The worldwide opioid crisis and the UN drug Conventions: why the international system is not working

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SCHLAGWÖRTER International criminal law – narcotics legislation, drug policy – opioids – decriminalisation

ABSTRACT The paper examines if the current international regime of drug regulation can provide effective answers to the global opioid crisis. The UN drug treaties are based on the distinction between licit/illicit drug use. Opioids transcend this distinction, which renders the current system ineffective. A fundamental revision of the system is necessary.

ZUSAMMENFASSUNG Der Beitrag untersucht, ob die aktuelle internationale Drogenregulierung effektive Antworten auf die globale Opioidkrise entwickeln kann. Die UN-Abkommen basieren auf der Unterscheidung zwischen legalem/illegalem Drogenkonsum, die von Opioiden durchbrochen wird, was das heutige System ineffektiv und eine grundlegende Überarbeitung notwendig macht.

RÉSUMÉ Est-ce que le régime international de réglementation des drogues peut trouver des réponses efficaces à la crise des opioids? Les traités sur les drogues sont basés sur la distinction entre l'usage licite/illicite. Les opioïdes transcendent cette distinction, ce qui rend le système actuel inefficace. Une révision fondamentale est nécessaire.

I. Introduction

Opioids are a group of drugs with great medical importance, especially as pain killers. But at the same time, they can be highly addictive. Today, the addiction to and abuse of opioids is growing at very high rates, and it is producing alarming results, with an estimated 115 000 deaths worldwide attributed to opioid overdoses in 2017.[1] It must truly be called a global crisis.[2]

What response does international law and, specifically, international criminal law offer to this crisis? The international regulation of drugs has evolved over a long time and is considered one of the most successful examples of international treaty systems in terms of state participation.[3] It consists of three UN Conventions from 1961, 1971 and 1988, which operate under an overarching dual objective: securing access to necessary medication and controlling all other, illicit use of drugs.[4]

But, in the case of opioids, this dual objective is clearly not reached. In this article, I explore a reason why the international drug regulation system has failed to deliver on its promises of a safer world, free from drug misuse. I argue that there is an underlying structural principle of the three UN Conventions that does not work in the context of opioids: that of the seemingly clear distinction between licit and illicit use. This principle emerged as a result of the development of the international treaty system, which was shaped by political power imbalances and individual interests of some strong stakeholders. Opioids transcend this principle and, thus, the dual objective of access vs. control cannot be reached through the international regulation in place today.

In order to understand the current international drug control system, I first evaluate how this system evolved, its history, development and main characteristics (II.A and II.B). I illustrate how the distinction of illicit from licit use and licit from illicit markets emerged in the de-

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1 WHO estimate. https://www.who.int/news-room/fact-sheets/detail/opioid-overdose, accessed on 1 February 2021.

2 United Nations Office on Drugs and Crime (UNODC), World Drug Report 2018, Part 1, Vienna 2018, 1; UNODC, Understanding the Global Opioid Crisis, Vienna 2019, 3.

3 Richard Vogler/Shahrzad Fouladvand, The Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 and the Global War on Drugs, in: Hauck/Peterke (eds.), International Law and Transnational Organised Crime, Oxford 2016, 107 ff., 107.

4 See e.g. Evan D. Anderson/Corey S. Davis, Breaking the Cycle of Preventable Suffering: Fulfilling the Principle of Balance, Temple International and Comparative Law Journal 2010, 329 ff.

velopment of the UN Conventions system and that it is a fundamental structural principle of all three Conventions (II.C). I shortly examine the current status of the international drug control regime, marked by ineffectiveness and subsequent deviation by state parties (II.D). Then, I identify some key aspects of the nature of the opioid crisis (III.A) and examine how these relate to the UN treaty system (III.B): opioids are particularly «ambivalent» in their potential for health *and* addiction and regularly transcend the boundaries between licit and illicit markets and medical and non-medical, abusive use. As a result, the inability of the current international system to regulate opioids effectively can be (at least partially) explained (IV).

