monitored, and there should be the possibility for prompt and considered policy revision in response to such impact assessments.

Monitoring the effects of a new policy *after* it has been implemented is a necessary step, but the policy needs to be implemented first. For legislative reform to be a serious proposal, alternative scenarios need to be visualized, and how they might operate, *before* they become enacted as policy.

One of the reports that the Beckley Foundation has commissioned for this purpose is a *Licensing and Regulation of the Cannabis Market in England and Wales: Towards a Cost / Benefit Analysis* (Bryan et al. 2013). As with any prognostication, there are significant uncertainties; these include, for example, the following:

- The size of the existing cannabis market is not known with any degree of accuracy.
- The assumption that the creation of a licensed market may increase cannabis use. However, it is not clear whether consumption of the more dangerous, high THC/low CBD strains is likely to rise or fall. (For a discussion of THC and CBD see above under the heading "Psychoactive Drugs in Science and Medicine" in the present chapter.) This makes the health impacts of reform hard to gauge.
- It is difficult to predict what share of the market will remain illicit. Estimates suggest that the black market accounts for around 12 % of the tobacco market. The figure for cannabis is unlikely to be much lower than this.
- "Gateway" effects are very hard to quantify. The "gateway" hypothesis is usually taken to mean that cannabis users may go on to use hard drugs. If this were the case, then increasing cannabis use would presumably also increase hard

drug use. However, it should be noted that countries such as the Netherlands and Portugal which have effectively decriminalized cannabis use, have lower heroin use than countries with more draconian policies, thereby throwing the gateway hypothesis into doubt.

Because of these uncertainties, the *Cost–Benefit Analysis* considers various eventualities and gives a wide range of possible outcomes, with net annual savings in England and Wales of between just under £700 million and just over £1 billion. The lists below summarize the major headings under which costs and benefits are being analyzed (although it presents no more than a highly simplified sketch of a complex and detailed analysis):

Main Predicted Costs

- Production costs; administration of regulation
- Information and health education campaigns
- Increased physical and mental illness treatment costs, including treatment for dependency (may be net benefit if prevalence of high-potency strains decreases, particularly among youth)
- Cost of cannabis-related accidents (may be net benefit if prevalence of high-potency strains decreases)

Main Predicted Benefits

- Savings in enforcement and criminal justice system
- Increased employability and earning potential of users, including tax on earnings lost during incarceration
- Tax revenue on sales of licensed products
- The "gateway" effect would be net cost if cannabis use increases significantly, but would be a net gain if, as found in Portugal and the Netherlands, heroin use decreases.

Conclusions

Psychoactive substances bring about changes in brain function that empirically have been found by shamans and other spiritual seekers throughout the millennia to be an aid in their quest for fuller awareness. The neurophysiology underlying these experiences is both fascinating and of great importance; and to engage in scientific exploration in order to throw light on the mysteries of consciousness is one of the Beckley Foundation's primary aims.

Cannabis and the psychedelics can be used for the benefit of mankind by stimulating and freeing-up brain function that is normally suppressed. Just as the shaman traveled to "other worlds" in traditional cultures, and brought back insights from the far shores of consciousness for the benefit of the group, so too can the modern psychonaut. For example, in the field of technology, many of the discoveries that spawned the IT revolution were attributed to altered states of awareness.

The late Steve Jobs, co-founder of Apple, described taking LSD as "one of the two or three most important things I have done in my life" (Markoff 2005).

Taking psychoactive substances should be neither encouraged nor criminalized. To encourage practices that have potential harms without taking steps to minimize those harms would be irresponsible. But, as made evident by alcohol prohibition in the 1930s, the innate desire of certain individuals to experiment with different techniques to alter consciousness is not extinguished by prohibition, and never will be. The use of psychoactives should therefore be regulated, because regulation provides the best mechanisms to minimize the potential harms.

Cannabis and the psychedelics also offer great potential benefits. The medical uses of cannabis and its components are becoming increasingly understood; and as brain-imaging and memory-recall investigations show, psilocybin and MDMA may also be valuable in medicine and psychotherapy. Prohibitionism has for too long thwarted the exploration and development of these potentially invaluable substances, thereby depriving patients of the possibility of new, fruitful, avenues of treatment.

Finally, we should not forget that there is an individual and societal benefit in allowing people to do things that they enjoy and value, so long as they cause no harm to others and minimal harms to themselves. Indeed, as illustrated by current policies, society is happy to tolerate the consumption of alcohol and tobacco even in the face of all the harms and expenses that this behavior brings in its wake.[7] Scientific evidence has shown that cannabis is less harmful—and therefore less costly to society—than either of these legal drugs.

After decades in the wilderness, cannabis and the psychedelics are beginning to resume their rightful place in scientific and medical research. Policy reform remains severely impeded by the UN Drug Conventions. But the tide of history is now surely with those leaders who are speaking out in favor of reconsideration, and of reform that eschews ideology and puts scientific evidence and common sense at its core.

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[7] The UK National Health Service (NHS) reports that over a million hospital admissions each year in England are related to alcohol, with a cost to the NHS of £2.7 billion (at 2006/2007 prices; NHS 2012a). It is estimated that nearly one in five deaths in England of adults over 35 are attributable to smoking (NHS 2012b).

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