Chapter 1

International Drug Policy in Context

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All of our countries share a common strategy on drugs. From Ghana to Russia, Thailand to Ireland, national governments have criminalised the cultivation, manufacture, distribution, possession and use of plant based and synthetic substances deemed harmful to 'health and well-being'. This stems from international treaty obligations, most saliently the 1961 UN Single Convention on Narcotics Drugs, the 1971 Convention on Psychotropic Substances and the 1988 Convention Against the Illicit Traffic in Narcotic Drugs and Psychoactive Substances. The treaties are interlocking and complementary, building on each other to plug gaps and perceived vulnerabilities to the drug trade 'evil' (1961 Convention). The treaties codify international control measures including in relation to those precursor chemicals that are required for the manufacture of controlled drugs (1988 Convention) and they establish a hierarchy (schedule) of drugs determined by their perceived danger to individual and public health. The treaty framework imposes on states the obligation to impose sanctions 'such as imprisonment or other forms of deprivation of liberty' for drug-related offences (1988 Convention, Art 3), mandates co-operation in law enforcement efforts and extradition processes and requires the seizure and destruction of illicitly cultivated plants and manufactured drugs.

As detailed by Woodiwiss and Bewley Taylor (2005), drug control is better understood as an international regime, with its own norms, governance structures and administrative, monitoring and reporting systems established by the treaties. Key organs are the Commission on Narcotic Drugs (CND), a 53 member central policy-making body elected on a four-yearly basis and the International Narcotics Control Board (INCB) comprising 13 members elected every five years. The INCB is independent while the CND is intergovernmental, with members elected on a country basis. Fourteen CND seats are held by Western European states, eleven are allocated to African and Asian countries, ten to Latin American

and Caribbean states and six to Eastern Europe states, with an additional seat rotating between Asian, Latin American and Caribbean countries.

The role of the CND includes the monitoring of drug trends, decisions on the inclusion or removal of substances from the control system (with advice and recommendations from the World Health Organisation) and the development and implementation of policies 'to better address the drug phenomenon', including through recommendations to the United Nations (UN) Economic and Social Council (ECOSOC) and General Assembly (through ECOSOC). The INCB monitors implementation of the conventions and administers the information and data that states are required to provide on national drug trends, including drug use, illicit trafficking, seizures and plant eradication.

The United Nations Office on Drugs and Crime (UNODC) plays an important role in supporting the control efforts of treaty bodies and assisting countries in fulfilling their treaty obligations. It positions itself as a 'global leader in the fight against illicit drugs and international crime'. Headquartered in Vienna with 20 field offices across 150 states, the UNODC 'works to educate people throughout the world about the dangers of drug abuse and to strengthen international action against illicit drug production and trafficking and drug-related crime' (United Nations Office at Vienna (UNOV), n.d.). This includes thorough illicit crop monitoring programmes, alternative development initiatives that seek to transition drug crop cultivators into the formal economy, prevention of crime and terrorism and criminal justice system reform.

The system of international drug control navigates a complex 'dual use' dilemma. Substances that can be 'misused' for pleasure or which for a minority of people can be dependence-inducing are also vital in medicine and scientific research. This includes plant-based substances such as cocaine (from the coca leaf), cannabis and opiates (opium poppy derivatives such as opium, morphine and heroin) and a range of synthetic, chemical-based substances such as MDMA, LSD and ketamine. The control system aims to achieve a delicate balance: on the one hand ensuring that the cultivation and manufacture of these drugs is sufficient to meet proven national level medical and scientific requirements, while on the other hand preventing leakage into unauthorised and 'recreational' markets.

Coercion and Militarisation

Eliminating unauthorised manufacture, distribution, possession and use has been the overriding preoccupation of the post-war (Second World War) system. The United States has been a key source of pressure on the international system to achieve this end, working aggressively within and outside the international control regime to advance more repressive responses to illicit drug markets. In the 1970s, the administration of President Richard Nixon redefined 'narcotic' drugs as a threat to US national security, setting the ground for a 'War on Drugs' that gained traction under President Ronald Reagan in the 1980s. The domestic front in this 'war' saw the introduction of draconian anti-drugs legislation (Anti-Drug Abuse Act of 1986) that was coercively policed and financed by a tripling of the federal drug budget.