II. The UN drug control treaty system

A. The three Conventions

The international system of drug control has its roots in diverse efforts to control the trade of opium.[5] These early treaties of the League of Nations were regulatory rather than prohibitionist in spirit and did neither declare drugs nor their use, production nor similar activities illicit.[6]

The contemporary UN drug control system is founded on the 1961 Single Convention on Narcotic Drugs,[7] complemented in 1971 by the Psychotropic Convention[8] and by the 1988 Trafficking Convention.[9] The Single Convention and the Psychotropic Convention consist of systems which schedule different drugs into four varying levels of control deemed necessary for each drug.[10] Additionally, they both contain measures to control the import and export of scheduled drugs and require state parties to introduce penal provisions regarding many activities related to the illicit use of scheduled drugs.[11] The 1988 Trafficking Convention aimed to fill gaps in the fight against illicit trafficking by harmonizing national drug-related criminal legislation and law enforcement efforts.[12]

B. The development of the international framework

Within the evolution of the international treaty system, three aspects of development can be identified. They pertain to the object of regulation, to the regulation of the supply and the demand side, as well as to the regulatory approach.

1. Object: organic and synthesized substances

First, important differences between the treaties lie in what substances each one regulates and in the extent of the respective regulatory efforts. While the Single Convention of 1961 focuses on drugs from organic substances such as opium, cocaine or cannabis, the Psychotropics Convention ten years later mainly regulates synthesized drugs.[13] «Organic» drugs were and still are mainly supplied from countries in the Global South, whereas many synthesized drugs are manufactured by pharmaceutical companies in states of the Global North.[14] The opposition between these two groups of countries – states where organic drugs are grown and states where synthesized drugs are manufactured – dominated the two conferences which lead to the 1961 and 1971 Conventions, respectively.[15] Both advanced similar arguments advocating weaker control of their «own» substances and stricter control of the «other» substances.[16] However there was (and still is) a significant power imbalance on the international level between the two states groups,[17] including the powerful and very actively lobbying pharmaceutical companies in the latter states.[18] As a result, the 1971 Psychotropic Convention is considered to be significantly weaker in its control measures.[19] Levels of control differ more from schedule

5 Jay Sinha, The History and Development of the Leading International Drug Control Conventions, Ottawa 2001, 5 f.

6 Martin Jelsma, The Development of International Drug Control – Lessons Learned and Strategic Challenges for the Future, Geneva 2010, 2.

7 United Nations (UN) Single Convention on Narcotic Drugs, adopted 30 March 1961, entered into force 13 December 1964 (Single Convention, SR 0.812.121.0).

8 UN Convention on Psychotropic Substances, adopted 21 February 1971, entered into force 16 August 1976 (Psychotropic Convention, SR 0.812.121.02).

9 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, adopted 20 December 1988, entered into force 11 November 1990 (Trafficking Convention, SR 0.812.121.03).

10 Sinha (fn. 5), 21.

11 Sinha (fn. 5), 24.

12 Sinha (fn. 5), 32 f.

13 Jelsma, Development (fn. 6), 3.

14 Vogler/Fouladvand (fn. 3), 117.

15 Sinha (fn. 5), 19 f. and 24.

16 Sinha (fn. 5), 24.

17 Vogler/Fouladvand (fn. 3), 117; Sinha (fn. 5), 24.

18 Jelsma, Development (fn. 6), 3; Sinha (fn. 5), 20.

19 E.g., the system of national estimates on licit consumption of drugs, included in Art. 19-20 of the Single Convention, was not adopted in the Psychotropics Convention, to the benefit of manufacturing states (William B. McAllister, Conflicts of Interest in the International Drug Control System, Journal of Policy History 1991, 143 ff., 157). Vogler/Fouladvand (fn. 3), 117; Sinha (fn. 5), 24.

to schedule: «street hallucinogens» (Schedule I) are subject to much stricter control measures than those in all the other schedules,[20] which benefits the manufacturers of the drugs contained in Schedules II to IV. Furthermore, derivatives of scheduled substances are not automatically included anymore, which makes it necessary to continually and explicitly add new derivatives by a complicated inclusion system,[21] and the presumption of illegality of the Single Convention is reversed in the Psychotropics Convention.[22] This power imbalance and the resulting differences in regulatory strength are essential to understand all further developments.

