

# THE RISE AND DECLINE OF CANNABIS PROHIBITION

THE HISTORY OF CANNABIS IN THE UN DRUG  
CONTROL SYSTEM AND OPTIONS FOR REFORM

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drug control system



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Cannabis is the most widely illicitly used substance worldwide and is produced in virtually every country on the planet. The 2013 World Drug Report estimated that it is used by 180.6 million people around the world or 3.9 per cent of the global population aged 15 to 64.<sup>1</sup> Compared to other controlled psychoactive substances, its potential harm, physiological or behavioural, is considered less severe and cannabis is better integrated into mainstream culture. The cannabis plant has been used for religious, medicinal, industrial and recreational purposes since early mankind.<sup>2</sup> Hemp fibre was used to produce paper, rope and sailcloth, enabling European powers to build their colonial empires, where they subsequently discovered that the plant was also widely used for its psychoactive and medicinal properties.<sup>3</sup>

In 1961, the Single Convention on Narcotic Drugs, the bedrock of the United Nations drug control system, limited “the production, manufacture, export, import, distribution of, trade in, use and possession” of cannabis “exclusively to medical and scientific purposes”.<sup>4</sup> During the negotiations on the Convention there was even a failed attempt to make cannabis the only fully prohibited substance on the premise that “the medical use of cannabis was practically obsolete and that such use was no longer justified”.<sup>5</sup> Instead, it was included under the strictest controls in the Convention. Cannabis is listed twice: in Schedule I, as a substance the properties of which give rise to dependence and which presents a serious risk of abuse; and in Schedule IV, among the most dangerous substances, including heroin, by virtue of the associated risks of abuse, its particularly harmful characteristics and its extremely limited medical or therapeutic value.

This chapter discusses the early history of cannabis control; traces the history of how cannabis ended up in the 1961 Convention; the subsequent deviations and waves of defections from the international control regime; as well as the international skirmishing about what some countries regarded as “lenient policies”.

### The early history of cannabis control

Cannabis control developed in the late 19th and early 20th centuries through varied national and international drug control initiatives often related to opium, and a growing supervision of pharmaceutical products.<sup>6</sup> Just as with opium poppy and coca bush the control debate preceded the United Nations and even its predecessor the League of Nations. A report by the 2002 Senate Special Committee on Illegal Drugs in Canada about the emergence of the international drug control regime summarized the situation:



(UNOG Library, League of Nations Archives)

The international regime for the control of psychoactive substances, beyond any moral or even racist roots it may initially have had, is first and foremost a system that reflects the geopolitics of North-South relations in the 20<sup>th</sup> century. Indeed, the strictest controls were placed on organic substances – the coca bush, the poppy and the cannabis plant – which are often part of the ancestral traditions of the countries where these plants originate, whereas the North's cultural products, tobacco and alcohol, were ignored and the synthetic substances produced by the North's pharmaceutical industry were subject to regulation rather than prohibition.<sup>7</sup>

Early control measures were often implemented as means of social control of groups operating on the fringes of society. Some authorities in the Arab world, for instance, regarded hashish use to be a loathsome habit, associated with the Sufis, an economically and socially disadvantaged sector of Muslim society. Following Napoleon's invasion of Egypt in 1798, the Emperor prohibited his soldiers to smoke or drink the extracts of the plant in 1800 out of fear that cannabis would provoke a loss of fighting spirit. A three-month prison term was imposed, implementing perhaps the first "penal law" on cannabis.<sup>8</sup>

In Egypt and a few other Mediterranean countries such as Turkey and Greece, cannabis prevalence was high and attracted strong legal responses. Hashish was banned in Egypt through a series of decrees. The cultivation, use, and importation of cannabis were first forbidden in Egypt in 1868, when the sultan of Turkey still ruled over Egypt. Nevertheless, a tax on cannabis imports was imposed in 1874, despite its possession having been made illegal. In 1877, the sultan ordered a nationwide campaign to confiscate and destroy cannabis, followed by another law making cultivation and importation illegal in 1879. In 1884, cultivation of cannabis became a criminal offence. However, customs officers were allowed to sell the hashish abroad, instead of destroying the confiscated amounts, to pay informers and customs officers responsible for the seizures.<sup>9</sup>

These early attempts to outlaw cannabis, reissued in 1891 and 1894, had very little effect on the widespread recreational and medicinal use among Egypt's urban and rural poor, the *fellahin*.<sup>10</sup> Hashish was cheap and easily grown or smuggled in from Greece or elsewhere. Exemptions for non-Egyptians and enforcement issues made the laws largely ineffectual.<sup>11</sup> Cultivation, importation, and use of cannabis was banned in Greece in 1890. Hashish was considered an "imminent threat to society," particularly among the urban poor and rebellious youth known as *manges* who gathered in the *tekedes*, cafes frequented by hashish smokers in the harbour area of Piraeus and the centre of Athens. Nonetheless, hashish continued to be widely used, and Greece remained a significant exporter of hashish to Turkey and Egypt well into the 1920s.<sup>12</sup>

### **The Indian Hemp Drugs Commission Report (1894) key recommendations<sup>13</sup>**

1. Total prohibition of the cultivation of the hemp plant for narcotics, and of the manufacture, sale, or use of the drugs derived from it, is neither necessary nor expedient in consideration of their ascertained effects, of the prevalence of the habit of using them, of the social and religious feeling on the subject, and of the possibility of its driving the consumers to have recourse to other stimulants or narcotics which may be more deleterious (Chapter XIV, paragraphs 553 to 585).
2. The policy advocated is one of control and restriction, aimed at suppressing the excessive use and restraining the moderate use within due limits (Chapter XIV, paragraph 586).
3. The means to be adopted for the attainment of these objects are:
  - adequate taxation, which can be best effected by the combination of a direct duty with the auction of the privilege of vend (Chapter XIV, paragraph 587).
  - prohibiting cultivation, except under license, and centralizing cultivation (Chapter XVI, paragraphs 636 and 677).
  - limiting the number of shops for the retail sale of hemp drugs (Chapter XVI, paragraph 637).
  - limiting the extent of legal possession (Chapter XVI, paragraphs 689 and 690). The limit of legal possession of *ganja* or *charas* or any preparation or mixture thereof would be 5 *tola* (about 60 grams), *bhanga* or any mixture thereof of one quarter of a *ser* (a quarter of a litre).

South Africa was another of the first states to control cannabis. An 1870 law, tightened in 1887, prohibited use and possession by Indian immigrants, principally due to the perception that white rule was threatened by the consumption of *dagga*, as it was known.<sup>14</sup> Nevertheless, cannabis was used for pleasure and medicinal and religious purposes without widely by rural Africans and did not constitute a problem.<sup>15</sup> Pressure to prohibit cannabis was growing elsewhere in the 1880s, as temperance movements expanded their mandate from alcohol to other psychoactive substances and against intoxication in general.<sup>16</sup> But it was not inevitable that such concerns would lead to a ban on cannabis.

The pragmatic recommendations of one of the first and to this day one of the most exhaustive studies about the effects of cannabis, *The Indian Hemp Drugs Commission Report* in 1894, pointed in another direction. The Commission convened not as the result of any major concerns in India itself, but because of a question that was raised in the British House of Commons by temperance crusaders. They were concerned about the effects of the production and consumption of hemp and claimed that the "lunatic asylums

## Cannabis prohibition in Brazil

Cannabis was first prohibited in Brazil in 1830 when the Rio de Janeiro municipal council issued a directive that forbade the sale or use of *pito de pango* (cannabis, commonly smoked in a kind of water pipe) as well as its presence on any public premises. Any person who sold *pango* was liable to a fine of 20 *milreis* (about \$40 at the 1830 exchange rate),<sup>17</sup> and any slave or other person who used *pango* could be sentenced to a maximum of three days in prison.<sup>18</sup> Other municipal councils followed with similar directives: Caxias in 1846, São Luís in 1866, Santos in 1870, and Campinas in 1876, although it is unclear whether these laws were actually enforced.<sup>19</sup> An 1886 directive in São Luís, capital of the northern state of Maranhão, prohibited the sale, public exhibition and smoking of cannabis. Slaves violating the law were to be punished with four days in jail.<sup>20</sup>

The cannabis plant was not indigenous to Brazil and, although how it arrived there is uncertain, it almost certainly came along with black slaves from Africa (for its recreational, religious and medicinal purposes) in the sixteenth century when they were brought over to work on the sugarcane plantations in the northeast. Myth has it that cannabis seeds were brought over concealed in cloth dolls tied to the ragged clothing worn by the slaves. A further indication that cannabis was introduced from Africa is that it was known as *fumo de Angola* (Angolan smoke) or *diamba*, *liamba*, *riamba* and *maconha*, all derived from Ambundo, Quimbundo and other languages in present-day Angola and Congo.<sup>21</sup>

The introduction of cannabis in Brazil was one more step in its diffusion over the globe. Cannabis, in fact, was not indigenous to Africa either, but had most likely been brought there by Arab traders from India. Arriving on the east coast at trade hubs such as Zanzibar and the Island of Mozambique, it moved up the Zambezi river basin and down the Congo River to the west coast of southern Africa, from where it travelled to Brazil.<sup>22</sup> In Angola the Portuguese colonial rulers introduced one of the first prohibitions of cannabis; its use by slaves was ‘considered a crime’ the explorer David Livingstone observed in 1857, noting that ‘this pernicious weed is extensively used in all the tribes of the interior’ (which would roughly cover today’s Zambia).<sup>23</sup> Another explorer noted that although the Portuguese prohibited slaves from using it, *diamba* was sold widely at the market in Luanda (Angola) and was grown round village huts nearly everywhere in the country.<sup>24</sup> The lives of some tribes in the Congo centered on cannabis, which was cultivated, smoked regularly in a *riamba* (a huge calabash more than a yard in diameter) and venerated.<sup>25</sup>

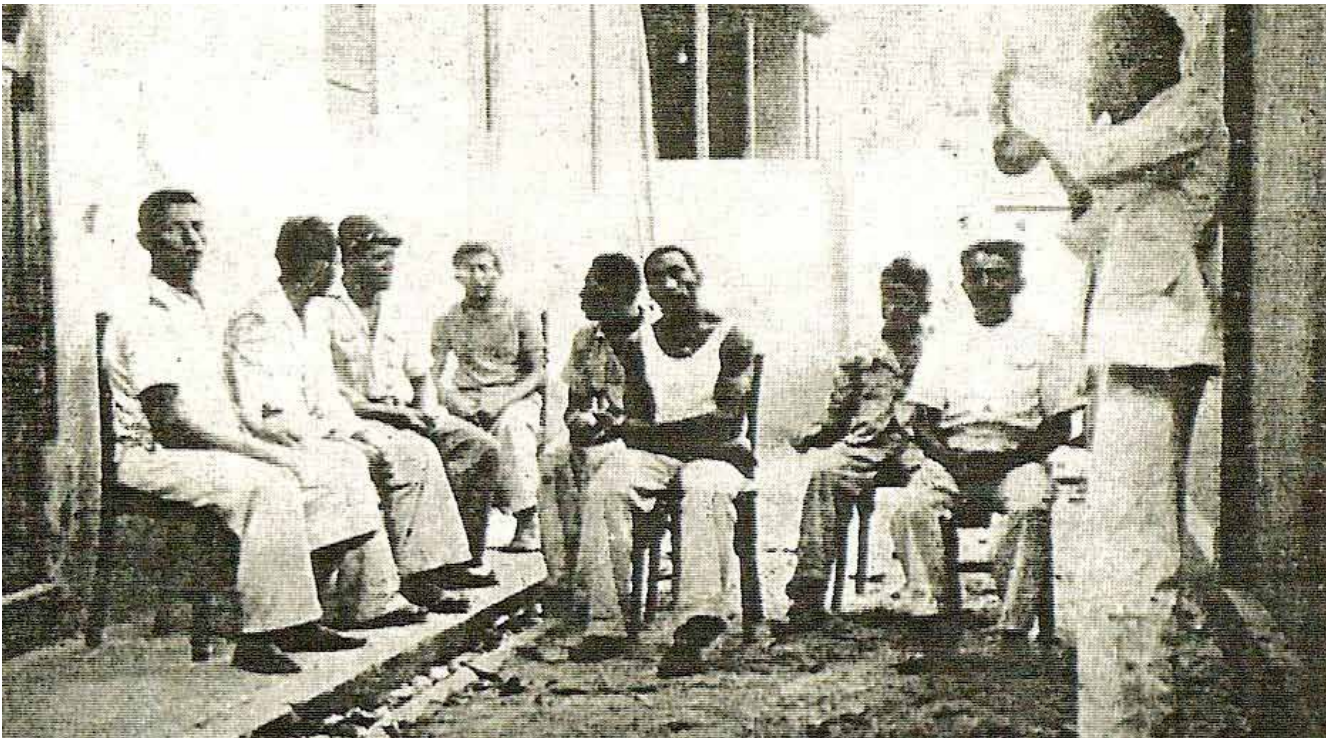
During the sugarcane boom in colonial Brazil’s Northeast,

quite commonly the slave owner enjoyed his tobacco cigar while allowing his slaves to grow and use cannabis.<sup>26</sup> The substance was in wide use in *quilombos*, runaway slave communities, early in the colonial period, as well as among fishermen, longshoremen and labourers later on. Its consumption eventually spread to the indigenous population. Cannabis use was also a form of socialisation in semi-ritualized smoking circles that gathered at the day’s end, known as *assembléias*, as well as occasionally in some African religious practices such as *umbanda* and *candomblé*.<sup>27</sup> Cannabis use, identified with Afro-Brazilian culture and folk medicine, was frowned upon by the white elite. Participants at the first Afro-Brazilian congress in Recife in 1934, attended by Gilberto Freyre,<sup>28</sup> identified cannabis as part of an Afro-Brazilian cultural tradition. Freyre saw the plant as a form of African cultural resistance in the Northeast.

However, it was not this emerging school of Afro-Brazilianist thought – which would eventually rehabilitate black heritage and culture in Brazil – that dominated the scientific and official discourse. An influential group of Brazilian doctors claiming to be concerned with the well being of the “Brazilian race” considered cannabis use to be a vice. Prominent among them was Rodrigues Dória, a psychiatrist and professor of Public Medicine at the Faculty of Law in Bahia, president of the Society of Legal Medicine and former governor of the state of Sergipe. He set the tone in a paper prepared for the Second Pan-American Scientific Congress in Washington, D.C., in December 1915, describing “the pernicious and degenerative vice” of cannabis smoking as a kind of “revenge of the defeated”, what he identified as the revenge of the “savage” blacks against “civilized” whites who had enslaved them.<sup>29</sup>

That first Brazilian analysis of cannabis stood as the reference for almost all subsequent studies on the subject for decades. This school of thought considered cannabis the “opium of the poor”, as it was allegedly used mainly among the lower classes, former slaves, criminals and the marginal fringe in society. This perspective dominated the cannabis discourse in Brazil until the 1960s, despite the fact that its agents had little direct knowledge of the subject. Comparing its effects to those produced by opium, cannabis was considered highly addictive and the cause of serious harm both to the physical and the mental health of its users, and blamed for multiple problems such as idiocy, violence, unbridled sensuality, madness and racial degeneration. Cannabis users were perceived of as being both deviant and sick, and in 1932 the plant was finally classified as a narcotic, the sale and use of which were definitively banned in 1938.<sup>30</sup>

An *Assembléia*, a quite common social gathering in the Northeast of Brazil until the 1940s in which *diamba* (cannabis) was consumed.



of India are filled with ganja smokers.”<sup>31</sup> Unfortunately, the seven-volume report’s wealth of information was largely ignored in the debates on cannabis control that were to unfold in the international arena under the auspices of the League of Nations and the United Nations in the 1920s, 1930s and the 1950s.