At the international level, the Reagan period marked a dramatic expansion of the role of the Department of Defence (DOD) in efforts to eliminate overseas drug cultivation and manufacture and in the prevention of drugs coming into the United States. The DOD budget for interdiction activities increased from US$4.9 million in 1982 to a staggering US$397 million by 1987 (Bagley, 1988, p. 165). This was supported by a sanctions regime that decertified states deemed non-compliant with US drug control efforts (blocking bilateral and multilateral lending). The overseas presence of drug-related personnel (Drug Enforcement Administration, police and judicial actors) was also dramatically expanded during the Reagan era, in turn positioning the United States to influence the replication of its own punitive drug legislation and coercive enforcement practices in countries transitioning to democracy. For Ayling (2005), the 'listing and certification process has been a critical part of coercive strategies used by the United States to further its drug control policies internationally'. From this perspective, states have been 'conscripted' into the US drug war, with those that are un-cooperative 'threatened with a combination of aid and trade sanctions'.

The Reagan administration was influential in pressing for strengthened international measures against trafficking and action in related areas such as money laundering and transnational organised crime, culminating in the 1988 Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. For Woodiwiss and Hobbs (2009), the 1988 Convention marked the internationalisation of US drug and crime fighting strategies. It served as a mechanism to re-galvanise and strengthen international commitment to drug control in a period of turbulent geopolitical change, and to institutionalise US approaches for advancing the goal of drug prohibition. As the war on communism came to an end, the war on drugs enabled police, military and intelligence budgets to be sustained and the US geostrategic presence in third countries extended.

Following the adoption of the 1988 Convention, the UN General Assembly held its first Special Session (UNGASS) on 'the world drug problem' in 1990. Buoyed by the prospect of enhanced international co-operation in the post-Cold War period, the UNGASS marked the introduction of a Global Programme of Action. This framed 1991–2000 as the United Nations Decade against Drug Abuse. As discussed by Jelsma (2003), this was a bold re-statement of prohibition goals and a pushback against those arguing for a rebalancing of international strategy towards demand reduction rather than the prevailing emphasis on supply prevention. As outlined by the INCB in 1994:

> The international community has expressed a desire not to reopen all debates but to build on those commonly defined strategies and broad principles and to seek ways to further strengthen measures for drug control […]. Any doubt, hesitation, or unjustified review of the validity of goals will only undermine our commitment. (Jelsma, 2003)

The Decade against Drug Abuse saw continued high-level exhortations. The slogan 'A drug-free world – we can do it!' dominated the 1998 UNGASS, at which

states committed to achieve significant and measurable reductions in the supply and demand for illicit drugs within a 10-year period. In an address to the meeting, UN Secretary General Kofi Annan set out his hopes to see the UNGASS 'go down in history as the time the international community found common ground to take on this task in earnest' and 'real progress towards eliminating drug crops by the year 2008' (Jelsma, 2003).

The Record of Drug Control

After stepping down as General Secretary of the UN, Kofi Annan joined the Global Commission on Drug Policy, an organisation that brings together 14 former heads of government and other eminent figures in an international campaign for drug policies based on scientific evidence, human rights, public health and safety. Following an all too familiar path of officials moving to a critical position on drug policy once out of high office, Annan joined the Commission in 2011 as the body published its first report calling for a paradigm shift from law enforcement to health-based responses to drugs. Subsequent annual publications by the Commission highlighted the rights violations, prejudice, stigma and health harms caused by criminalisation and set out strategies and options for drug policy reform, including decriminalisation and legal regulation of substances.

The work of the Commission draws on an accumulated and sizeable body of evidence suggesting that current drug strategies are ineffective and cause more harm than good. Rather than advancing towards a utopian world free of drugs, the international control system has instead presided over an increase and diversification in types of mind and mood altering drugs available, a reduction in the price of controlled substances and an increase in purity. More people in a wider range of geographical spaces are using illegal drugs than at any point in the history of the control regime. Based on figures for 2017, the UNODC's 2019 annual World Drug Report estimated that 271 million people (within a range of 201 million to 341 million) between the ages of 15 and 64 had used drugs at least once the previous year, equivalent to 5.5% of the global population aged 15–64. Cannabis is the most commonly used scheduled substance with 188 million users, followed by opioids (53 million), amphetamines and prescription stimulants (29 million), MDMA/Ecstasy (21 million) and cocaine (18 million). By way of contrast to the narrative of generic drug use 'evils' (Lines, 2010), the UNODC acknowledges that approximately 85% of drug users consume drugs infrequently and without problems of addiction or dependence (UNODC, 2019a, p. 11), with drug use disorders concentrated within an estimated 13% of total user numbers.