2. Supply and demand side regulation

Second, within all three Conventions there is a shift regarding *where* regulation takes place: from focusing solely on *supply side* control towards including more *demand side* interventions.[23] The Single Convention concentrates its efforts of control almost exclusively on the supply side of the global drug trade, making reference to the reduction of demand only in the markedly vague[24] Art. 38.[25] In contrast to this, the Psychotropics Convention contains the «milestone» Art. 20, which addresses the prevention of consumption.[26] However, this provision does not impose any strict legal obligations on states to address prevention issues.[27] The Trafficking Convention, then, extends its obligations on state parties to criminalise the possession of scheduled drugs for illicit use,[28] thus turning its policing efforts also towards domestic consumption.[29] Over the three Conventions, we can identify a clear increase in focus on the demand side, but supply oriented mechanisms remain dominant.[30]

This second development strain can be traced back to the same explanation as that of the first development. In order to avoid strict controls of supplying activities of so-called «Psychotropics», manufacturing states and their pharmaceutical industries emphasize the personal responsibility of consumers. This conforms with a general depiction, e.g. in the preamble, that synthesized drugs, especially those produced by pharmaceutical companies, are less *intrinsically* dangerous than the «Narcotics» of the Single Convention.[31]

3. Regulatory approach

The third development is quite closely related to the second point. In addition to focusing increasingly on the demand side, i.e. the (ab)users of drugs, the regulatory approach later developed from a perspective based purely on administrative controls and penal sanctions to a more comprehensive approach.[32] In the 1961 version of the Single Convention, minimal attention was paid to the social side of drug abuse.[33] The Psychotropics Convention introduces measures of public education and drug use prevention to address social aspects.[34] With regards to penal sanctions, the 1971 Convention opens up the option for states to use treatment, rehabilitation and social re-integration measures in conjunction with criminal punishment for drug users.[35] In the Trafficking Convention, this approach to criminal sanctions reinforced by social measures continues[36] and in «appropriate cases of minor nature», penal sanctions can be replaced entirely by treatment measures.[37] In addition, the scope has been widened, no longer limited solely to drug users, but including also other drug offenders.[38] Nonetheless, in essence the Trafficking Convention still relies forcefully on criminalisation as an approach to combat both the supply and demand sides of drug trafficking.[39]

20 Jelsma, Development (fn. 6), 3 f.
21 Sinha (fn. 5), 27 f.
22 Vogler/Fouladvand (fn. 3), 117.
23 Vogler/Fouladvand (fn. 3), 111.
24 Sinha (fn. 5), 23.
25 Vogler/Fouladvand (fn. 3), 115.
26 Vogler/Fouladvand (fn. 3), 117.
27 Sinha (fn. 5), 29.
28 Art. 3(2) Trafficking Convention.
29 Vogler/Fouladvand (fn. 3), 119.
30 Letizia Paoli/Victoria A. Greenfield/Peter Reuter, Change is Possible: The History of the International Drug Control Regime and Implications for Future Policymaking, Substance Use & Misuse 2012, 923 ff., 931.
31 Sinha (fn. 5), 25 f.
32 United Nations, Commentary on the United Nations Convention on Psychotropic Substances 1971, New York 1976, 330.
33 Sinha (fn. 5), 23. This was later amended by the 1972 Protocol to the Single Convention, which mirrored the Psychotropics Convention's provisions on drug use prevention (Sinha (fn. 5), 32).
34 Art. 20 Psychotropics Convention; Sinha (fn. 5), 29.
35 Art. 22(1)(b) Psychotropics Convention. United Nations, 1971 Commentary (fn. 32), 346; Sinha (fn. 5), 29.
36 Art. 3(4)(b) Trafficking Convention.
37 Art. 3(4)(c) Trafficking Convention.
38 United Nations, Commentary on the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, New York 1998, 87.
39 Vogler/Fouladvand (fn. 3), 111; Sinha (fn. 5), 33.