Its absence from international discussions is pertinent today since almost nothing of significance in the conclusions of this landmark report on the cannabis problem in India has been proven wrong in over a century since its publication. The Commission looked into earlier considerations in India to prohibit cannabis in 1798, 1872 and 1892, concluding that those proposals had always been rejected on the grounds that the plant grew wild almost everywhere and attempts to stop the common habit in various forms could provoke the local population and drive them into using more harmful intoxicants. The report concluded: “In respect to the alleged mental effects of the drugs, the Commission have come to the conclusion that the moderate use of hemp drugs produces no injurious effects on the mind. [...] As a rule these drugs do not tend to crime and violence.” The report also noted “that moderate use of these drugs is the rule, and that the excessive use is comparatively exceptional. The moderate use produces practically no ill effects.”<sup>32</sup>

Had the wisdom of the Indian Hemp Commission’s recommendations prevailed, we might now have a system not dissimilar to the new legislation on cannabis regulation adopted recently in Uruguay or the regulation models in Colorado and Washington being implemented after the successful ballot initiatives to tax and regulate cannabis in both states. Unfortunately, the international community chose to take another course of action and decided to ban

cannabis in the 1961 United Nations Single Convention on Narcotic Drugs. As the name suggests, the Single Convention is a consolidation of a series of multilateral drug control treaties negotiated between 1912 and 1953. In the following sections a short historical overview discusses what led to this decision.

### Initial attempts at international control

Internationally the drive to control psychoactive substances was initially concentrated on opium, in particular in China, where Western missionaries were appalled by the widespread and, in their eyes, destructive use of opium. Other substances would soon be included. One of the classic historic accounts of international drug control, *The Gentlemen’s Club* from 1975, includes the chapter “Cannabis: International Diffusion of a National Policy”.<sup>33</sup> As the title indicates, national control measures and prohibitions were subsequently internationalised, leading in turn to national bans in other countries. Before cannabis became subject of the international drive to control psychoactive substances, two very distinct models were already competing in the few countries that imposed controls: a prohibition model, which was largely ineffective; and a more sophisticated model of regulation, largely unknown and barely implemented. The large majority of countries did not have any controls at all.

The path towards prohibition was not always straightforward, and even when a ban was introduced, it was not always effectively enforced. In Egypt, for instance, by 1892 the cannabis ban was already being reconsidered. Caillard Pasha, Egypt’s British general director of customs, noted that Egypt’s prohibition had generated trafficking

### Morocco: regulation, prohibition or turning a blind eye

Cannabis has been used in Morocco for centuries. Traditionally, chopped cannabis herb mixed with chopped tobacco, a mixture known as *kif*, is smoked in a pipe with a small clay or copper bowl called a *sebsi*. Cannabis was also used in sweets (*majoon*) and tea, while limited medicinal and religious uses have also been reported.<sup>34</sup> Local administrations collected taxes on the sale of tobacco and *kif*, which were transferred to the sultan.<sup>35</sup> At the end of the nineteenth century, 90 per cent of France's need for pharmaceutical cannabis was imported from Morocco. With the arrival of European colonial powers at the end of the nineteenth century, a control regime developed that would over time vary between regulation, prohibition and, ultimately, turning a blind eye to cultivation in the isolated Rif mountains of northern Morocco.

Around 1890, Sultan Muly Hassan confirmed an authorized to cultivate cannabis in five *douars* (villages) the Berber tribal areas of Ketama, Beni Seddat and Beni Khaled in the Rif, while restricting its trade elsewhere.<sup>36</sup> This area is still the heartland of cannabis cultivation today, despite the prohibition of its cultivation in 1956 when the country became independent. Well-kept cannabis fields are everywhere on terraced slopes, even along the side of the main roads. Local villagers claim they are allowed to grow cannabis due to a *dahir* (decree) issued in 1935 by the authorities of the Spanish protectorate of northern Morocco (1912-56), based on a previous one dating from 1917.<sup>37</sup>

According to the 1917 decree, the *kif* had to be sold to the *Régie marocaine des kifs et tabac*, a multinational company based in Tangier, largely controlled by French capital, which acquired the monopoly to trade cannabis and tobacco in Morocco at the 1906 Algeciras Conference convoked to determine the status of the country. In 1912, the country was divided into two zones, one under French administration, the other under Spanish rule in the north, the latter comprising the cannabis cultivation zone in the Rif area. The aim of the *dahirs* regulating the cultivation, transport, sale and consumption of *kif* was to protect the interests of the monopoly against clandestine producers and sellers.<sup>38</sup> Farmers depended on the *Régie* for permission to grow and were obliged to hand in their harvest at factories in Tangiers and Casablanca where it was processed for commercial sale in tobacco shops.<sup>39</sup>

Use was largely unproblematic. Many smoked a few pipes in the evening while sipping coffee or a cup of tea. "The number of these 'careful' smokers is fairly high in the towns among the artisans and small shopkeepers", a UN study in 1951 reported.<sup>40</sup> In Tunisia, during the French protectorate that lasted until 1956, a similar system of "controlled toleration" existed, restricting contraband and maintaining consumption within moderate limits. The sale of chopped cannabis ready for smoking (*takrouri*) was organised by a

state monopoly like the sale of tobacco. The *Direction des monopoles* issued cultivation permits, fixed the area of authorized plantations every year, and bought the complete crop of whole plants from the producers. The Tunis Tobacco Factory prepared *takrouri* and distributed it in packets of five grams, which were sold in all the tobacco shops of the Tunis Regency.<sup>41</sup>

However, the status of cannabis was not undisputed in the Rif. During the short-lived Republic of the Rif (1923-26), established by Mohammed ben Abdelkrim who had unified the Berber tribes against Spanish occupation, the cultivation and consumption of *kif* was prohibited. Abdelkrim considered cannabis contrary (*haram*) to Islam. How effective the ban was is unclear, but in any event when Abdelkrim was defeated the Spanish and French occupational authorities allowed cultivation again. In the French-controlled area "a zone of toleration to the north of Fez" close to the Rif was established, "in order to allow adaptation to the new economic order of tribes" and contain cannabis smuggling from the Spanish zone.<sup>42</sup>

France, due to its perceived obligations under the 1925 Convention, issued a decree in 1932 prohibiting the cultivation of cannabis in its zone except for cultivation undertaken for the *Régie* around Kenitra (Gharb) and Marrakech (Haouz).<sup>43</sup> Although Spain adhered to the convention in 1928, licensed cultivation continued in the Spanish zone, which became the main source for licensed *kif* in the French zone as well. Apparently the regulation of 1917 was widely circumvented and the *kif* grown in the Spanish zone largely escaped the *Régie's* regulation.<sup>44</sup> Consequently in 1935 a decree in the Spanish zone restricted the cultivation area to the original villages in the area of Ketama, Beni Seddat and Beni Khaled. However, subsequent decrees did not specifically mention any area.

Only in 1954 did the French protectorate prohibit all cultivation. In the Spanish part, a *dahir* in 1954 still authorized the cultivation, production and distribution under licence of the monopoly, but with a significant possession threshold of 5 kilograms. Amounts surpassing that limit would incur administrative sanctions. Cultivation was allowed in unnamed municipalities with the authorization of local authorities and the monopoly.<sup>45</sup> In 1956, when Morocco gained independence and adhered to the existing drug control conventions, cannabis prohibition was extended to the former French and Spanish zones.<sup>46</sup> However, King Mohammed V decided to condone cannabis cultivation in the five historical *douars* after quelling an insurrection in the Rif, due to among other things the ban on cultivation.<sup>47</sup> At the time, the number of occasional or regular smokers has been estimated at nearly one million,<sup>48</sup> or about 8 per cent of the population.

The control regime under which cannabis cultivators in the Rif area have operated has varied from official authorization to informal toleration by the subsequent powers gov-

erning the area. Nevertheless, cultivation of the plant has flourished for over a century despite eradication campaigns and alternative development projects for crop substitution since the 1970s. The market has changed from domestic consumption to international export while the product has changed from *kif* to hashish, with the arrival of the sieving production method from Lebanon around the end of the 1970s. New strains were also introduced, first from Lebanon, followed increasingly in recent years by hybrids from commercial grow houses with much larger yields and potency, so much so, that the original Moroccan varieties are rapidly disappearing.<sup>49</sup>

Cultivation rapidly increased in the 1980s, due to the growing demand from Europe, probably peaking around 2003 when a crop monitoring survey by the UNODC and

networks supplying the country with all the hashish the clandestine market demanded, as well as illicit smoking dens, smuggling and corruption. He advocated that the Egyptian government should duplicate control and restriction policies put in place in India to contain excessive use and allow for moderate consumption, and pointed out that licences and taxation in India were providing revenue, while consumption had diminished.<sup>53</sup>

As with opium, it was clear that prohibition at the national level was unworkable without control of international trade. Subsequently, cannabis was included in the preparations for the International Opium Conference in 1911 in The Hague. The conference, building upon the outcomes of the 1909 Shanghai Commission, would lead to the 1912 International Opium Convention. As negotiations proceeded, substances other than opium and opiates came within the Conference's remit. The Italian delegation, worried by hashish smuggling in its North African colonies (present-day Libya, taken from Turkey during a war in 1911), raised the issue of international cannabis control.<sup>54</sup>

Many delegates were bewildered by the introduction of cannabis into the discussions. Pharmaceutical cannabis products were widespread in the early 20th century and the participants had no substantive knowledge, due to lack of statistics on international trade or even a clear scientific definition of the substance. Nor did delegates have any instructions from their governments on how to deal with the issue. The Dutch chairman, Jacob Theodor Cremer, suggested that countries deal with cannabis internally and that the subject might not even be part of the international drug control problem.<sup>55</sup> The United States alone supported Italy, whose delegation had already left after the first day of the Conference. The United States was only able to obtain a resolution in the addendum to the Convention.<sup>56</sup>

The Conference considers it desirable to study the question of Indian hemp from the statistical and scientific point of view, with the object of regulat-

ing its abuses, should the necessity thereof be felt, by international legislation or by an international agreement.<sup>57</sup>

the Moroccan government revealed that 134,000 hectares were under cultivation and the country was considered to be the largest hashish producer in the world. A subsequent survey in 2005 showed a significant decrease to 72,500 hectares and in 2011 cultivation was estimated to be 47,500 hectares.<sup>50</sup> The Moroccan government increased eradication significantly after 2003, using slash-and-burn campaigns and spraying of herbicides.<sup>51</sup> However, according to recent research, the actual production of hashish (as opposed to the area cultivated) might not be diminishing due to the introduction of higher-yield strains. Since 2013, the Moroccan parliament has been considering regulating cannabis for industrial and medicinal uses, in an effort to normalize the situation,<sup>52</sup> which might shift the pendulum on the status of cannabis toward regulation again.

Present at the Conference was Hamilton Wright, a State Department official who not only coordinated the international aspects of U.S. drug control policy, and was also responsible for drafting domestic drug legislation. In 1910 he had tried to include cannabis in a bill, arguing that if one "dangerous" drug would be effectively prohibited, habitual users would switch to another substance. Anticipating a shift away from opiates and cocaine, cannabis should be prohibited, Wright reasoned. And hence as many psychoactive substances as possible should be banned. He believed in "a hydraulic model of drug appetites,"<sup>58</sup> a kind of reverse gateway theory, which would become popular in later years. His bill (a precursor of the Harrison Narcotics Tax Act of 1914 to control opiates and cocaine) was defeated, principally due to opposition from the pharmaceutical industry, and cannabis would not be federally prohibited until 1937.

The 1912 Hague Convention called upon signatories to license manufacturers, regulate distribution and halt exports to those jurisdictions that prohibited its import. The main concern at the time was that the unregulated free trade in opium, heroin, morphine and cocaine would lead to an increase in domestic drug use. Hence basic controls on international trade had to be introduced. As most states were reluctant to penalise non-medical use of those psychoactive substances, the treaty predominantly addressed supply-oriented regulation of the licit trade and the availability for medical purposes.<sup>59</sup>

Nevertheless, the discussion on cannabis at the conference had early repercussions. The colonial government of Jamaica added cannabis in their legislation when they ratified the 1912 Hague Convention in 1913, and outlawed it a decade later. Cannabis had been introduced on the island by Indian contract labourers who arrived after the abolition of slavery in 1838.<sup>60</sup> British Guyana and Trinidad

Cannabis drying in the sun (Morocco, July 2009), Photo: Pien Metaal



also passed legislation that prohibited the cultivation of cannabis and regulated its sale and possession. Cannabis was sold under licence to Indian plantation workers until 1928.<sup>61</sup>

### Cannabis under the League of Nations

The supply-side approach was continued under the new multilateral structure developed in the wake of the First World War. Having assumed responsibility for the issue, including supervision of the 1912 Hague Convention, the League of Nations, through the Advisory Committee on Traffic in Opium and Other Dangerous Drugs, continued to strengthen transnational aspects of the emergent international drug control system and to institute controls over a wider range of drugs. The main concern was still opium, morphine and cocaine, but a letter from South Africa to the Committee in November 1923 put cannabis back on the agenda.

The South Africans, who had proclaimed a nationwide ban on the cultivation, sale, possession and use of cannabis in June 1922, wrote that from their perspective “the most important of all the habit-forming drugs” was cannabis, which was not included on the Convention’s list.<sup>62</sup> The Advisory Committee asked governments for information on the production, use and trade in the drug in a circular letter in November 1924. That same month, a Second Opium Conference that would significantly alter the legal status of cannabis was convened.

The Conference gathered in Geneva to discuss measures to be taken to implement the 1912 Opium Convention and set maximum limits on the production of opium,

morphine and cocaine and restrict the production of raw opium and coca leaf exported for medicinal and scientific purposes. However, on the second day of the meeting, Mohamed El Guindy, the delegate from Egypt, now nominally independent from Great Britain, proposed the inclusion of cannabis in the deliberations and moved to bring it under the scope of the Convention. He asserted that hashish was “at least as harmful as opium, if not more so.”<sup>63</sup> Support came from Turkey, Greece, South Africa and Brazil, countries that had experience with or banned cannabis already, although with only limited or virtually no success. Despite the British delegation’s argument that cannabis was not on the official agenda, El Guindy insisted and submitted an official proposal.