The demography and geography of drug use has experienced dramatic change during this period of increasingly repressive measures against engagement in the illegal trade. A key trend, as analysed by many in this book, is the increase in the number of women using drugs (Arpa, 2017; Measham, 2002; UNODC, 2018a). There are also notable patterns of poly-drug use, a lengthening of the drug using careers of individuals and an increase in consumption in Global South countries traditionally insulated from the trade. Rather than a world simplistically bifurcated and contained as 'consumer' Northern and 'producer'

Southern regions, twenty-first century drug markets are characterised by complex patterns of globalised, regionalised and domestic drug cultivation, manufacture and consumption across, within and between states. As acknowledged by the INCB (2012): 'To varying degrees, all countries are drug-producers and drug-consumers and have drugs transiting through them'.

Rather than ending illicit drug crop cultivation within a decade, including through aggressive (US led) eradication activities, the cultivation of cannabis, opium poppy and coca has continued to expand in key cultivating states. In 2017, coca cultivation in Colombia reached the highest ever recorded figure at 171,000 hectares, a 17% increase from 2016. As outlined by the UNODC, 80% of coca was grown in the same areas where it had been cultivated over the past decade, and concentrated in the departments of Antioquia, Putumayo, Norte de Santander and Cauca (UNODC, 2017). The prices of coca leaf, coca paste and cocaine hydrochloride fell by 28%, 14% and 11%, respectively, but their trade still generates estimated in-country revenues of US$2.7 billion. Cultivation did fall back in 2018, but only by a modest 1.16%, to 169,000 hectares, with potential cocaine output rising 5.8% on the figure for 2017, to 1,120 metric tons. Similarly, in Afghanistan, the centre for 85% of global opium production, the area under cultivation increased by 63% between 2016 and 2017, from 201,000 hectares to an estimated 328,000 hectares (UNODC, 2018b). As in Colombia, opium poppy cultivation in key growing countries Afghanistan and Myanmar did decrease in 2018, falling 17%, with a 25% decline in opium production levels. However, the UNODC acknowledged in its 2019 Annual Report that the global area under cultivation remained at an estimated 346,000 hectares in 2018, with opium production 'among the highest in the past two decades', with continued increases in cultivation in Mexico (UNODC, 2019a, p. 30).

The failure of the control system to reduce the volume of illicit drug supply was amplified by one of the most important trends of recent years: the rise in synthetic drug manufacture and use. The preface to the UNODC's 2013 World Drug Report sets out that use of amphetamine-type stimulants (ATS) 'appears to be increasing in most regions', with crystalline methamphetamine presenting 'an imminent threat'. As outlined by the UNODC in 2019: 'The ATS market underwent remarkable changes over the last decade', including:

> increased differentiation of the ways synthetic drugs are sold and consumed (e.g. powder, tablets, capsules, crystals), changes in precursors over time [and...] the discovery of new ways of trafficking (e.g. dark net).

Underscoring this growth trend, the global quantity of ATS seizures increased more than four times, from 60 tons in 2008 to 261 tons in 2017 (UNODC, 2019b).

Running parallel with the growth of ATS markets has been the emergence of new psychoactive substances (NPS). These 'legal highs' fall outside of the schedule of controls that apply to 234 substances but they have become subject to some national level regulations. Control efforts, however, are complex (Measham, 2011). Minute chemical modification can automatically take these substances

back outside of regulatory frameworks, and many of these substances are dual use and marketed for purposes other than consumption. According to the UNODC, NPS availability increased dramatically after 2008. At the end of 2015, 602 unique substances had been identified, representing a 55% increase from the 388 substances reported the previous year (UNODC, 2015c).

Not only has drug control failed to reduce supply and demand for controlled drugs, the system has demonstrated limited ability to deftly navigate the dual use dilemma. Over recent years, the differentiated systems of national and international controls and regulation of psychoactive substances – from cocaine and NPS to alcohol, tobacco and pharmaceutical medications – has been shown as unworkable, arbitrary and unrepresentative of the actual harms caused by substances. Non-medical use of diverted and fake pharmaceutical drugs is a particular challenge for international and national authorities across the globe. Klein (2019) outlines the particular challenges emerging in relation to the synthetic opioid Tramadol:

> Tramadol is […] widely used as an analgesic for alleviating pain of moderate to medium intensity. With potency estimated to be about one-tenth that of morphine, tramadol is considered as relatively safe with regard to poisonings or dependency. Yet there are increasing reports of widespread non-medical consumption of tramadol in North and West Africa.