4. Interim conclusion

Overall, the scope of regulation has been widened: the treaties today include both organic and synthesized drugs. However, the degree of regulation is stricter on average when it comes to organic drugs; synthesized drugs are rather less strictly regulated, because they are deemed to be of greater medical value (licit uses). The regulatory approach has also changed, the international Conventions today address both the supply and demand side. The demand side especially is considered more comprehensively, not just as an object of criminal law, but as a health and society issue. Criminal sanctions and *control* remain the focus of the whole UN treaty system, although social and etiological issues are included in an increasingly comprehensive approach.[40] Overall, the international system to control the transnational drug market(s), as contained in the international legal instruments, continues to be defined by the prohibitionist spirit on which it was founded.[41]

C. The distinction between licit and illicit drug use and markets

These developments are important and have led to a more all-encompassing international drug regulation regime. But there is a constant that has been present ever since the first Convention was written in 1961: The current international drug control system relies heavily on the distinction between licit and illicit use of drugs.

This distinction is based on the idea that drugs have an inherently ambivalent nature, that each drug has the potential to improve health or to bring harm.[42] Therefore, none of the Conventions declare the scheduled drugs «illegal» *per se*. Instead, they operate on the basis that specific drugs are neither inherently «bad» nor «good», but that such classifications depend on their *use* in a specific case and cannot be made in general. Recognising the ambivalent nature of drugs, i.e. their potential for both licit use and illicit abuse, the Single Convention and the Psychotropics Convention emphasize the need to guarantee access to indispensable medicines (especially for pain relief), while controlling dangerous substances as much as necessary.[43] This is the duality of the objectives of the Conventions system: access and control.

It has been a basic principle of the Conventions from the beginning that drug use should be possible, if it is for medical or scientific reasons.[44] The Conventions accordingly limit the use of scheduled drugs to medical and scientific purposes, «licit use».[45] *All other use* is considered illicit.[46] All three Conventions contain this distinction between licit and illicit use. The potential of each drug of medical use on the one hand and addiction and abuse on the other hand is then accounted for in scheduling the drug, i.e. in determining the level of control and of access.[47] The more dangerous and less medically useful a drug is considered, the stricter is the schedule of control it is subjected to.[48] However, no actual definitions of medical use exist.[49] This made the scheduling system less stable and more dependent on political decisions of the relevant stakeholders. As a result, the abovementioned power imbalance came into play again. In the Single Convention, e.g. cannabis is placed in the schedule of the Single Convention which contains the strictest control measures (Schedule IV), reserved for substances like heroin with a very high abuse potential and only «obsolete» medical use according to the WHO – even though the WHO now finds important medical uses for cannabis.[50] In general, the organic drugs in the Single Convention are considered hazardous until proven not to be; whereas this assumption was reversed by the powerful manufacturing states in 1971, where drugs are only scheduled if they are proven to be harmful.[51] In a very similar manner, the Single Convention considers licit use (of organic drugs) much less likely[52] than the Psychotropics Convention estimates licit, usually medical use (of synthetic drugs).[53] Although

40 Sinha (fn. 5), 3.

41 Sinha (fn. 5), 3; David R. Bewley-Taylor, Challenging the UN Drug Control Conventions: Problems and Possibilities, International Journal of Drug Policy 2003, 171 ff., 178; Vogler/Fouladvand (fn. 3), 114.

42 Vogler/Fouladvand (fn. 3), 107.

43 See the Preambles of both Conventions. See further Anderson/Davis (fn. 4); see also Vogler/Fouladvand (fn. 3), 107.

44 United Nations, Commentary on the Single Convention on Narcotic Drugs 1961, New York 1973, 110.

45 Jelsma, Development (fn. 6), 5.

46 Cf Sinha (fn. 5), 3.

47 Sinha (fn. 5), 3.

48 Cf Art. 3(5) Single Convention; Art. 2(4)(b) Psychotropics Convention.

49 Jelsma, Development (fn. 6), 13; David R. Bewley-Taylor, Harm Reduction and the Global Drug Control Regime: Contemporary Problems and Future Prospects, Drug and Alcohol Review 2004, 483 ff., 484.

50 Sinha (fn. 5), 22.

51 Sinha (fn. 5), 26.

52 Cf the provisions relating to reservations of state parties because of traditional use of e.g. coca leaves or opium, which require them to abolish all such use within 15–25 years (Art. 49 Single Convention).

53 Cf the Preambles; Sinha (fn. 5), 26.

the assumptions about medical use are reversed when it comes to the different substances in the 1961 and the 1971 Conventions, the underlying idea – that there is such a thing as licit or illicit drug use and that the two can be clearly distinguished – is part of the very fabric of the international drug regulation regime.