In his speech presenting the proposal, he painted a horrific picture of the effects of hashish. Although he conceded that taken “occasionally and in small doses, hashish perhaps does not offer much danger,” he stressed that once a person “acquires the habit and becomes addicted to the drug [...] it is very difficult to escape.” He claimed that a person “under the influence of hashish presents symptoms very similar to those of hysteria”; that the individual’s “intellectual faculties gradually weaken and the whole organism decays”; and that “the proportion of cases of insanity caused by the use of hashish varies from 30 to 60 per cent of the total number of cases occurring in Egypt.” Cannabis not only led to insanity, according to El Guindy, but was a gateway to other drugs, and vice versa. If it was not included on the list with opium and cocaine, he predicted, cannabis would replace them and “become a terrible menace to the whole world.”<sup>64</sup>

Most countries represented at the Conference had little to no experience with cannabis and were inclined to rely



upon those that did, notably Egypt, Turkey and Greece. The Egyptian ban on cannabis had affected the entire eastern Mediterranean and beyond. Greece, Cyprus, Turkey, Sudan, Syria, Lebanon and Palestine were requested to assist Egypt's law enforcement authorities by restricting cultivation and trade. El Guindy's proposal was certainly motivated by failed efforts to stem smuggling from those countries into Egypt.<sup>65</sup>

Despite the lack of evidence in his emotional speech supporting his claims about the effects of hashish, delegates were unprepared to contradict them. The assertion that 30 to 60 per cent of insanity was caused by hashish was, to be generous, an exaggeration. The 1920-21 annual report of the Abbasiya Asylum in Cairo, the larger of Egypt's two mental hospitals, recorded 715 admissions, of which only 19 (2.7 per cent) were attributed to hashish, considerably less than the 48 attributed to alcohol. Moreover, even the modest number of cases attributed to cannabis were "not, strictly speaking, causes, but conditions associated with the mental disease."<sup>66</sup>

El Guindy's excessive claims caused a moral panic among the delegates, the majority ill-informed, who applauded his intervention, despite some admitting that their knowledge on the issue was quite limited. The reaction was not unanimous, however. Delegates from India, the United Kingdom and France expressed sympathy for the Egyptian delegate's position, but argued that, as his government had

failed to give prior notice to the secretariat, the Conference was not competent to apply the provisions of the 1912 Hague Convention to hashish. The issue was referred to a subcommittee for further study, in which El Guindy introduced the proviso:

The use of Indian hemp and the preparations derived therefrom may only be authorised for medical and scientific purposes. The raw resin (charas), however, which is extracted from the female tops of the *cannabis sativa*, together with the various preparations (hashish chira, esrar, diamba, etc.) of which it forms the basis, not being at present utilised for medical purposes and only being susceptible of utilisation for harmful purpose, in the same manner as other narcotics, may not be produced, sold, traded in, etc., under any circumstances whatsoever.<sup>67</sup>

The subcommittee reported in favour of the complete prohibition of cannabis. Only three of the sixteen nations represented on the committee (the United Kingdom, India and the Netherlands) opposed the drastic step.<sup>68</sup> Curiously, neither the Indian and British delegates mentioned the 1895 Indian Hemp Drugs Commission's report, which offered a much more nuanced assessment of the benefits, risks and harms of cannabis.

The British and Indian delegates attached reservations to Guindy's controversial paragraph. Beyond restriction of

Second Opium Conference, Geneva, 1924-25 (UNOG Library, League of Nations Archives)



Advisory Committee on Traffic in Opium, 1938  
(UNOG Library, League of Nations Archives)



international trade, it interfered in domestic policy and legislation – at that time deemed a step too far. The U.S. had wanted to introduce similar provisions for opium, but was blocked by other delegations, precipitating the Americans’ angry departure from the Conference. Hence the recommendations were diluted significantly by the drafting committee for the new Convention, despite, what the subcommittee chairman qualified as the “somewhat uncompromising insistence” of El Guindy, a reprimand uncommon in the diplomatic world. Consequently cannabis was included in the International Opium Convention of 1925, under a limited regime of international control: prohibition of cannabis exportation to countries where it was illegal and the requirement of an import certificate for countries that allowed its use.<sup>69</sup>

Without due consideration of relevant evidence to support the necessity for control and at the request of Egypt alone, the Conference decided formally that ‘Indian hemp’ was as addictive and as dangerous as opium and should be treated accordingly, and cannabis was placed under legal international control in the 1925 Geneva Convention.<sup>70</sup> The Convention only dealt with the transnational dimension of the cannabis trade. The new control regime did not prohibit the production of or domestic trade in cannabis; it did not impose measures to reduce domestic consumption; nor ask governments to provide cannabis production estimates to the Permanent Central Opium Board (PCOB), established by the treaty to monitor and supervise the licit international trade, which at the time was the main source of supply for illicit markets.<sup>71</sup>

Following the approval of the 1925 International Opium Convention, European countries gradually outlawed cannabis possession and often its use as well (for example, the United Kingdom’s Dangerous Drugs Act, 1928; a revised Dutch Opium Law,<sup>72</sup> 1928; Germany’s second Opium Law, 1929).<sup>73</sup> These laws exceeded the obligations in the Convention, despite the absence of problems related to cannabis use in those countries. Bans issued on a national level on a substance demonized on the basis of questionable evidence set into motion stricter controls internationally. Soon after Egypt had forced cannabis control onto the international agenda, more powerful countries would become entangled in the process of increasing criminalisation and seeking tighter international prohibitive measures. The British drugs law, for instance, would serve as model for legislation in the British West Indies.<sup>74</sup>

At the League of Nations the issue didn’t attract significant interest after the 1925 Geneva Convention was adopted. In the 1930s, however, the Advisory Committee began to pay increasing attention to cannabis, under pressure from Egypt, but especially from the U.S. and Canada. At the Committee’s 19th session in 1934, a report was tabled that estimated there were no less than 200 million cannabis users worldwide, although it was unclear how that figure was arrived at. The Egyptian delegation demanded “the worldwide outlawing of the cannabis indica plant”, but other delegations were unimpressed by the poorly substantiated statements.<sup>75</sup> Consequently, the issue was referred to a subcommittee.

Criticism of the prohibitive trend appeared occasionally. A 1926 *New York Times* article questioned El Guindy's allegations against cannabis. The article quoted the 1894 Indian Hemp Drugs Commission report, contending that neither insanity nor criminality was related to cannabis, "but when excesses were noted they were usually connected with other vices, such as alcohol and opium. Not a single medical witness could clearly prove that the habit gave rise to mental aberration."<sup>76</sup> The article referred to research among U.S. military personnel in the Panama Canal Zone with 17 volunteers smoking marijuana under medical supervision. The investigating committee reported that the "influence of the drug when used for smoking is uncertain and appears to have been greatly exaggerated" and concluded "there is no medical evidence that it causes insanity," and that "there is no evidence that the marijuana grown locally is a habit-forming drug [...] or that it has any appreciable deleterious effects on the individuals using it." The committee recommended that "no steps be taken by the authorities of the Canal Zone to prevent the sale or use of marijuana, and that no special legislation [...] was needed."<sup>77</sup>

### Enter the United States

At the time of the 1925 Opium Convention the United States was ineffectually implementing a prohibition regime for alcohol (1920-1933). A moral panic fed by sensationalist newspaper reports about violence supposedly incited by marijuana use among Mexicans immigrant labourers was building. As a result, requests were made to include marijuana in the Harrison Act. The Federal Bureau of Narcotics (FBN), established in 1930 and headed by Commissioner of Narcotics Harry J. Anslinger until 1962, at first minimized the problem, arguing that cannabis control should be handled by individual states rather than the federal government. He considered heroin a much more dangerous substance and was cautious about committing the FBN to the control of a substance that grew freely across many, particularly southern, U.S. states. However, pressure to do something mounted: from local police forces in affected states, then from governors, and from the governors to the Secretary of the Treasury, Anslinger's boss.<sup>78</sup>

Passing federal legislation in the United States is a complicated affair, due to constitutional restraints allowing states substantial control in their domestic affairs. The Bureau's attempts to design a federal law were initially based on the treaty-making powers of the federal government as the authority that could introduce an anti-marijuana statute.<sup>79</sup> That might explain the increased activity of the U.S. at the Advisory Committee. Anslinger's predecessors had used those same tactics in 1912 and 1925 "to enforce domestic legislation in time to underline the seriousness of U.S. intentions at international meetings and thereby increase their capacity to influence international decisions;

at the same time, they used international obligations as an argument for domestic legislation."<sup>80</sup>

Although not a member of the League of Nations, the United States maintained extra-official presence as an observer in the deliberations and voiced its dissatisfaction with the lenient approach of the European colonial powers who had significant financial interests in the production of opium and coca and the manufacturing of their derivatives, morphine, heroin and cocaine. One of the reasons the U.S. had withdrawn from the 1924-1925 Geneva Conference was the producing countries' refusal to commit to specific measures restricting production of raw opium and coca leaves to medical and scientific needs. Washington saw this as a major gap in the international system of control. Limitation of the available supplies could not be achieved without control at the source: restricting the cultivation of the plants.<sup>81</sup>

The U.S. tried to introduce stricter measures, including for cannabis, at the Conference for the Suppression of the Illicit Traffic in Dangerous Drugs in Geneva in 1936. The Conference was convened to address the increasing problem of illicit drug trafficking, an unintended consequence of the increased effectiveness of the control regime imposed on licit international drug markets. The U.S. proposal for the draft convention included compulsory severe penalties on anyone promoting or engaging in cultivation, production, manufacture, or distribution for non-medical and non-scientific purposes. Other delegations rejected that path and, reminiscent of the 1925 Geneva Conference, the U.S. delegation walked out of the meeting, dissatisfied with limited application of the convention. The U.S. strategy was to influence its domestic policy, establishing a constitutional basis, via treaty, for federal regulation of the cultivation and production of opium and cannabis,<sup>82</sup> and according to the historian William B. McAllister "perhaps individual use as well".<sup>83</sup> However, the delegation considered the 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs to be "a retrograde step."<sup>84</sup>

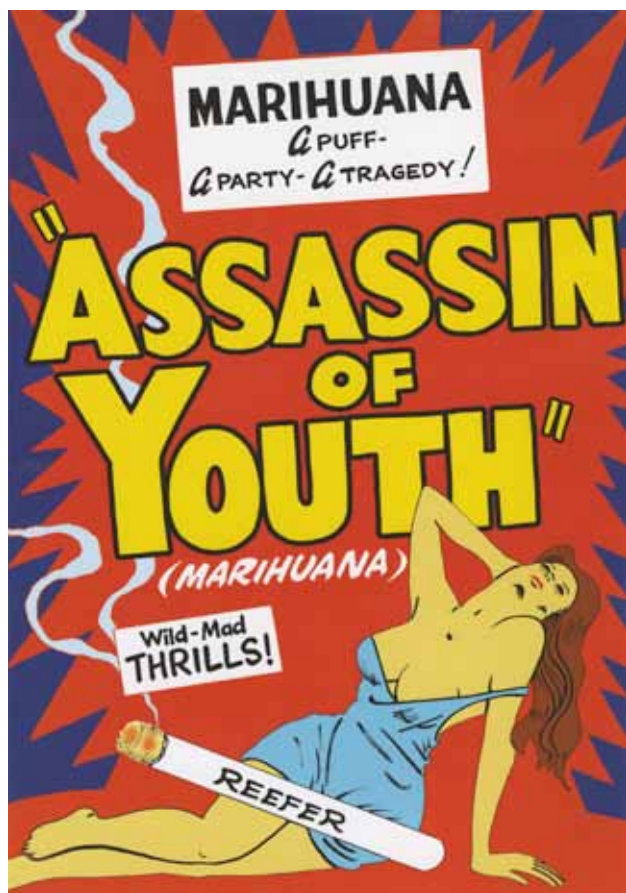
Shortly after his return to Washington, Anslinger and the Treasury Department went ahead with preparations for the passage of a federal bill to control cannabis, replete with what was effectively a scare campaign on Capitol Hill and in the media. Following a by now well-practiced approach, in April 1937, for example, he assured a House of Representatives committee that under the influence of marijuana "some people will fly into a delirious rage and may commit violent crimes." In a response to a follow-up question, he said that the drug was "dangerous to the mind and body and particularly dangerous to the criminal type, because it releases all of the inhibitions."<sup>85</sup> Anslinger's also testified:

Most marijuana smokers are Negroes, Hispanics, jazz musicians, and entertainers. Their satanic music is

driven by marijuana, and marijuana smoking by white women makes them want to seek sexual relations with Negroes, entertainers, and others. It is a drug that causes insanity, criminality, and death – the most violence-causing drug in the history of mankind.<sup>86</sup>

Such views were widely reproduced in radio appearances, public forums, magazine articles and in the film *Reefer Madness*. Accompanying the racist and xenophobic undertone, the demonization bordered on the ridiculous. At one point Anslinger even claimed that marijuana had a strangely exhilarating effect upon the musical sensibilities, noting that cannabis had long been used as a component of “singing seed” for canary birds.<sup>87</sup>

Collection Hash Marihuana & Hemp Museum Amsterdam/Barcelona



Such was the atmosphere in August 1937 when the federal government approved the Marijuana Tax Act, effectively banning cannabis in the country. The law imposed an occupational tax upon importers, sellers, dealers and anyone handling the drug. The provisions of the Act were not designed to raise revenue, or even regulate the use of marijuana. The purpose was to provide the legal mechanisms to enforce the prohibition of all use of marijuana.<sup>88</sup> This was the case even though debate for the passage of the bill in the House of Representatives lasted only half an hour and contained no medical or scientific data. Reflecting the laxity and indifference of discussion, Texas Congressman Sam Rayburn responded to a question about the bill's provisions: “It is something to do with something that is called marijuana. I believe it is a narcotic of some kind.”<sup>89</sup> Before the introduction of the law only

four states had enacted prohibitions against non-medical usage of marijuana, California (1915), Texas (1919), Louisiana (1924), and New York (1927), but in 1937, 46 of the nation's then 48 states had banned the substance.

The U.S. subsequently reinforced its drive to strengthen international control and lead the international anti-cannabis movement. It presented extensive documentation to a subcommittee of the League of Nation's Advisory Committee, claiming a link between crime, dementia and cannabis, whilst promoting the gateway theory that cannabis use leads to heroin addiction. Anslinger declared in 1938 before the Advisory Committee: “[...] the drug [marihuana] maintains its ancient, worldwide tradition of murder, assault, rape, physical and mental deterioration. The office's archives prove that its use is associated with dementia and crime. Thus, from the point of view of policing, it is a more dangerous drug than heroin or cocaine.”<sup>90</sup>

In contrast, one of the most important documents finally produced by the sub-committee insists that there is no link between violence and cannabis in Africa. The subcommittee's work, completed in December 1939, demonstrated sensitivity to cultural differences in cannabis use – even though the Indian situation and the lessons from the Hemp Commission were once again ignored – and an appreciation of the difficulties to be expected in efforts to control the substance. The subcommittee concluded that more studies were necessary on the precise content of cannabis, on the causes of addiction and its connection with dementia and crime, and on the growing phenomenon of substitution of cannabis with heroin that was occurring in North Africa, Egypt and Turkey. In an earlier report an increase in heroin use in Tunisia was attributed to cannabis control, and it raised the concern that “[...] at present, total suppression (at least in countries where cannabis use is a very ancient custom) would result in an increase in addiction to manufactured drugs, which are far more dangerous [...]”<sup>91</sup>

The work of the League of Nations ended with the outbreak of the Second World War. After 1945, with the full weight of the U.S. brought into play, the parameters for international cannabis control changed significantly. Meanwhile, attracting little if any attention, other control models also persisted. In India, Tunisia and French Morocco, for example, systems of controlled sales had been adopted.<sup>92</sup>

### Towards the 1961 Single Convention

With the creation of the United Nations, the Commission on Narcotic Drugs (CND) replaced the Advisory Committee of the League of Nations. During its first meeting in 1946 future discrepancies in the cannabis debate were already beginning to show. At that meeting, medical opinions from the U.S. and Mexico were referred to that refuted any significant health-related harms from

## Cannabis and insanity

A recurrent issue in the debate on whether or not to prohibit cannabis is the supposed link between cannabis and insanity, or as the debate evolved, cannabis and psychosis/schizophrenia. Since the 1840s cannabis has been accused of triggering insanity and hailed as a cure for it. With the benefit of hindsight and incalculable scientific research, the verdict is that “[c]annabis is associated with psychosis (a symptom) and schizophrenia (an illness where this symptom is persistent) in complex, contradictory and mysterious ways”.<sup>93</sup>

One of the key psychoactive components of cannabis, tetrahydrocannabinol (THC), might sometimes induce psychosis-like effects, such as anxiety and paranoid delusions, but transient paranoia is not schizophrenia. Persistent cannabis use (or that of any kind of psychoactive substance) may precipitate psychosis in individuals with genetically predisposing factors, and complicate and worsen symptoms in a person with schizophrenia, but there is no evidence it can cause psychosis.<sup>94</sup> On the other hand, another key component in cannabis, cannabidiol (CBD), has powerful antipsychotic and anti-anxiety properties, so effective that “CBD may be a future therapeutic option in psychosis, in general and in schizophrenia, in particular”.<sup>95</sup> This might explain why people with schizophrenia or predisposed to psychotic symptoms report relief after using cannabis.