The United States has experienced a well-documented crisis of opioid fatalities, initially linked to aggressive marketing by pharmaceutical companies in the late 1990s and in a context of deficient and unaffordable public health care and access to pain relief. The US Centre for Disease Control (CDC) highlights three 'waves' of opioid overdose between 1999 and 2017, leading to the death of 400,000 people (Scholl, Seth, Kariisa, Wilson, & Baldwin, 2019). The first wave involved an increase in the prescription of opioids in the 1990s (natural and semi-synthetic opioids and methadone). The second wave began in 2010, with rapid increases in overdose deaths involving heroin, with the third wave, dating from 2013, involving the illicitly manufactured synthetic opioid fentanyl. The CDC highlights the dynamics of the illicit fentanyl market, with combinations of heroin and cocaine.

In stark contrast to the lax regulation of pharmaceutical drugs and the inability of the control regime to delimit diversion from pharmaceutical markets, overly robust controls imposed on controlled substances authorised for medical and scientific use and classified as essential medicines by the World Health Organisation has created a 'global crisis of pain'. As outlined by Bhadelia et al. (2019):

> The poor, worldwide, have little or no access to palliative care or pain relief. Approximately 298 metric tons of morphine-equivalent opioids are distributed in the world each year. However, only 0.1 metric tons – 0.03% – are distributed to low-income countries. More than 61 million people worldwide experience serious health-related suffering annually throughout the life course that could

be alleviated if they had access to palliative care. More than 80% of these individuals reside in low- and middle-income countries where palliative care is limited or non-existent.

Elaborating on the gross inequalities that have been structured by the system, the authors highlight that in relation to access to opioid analgesics for palliative care:

In Nigeria, less than 1 milligram of distributed opioids is available per patient in need of palliative care per year, enough to meet only 0.2% of need. By contrast […] Canada has 3090% available for distribution per patient in need of palliative care.

For scientists and clinicians wishing to research substances that may have beneficial effects for physical and mental health, including psychedelic and hallucinogenic substances, drug control requires licenses be approved by policing and judicial authorities, not medical councils.

International drug control is intended to serve the 'health and well-being of mankind' as set out in the 1961 UN Single Convention and reiterated in subsequent treaties. Moreover, and in a final indictment of the performance of the control regime, access to treatment services remains unacceptably low (Harm Reduction International, 2018). Where services are available, these are frequently inappropriate, underfunded, do not adequately address the problem, and, as highlighted in many chapters in this collection, are inaccessible to women. As explained by Boister (2002), the international drug control system must be understood as a 'suppression regime', one that has been preoccupied with preventing, policing, punishing and persecuting in pursuit of prohibition goals rather than enabling access to essential medicines. To this end, an estimated 70% of drug policy spending is concentrated on law enforcement activities.

Drug Control as Policy Fiasco

Interpreting and defining policy failure is complex and dependent on the type of methodology, data and evaluation used (Weimer & Vining, 2005). Over-exaggeration of certain policy aspects can skew assessment, norms and values can distort interpretation, and a focus on only specific elements of the policy process (objectives, design, implementation and outcomes) can limit effective and evidenced-based judgement (McConnell, 2010). Drug policy has clearly defined goals enabling its performance to be objectively measured. As demonstrated by the quantitative information discussed above, drug policy has not only been unsuccessful in the goal of reducing the global supply, distribution and use of controlled substances, but also in protecting health and well-being. On this basis, drug policy is a 'high level' policy failure. But beyond goal failure and with wider reference to drug policy processes, drug policy can be better understood as a policy 'fiasco' defined as: 'a negative event that is […] at least partially caused by avoidable and blameworthy failures of public policymakers' (Bovens & t'Hart,

1996, p. 15). This draws attention to the causes and rationales that prompted the policy, the lack of accountability, information processing and stakeholder engagement in drug policy processes, negative and avoidable policy impacts and the institutional rules guiding the selection of actions.