Considerations about drug use concern only one side: that of demand. But the licit/illicit distinction also applies to the supply side of drug regulation, to the markets and trade (or trafficking). Just like on the demand side, the definition of illicit markets and traffic is made negatively: Anything that is not licit, as explicitly allowed by the Conventions, is part of the illicit market (see Art. 1(j) Psychotropics Convention). The meaning of «licit» is, again, defined by the use of the specific drug in a medical or scientific setting (see Art. 5(2) Psychotropics Convention).

D. The current legal reality

So, the distinction between licit and illicit use and markets has been woven throughout the fabric of the UN drug treaty system ever since it started. But how does this system look today?

The contemporary international legal system relating to drugs still consists mainly of the three Conventions of 1961, 1971 and 1988. Since then, no new international agreements have been concluded. This does not mean that «the drug problem» has been solved. Rather, the problem has evolved and changed, and so has the international environment. The regulatory framework, on the other hand, has remained unchanged for more than the last three decades – at least on paper. Some characteristics of today's legal reality are described in the following part.

1. Lack of success and unintended consequences

In international drug policy, the most notable development lies in the fact that global consensus on the right way of dealing with drugs is imploding; policy ideas are increasingly fragmented. This also means that support for the existing regime is dwindling.[54] The reasons for this are numerous: On the one hand, the current system, dominated by the US-led «War on Drugs», has proven ineffective in combatting the illicit drug market and consumption.[55] At the same time, the strict control system may have unduly limited accessibility and availability of essential medication.[56] On the other hand, not only has the international regime failed to come closer to realizing its dual objective, but it has also produced many unintended negative consequences:[57] Criminalisation has obstructed access to health services, including HIV/AIDS prevention, and led to a sharp increase in the worldwide prison population.[58] Violence and human rights violations are prevalent, both in the illicit drug market itself and in «successful» drug control measures.[59]

2. State parties exploiting latitude of the Conventions

A well-known and often-debated symptom of dwindling support for the current UN treaty system lies in the various ways that state parties make use of the latitude in the Conventions, introducing measures of drug regulation which deviate from the punitive-prohibitionist approach of the Conventions.[60] Today, there is a wide variation in how countries interpret their legal obligations stemming from the international Conventions system.[61]

Different strategies can be identified. Numerous countries actively exploit existing *loopholes* in the conventions,[62] especially the so-called «escape clause» of Art. 3(2) Trafficking Convention.[63] This provision stipulates the criminalisation of drug possession for personal use «subject to [the] constitutional principles and the basic concepts of [the] legal system» of each state party, thus allowing some leeway for states to avoid criminalising consumption and possession of small amounts of some

54 Dan Werb, Post-War Prevention: Emerging Frameworks to Prevent Drug Use After the War on Drugs, International Journal of Drug Policy 2018, 160 ff., 160.

55 Global Commission on Drug Policy, Taking Control: Pathways to Drug Policies That Work, Geneva 2014, 12; Paoli/Greenfield/Reuter (fn. 30), 931 f.; see also Werb (fn. 54), 161 f.

56 Scott Burris/Corey S. Davis, A Blueprint for Reforming Access to Opioid Medications: Entry Points for International Action to Remove the Policy Barriers to Care and Treatment, Philadelphia 2009, 8 f.

57 Though whether these consequences are actually unintended or not is be debatable, see Vogler/Fouladvand (fn. 11), 125.

58 Jelsma, Development (fn. 6), 1; Global Commission on Drug Policy (fn. 55), 12.

59 Jelsma, Development (fn. 6), 7; Global Commission on Drug Policy (fn. 55), 12; Damon Barrett, Reflections on Human Rights and International Drug Control, in: Collins (ed.), Governing the Global Drug Wars, London 2012, 56 ff., 57 f.

60 David R. Bewley-Taylor/Martin Jelsma, The UN Drug Control Conventions: The Limits of Latitude, Series on Legislative Reform of Drug Policies Nr. 18, Amsterdam 2012, 4.