Although the number of users increased and average strength of cannabis has raised significantly, the numbers of people being diagnosed with schizophrenia has remained stable over time.<sup>96</sup> That is not to say that cannabis is completely harmless, but that the harms are often exaggerated and other environmental factors, such as alcohol for instance, are frequently overlooked. A systematic review of epidemiological data on cannabis dependence (1990-2008) indicates:

the modest increase in risk and the low prevalence of schizophrenia mean that regular cannabis use accounts for only a very small proportion of the disability associated with schizophrenia. From a population health perspective, this raises doubt about the likely impact of preventing cannabis use on the incidence or prevalence of schizophrenia [...].<sup>97</sup>

The object here is not to review all the often conflicting evidence on the relation between cannabis and psychosis, but to how one argument, that cannabis causes insanity, prevailed. And this position prevailed despite the lack of evidence to substantiate the claim overriding significant doubts about the relationship that existed from the beginning of the debate. One of the earliest inquiries, by the colonial government of India in 1872, did indeed conclude that habitual ganja use tended to produce insanity, but a careful examination of the evidence presented in the

reports underlying that conclusion, shows that the alleged relationship lacked “solid or sound foundations” and its accuracy was often disputed by medical officers.<sup>98</sup> However, “bad information, administrative expedience and colonial misunderstandings of a complex society” turned into statistics and the statistics provided the “evidence” that cannabis led to mental illness.<sup>99</sup>

The *Indian Hemp Drugs Commission* in 1894 was also instigated by claims that the lunatic asylums of India were filled with ganja smokers. After extensive research into the nature of asylum statistics the majority of the Commission members agreed “that the effect of hemp drugs in this respect ha[d] hitherto been greatly exaggerated”.<sup>100</sup> Most medical doctors involved in the study were convinced that cannabis use did not cause insanity, but rather stimulated a mental illness that “was already lurking in the mind of the individual” and that alcohol played at least an equal if not a more important role.<sup>101</sup> That conclusion seems to summarize current opinions about the relationship between cannabis and psychosis.

As mentioned in this chapter, the dramatic announcements on the mental health implications of cannabis use by the Egyptian delegate Mohammed El Guindy at the Geneva conference had a significant impact on the deliberations to include cannabis in the 1925 Convention. El Guindy produced statistics supporting his claims that 30 to 60 per cent cases of insanity were caused by hashish. In a subsequent *Memorandum with reference to hashish as it concerns Egypt*, submitted by the Egyptian delegation to support El Guindy, the figure was even more alarming, claiming that “about 70 percent of insane people in lunatic asylums in Egypt are hashish eaters or smokers”.<sup>102</sup> El Guindy’s figures were probably based on the observations of John Warnock, the head of the Egyptian Lunacy Department from 1895 to 1923, published in an article in the *Journal of Mental Science* in 1924.<sup>103</sup>

However, as historian James Mills showed, Warnock made broad generalizations about cannabis and its users despite that those he saw were only the small proportion of them in hospitals. Whether this was an accurate picture of cannabis use in Egypt did not seem a relevant question to him. Other Egyptian statistics showed a very different picture.<sup>104</sup> This tendency among some doctors to extrapolate their experiences in mental health departments to society at large was common in many studies in many countries and resulted in ignoring the fact that the vast majority of cannabis users did so without any problem. Studies often generalised cases of a few single individuals with personality disorders to make broad claims about the overall harmful effects of cannabis.<sup>105</sup>

Not all directors of mental health hospitals reached the same conclusions. The Mexican psychiatrist Leopoldo Salazar Viniegra, for instance, who had earned a reputation as a result of his work with addicts in the national mental

health hospital, refuted the existence of a marijuana psychosis. In an article in 1938, entitled *El mito de la marihuana* (The Myth of Marijuana), he argued that that assumption in public and scientific opinion was based in myth. The link of the substance with insanity, violence and crime, which had dominated the public discourse in Mexico since the 1850s, was the result of sensational media reports and, in later years, U.S. drug enforcement authorities.<sup>106</sup> According to Salazar, at least in Mexico, alcohol played a much more important role in the onset of psychosis and social problems.

Shortly after he was appointed as head of Mexico's Federal Narcotics Service, he told U.S. officials that the only way to stem the flow of illicit drugs was through government-controlled distribution. Due to Mexico's 1920 cannabis prohibition, 80 per cent of the drug law violators were cannabis users. He argued that Mexico should repeal cannabis prohibition to undercut illicit trafficking (the suppression of which he considered impossible in Mexico due to widespread corruption) and focus on the much more serious problems of alcohol and opiates. In 1939, he initiated a programme of clinics dispensing a month's supply of opiates to addicts through a state monopoly.<sup>107</sup> Salazar argued that the traditional perceptions of addicts and addiction had to be revised, including "the concept of the addict as a blameworthy, antisocial individual".<sup>108</sup>

In doing so, Salazar not only made an enemy out of the powerful U.S. Commissioner of Narcotics Anslinger, who had used the alleged relation to push through the prohibitive Marijuana Tax Act, but also went against the opinions of the established medical opinion in Mexico. As a delegate to the Advisory Committee of the League of Nations and participating in its meeting in Geneva in May 1939, he saw that the intolerance of and demands for prohibiting cannabis had increased exponentially under the leadership of the American delegates and their allies.<sup>109</sup> He infuriated Anslinger with his proposal to treat addicts in and out of prison with a morphine step-down project.<sup>110</sup> Back home, in an article in the *Gaceta Medica de México*, he challenged the validity of the data relating hashish to schizophrenia in a report from Turkey submitted to the Committee.<sup>111</sup>

Salazar considered the then existing international drug control conventions "as practically without effect".<sup>112</sup> His opinions opposed Washington's punitive supply-side

cannabis use and its minimal influence on criminal behaviour. The Mexican representative claimed that too many restrictions on cannabis could lead to it being substituted by alcohol, which would have worse consequences. The Indian delegate declared that Indian people used *ganja* and *bhang* in moderation.<sup>118</sup>

The U.S. representative, Commissioner Anslinger, insisted on proving the connection between cannabis use and

approach on drug control and he stepped on too many toes both nationally and internationally. The U.S. consul general in Mexico suggested that ridicule would be the best way to stop the "dangerous theories" of Salazar.<sup>113</sup> After a concerted campaign in which U.S. and Mexican officials set out to destroy him personally, the Mexican press depicted him as a madman and "propagandist for marijuana".<sup>114</sup> Due to the intense diplomatic and public pressures, he was forced to resign as head of the Federal Narcotics Service and was replaced by someone more complaisant in the eyes of the U.S. State Department and the FBN.<sup>115</sup>

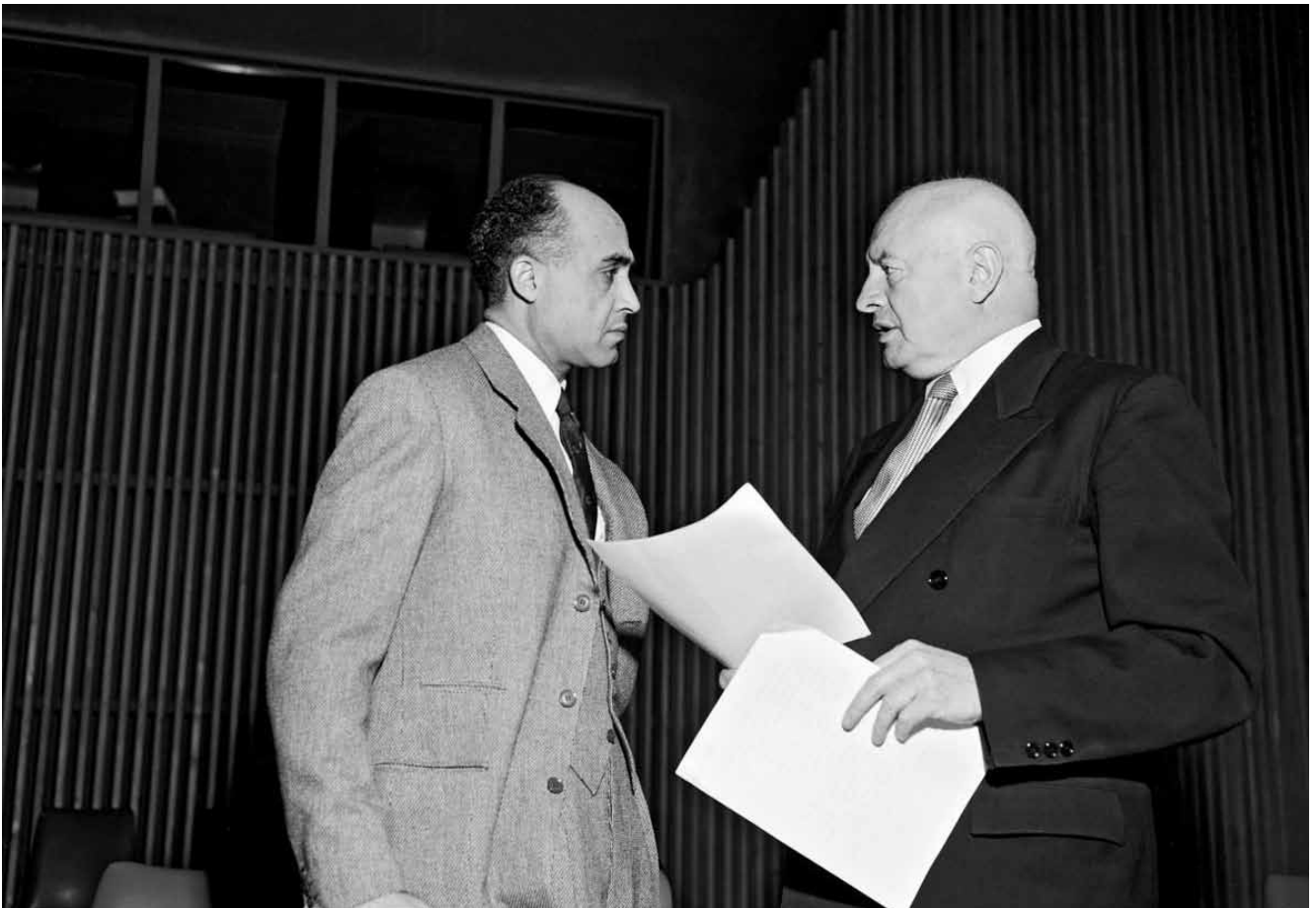
Not surprisingly, Salazar's work was dismissed by Pablo Osvaldo Wolff in his booklet *Marihuana in Latin America*. As discussed later in this chapter, Wolff, who claimed that cannabis did cause psychosis, was much more astute in assuring his opinions were dominant across the relevant UN institutions. Nevertheless, after the 1961 Single Convention was adopted, the UN Bulletin on Narcotics published a review in 1963 that shed substantial doubt on the relationship and, if there was one, about its prevalence. In the review, the Canadian psychiatrist H.B.M. Murphy concluded: "It is exceedingly difficult to distinguish a psychosis due to cannabis from other acute or chronic psychoses, and several suggest that cannabis is the relatively unimportant precipitating agent only." He elucidated that "it probably produces a specific psychosis, but this must be quite rare, since the prevalence of psychosis in cannabis users is only doubtfully higher than the prevalence in general populations".<sup>116</sup>

The debate continues and opinions on how and why cannabis use is related to psychosis and schizophrenia still spark debate among medical observers today. A 2010 editorial in the *International Drug Policy Journal* called for a more rational approach, decrying that "overemphasis on this question by policymakers has distracted from more pressing issues" and concluded that they

should give greater voice to the risks and harms associated with particular cannabis policies and to the evaluation of alternative regulatory frameworks. Given the decades of research and experience with cannabis prohibition, it seems reasonable to reorient the cannabis policy debate based on known policy-attributable harms rather than to continue to speculate on questions of causality that will not be definitively answered any time soon.<sup>117</sup>

crime, and launched an attack against a report issued in 1944 by New York's mayor, Fiorello La Guardia, the goal of which was to provide a thorough, impartial and scientific analysis of marijuana smoking among the city's Latin and black population.<sup>119</sup> Based on five years of interdisciplinary research, the study refuted the scare stories the FBN was circulating in the press and other media and claims by officials about the dangers of cannabis. Among its conclusions was that the "practice of smoking

US Narcotics Commissioner Harry J. Anslinger meets delegate Saleh A. Mahmoud from Egypt at the 1952 CND in New York (Photo: UN Photo/MB)



marijuana does not lead to addiction in the medical sense of the word” and that the drug was “not the determining factor in the commission of major crimes.” Moreover, “the publicity concerning the catastrophic effects of marijuana is unfounded [...] There [is] no direct relationship between the commission of crimes of violence and marihuana [... M] arihuana itself has no specific stimulant effect in regard to sexual desires” and that “use of marihuana does not lead to morphine or cocaine or heroin addiction.” In light of such findings, it called for an intelligent approach to the drug.<sup>120</sup>

In the absence of an international normative consensus about drug use and the willing capacity to coerce nations to adhere to stringent control policies the League of Nations had been unable to secure the global prohibition of certain drugs for non-medical purposes. The voluntary nature of adherence to the conventions ensured that the pre-UN framework had a more regulatory character, concerned predominantly with “restrictive commodity agreements”.<sup>121</sup> This was about to change. After the Second World War the United States was the dominant world power and could “persuade” other states to adopt stricter policies.<sup>122</sup> This power shift led to dismissing impartial evidence on the benefits, risk and harms of cannabis and its potential medical usefulness, and eased the way for providing biased evidence supporting the U.S. decision to prohibit the substance. For example, a CND secretariat paper continuing the work of the subcommittee from the 1930s omitted all references to the La Guardia report because the U.S. did not submit it.