The performance of international drug policy and the international control regime has been shambolic. In no other area of public policy has such a poor record been allowed to continue without prompting major revision, overhaul and accountability. Drug policy is seemingly unique in standing above the usual scrutiny and performance evaluation established for areas such as education, health, transportation and housing. Not only has drug control remained impervious to the rigours of new public management, cost analysis and outcome review, but it has also been immune to effective and institutionalised processes of impact evaluation. The metrics of international drug policy, which is to say the performance indicators that states are required to report to drug control bodies, are simplistic and largely configured around quantitative law enforcement data such as number of drug users, arrests, interceptions and seizures. Much of the information is unreliable, owing to weak epidemiological capacity in many countries and the inevitable constraints of surveying criminalised and hidden populations. Countries are variously incentivised by risk of sanction or opportunity of financial support to overstate and/or understate law enforcement performance. There are issues of double counting between states in relation to cross border operations, and comparability of national level performance is difficult owing to the different methodological approaches used by countries and national institutions.

The UNODC itself acknowledges that owing to the inadequacy of data, projections of trends are based on information from North America and Europe. Constrained by simplistic monitoring and reporting procedures, the early warning capacity of drug control is, in all but a few country cases, weak and largely reactive, as exemplified by the seemingly unanticipated growth of markets in ATS, NPS and diverted pharmaceuticals. It was only in 2008 that the UNODC launched dedicated ATS analysis through the Global SMART Programme, tasked with generating, analysing and reporting synthetic drug market information and improving global responses to expanding ATS markets. Drug control does not engage in exercises of the counterfactual (what would have happened in the absence of the intervention) and has remained insulated from the promotion and uptake in policy and programming of rights-based approaches, conflict sensitivity, stakeholder engagement and gender mainstreaming. In sum, drug policy has occupied a silo in the international system. Legitimised on the basis of a higher moral good, it has deflected any responsibility for the use of evidence in policy, for the manifest failure to meet targets, or for the negative impacts of policy implementation.

While engaging in the rhetoric and practice of a drug 'war', drug control has consistently overlooked and marginalised the experience of drug war casualties. The absence of robust impact assessment has enabled drug control to abjure responsibility for systematic and egregious violations of human rights in enforcement practices, for the ill health and disease spread resulting from the criminalisation of behaviours, and for the intergenerational transmission of poverty

and exclusion that has resulted from drug policy policing and criminal justice processes. As discussed below, these negative outcomes have been exacerbated by the escalation of coercive and aggressive enforcement strategies that aim to achieve the unattainable goal of a drug free world.

The Legacy of History

While the 1961 Single Convention is recognised as the key treaty of the contemporary drug control system, drug control efforts have a far longer history dating back over a century. The treaty framework (12 treaties in all) and regime apparatus evolved from a foundational international conference in Shanghai in 1909 and built upon the 1912 Hague International Opium Convention, the first international drug control treaty. This process of addition and layering onto founding principles, norms and approaches has created an institutional path dependence in which history has conditioned and constrained contemporary policy actions (David, 2007). The result is institutional inertia and rigidity. Drug policy in our age of crypto markets, digital currencies, chemical advance and transnational movement is informed by ideas and strategies shaped in the late Victorian period: an age of Empire, rudimentary science and social Darwinism.

The United States took a lead role in convening the 1909 Shanghai conference. It marked that country's first significant foray on the international stage, with US 'narco-diplomacy' and unique experience of Protestant evangelicism, slavery and late immigration informing the subsequent global pursuit and strategy of drug prohibition (McAllister, 1999). The key concern of the period was the trade in opium, a commodity that until the turn of the twentieth century was freely available, used widely in self-medication and which had been traded for centuries. The United States capitalised on a window of opportunity: demands for stricter control, if not abolition, of the opium trade led by an eclectic collection of Quakers, evangelicals, Marxists, professional medical and pharmaceutical associations and anti-imperialist lobbies.

In the period before the Second World War, the United States failed to convince European colonial powers to adopt a policy of prohibition and an outright ban on psychoactive substances: Spain, the Netherlands but in particular the British, having subsidised their colonial enterprises through monopolies on opium retail sales and exports. United States concerns were seen as exaggerated and prohibition unenforceable. This early period was nonetheless important in establishing key normative, strategic and institutional elements of contemporary drug control. While rejecting prohibition, Europeans accepted a regulatory system and to work cooperatively to limit the volumes of opium traded and consumed, with common agreement parlaying into six international conventions in the inter-war period. In accepting monitoring and reporting on the import and export of opium (subsequently extended to coca and the derivatives of these plants) and a role for the League of Nations in administering the conventions, states conceded sovereign control on the 'drug problem' to international bodies (McAllister, 1999).