61 Vogler/Fouladvand (fn. 3), 120; Bewley-Taylor/Jelsma (fn. 60), 4.

62 Vogler/Vogler/Fouladvand (fn. 3), 120.

63 Jelsma, Development (fn. 6), 7; Bewley-Taylor/Jelsma (fn. 60), 5 f.

drugs, especially cannabis, for personal use. Further, there is the practice of «*soft defection*» from treaty provisions, where state parties relax the implementation of their obligations to criminalise possession of cannabis, either legally (by deflecting from criminal to administrative or to no sanctions at all)[64] or factually (by prosecuting small cases of possession less strictly).[65]

Finally, many states put strategies of *harm reduction* into practice,[66] focusing on the health aspects of drug use.[67] This can include replacing or supplementing criminal sanctions with measures of treatment, rehabilitation or education or providing safe «injection rooms» and needles for drug users in order to prevent the spread of HIV/AIDS.[68]

Many of these options are, today, generally considered permissible policy options within the international treaty framework, while others, such as drug «injection rooms»,[69] are rather contested.[70] As another example, approaches which largely tolerate drug consumption[71] are said to be testing the limits of latitude within the current regime.[72]

III. Opioid regulation under the current UN treaty system

A. Opioids: core characteristics and the current crisis

The term «opioid» refers to a relatively broad range of drugs, some derived from opium or other natural sources, like morphine, others of synthetic origin. This latter group includes prescription drugs like oxycodone, but also heroin, methadone and fentanyl.[73] In medicine, opioids are mainly used for pain relief.[74]

Much has been written about the so-called opioid crisis in North America, especially the United States, where drug overdose deaths increased three-fold within 15 years, two thirds of which are attributed to abuse of opioid drugs.[75] But opioid abuse is also widespread in other regions of the world. Especially in different African and Asian countries, the abuse of tramadol, a synthetic opioid, is on the rise.[76] Around the globe, people from a wide range of demographics become addicted to opioids.[77] Opioid abuse has truly become a global problem[78] of epidemic proportions.[79]

However, this global problem has some important regional differences, especially in the substances used with different medical properties. This implies significant differences in their legal regulatory status on the international level. The control status of different drugs in national jurisdictions is even more diverse, because such legislative frameworks are formed partly in reaction to country-specific challenges.[80] This renders an *in globo* assessment of the legal status of opioids even more difficult.

A comparison of two examples can help illustrate this difficulty. In the United States, most overdose deaths are attributed to fentanyl,[81] which is scheduled in Schedule I of the Single Convention and is a controlled substance in many countries. On the other hand, tramadol is the substance of highest concern in Africa and parts of Asia. It is a moderately potent pain killer, with powerful stimulating and mood-enhancing effects.[82] Tramadol used to be considered to have low abuse and dependency potential due to its rather low potency, but recent evidence is emerging to the contrary – reported fatalities are on the rise.[83] The drug is not scheduled in the international drug con-

64 E.g. the Netherlands, Switzerland, Luxembourg, Belgium, Spain, Portugal, Ireland, the Czech Republic, and some US states (Jelsma, Development (fn. 6), 9).

65 Most of the other EU countries (Jelsma, Development (fn. 6), 9); Vogler/Fouladvand (fn. 3), 121.

66 See Bewley-Taylor (fn. 49).

67 Vogler/Fouladvand (fn. 3), 121.

68 Bewley-Taylor/Jelsma (fn. 60), 9.

69 Vogler/Fouladvand (fn. 3), 121. Switzerland was a pioneer in this area, see for more details Diane Steber Buechli/Ruth Dreifuss, Swiss Drug Policy in International Context – Fought, Ignored, Admired, in: Collins (ed), Governing the Global Drug Wars, London 2012, 43 ff.

70 Bewley-Taylor/Jelsma (fn. 60), 4 ff.

71 E.g., the Dutch, Spanish or Californian approach. Bewley-Taylor, Drug Conventions (fn. 41), 178; Jelsma, Development (fn. 6), 9.

72 Bewley-Taylor, Drug Conventions (fn. 41), 171; Jelsma, Development (fn. 6), 9.

73 Enno Freye, Opioids in Medicine: A Comprehensive Review on the Mode of Action and the Use of Analgesics in Different Pain States, New York 2008, 85.