In 1948 the recently formed UN Economic and Social Council (ECOSOC) approved a U.S.-drafted and CND-sponsored resolution requesting the UN’s Secretary General to draft a new convention replacing all the existing treaties from the 1912 Hague Convention onwards. Owing much to Anslinger’s endeavours, work on a kind of “single” or “unified” treaty began. It would have three core objectives: limiting production of raw materials; codifying existing conventions into one; and simplifying the existing drug control apparatus. Between 1950 and 1958, the nascent document went through three drafts.<sup>123</sup>

A first draft of the future single convention was presented in February 1950 by the CND Secretariat. The proposals for cannabis were drastic. The draft text incorporated two alternative approaches, both holding that recreational cannabis use needed to be rigorously discouraged. The first alternative worked on the conjecture that cannabis had no legitimate medical use that could not be met by other “less dangerous substances”. With the exception of small amounts for scientific purposes, the production of cannabis would be prohibited completely.<sup>124</sup>

The second option recognized that cannabis did have legitimate medical purposes. It should be produced and traded exclusively by a state monopoly only for medical and scientific ends. To ensure that no cannabis leaked into “illicit traffic” a range of measures, such as state-run cultivation and the uprooting of wild plants, was proposed. In countries with significant traditional recreational use, “a

reservation” could allow production on the strict condition that the reservation would “cease to be effective unless renewed by annual notification [...] accompanied by a description of the progress in the preceding year towards the abolition of such non-medical use and by explanation of the continued reasons for the temporary retention of such use.”<sup>125</sup>

No agreement was reached and decisive action was stalled. More information was needed as “a rigid limitation of the use of drugs under control to exclusively medical and scientific needs does not sufficiently take into consideration long established customs and traditions which persist in particular in territories of the Middle and Far East and which is impossible to abolish by a simple decree of prohibition.”<sup>126</sup> The draft boldly claimed that all non-medical consumption of cannabis was harmful and recommended that countries in which traditional recreational use was common should be obliged to ban such practices, denying that social use of cannabis in many southern countries was commonly accepted by many as a phenomenon comparable to the social use of alcohol in the U.S. and Europe.<sup>127</sup> Years later, Hans Halbach, head of the WHO Section on Addiction Producing Drugs from 1954 to 1970, pointed out the cultural bias: “If in those days the opium-producing countries had been as concerned about alcohol as Western countries were concerned about opium, we might have had an international convention on alcohol.”<sup>128</sup>

By deferring cannabis for further study the issue risked ending up in the same indecisive state as in the pre-war period under the auspices of the League of Nations, when it was studied year in year out, without a noticeable

impact on the decision-making process. Much valuable information was gathered, but its often contradictory nature did not help to reach a suitable policy conclusion. The dominant position of the U.S. and the emergence in the post-war years of what historian McAllister has called an “inner circle” of drug control advocates at the UN who were determined to set a “radical” agenda were central to breaking the impasse.<sup>129</sup>

One of the crucial issues was whether cannabis had any justifiable medical use. The body mandated to determine medicinal utility was the WHO Expert Committee on Drugs Liable to Produce Addiction. In 1952 the Committee declared “cannabis preparations are practically obsolete. So far as [we] can see, there is no justification for the medical use of cannabis preparations.”<sup>130</sup> That verdict was not substantiated by any evidence and was clearly influenced by ideological positions of certain individuals holding powerful positions. The secretary of the Expert Committee was Pablo Osvaldo Wolff, the head of the Addiction Producing Drugs Section of the WHO (1949-1954). Wolff, described as an American protégé, was part of that “inner circle” of control advocates and was made the WHO’s resident cannabis expert due to vigorous U.S. sponsorship.<sup>131</sup>

Anslinger wrote the preface to the 1949 English edition of Wolff’s booklet *Marijuana in Latin America: The Threat It Constitutes*, as a polemic against the La Guardia report that argued, in contrast to Anslinger and Wolff’s opinion, that the use of marijuana did not lead to mental and moral degeneration. Wolff’s work supported the pre-war claims and arguments of the U.S. government, such as the estimate that there were 200 million cannabis addicts in

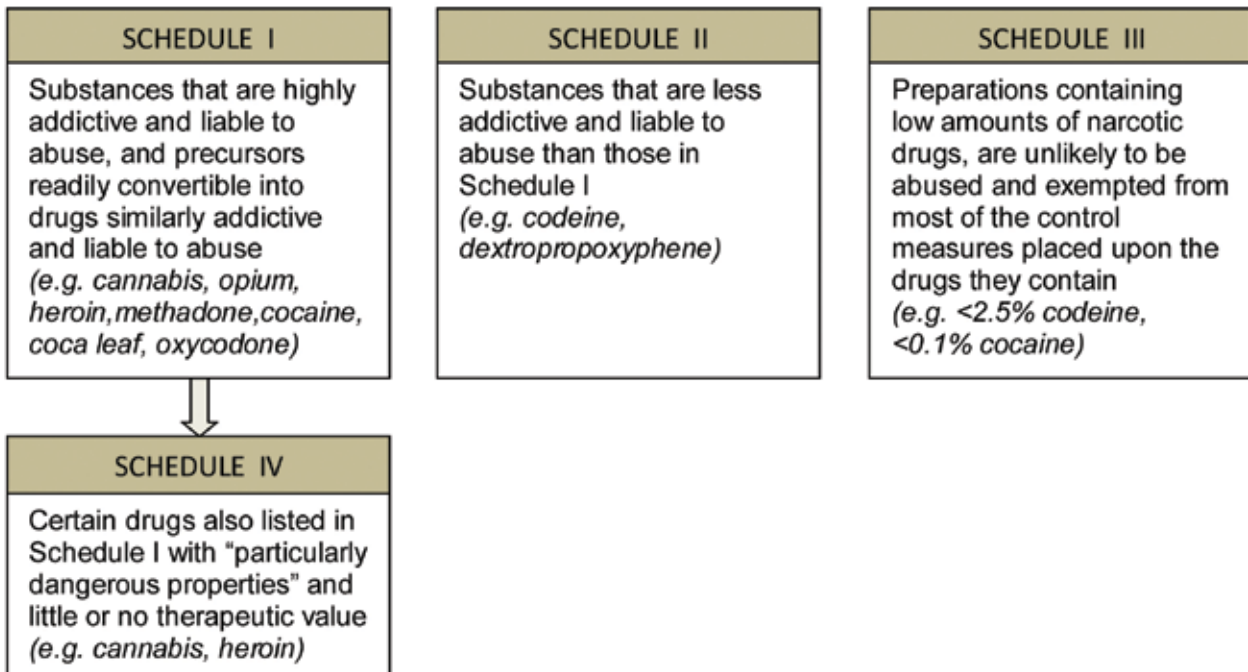
Cannabis in the Rif mountains (July 2009). Photo: Pien Metaal





## Schedules under the UN drug control conventions

### 1961 Single Convention on Narcotic Drugs



### 1971 Convention on Psychotropic Substances

SCHEDULE I	SCHEDULE II	SCHEDULE III	SCHEDULE IV
Drugs presenting a high risk of abuse, posing a particularly serious threat to public health with little or no therapeutic value (e.g. <i>LSD, MDMA, cathinone</i> )	Drugs presenting a risk of abuse, posing a serious threat to public health, which are of low or moderate therapeutic value (e.g. <i>dronabinol, amphetamines</i> )	Drugs presenting a risk of abuse, posing a serious threat to public health, which are of moderate or high therapeutic value (e.g. <i>barbiturates, buprenorphine</i> )	Drugs presenting a risk of abuse, posing a minor threat to public health, with a high therapeutic value (e.g. <i>tranquillizers, including diazepam</i> )

### 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances

TABLE I	TABLE II
Precursors of psychotropic substances, such as ephedrine, piperonal, safrole, phenylacetic acid, lysergic acid; and a few key reagents such as acetic anhydride used in the conversion of morphine into heroin and potassium permanganate used in the extraction of cocaine	A wide range of reagents and solvents that can be used in the illicit production of narcotic drugs and psychotropic substances, but also have widespread licit industrial uses, including acetone, ethyl ether, toluene and sulphuric acid



the world.<sup>132</sup> The booklet has been qualified as “primarily a diatribe against marihuana [...] practically devoid of hard data”<sup>133</sup> that provided little to no scientific evidence regarding the alleged association between cannabis and crime.

Rather than a credible study, it is a pamphlet admonishing cannabis’ menacing effect. “With every reason, marihuana [...] has been closely associated since the most remote time with insanity, with crime, with violence, and with brutality,” Wolff concludes. The bombastic language discredits any scientific reliability and impartiality. For example, cannabis: “changes thousands of persons into nothing more than human scum,” and “this vice... should be suppressed at any cost.” Cannabis is labelled as a “weed of the brutal crime and of the burning hell,” an “exterminating demon which is now attacking our country.” Users are referred to as addicts whose “motive belongs to a strain which is pure viciousness.”<sup>134</sup>

Wolff also distorted available evidence by cherry-picking from reports to support his position, claiming for instance, “an American commission which studied marijuana addiction in the Panama garrisons found among the addicts individuals who were under charges of violence

and insubordination.” That commission was the Panama Canal Zone one mentioned above, which had reached the diametrically opposite conclusion based on evidence that acts of violence and insubordination had little to no relation to cannabis, but were, in fact, caused by alcohol.<sup>135</sup> Wolff’s claim that there was “no medical indication whatsoever that will justify its use in the present day”<sup>136</sup> was taken onboard by the WHO expert committee about cannabis in 1952, of which he was the secretary.

The deliberations from 1950 to 1955 would determine the status of cannabis in the 1961 UN Single Convention on Narcotic Drugs.<sup>137</sup> And Wolff practically unilaterally determined the WHO position during these crucial years. At the 1953 CND meeting a study programme was approved to evaluate existing control regimes in cooperation with the Food and Agriculture Organization (FAO) and the WHO. The importance of the WHO undertaking a study on the physical and mental effects was stressed. When the CND met in 1955 the delegates were presented a report, *The Physical and Mental Effects of Cannabis*, written by Wolff.<sup>138</sup> Little more than an update of his earlier booklet, and no less biased, it concludes that “cannabis constitutes a dangerous drug from every point of view, whether physical,

mental, social or criminological,” and “not only is marihuana smoking per se a danger but that its use eventually leads the smoker to turn to intravenous heroin injections.”<sup>139</sup>

The report is relentless in its drive to reach that conclusion. Wolff has little indulgence for those “inclined to minimize the importance of smoking marihuana.”<sup>140</sup> The literature cited is highly selective and the work of the League’s Subcommittee in the 1930s barely acknowledged. There are also serious doubts about the official status of the document: it did not represent the WHO’s institutional point of view and was not endorsed by the relevant expert committee nor mentioned in its reports. Wolff’s successor, the aforementioned Hans Halbach, referred to the report “as a working paper for the WHO Secretariat [...] made available for distribution by the WHO Secretariat.”<sup>141</sup> However, at the CND meeting, many delegates perceived the document as representing the WHO position.

### **Cannabis condemned: the 1961 Single Convention**

The CND reached the verdict that cannabis had no medicinal value at its 1955 meeting on the basis of the minimal and biased documentation presented.<sup>142</sup> Proof that cannabis had a medicinal use in traditional Indian medicine, for example, did not stymie the prohibition impetus. India’s objections had little effect against the powerful anti-cannabis bloc.<sup>143</sup> As a result, the third draft of the Single Convention of 1958 included a special section under the heading “prohibition of cannabis”. But opposition prevented its adoption at the Plenipotentiary Conference that negotiated the draft version in New York from 24 January to 25 March 1961. In attendance were representatives of 73 states and a range of international organisations.

India objected because it opposed banning the widespread traditional use of *bhang* made from cannabis leaves with a low psychoactive content, described by the Indian delegate as a “mildly intoxicating drink” that was “far less harmful than alcohol.”<sup>144</sup> Pakistan argued against prohibition, as did Burma, leading to an interesting interlude in which the supply of cannabis for elephants used in the timber industry was discussed. Other states supported continued use of cannabis in some pharmaceutical preparations as well as in indigenous medicine, professing that future research might well reveal further medicinal benefits. Deviating from the zero-tolerance bias so prevalent at the Conference, leaves and seeds were explicitly omitted from the definition of cannabis, which now only referred to the “flowering or fruiting tops of the cannabis plant.”<sup>145</sup> As such, the traditional use of *bhang* in India could continue.

Questions about “indigenous medicine”, “quasi-medical uses”, “traditional uses” and precise definitions of the plants or derived substances that should be placed under

control remained unresolved. Several delegations argued that using the phrasing “medical, scientific and other legitimate purposes” could provide a solution for allowing certain traditional uses such as the Indian *bhang* brew and “indigenous medicinal” applications. Deemed confusing and deviating from the fundamental principle of limitation to medical and scientific purposes only, the insertion “other legitimate purposes” was rejected. The exceptions for industrial purposes of cannabis (fibre and seed) were cited in separate articles.

Widely socially accepted uses of cannabis in many Asian and African countries, were thus condemned to be abolished, a culturally biased approach that was also extended to coca leaf chewing. Article 49 required the abolition of the non-medical and non-scientific use of cannabis, cannabis resin, extracts and tinctures of cannabis as soon as possible, with a maximum delay of 25 years. The required number of 40 ratifications of the treaty to enter into force was reached in December 1964, hence the 25-year phase-out scheme for cannabis ended in 1989.<sup>146</sup>

Along with heroin and a few other selected drugs cannabis was included in Schedule I (containing those substances considered most addictive and most harmful) and in the strictest Schedule IV (containing those substances to be the most dangerous and regarded as exceptionally addictive and producing severe ill effects) of the Single Convention. Thus, it became classified it among the most dangerous psychoactive substances under international control with extremely limited therapeutic value. Cannabis, cannabis resin and extracts and tincture of cannabis are therefore subject to all control measures foreseen by the Convention.<sup>147</sup> With regard to Schedule IV, article 2, 5 (b) of the Convention stipulates that any signatory “shall, if in its opinion the prevailing conditions in its country render it the most appropriate means of protecting the public health and welfare, prohibit the production, manufacture, export and import of, trade in, possession or use of any such drug except for amounts which may be necessary for medical and scientific research only.” Due to its inclusion in Schedule IV, the Convention hereby suggests that parties should consider prohibiting cannabis for medical purposes and only allow limited quantities for medical research.<sup>148</sup>

The key provision of the Convention is found under General Obligations in Article 4: “The parties shall take such legislative and administrative measures [...] to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs”.