These institutions and the early systems established for oversight and reporting of agricultural commodity cultivation and exchange were the forerunners of the governance structures and the reporting metrics of contemporary drug control. In terms of strategy, this foundational period configured international policy towards containment and prevention of supply, skewing responsibility away from demand-side activity in drug markets. This placed the financial and administrative burden for regulation and post-Second World War control efforts on those geographical spaces where cultivation activities took place, identified in the contemporary period as countries of the Global South.

European and North American countries not only delimited their role and responsibility in global markets to one of instruction and supervision of supply states, they also structured a control regime that disproportionately focussed on plant-based substances. Pharmaceutical lobbies in the Global North were highly effective in ensuring that chemicals received more lenient treatment within the emerging control framework, ensuring that opiates, coca (cocaine) and cannabis remained the primary substances of concern (Brunn, Pan, & Rexed, 1975; Buxton, Bewley-Taylor & Hallam, 2017). This explains the inability of the contemporary control regime to anticipate the surge in ATS and NPS markets in the twenty-first century or effectively respond to the problems of dependence and overdose of non-medical pharmaceutical drugs.

Finally, this period is particularly important for the norms and values that were propagated to legitimise the emerging control system and socialise populations into seeing commonly used and naturally occurring substances as evil and dangerous. As has been extensively documented, racism, 'othering' and stigma were key tools mobilised to transform attitudes towards the use of plant-based substances. This was most particularly the case in the United States, which pursued national level prohibition in the face of recalcitrant liberal internationalists. In a pattern that was to gain traction globally in the period after Second World War, opium, cocaine, cannabis and their users were constructed as threatening. Those persisting in the use of these substances, either through dependence or desire, were condemned as immoral, deviant and deserving of punishment and sanction (Musto, 1999).

The period after the Second World War saw the United States positioned to internationalise its quest for a global prohibition regime. With European powers destroyed or bankrupt in global conflict, the United States gained superpower status and control over post-war international governance institutions. The 1961 Single Convention advanced US prohibition goals by criminalising unauthorised cultivation, manufacture, distribution and use, extending to possession related offences through the 1988 Convention on Illicit Traffic. As discussed at the beginning of this chapter, the inability to achieve end goals of zero cultivation and a drug free world, expected within a 20 year time frame under the 1961 Convention, has led to the escalation of repressive and militarised efforts against the illegal drug trade. As explained below, these can never be successful and their impacts are unacceptable.

Before addressing these manifest limitations, it should be emphasised that the prohibition paradigm has not been without its challengers. To date, over

30 countries and over 20 US states have introduced some form of decriminalisation or depenalisation, largely in relation to cannabis (Talking Drugs, n.d.). As argued by Bewley Taylor (2012), the international drug control consensus is fracturing as the financial, social, environmental and political costs of current strategies are increasingly recognised. Two key strands of reform pressure relate to alternative development and harm reduction. Initiatives in these areas have more recently been accepted to some extent by international drug control authorities, but their full potential cannot be realised within a macro policy and ideological framework of prohibition.

An Unwinnable War

Prohibition-based drug strategies are flawed on many counts. Three well-established reasons are highlighted. Firstly, and going against the assumptions of early US drug prohibition policy 'entrepreneurs', criminalisation, eradication and interception do not terminate cultivation, manufacture, supply or demand – quite the opposite. The risk associated with the supply of criminalised substances creates value added, in turn generating lucrative illegal markets (Reuter & Kleiman, 1986). In relation to plant-based drugs, price at source accounts for less than 2% of retail prices in developed countries. As a result, and as detailed by Caulkins and Reuter (2010) even if crop eradication or enforcement in cultivation areas increases prices, the effect on retail prices downstream is modest. Drug markets and drug market actors are flexible, innovative and dynamic. Changes in price, supply and demand in relation to a particular substance only serves to encourage innovation, change and substitution by both suppliers and consumers.