74 Freye (fn. 73), 85.

75 Nalini Vadivelu et al., The Opioid Crisis: A Comprehensive Overview, Current Pain and Headache Reports 2018, 16 ff.

76 UNODC, World Drug Report 2018 I (fn. 2), 1.

77 See Vadivelu et al. (fn. 75), 18.

78 UNODC, Global Opioid Crisis (fn. 2), 9.

79 UNODC, World Drug Report 2018 I (fn. 2), 1.

80 UNODC, Global Opioid Crisis (fn. 2), 9.

81 Vadivelu et al. (fn. 75), 16.

82 Sahba Jalali et al., Higher Regulatory Control of Tramadol to Prevent its Abuse and Dependence, Journal of Drug Policy Analysis 2017, 1 ff., with further references.

83 Medhat M. Bassiony et al., Adolescent Tramadol Use and Abuse in Egypt, American Journal of Drug and Alcohol Abuse 2015, 206 ff., 206.

ventions.[84] Both drugs are perceived as some of the most threatening opioids, but their status in international regulation could not be more different.

There is great diversity in sociodemographic backgrounds, nationalities and substances concerned. However, a common theme of opioid addiction and abuse lies in its origin: addictions to opioids predominantly starts with prescription opioids, which were either diverted from licit channels or were illicitly manufactured.[85]

B. Opioids in the international regime

The three UN Conventions provide a framework to regulate all drugs on an international level. This includes opioids – 46 percent of substances regulated in the three UN Conventions belong to the group of opioids.[86] Nonetheless, the opioid crisis is one of the most pressing problems of international drug regulation. It seems that the international treaty system is ineffective at combatting the opioid crisis, but why? The following section evaluates how some characteristics of opioids interact with two key features of the existing global drug control regime, effectively rendering these two key features inapplicable or unusable for the case of opioids.

1. Licit/illicit distinction

The distinction between licit and illicit use is at the centre of all three Conventions, as seen above (II.C). However, this distinction is not easily made: There are no exact definitions of medical (or scientific) use.[87] Medical use is purposely left undefined, because its meaning must be adaptable to medical knowledge at a certain time and to the specific circumstances of a case.[88] In addition, states are deliberately given some marge of manoeuvre in their interpretation of the term «medical use».[89]

So, the task of delimiting licit (i.e., medical or scientific) and illicit (i.e., all other) use was not an easy one from the start. Opioids exacerbate this difficulty, and even challenge the usefulness of the distinction entirely. In several instances it is legally very difficult to determine where to draw the line between medical and illicit use. The source of opioid addictions and abuse often lies in prescriptions, i.e., their *licit* use.[90] A person might first medically use opioids as painkillers and subsequently abuse them as an addicted individual: at what moment does licit use turn into illicit use? In addition, situations may arise where opioids are prescribed without a real medical necessity, either in cases where medical professionals unduly and excessively prescribe opioids or when patients demand prescriptions. The drafters of the Conventions either did not anticipate such situations, or sometimes expressly discussed them, but then considered that «such a situation could rarely if ever arise».[91]

Furthermore, treatment of addiction itself always presents a mixed question: even in 1976, it was considered that addiction treatment can and often will constitute medical use.[92] But especially with opioids taken by addicts without express medical recognition of their addiction (also for financial reasons),[93] the line between licit treatment, licit or illicit self-medication and illicit so-called «recreational use» is thin.[94]

The above relates to the *demand side* distinction between licit and illicit *use* of drugs, but the *supply side* question of (il-)licit drug *markets* is closely linked to it. Many illicitly used opioids are diverted from licit channels.[95] Opioid addicts often switch from licit sources to illicit, less expensive drug procurement channels. Some tramadol users obtain their drugs without prescription, but from licit distribution places.[96] All in all, distinguishing between markets that are licit or illicit, safe or unsafe etc. is increasingly difficult; «most of the market is decidedly grey».[97] This problem with defining licit or illicit markets has significant impacts for practical law enforcement on the supply side. Repression of suppliers is much more difficult, if most of them operate in a legal grey area. It seems impossible to penalise and criminally prosecute unsuspecting pharmacy workers or doctors.