### **THC and the 1971 “Psychotropics” Convention**

The psychoactive compounds of cannabis were identified after the 1961 Convention was concluded. In 1963, Raphael Mechoulam and his research partners at the

### **WHO & the scheduling of dronabinol / THC: the unfinished saga<sup>150</sup>**

- 1971** Dronabinol included in Schedule I of the 1971 Convention
- 1987** U.S. government requests UN Secretary General to transfer it from Schedule I to II
- 1989** WHO 26<sup>th</sup> Expert Committee recommends transferring dronabinol to Schedule II
- 1990** CND rejects in March the recommendation, fearing increase of abuse
- 1990** WHO 27<sup>th</sup> Expert Committee again recommends in September de-scheduling to Schedule II, adding evidence of therapeutic usefulness and low risk of abuse
- 1991** CND adopts recommendation and dronabinol is transferred to Schedule II
- 2002** WHO 33<sup>rd</sup> Expert Committee meeting undertakes new critical review and recommends transfer to most lenient Schedule IV, requiring hardly any control measures
- 2003** WHO recommendation is deliberately kept away from the CND through political interference in the procedure by UNODC under US pressure
- 2006** WHO 34<sup>th</sup> Expert Committee meeting “updates” its previous review and now recommends transfer to Schedule III
- 2007** CND decides not to vote on the new recommendation, instead requesting WHO to update the review when additional information becomes available
- 2012** Lack of funding obstructs its functioning and only after six years the 35<sup>th</sup> WHO Expert Committee meets and decides there is not sufficient new evidence to merit another review
- 2013** WHO communicates to the CND that in absence of relevant new evidence its recommendation to transfer dronabinol to Schedule III still stands
- 2013** CND keeps it off the agenda and no vote takes place; minority discontent leads to the decision to put the issue of CND handling of WHO recommendations on the 2014 agenda

Hebrew University of Jerusalem revealed the structure of cannabidiol (CBD). By the following year they had isolated delta-9-tetrahydrocannabinol (THC), established its structure and synthesized it.<sup>149</sup>

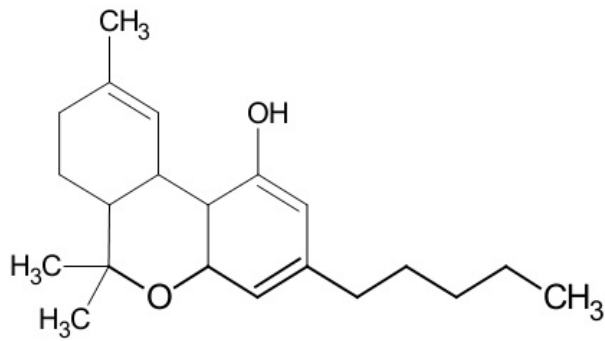
As mentioned above, cannabis, or more precisely its “flowering and fruiting tops” and its resin, were included

in Schedules I and IV of the 1961 Single Convention. The active alkaloids of other plant materials controlled under the 1961 Convention, like cocaine that can be extracted from the coca leaf or morphine from opium poppy, were included in the Schedules of the same convention. In the case of cannabis, however, the basic rationale of the Single Convention was abandoned with the decision instead to control its main active ingredient, THC, under the 1971 Convention on Psychotropic Substances. Dronabinol, a pharmaceutical formulation of THC, was included in the most stringent Schedule I when the 1971 Convention was adopted, corresponding in severity of control measures with Schedule IV of the 1961 Convention. As explained in INCB training materials, the use of those substances “must be prohibited except for scientific and very limited medical purposes.”<sup>151</sup>

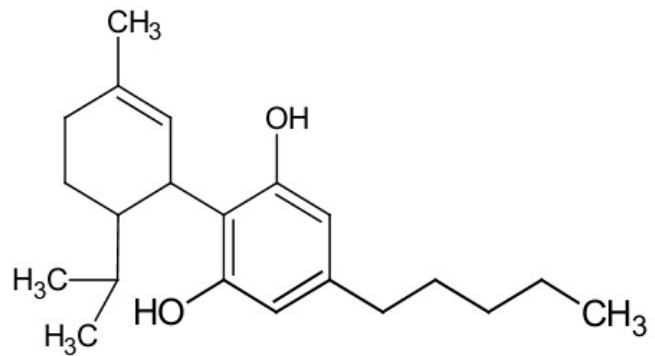
In 1969 the WHO Expert Committee announced it “strongly reaffirms the opinions expressed in previous reports that cannabis is a drug of dependence, producing public health and social problems, and that its control must be continued” and that “medical need for cannabis as such no longer exists.”<sup>152</sup> The WHO Expert Committee and the INCB still had few differences of opinion at the time. After discussing a draft of what would eventually become the 1971 Convention on Psychotropic Substances, the WHO Expert Committee in 1970 suggested a division of five categories and recommended the inclusion of tetrahydrocannabinols in the strictest category of “drugs recommended for control because of their liability to abuse constitutes an especially serious risk to public health and because they have very limited, if any, therapeutic usefulness.”<sup>153</sup>

The pharmaceutical industry, meanwhile, had become interested in the medicinal potential of cannabinoids, and preferred they be dealt with under a new treaty rather than added to the 1961 Convention, to keep exploration and commercial development separated from the politically charged controls the Single Convention had placed on cannabis itself. During the 1971 conference, disputes regarding the separation of control measures for cannabis from those for its active principles, erupted several times. One of the difficulties was how to define and control the production or manufacture of “psychotropic” substances. As the official records of the Conference note, “The Technical Committee had discussed the problem in connexion with the tetrahydrocannabinols, derived from the cannabis plant. If “production” meant planting, cultivation and harvesting, then cannabis would have to be treated as a psychotropic substance.”<sup>154</sup>

It was finally decided, in the words of the Indian delegate, that “all references to production should be dropped” because otherwise the fact that “tetrahydrocannabinols had been included in Schedule I” and since “cannabis was the plant from which those substances were derived”, it “would mean that cannabis would fall within the scope” of the treaty as well.<sup>155</sup> The 1971 conference thus adopted



Tetrahydrocannabinol (THC)



Cannabidiol (CBD)

a control logic completely different from the rationale behind the 1961 Convention. The issue of cultivation, production and required precursors, whether plants or other substances, for psychotropic substances was deliberately kept out of the treaty.<sup>156</sup>

Including THC in Schedule I allowed its use in medical research, but posed obstacles for the development and marketing of pharmaceutical preparations for medical uses. Successful lobbying of the pharmaceutical industry, based on a slowly increasing body of evidence regarding medicinal efficacy of cannabis and its cannabinoids, led to a 1982 U.S. government request to transfer dronabinol from Schedule I to II. Several years later the WHO Expert Committee conducted a critical review resulting in a positive recommendation. The CND adoption in 1991 of the WHO recommendation to deschedule dronabinol and all its stereoisomers to the less stringent Schedule II of the 1971 Convention was the first step in the still ongoing process of formal acknowledgement at UN level of the medical usefulness of the main active compound of cannabis.<sup>157</sup> (See Box: WHO & the scheduling of dronabinol / THC: the unfinished saga)

### First wave of soft defection

The 1961 Single Convention was not even in print before the debate about the status of cannabis restarted. At the CND session immediately following the 1961 conference, comments from professionals in the Dutch press that cannabis addiction was no worse than alcoholism triggered a debate. Views not entirely consistent with the international control policy only just embodied in the Single Convention were being voiced. The majority opinion in the CND argued that the international community had agreed that cannabis use was a form of drug addiction and emphasized that any publicity to the contrary was misleading and dangerous.<sup>158</sup> Over the years, this would become the stock response whenever anyone dared to voice dissent. Known today as the “Vienna consensus” (since the UN drug control machinery moved from Geneva to Vienna in 1980) that so-called consensus is hailed by its promoters as the

bedrock of the UN drug control system. Those favouring reform see it as a barrier to modifying the status quo of an increasingly inadequate regime no longer fit for purpose.

Due to its growing popularity and increasingly widespread use, particularly its close association with the emerging counter-cultural movements, cannabis became the focus of drug enforcement activities in many western countries in the 1960s. Meanwhile, western cannabis pilgrims were heading off for the countries in which cannabis consumption remained a traditional custom. The shift in drug use patterns within these western nations coincided with the coming into force of the Single Convention and the birth of the new era in international drug control, ironically, including increased controls on the drugs under the UN operated regime. Arrests for drug offences reached unprecedented levels, driven largely by the growth in cannabis offences, including those for simple possession. In the U.S., for example, offences relating to the drug rose by 94.3 per cent between 1966 and 1967, the year the Convention was ratified in Washington, with even small amounts of cannabis potentially resulting in custodial sentences of up to ten years.<sup>159</sup>

Although this was an extreme, large numbers of predominantly young people were receiving criminal convictions, fines and, in some cases, prison sentences in a range of western countries. The handling of cannabis users within a variety of national legal systems consequently triggered significant domestic debate. Extensive public inquiries or commissions were established to examine drug use and recommended changes in the law on cannabis, in a number of nations, principally the U.K. (Report by the Advisory Committee on Drugs Dependence, the so-called Wootton Report, 1969), the Netherlands (The Baan Commission, 1970 and Hulsman Commission, 1971), the U.S. (The Shafer Commission Report, *Marihuana: A Signal of Misunderstanding*, National Commission on Marihuana and Drug Abuse 1972), Canada (The Commission of Inquiry into the Nonmedical Use of Drugs, commonly referred to as the Le Dain Commission, 1973) and Australia (Senate Social Committee on Social Welfare, 1977).



As with earlier inquiries, including the Indian Hemp Commission of 1894, the Panama Zone Report in 1925 and the 1944 La Guardia Report, all the exercises came to broadly the same conclusions. Cannabis was not a harmless psychoactive substance, yet compared with other drugs the dangers were being exaggerated. Further, as commentators have pointed out, there was general agreement that “the effects of the criminalization of cannabis were potentially excessive and the measures even counterproductive.” Consequently, “lawmakers should drastically reduce or eliminate criminal penalties for personal use.”<sup>160</sup> As was largely the case at the national level, the reports had little noticeable effect on the attitude of the international drug control community, though their spirit may have influenced to some extent the 1972 Protocol Amending the Single Convention on Narcotic Drugs. A minor reorientation of the regime toward greater provision for treatment and social reintegration was proposed, as was the option of alternatives to penal sanctions for trade and possession offences when committed by drug users.<sup>161</sup> The prohibitive ethos and supply-side focus of the drug control regime, however, remained untouched.

Such stasis on the international stage did not prevent a number of waves of “soft defection” from the conventions’ dominant zero-tolerance approach. Despite, and often due to, the U.S. federal government’s continued opposition to any alteration of the law, a number of U.S. states relaxed their policies regarding possession and decriminalized or depenalized personal use in the 1970s. Thus, while Washington was successfully imposing its prohibitionist policy on the rest of the world, the federal government had major difficulties in maintaining its policy domestically.<sup>162</sup>

That dichotomy began when the Nixon administration introduced the Controlled Substances Act in 1970 and initiated the “war on drugs”. The law placed cannabis in the same schedule as heroin (Schedule I drugs regarded as possessing a high potential for abuse with no medicinal value) and prohibited the recreational use of the drug nationwide. At the same time Nixon also appointed the Shafer Commission to study cannabis use in the country. The results were not to the President’s liking, the Commission favouring an end to cannabis prohibition and the adoption of other approaches, including a social-control policy seeking to discourage marijuana use. In his presentation to Congress in 1972, the Commission’s chairman recommended the decriminalization of small amounts of amounts, saying, “criminal law is too harsh a tool to apply to personal possession even in the effort to discourage use.”<sup>163</sup>

Nixon dismissed the Commission’s findings. Nevertheless, the report had a considerable impact on the diverging trends on cannabis in the U.S. In 1973 Oregon became the first state to decriminalize cannabis. Possession of one ounce (28.35 grams) or less became punishable only by a \$500 to \$1,000 fine. California followed in 1975, making possession under one ounce for non-medical use punishable by a \$100 fine. The Alaska Supreme Court ruled in 1975 that possession of amounts up to one ounce for personal use were legal in one’s own house under the state constitution and its privacy protections. Other states followed with varying policies, including measures such as fines, drug education, treatment instead of incarceration or assigning the lowest priority to various cannabis offences for law enforcement.<sup>164</sup>

Outside the U.S., in an isolated example of national politicians taking on board commission advice, Dutch authorities acted on many recommendations made by the Baan and Hulsman Commissions and began re-evaluating how to deal with cannabis use, a process that was to lead to the coffeshop system. The Dutch government at the time was even prepared to legalize cannabis, according to a government memorandum in January 1974:

The use of cannabis products and the possession of them for personal use should be removed as soon as possible from the domain of criminal justice. However, this cannot be realized as yet, as it would bring us into conflict with our treaty obligations. The Government shall explore in international consultations whether it is feasible that agreements as the Single Convention be amended in a way that nations will be free to institute, at their discretion, a separate regime for cannabis products.<sup>165</sup>

Fully aware that an amendment of the Single Convention was impossible when on the other side of the Atlantic a war on drugs had been declared, the Dutch government did not insist. Nevertheless, a breakthrough in the United States, not unlike what would eventually be achieved in Colorado, Washington and Uruguay, did seem possible only a few years later. In August 1979, President Jimmy Carter, in a message to Congress, took up the recommendations of the Shafer report that had been dismissed by his predecessor Nixon:

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 possession of marijuana in private for personal use. We can, and should, continue to discourage the use of marijuana, but this can be done without defining the smoker as a criminal. States which have already removed criminal penalties for marijuana use, like Oregon and California, have not noted any significant increase in marijuana smoking. 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.<sup>166</sup>

Carter supported legislation amending federal law to eliminate all federal criminal penalties for the possession of up to one ounce of marijuana, leaving the states to remain free to adopt whatever laws they wished concerning cannabis use. Stressing that decriminalization was not legalization (in that the federal penalty for possession would be reduced and a person would receive a fine rather than a criminal penalty), the proposed policy shift nevertheless signified a substantial change.

However, amidst growing public opposition lessening the punitive response to cannabis use,<sup>167</sup> hope of reform ended

with Carter's defeat in the 1981 presidential election and the concomitant conservative backlash across many areas of public policy. President Ronald Reagan re-initiated Nixon's war on drugs and introduced new more punitive prohibitive legislation. Moreover, Reagan not only introduced stricter laws in the U.S., but embarked on a mission at the international level to accomplish what U.S. delegates had not been able to achieve in the 1930s and Anslinger had failed to accomplish satisfactorily with the 1961 Convention and its 1972 Amending Protocol: prevent the growth of an increasingly lucrative criminal market and the massive expansion of illegal drug trafficking networks supplying it.

Consequently, just as in the 1930s and the development of the 1936 Convention for the Suppression of the Illicit Traffic in Dangerous Drugs, an additional convention was deemed necessary to counter drug trafficking and pursue the earnings from drug trafficking in an effort to remove both the incentive (profit) and the means (operating capital). The result was yet another international control mechanism and the beginnings of an anti-money-laundering regime to identify, trace, freeze, seize and forfeit drug-crime proceeds.<sup>168</sup> The 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances significantly reinforced the obligation of countries to apply criminal sanctions to combat all the aspects of illicit production, possession and trafficking of drugs.

### Successive waves of soft defections

Current policies in both the Netherlands and in some U.S. states can be seen as the legacy of policy choices made during a first wave of cannabis liberalization four decades ago. More recently, a second wave of policies softening the prohibition of recreational cannabis use can be identified around the globe: what has been called a "quiet revolution" of decriminalization in several Latin American and European countries and within Australian states and territories.<sup>169</sup>

These waves of soft defection mainly consist of softening or abolishing penal provisions for personal use, possession for personal use, and in some instances the cultivation of a limited amount of plants for personal use. The medical-marijuana movement in the U.S. might be seen as a third wave of soft defection although concomitant with the second one. In 1996, voters in California passed Proposition 215, the Compassionate Use Act, exempting medical use of cannabis from criminal penalties. This does not legalize cannabis, but changes how patients and their primary caregivers are treated by the court system. California's law allows for individuals to possess, cultivate and transport cannabis as long as it is used for medical purposes with a doctor's written "recommendation", as opposed to a prescription.<sup>170</sup>

Since 1996 other states have followed the Californian example to varying degrees. Currently there are 21 with medical marijuana laws and 14 that have decriminalized cannabis one way or another. Medical-marijuana dispensaries and cannabis buyers' clubs have emerged to provide cannabis to those with legitimate medical need. A grey market has developed through trial and error in which cannabis is now available as a medical treatment in several U.S. states to almost anyone who tells a willing physician that discomfort would be lessened if he or she smoked.<sup>171</sup> Despite substantial differences across counties and cities, the "Californian model" has grown into something close to de facto legalization for recreational use.