Secondly, demand for mind and mood-altering substances can never be eliminated. Experimentation, intoxication and the quest for relief of mental and physical pain are among the most basic of human drives. They have existed throughout human history and are celebrated in diverse cultural practices and social traditions. Processes of globalisation that were feted during the 'triumph' of democracy in the early 1990s have enabled more people in more places to access drugs, with education, personal finance and liberal freedoms positioning individuals to challenge the state's control of personal choice. Efforts by individual states to prevent the use of controlled drugs, including through 'education', the socialisation of stigma and through deprivation of employment, housing, liberty and even the life of drug law 'offenders' (Girelli, 2019) has recurrently failed to diminish drug use or promote popular acceptance that it is the role of the state to police and regulate behaviours. Rather repression and the use of coercion and punishments perceived as disproportionate and ineffective has served to discredit and delegitimise state actors and institutions (Inkster & Comolli, 2012; Organisation of American States, 2013).

A third aspect of drug policy failure relates to the neglect of the structural causes of drug supply and use. Drug policy does not engage with the complexities of land inequalities, inequality and poverty that render engagement in drug crop cultivation, manufacture and trafficking a livelihood option for significant

numbers of people excluded from and impoverished by neoliberal adjustment and transnational marketisation. Supply actors have been simplistically distilled to the status of criminals, assumed to be motivated only by the potential of illicit profit rather than understood as vulnerable groups on the margins of formal economies and institutions. Drug control institutions and the international drug treaties steer narratives, action and strategy towards high level and transnational criminality, in turn justifying expensive, violent and ultimately ineffective policy responses. In relation to demand, drug control authorities have continued with a generic repressive approach that has failed to differentiate between the majority who use without any form of drug-related physical or mental health problem, and those needing treatment and support. As discussed in the contributions to this collection, problematic drug use correlates with a range of traumas and abuses – most particularly in women (Downs & Miller, 2002), which treatment and prevention programmes fail to address and disentangle. Rather than dedicating services and support to addressing cause, drug policy is locked on symptom.

Implementation Impacts

In pursuing coercive approaches, drug policy has sharply negative impacts that continue to go barely acknowledged and largely unaddressed in international programming and strategy. As is extensively documented, drug policing and criminal justice processes are not neutral. Rather, they are deeply political and function as a tool of social control. Within countries, drug policy enforcement target groups deemed threatening or dangerous due to race, ethnicity, religion, sexual and gender identity or ideological belief (Baum, 2016; Fellner, 2009; Levine & Peterson Small, 2008). Between countries, drug control has served as a mechanism to bend Global South states to the security preoccupations of the North, forcing alignment of policy and dedication of scarce resources to 'problems' and their solutions defined by advanced industrialised societies (Gibert, 2009; Keefer, Loayza & Soares, 2008).

From the outset, drug policy has worked with universalist assumptions that have proved false over time and which have framed policy responses that are deleterious to justice, development, peace and security, two of which are pertinent here. Firstly, the assumption that the global community is a construct of Westphalian states with functioning bureaucracies and control over borders and geographic spaces. This is not the case for the majority of countries, and is reflected in the weak ability of states to control the movement of people and illegal commodities. Secondly, drug control works within a simplistic binary of formal and informal economies, a 'good' state and a 'bad' drug trade. The reality for all countries is a more complex grey area in which the state, economy and institutions are corrupted and corroded by the opportunities for abuse of power and illicit enrichment generated by a criminalised drug trade.

The negative impacts of prohibition-based strategies are multiple, have been extensively documented and are distilled here into five core critiques. Firstly, criminalisation generates multiple forms of violence. Actors in the illicit trade do not have recourse to arbitration or the rule of law to ensure that agreements are

upheld. Violence and coercion and the threat of violence become mechanisms for enforcing justice and respect within illegal markets (Sandberg & Pedersen, 2009; Zaitch, 2005). Related here, the use of violence by the state to confront illicit interests galvanises an arms race within which drug market actors defend market share and supply chains through acquisition of weapons and the use of performative terror to intimidate, defend and coerce. The circulation of small arms and light weapons combined with the erosion of state legitimacy and the rule of law that results from state engagement in drug 'wars' in turn reproduces or creates new forms of violence such as paramilitarism and feminicide (Youngers, 2004). Finally, shortages resulting from 'successful' seizures by enforcement authorities serve only to create violent competition for illicit market share (Durán-Martínez, 2015). Smooth functioning drug markets can be peaceful, as underscored by the contrasting examples of the Netherlands and Mexico (violent interruption) (Castillo, Mejía, & Restrepo, 2014).