The intransigence of the federal government regarding states' medical-marijuana arrangements, in particular the move towards de facto regulation of cultivation for recreational use in some states, has made cannabis policy a battleground for activists, law enforcement, voters, local, state and federal legislators and, in the final instance, the courts. The regulation of medical-marijuana cultivation could be considered a precursor to the legal regulation of the recreational cannabis market, not unlike alcohol-regulation models. The successful ballot initiatives in Washington and Colorado in November 2012 are the most recent stage in this process, and are expected to be the start of yet another wave that now moves from soft to hard defection, leading to treaty breaches.

At the UN level the increased soft defection regarding cannabis in some western countries led to a reaction at the 2002 session of the CND. The attempt was based on the 2001 annual report of the INCB, which contained strong language about the leniency trend. On the first day of the session the president of the INCB, Hamid Ghodse, stated: "In the light of the changes that are occurring in relation to cannabis control in some countries, it would seem to be an appropriate time for the Commission to consider this issue in some detail to ensure the consistent application of the provisions of the 1961 Convention across the globe." The hard liners in international drug control took up this invitation and expressed their grave concern. Morocco, for instance, pointed at the emerging contradiction between the trend towards decriminalization of cannabis use and a continuing pressure on "southern" countries to eradicate cannabis with repressive means.<sup>172</sup>

Although Morocco, a major supplier of hashish for the European market, certainly had a point, one cannot ignore that in many so-called southern producer countries, often with a long tradition of cannabis use, law-enforcement services habitually turn a blind eye to domestic cannabis use as well. In the end, the selective focus towards cannabis use in developing countries and a variety of decriminalization policies in western countries are quite similar. One could, therefore, point to the hypocrisy on both sides of the debate and the lack of realization that there is in fact more common ground than is apparent in arguing for a regime change, in particular where cannabis is concerned.

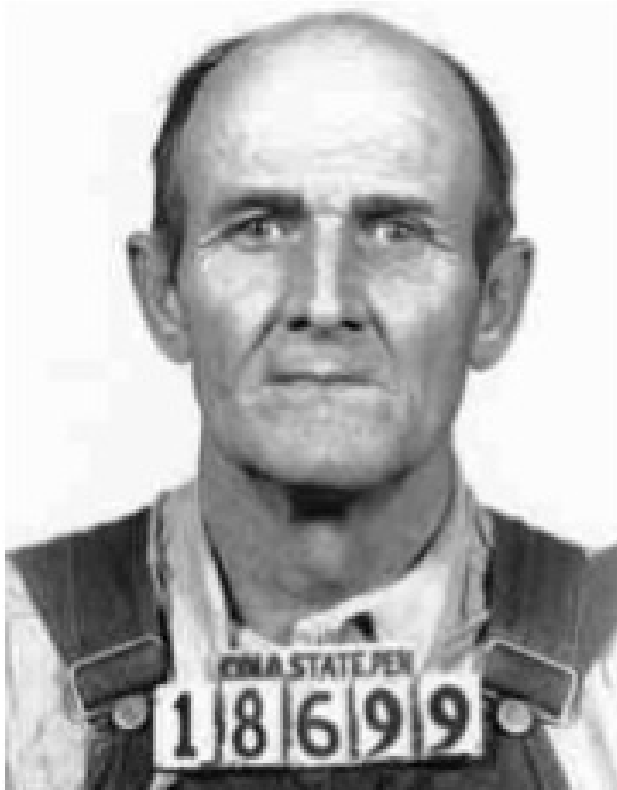
The skirmishing about "lenient policies" continued at the CND in 2003, remaining unresolved. One of the outcomes of the debate was a request to the United Nations Office on Drugs and Crime (UNODC) to prepare a global market survey on cannabis,<sup>173</sup> which resulted in a special chapter in the 2006 World Drug Report, entitled "Cannabis: Why we should care". In the report the UNODC recognized that "much of the early material on cannabis is now considered inaccurate, and that a series of studies in a range of countries have exonerated cannabis of many of the charges levelled against it."<sup>174</sup> It goes on to note that "[M]edical use of the active ingredients, if not the plant itself, is championed by respected professionals." That in itself is surely a valid reason to remove cannabis from Schedule IV, now that the UNODC also acknowledges that the scientific basis for putting cannabis on the list of the 1961 Single Convention at the same level as heroin has been incorrect.

Nevertheless, the report is inconsistent due its effort to balance or counter scientific research with the political correctness of the global drug prohibition regime. In its preface, written by the then UNODC Executive Director Antonio Maria Costa, the unsubstantiated allegations about cannabis re-emerged. Costa claimed that the unlimited supply and demand of cannabis were "devastating" and that the world was experiencing a "cannabis pandemic." According to Costa, "the characteristics of cannabis are no



A hemp drug shop in the Khandesh region in India, displaying bhang, ganja, and majum. From the Indian Hemp Drugs Commission Report (1894). (Courtesy: National Library of Scotland)





**First conviction for marijuana in the U.S.**

Samuel R. Caldwell was the first person convicted of selling cannabis under the Marijuana Tax Act of 1937, after drug-enforcement agents busted him with 3 pounds of cannabis in his apartment in Denver, Colorado. He was sentenced to four years of hard labour, in addition to a \$1,000 fine. Federal Bureau of Narcotics chief Harry Anslinger came to Denver to watch the trial. Caldwell was incarcerated in 1937, at age 58, and released in 1940 at age 60. Caldwell died one year after his release. Seventy-six years later, Colorado was the first state to allow a regulated cannabis market.

(Source: *Marijuana in Colorado has a long history and an uncertain future*, The Denver Post, December 31, 2013)

longer that different from those of other plant-based drugs such as cocaine and heroin.” In so doing the executive director echoed the unsubstantiated claims of Anslinger and Wolff from more than fifty years earlier. Central to these claims were the emergence of high potency cannabis on the market and the failure to control supply at global level.

Costa’s strong language was at odds with the more cautious section about cannabis in the World Drug Report, however. To be sure, the claim of a devastating cannabis pandemic is not anywhere substantiated. Further, the report suffers from an attempt to bridge the gap between the exaggerated claims within Costa’s preface and the more cautious content of the main text itself. Although it contains much valuable information, in trying to span the two the report tends to stress the negative and discard the positive. It basically ignores the increased medical use of cannabis. In discussing potential health and addiction problems the UNODC admits that much of the scientific data is still inconclusive, but the report tends to highlight research that indicates problems, while research that contradicts these conclusions is disregarded.<sup>175</sup> The report does, nonetheless, demonstrate that supply reduction is impossible given the potential to grow the plant anywhere and that all past attempts to control availability have failed.

In its final conclusion, however, the report raises the key issue concerning cannabis today, as evidenced by the pioneering reform initiatives in Uruguay, and Washington and Colorado:

The world has failed to come to terms with cannabis as a drug. In some countries, cannabis use and trafficking are taken very seriously, while in others, they are virtually ignored. This incongruity undermines the credibility of the international system, and the time for resolving global ambivalence on the issue is long overdue. Either the gap between the letter and spirit of the Single Convention, so manifest with cannabis, needs to be bridged, or parties to the Convention need to discuss redefining the status of cannabis.<sup>176</sup>

Now, nearly eight years after the writing of those words, and given the fact that some jurisdictions are allowing a regulated market for recreational use, the debate about a different status of cannabis in the international drug control regime seems to be more necessary than ever.

## Endnotes

**The history of cannabis in the international drug control system**

- 1 WDR (2013), p. xi
- 2 Abel (1980)
- 3 Cannabis was first described in a medical context by the Chinese emperor Shen-Nung in 2700 BC to treat “beri-beri, constipation, female weakness, gout, malaria, rheumatism and absentmindedness”. See: Geller (2007)
- 4 United Nations (1961), Article 4, General Obligations
- 5 Bewley-Taylor and Jelsma (2012a), quoting: E/CONF.34/24 (1964)
- 6 Ballotta, Bergeron and Hughes (2009)
- 7 Senate Special Committee on Illegal Drugs (2002)
- 8 Ballotta, Bergeron & Hughes (2009)
- 9 Kozma (2011)
- 10 Mills (2003), pp. 177-180; Smoking hashish is still popular in Egypt and the harsh laws, including capital punishment, are rarely enforced. See: Cunningham and Habib (2013).
- 11 Kendell (2003)
- 12 Stefanis, Ballas and Madianou (1975)
- 13 The chapters and paragraphs indicated are those used in the Report of the Indian Hemp Drugs Commission (1895). See also: Mills (2003), p. 130. *Ganja* is a term of Sanskrit origin for cannabis, *charas* is a type of hashish and *bhang* is a preparation from the leaves and flowers (buds) of the female cannabis plant with a low THC content, smoked or consumed as a beverage.
- 14 Ballotta, Bergeron and Hughes (2009); Du Toit (1977)
- 15 Ames (1958)
- 16 Geller (2007)
- 17 The price for a slave in 1830 was 250 milreis and the annual wage of a skilled urban tradesman about 175 milreis. See Frank (2004). The money the fine levied could buy 250 pounds of bread.
- 18 Freyre (1932/2002), pp. 446-47; Cordeiro de Farias (1955); Hutchinson (1975); Henman (1980).
- 19 Vidal (2008); Paulraj (2013).
- 20 Röhrig Assunção (1995), p. 159
- 21 Henman (1980); Paulraj (2013).
- 22 Ames (1958); Du Toit (1975)
- 23 Livingstone (1857), p. 540; Du Toit (1975)
- 24 Monteiro (1875), p. 26 and pp. 256-58
- 25 Ames (1958)
- 26 Hutchinson (1975).
- 27 Henman (1980); Paulraj (2013).
- 28 Gilberto Freyre, one of Brazil’s foremost sociologists and cultural anthropologists openly admitted to have smoked cannabis, which he had learned from sailors from Alagoas “without the danger of slipping in amok,” indicating responsible use of the substance (Freyre, 1975).
- 29 Dória (1915)
- 30 MacRae and Assis Simões (2005)
- 31 Kendell (2003); Mills (2003), pp. 93-99
- 32 Report of the Indian Hemp Drugs Commission (1895). See also: Mills (2003), pp. 118-121. The seven volumes comprise 3,281 pages.
- 33 Ketill, Pan and Rexed (1975), pp. 181-203
- 34 Benabud (1957); Carpentier, Laniel and Griffiths (2012)
- 35 Ounnir (2006). See also: *Boletín de la Sociedad Geográfica de Madrid*, Tomo XVI, Año IX, Número 1, January 1884, pp. 35 and 42; available at <http://prensahistorica.mcu.es/es/consulta/registro.cmd?id=11000051886>.
- 36 Labrousse and Romero (2001); Chouvy, (2008); Afsahi (2011).
- 37 Personal observation by the author in the village of Azila near Ketama during a research mission in July 2009. The farmers showed us a copy the 1934 *dahir*. The 1917 decree (*Reglamento para la repesión del contrabando de tabaco y kif en la zona de influencia de España en Marruecos*) was published in the *Boletín Oficial de la Zona de Influencia española en Marruecos*, nr. 5, March 10, 1917, available at <http://hemerotecadigital.bne.es/issue.vm?id=0003838902>. The 1935 decree (*Dahir dictando medidas provisionales para prohibir el cultivo de tabaco y kif en las cabilas de nuestro Zona de Protectorado*) was published in the *Boletín Oficial de la Zona de Protectorado Español en Marruecos*, nr. 24, August 31, 1935, pp. 1071-73, available at <http://prensahistorica.mcu.es/es/consulta/registro.cmd?id=11000159175>
- 38 Benabud (1957), Chouvy (2005)
- 39 The mixture consisted of two-thirds of cannabis and one-third of tobacco. See: El Atouabi (2009).
- 40 Bouquet (1951).
- 41 Bouquet (1951).
- 42 Benabud (1957), Chouvy (2005), El Atouabi (2009).
- 43 Labrousse and Romero (2001); Chouvy (2005).
- 44 El Atouabi (2009).
- 45 *Dahir aprobando el Reglamento para la repesión del contrabando de tabaco y kif en la Zona de Protectorado*, Boletín oficial de la zona de Protectorado español en Marruecos, nr. 53, December 31, 1954, available at <http://prensahistorica.mcu.es/es/consulta/registro.cmd?id=11000159036>
- 46 Morocco adhered to the 1961 Single Convention in 1966 and followed France in its drug legislation. The 1974 drug law penalised import, production, manufacture, transport, export and possession of substances or plants classified as narcotics (article 2), as well as its use (article 8). *Dahir portant loi n°1-73-282 du 28 rebia II 1394 (21 mai 1974) relatif à la répression de la toxicomanie et la prévention des toxicomanes*, Bulletin Officiel nr 3214, June 5, 1974; available at <http://adala.justice.gov.ma/production/html/Fr/liens/..%5C71772.htm>
- 47 Chouvy (2005)
- 48 Benabud (1957)
- 49 Chouvy and Afsahi (2014)
- 50 Chouvy and Afsahi (2014)
- 51 Le Braz (2010)

- 52 Karam (2013)
- 53 Kozma (2011)
- 54 Bruun, Pan & Rexed (1975), pp. 181-82; Mills (2003), pp. 154-56. Italy only consented to the conference after its request was accepted that the trade in Indian hemp and hashish be considered. See: Taylor (1969).
- 55 Mills (2003), pp. 154-56
- 56 Musto (1999), p. 51
- 57 Bruun Pan and Rexed (1975), p. 182
- 58 Musto (1972)
- 59 Bewley-Taylor & Jelsma (2011)
- 60 Chevannes (2001)
- 61 Fraser (1974)
- 62 Mills (2003), p. 160
- 63 Mills (2003), p. 167
- 64 Kendell (2003); Mills (2003), pp. 169-71
- 65 Kozma (2011)
- 66 Kendell (2003)
- 67 Mills (2003), p. 173
- 68 Bewley-Taylor (2002b), p. 32
- 69 The 1925 Convention included the following provisions in a separate chapter on Indian Hemp (Chapter IV). Article 11 §1 stated: "In addition to the provisions of Chapter V [Control of International Trade] which shall apply to Indian hemp and the resin prepared from it, the Contracting Parties undertake: (a) To prohibit the export of the resin obtained from Indian hemp and the ordinary preparations of which the resin forms the base... to countries which have prohibited their use, and in cases where export is permitted, to require the production of a special import certificate issued by the Government of the importing country stating that the importation is approved for the purposes specified in the certificate and that the resin or preparations will not be re-exported". Article 11 §2 established the general rule: "The Contracting Parties shall exercise an effective control of such a nature as to prevent the illicit international traffic in Indian hemp and especially in the resin". See: UNODC (2009).
- 70 Kendell (2003)
- 71 UNODC (2009); Bewley Taylor and Jelsma (2012a)
- 72 The Netherlands was one of the first countries in which cannabis became the object of statutory regulation. The import and export of cannabis was introduced into the Opium Act in 1928. Possession, manufacture, and sale became criminal offences in 1953. Statutory decriminalization of cannabis took place in 1976. De facto decriminalization, however, set in somewhat earlier. See: Korf (2002)
- 73 Ballotta, Bergeron & Hughes (2009)
- 74 Fraser (1974)
- 75 Bruun, Pan & Rexed (1975), p. 185-87; Mills (2013), p. 44
- 76 NYT (1926). The issue received more attention as the previous year a group "said to be Mexicans" had been growing marijuana in public parks in New York City, causing quite an uproar, followed by features in Sunday tabloids about the "fearful consequences of using this allegedly habit-forming and dreadful weed".
- 77 The research continued off and on well into the 1930s, due to soldiers' ongoing habit of marijuana smoking, but did not significantly alter the conclusions. Commanders unduly emphasized the effects of marijuana and delinquency, "disregarding the fact that a large proportion of the delinquents are morons or psychopaths, which conditions of themselves would serve to account for delinquency". Marijuana use among soldiers was prohibited. See: Siler et al. (1933). This study built upon the Panama Canal Zone Military Investigations (1916-1929) comprising a succession of military boards and commissions on marijuana smoking by U.S. military personnel stationed in the Zone.
- 78 Musto (1999), pp. 221-23. However, other studies indicate that prior to the efforts of the FBN to publicize the evils of marijuana in the mid-1930s the drug was virtually ignored on the national level. See: Himmelstein (1983).
- 79 McWilliams (1990), pp. 66-7
- 80 Bruun, Pan and Rexed (1975) p. 139; Bewley-Taylor (2002), p. 158
- 81 Taylor (1969); Bewley-Taylor & Jelsma (2011a)
- 82 Taylor (1969), p. 297; Bruun, Pan & Rexed (1975), p. 138
- 83 McAllister (2000), p. 123
- 84 NYT (1936); Bewley-Taylor (2001), p. 41
- 85 McWilliams (1990), p. 70
- 86 Gerber (2004), p. 9
- 87 Anslinger and Cooper (1937)
- 88 McWilliams (1990), pp. 67-80. The act only required purchase of a one-dollar tax stamp by all who possessed, traded, or prescribed cannabis. "But the devil was in its associated 60 pages of regulations, which detailed the application and maintenance process for obtaining the stamp. Doctors who wished to prescribe it had to give the FBN extensive information, including the names and addresses of patients, circumstances surrounding the prescriptions, and so on. Frequent reports and Treasury Department inspections were required, and errors were punishable by a fine of \$2,000 (about \$25,000 in today's dollars), a five-year imprisonment, or both." See: Geller (2007).
- 89 McWilliams (1990), p. 75; see also: Musto (1999), pp. 228-229
- 90 Anslinger (1938)
- 91 Bruun, Pan and Rexed (1975), p. 193
- 92 Bouquet (1951)
- 93 See for a good and recent overview: Measham, Nutt and Hulbert (2013).
- 94 Zuardi, et al. (2012); Measham, Nutt and Hulbert (2013).
- 95 Zuardi, et al. (2012)
- 96 Measham, Nutt and Hulbert (2013); Frisher et al. (2009).
- 97 Degenhardt, Ferrari, Calabria, Hall, Norman et al. (2013).
- 98 Mills (2003), pp. 82-92.
- 99 Mills (2003), pp. 91-92
- 100 Mills (2003), p. 119
- 101 Mills (2003), p. 211
- 102 Mills (2003), pp. 183-87

- 103 Mills (2003) mentioning: John Warnock, ‘Twenty-Eight Years’ Lunacy Experience in Egypt (1895-1923),’ *Journal of Mental Science*, 70 (1924): 233-61
- 104 The 1920-21 annual report of the Abbasiya Asylum in Cairo, the larger of Egypt’s two mental hospitals only attributed 2.7 per cent of its admissions to cannabis and even that modest number represented “not, strictly speaking, causes, but conditions associated with the mental disease.” See Kendell (2003).
- 105 See for instance Murphy (1963)
- 106 Salazar Viniegra (1938), Campos (2012), pp. 225-26. According to Salazar “the suggestive load and the ideas which surround marihuana are formidable and have accumulated during the course of time. Marihuana addicts, journalists and even doctors have been the ones charged with transmitting the legend from generation to generation.” See: Bonnie and Whitebread (1974), pp.193-94.
- 107 Walker (1996), pp. 67-71; Bonnie and Whitebread (1974), pp.193-94; Astorga (2003), p. 219, De Mauleón (2010).
- 108 Walker (1996), pp. 67-71
- 109 Pérez Montfort (1995)
- 110 Carey (2009)
- 111 Salazar Viniegra (1939)
- 112 Walker (1996), pp. 67-71
- 113 Astorga (2003), p. 209; Walker (1996), pp. 67-71
- 114 Carey (2009)
- 115 Leopoldo Salazar Viniegra “had the audacity to point out certain facts that are now virtual givens in the literature on drug policy—that prohibition merely spawned a black market whose results were much worse than drug use itself and that, in particular, marijuana prohibition led to the harassment and imprisonment of thousands of users who posed very little threat to society [...] Though historians have correctly viewed Salazar as a victim of an increasingly imperialist U.S. drug policy, it has not been sufficiently emphasized that he was also a victim of Mexico’s home-grown anti-drug ideology that still dominates public opinion today.” See: Campos (2012).
- 116 Murphy (1963)
- 117 IJDP (2010), pp. 261–264
- 118 Bruun, Pan and Rexed (1975), p. 195
- 119 McWilliams (1990), pp. 102-103
- 120 New York Academy of Medicine (1944); Woodiwiss (1988), pp. 58-59
- 121 May (1948), p. 350
- 122 Bewley-Taylor (2002b), p. 47
- 123 Bewley-Taylor and Jelsma (2011a)
- 124 Mills (2013), pp. 97-98
- 125 Mills (2013), pp. 97-98
- 126 Mills (2013), p. 98, quoting E/CN.7/216, Report of the Commission on Narcotic Drugs (Fifth Session)
- 127 Bewley-Taylor and Jelsma (2011a)
- 128 BJA (1992)
- 129 McAllister (2000), pp. 156-57; see also Bruun, Pan and Rexed (1975), p. 124-25
- 130 WHO (1952)
- 131 King (1974)
- 132 Bruun, Pan & Rexed (1975), p. 124 and pp. 196-97. The booklet was originally published as an article in Spanish as ‘La marihuana en la America Latina; la amenaza que constituye’, *Revista de la Asociacion Medica Argentina*, Buenos Aires, 1948.
- 133 Kalant (1968), p. 25
- 134 Goode (1970), pp. 231-32
- 135 Kaplan (1975), pp. 101-02
- 136 Bruun, Pan and Rexed (1975), pp.196-197
- 137 Bruun, Pan and Rexed (1975), p. 197
- 138 E/CN.7/L.916 (1955)
- 139 E/CN.7/L.916 (1955), Bruun, Pan and Rexed (1975) pp. 198-99
- 140 E/CN.7/L.916 (1955), Mills (2013) pp. 102-03
- 141 Bruun, Pan and Rexed (1975) pp. 198-99, quoting a letter from Halbach to Bureau of Narcotics of 27 October 1965.
- 142 As Mills discusses, while evidence concerning “routine users of cannabis engaged in harmless activities” were available during discussions of the drug in 1957, the Commission did not refer to them. Moreover, in presenting its summary of where the Commission had reached on cannabis “as it entered the final phase of redrafting the Single Convention” it quoted Wolff’s conclusion that “cannabis drugs were dangerous from ‘every point of view’”. Mills (2013), p. 107
- 143 Bewley-Taylor and Jelsma (2011)
- 144 Bewley-Taylor and Jelsma (2011) quoting E/CONF.34/24 (1964), pp. 58–62; Mills (2013), p.112
- 145 Bewley-Taylor and Jelsma (2011)
- 146 Bewley-Taylor and Jelsma (2011)
- 147 Bewley-Taylor (2012) p.154
- 148 Bewley-Taylor & Jelsma (2011); Bewley-Taylor (2012) pp. 154-156
- 149 Leichman, Abigail (2012). The work in Israel initiated research into medical use of cannabis, resulting in a thriving medical cannabis industry that now covers some 10,000 patients. However, the first true cannabinoids were isolated and described by the Scottish biochemist Alexander R. Todd in 1939 and the American Roger Adams. The latter’s extensive 1940 series in the *Journal of the American Chemical Society* served as the primary basis of cannabinoid knowledge for decades. Commissioned by the FBN in the late 1930s, Adams produced moderately pure cannabidiol and cannabinol from wild hemp. See: Geller (2007).
- 150 WHO Expert Committee reports, available at :  
CND reports available at: <http://www.unodc.org/unodc/en/commissions/CND/session/cnd-documents-index.html>
- 151 Secretariat of the International Narcotics Control Board, Psychotropics Control Section, Vienna 2012.
- 152 WHO (1969) Geneva, pp. 19-20
- 153 WHO (1970) Geneva, p. 13
- 154 E/CONF.58/7/Add.1 (1973), p. 38
- 155 Ibid., p. 78

- 156 In recent years, CND resolutions refer to “illicit cultivation of crops used for the production of narcotic drugs and psychotropic substances”, an improvement over the imprecise “illicit crops” or “illicit cultivation of narcotic drugs”. But the addition of “psychotropic substances” to that improved wording is a terminological error as cultivation and plants were explicitly left out of the 1971 Convention. Hence there is no such thing as “illicit cultivation of crops used for the production of psychotropic substances”.
- 157 WHO (2006), pp. 2-3
- 158 Bruun, Pan and Rexed (1975), p. 201
- 159 Bewley-Taylor (2012), p. 158
- 160 Room et al. (2008) p. 96; Ballotta, Bergeron & Hughes (2009) pp. 106-09
- 161 “Parties may provide, either as an alternative to conviction or punishment or in addition to conviction or punishment, that such abusers of drugs shall undergo measures of treatment, education, after-care, rehabilitation and social reintegration.” Article 38 of the Single Convention as amended by the 1972 Protocol follows very closely article 20 of the 1971 Convention. See: E/CN.7/588 (1976), p. 330.
- 162 Blickman & Jelsma (2009)
- 163 National Commission on Marihuana (1972).
- 164 Blickman & Jelsma (2009)
- 165 De Kort (1994), pp. 417-427, quoting a Memorandum [*Nota*] of 4 January 1974 in the *Nederlandse Staatscourant* (*Netherlands State Gazette*), No. 5, 8 January 1974.
- 166 Carter (1977)
- 167 Musto and Korsmeyer (2002), pp. 185-241.
- 168 See for instance: Blickman (2009)
- 169 Bewley-Taylor (2012), pp. 157-190; Rosmarin and Eastwood (2012)
- 170 Blickman & Jelsma (2009)
- 171 An owner of a dispensary estimated that 40 percent of clients suffer from serious illnesses such as cancer, AIDS, glaucoma, epilepsy and multiple sclerosis. The rest claim to have less clearly defined ailments like anxiety, sleeplessness, attention deficit disorder, and assorted pains. See: Samuels (2008)
- 172 Some observers pointed a finger at the United States as instigating the attack, see Bewley-Taylor (2012), pp. 202-05. See also: Blickman (2002).
- 173 UN General Assembly resolution 59/160 (2004)
- 174 WDR (2006) p.156
- 175 See, for example: Woodridge, E, Barton, S, Samuel, J, Osorio, J, Dougherty, A, & Holdcroft A, (2005) ‘Cannabis Use in HIV for Pain and Other medical Symptoms’, *Journal of Pain and Symptom Management*, Vol. 29, Issue 4, pp. 358-357
- 176 WDR (2006) p. 186

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The cannabis plant has been used for spiritual, medicinal and recreational purposes since the early days of civilization. In this report the Transnational Institute and the Global Drug Policy Observatory describe in detail the history of international control and how cannabis was included in the current UN drug control system. Cannabis was condemned by the 1961 Single Convention on Narcotic Drugs as a psychoactive drug with “particularly dangerous properties” and hardly any therapeutic value. Ever since, an increasing number of countries have shown discomfort with the treaty regime’s strictures through soft defections, stretching its legal flexibility to sometimes questionable limits.

Today’s political reality of regulated cannabis markets in Uruguay, Washington and Colorado operating at odds with the UN conventions puts the discussion about options for reform of the global drug control regime on the table. Now that the cracks in the Vienna consensus have reached the point of treaty breach, this discussion is no longer a reformist fantasy. Easy options, however, do not exist; they all entail procedural complications and political obstacles. A coordinated initiative by a group of like-minded countries agreeing to assess possible routes and deciding on a road map for the future seems the most likely scenario for moving forward.

There are good reasons to question the treaty-imposed prohibition model for cannabis control. Not only is the original inclusion of cannabis within the current framework the result of dubious procedures, but the understanding of the drug itself, the dynamics of illicit markets, and the unintended consequences of repressive drug control strategies has increased enormously. The prohibitive model has failed to have any sustained impact in reducing the market, while imposing heavy burdens upon criminal justice systems; producing profoundly negative social and public health impacts; and creating criminal markets supporting organised crime, violence and corruption.

After long accommodating various forms of deviance from its prohibitive ethos, like turning a blind eye to illicit cannabis markets, decriminalisation of possession for personal use, coffeeshops, cannabis social clubs and generous medical marijuana schemes, the regime has now reached a moment of truth. The current policy trend towards legal regulation of the cannabis market as a more promising model for protecting people’s health and safety has changed the drug policy landscape and the terms of the debate. The question facing the international community today is no longer whether or not there is a need to reassess and modernize the UN drug control system, but rather when and how to do it.

### **Transnational Institute**

Since 1996, the TNI Drugs & Democracy programme has been analysing the trends in the illegal drugs market and in drug policies globally. The programme has gained a reputation worldwide as one of the leading international drug policy research institutes and a serious critical watchdog of UN drug control institutions. TNI promotes evidence-based policies guided by the principles of harm reduction and human rights for users and producers, and seeks the reform of the current out-dated UN conventions on drugs, which were inconsistent from the start and have been overtaken by new scientific insights and pragmatic policies that have proven to be more successful. For the past 18 years, the programme has maintained its focus on developments in drug policy and their implications for countries in the South. The strategic objective is to contribute to a more integrated and coherent policy – also at the UN level – where drugs are regarded as a cross-cutting issue within the broader development goals of poverty reduction, public health promotion, human rights protection, peace building and good governance.

### **Global Drug Policy Observatory**

National and international drug policies and programmes that privilege harsh law enforcement and punishment in an effort to eliminate the cultivation, production, trade and use of controlled substances – what has become known as the ‘war on drugs’ – are coming under increased scrutiny. The Global Drug Policy Observatory aims to promote evidence and human rights based drug policy through the comprehensive and rigorous reporting, monitoring and analysis of policy developments at national and international levels. Acting as a platform from which to reach out to and engage with broad and diverse audiences, the initiative aims to help improve the sophistication and horizons of the current policy debate among the media and elite opinion formers as well as within law enforcement and policy making communities. The Observatory engages in a range of research activities that explore not only the dynamics and implications of existing and emerging policy issues, but also the processes behind policy shifts at various levels of governance.