A second impact of enforcement is the violation of fundamental human rights related to the impunity with which drug 'wars' are conducted by state authorities (Lines et al., 2017). Rights' violations also result from the stigma created by criminalisation. Stigma legitimises social and state violence against people who are engaged directly or indirectly, through choice, coercion or lack of economic or medical alternative into the cultivation, manufacture, supply, distribution and use of illegal substances. Violation of fundamental human rights is a constant feature of policy enforcement, including in relation to access to justice, appropriate health care and treatment, sexual and reproductive health rights and freedom from torture, arbitrary detention and cruel and degrading treatment.

A third aspect of enforcement impacts relates to the trend of fragmentation that is observed in response to market disruption and as drug supply chains restructure to reduce interception risk and maximise profit. Steps forward in intercepting and removing illegal substances or drug trade actors from markets create a balloon effect, squeezing activity in one area for it only to pop up and expand in another. Any success in eliminating supply of coca, cannabis or opium poppy in one geographical area leads to relocation of planting activities to another (Buxton, 2015; Dion & Russler, 2008); eradication of plant cultivation leads to market substitution with synthetics; closing down one supply chain generates a reconfiguring through new territories and adaptation of modes of transportation; arresting a lead actor in a trafficking organisation leads to the hydra syndrome and the fragmentation of hierarchical structures (Calderón, Robles, Díaz-Cayeros, & Magaloni, 2015). The end result of recent decades of coercive enforcement is the dissipation and spread of drug trade activities into new territories and communities around the world, a dynamic driven by the profits created by criminalisation.

A further negative impact relates to the health risks that are created by criminalisation (Csete et al., 2016). Rather than terminating the use of psychoactive substances, criminalisation has increased the dangers of consuming controlled substances. People who use drugs most usually do not know the content or the purity of the substance that they are smoking, snorting, swallowing or injecting, elevating risks of poisoning, overdose and death. Sanctions on drug use

discourage individuals from contacting emergency services in the event of a drug-related health incident. Stigma and punitive legal measures can lead to unsafe drug use practices, including injection, with risks further elevated by lack of access to clean and sterile injecting equipment.

Finally, and as observed by the majority of contributors to this collection, drug policy enforcement has repeatedly targeted the lowest level in drug market chains, the 'low hanging fruit' that are relatively risk free for police and counter-narcotics agencies to pursue and which make for good statistical presentation in drug policy performance indicators. These practices have focussed primarily on those who already suffer discrimination or criminalisation (of behaviours and lifestyles) within individual country contexts. In the United States, enforcement of drug policy has disproportionately impacted black Americans (Fellner, 2009), and racialised patterns of enforcement are identifiable across much of the globe. The travesty of drug policy is that rather than operationalised as a 'war' on drugs, it has instead been a war on the poor – the poorest individuals and the poorest communities – and it has been most aggressively operationalised in the poorest and most unequal countries of the world (Christian Aid, 2019; Keefer et al., 2008).

Conclusion

The accumulation of evidence of drug policy failure is forcing policy shift and acknowledgement of enforcement harms. Over recent years, international drug control authorities (Alimi, 2019; Bridge, 2017) and some national and municipal level governments have tentatively engaged with efforts to address underlying structural causes rather than fighting the outward manifestations of a drug 'problem'. There are moves to understand and rectify the unfair and unbalanced distribution of costs, responsibilities and outcomes of criminalisation strategies and to address the gender blindness of drug policy (Schleifer & Pol, 2017). Nonetheless, significant gaps remain between declaratory statements and actual implementation, and between recognition of rights and evidenced-based approaches and actual integration into drug policy initiatives and performance metrics. International consensus is certainly fracturing, and a number of countries are experimenting with policy reform and innovation. While this is to be welcomed, it does not reflect the direction of travel for the majority of countries, and the reforms have been largely limited to a particular substance (cannabis) and market element (demand). The prohibition paradigm persists, sustaining the fiasco of drug policy processes. Within this rigid schema, enforcement continues to generate major harms, and as discussed in this collection these impact women in distinct and disproportionate ways. The following chapter moves from the generic critique of international drug policy presented here to consideration of the contexts of gendered inequality in which drug policy is enforced.