Both the distinctions between licit and illicit use as well as licit and illicit markets are not useful in the case of opi-

84 UNODC, World Drug Report 2018 I (fn. 2), 9; Jalali et al. (fn. 82), 4.
85 UNODC, World Drug Report 2018 I (fn. 2), 7; Vadivelu et al. (fn. 75), 17.
86 UNODC, Global Opioid Crisis (fn. 2), 5.
87 Jelsma, Development (fn. 6), 13.
88 United Nations, 1961 Commentary (fn. 44), 111; United Nations, 1971 Commentary (fn. 32), 139.
89 E.g., it could also include use in «traditional», non-western medicine (United Nations, 1961 Commentary (fn. 44), 111). See also Bewley-Taylor/Jelsma (fn. 60), 9.
90 Vadivelu et al. (fn. 75), 17.
91 United Nations, 1961 Commentary (fn. 44), 68.
92 United Nations, 1971 Commentary (fn. 32), 140 f.
93 This lack of medical recognition of addictions could be attributed to high thresholds to access medical assessment and care, financial thresholds as well as psychological factors such as shame and fear of stigmatisation.
94 Similar Jelsma, Development (fn. 6), 13.
95 UNODC, World Drug Report 2018 I (fn. 2), 7.
96 Bassiony et al. (fn. 83), 209.
97 Jelsma, Development (fn. 6), 13.

oids. This challenges one of the foundations of the current international regulatory system.

2. Access versus control

The international drug regime has two fundamental objectives: guaranteeing access to necessary medicines and scientific research and prohibiting the use of certain drugs for all other uses.[98] These goals are very closely related to the distinction of licit or illicit use: access to drugs for licit uses should be guaranteed, all other drug use controlled and suppressed.

With respect to opioids, these two objectives are in fundamental conflict with each other. Many opioids such as oxycodone, methadone, fentanyl, or tramadol are (also) prescription drugs. This means that they have a licit, often very important, medical use, especially as pain killers. On the other hand, many opioids are highly addictive, which (amongst others) gives them a high potential of dangerous side effects.[99] Hence, opioids have an even more ambivalent nature than many other drugs: they are torn between the two poles of medical usefulness and abuse potential. It may seem that these two poles are both so strong that all compromise between them must be deeply flawed.

With regard to all drugs, the two objectives always imply trade-offs.[100] But the reality goes further than that: neither of the two objectives has been reached in the slightest; numbers of illicit drug users are as high as ever and in many places of the world, while access to even the most fundamental of medicinal drugs is not guaranteed.[101] Tramadol may serve as a forceful example: sometimes within the same country, people may not have access to basic painkillers such as tramadol, while in other parts, tramadol abuse leads to soaring rates of opioid addictions.[102]

IV. Conclusion

In 1961 «narcotic» (i.e., organically derived) drugs were subjected mostly to rigorous control. In 1971 the importance of guaranteeing access to the synthetic «Psychotropics» emerged. Out of these developments, a system was born which relies on the distinction between licit, good, medical use of drugs and all other, illicit uses. On the one hand, this distinction is based on the valid consideration that all drugs are ambivalent: They can be good or bad, depending on how they are applied. But the distinction was also based on power imbalances and influences of a political and economic nature, which are not concerned with the «health and welfare of humankind».[103] Today, opioids transcend the boundaries between medical and illicit uses, the distinction of which is increasingly impossible. The conflicting goals of either guaranteeing access to opioids for licit purposes or controlling and prohibiting their availability for any other use do not seem achievable at the same time. That the distinction is a structural principle of the international drug regulation regime results in the appalling situation of crisis that we find ourselves in today. Opioids question the very bases of the international drug treaties.

If such is the diagnosis, what, then, could be the medicine for an effective international drug regulation? I find myself unable to provide a satisfactory answer to that. Abandoning the distinction between licit and illicit uses completely would mean introducing a single regulated market for all drugs – a prospect which would effectively end drug regulation as we have known it at least since 1961, a prospect which seems unlikely to find acceptance today.[104] Surely, the increasing focus on health, harm reduction (on the demand *and* increasingly also on the supply side)[105] and human rights[106] is a fundamentally important development.[107] Whether this medicine is strong enough will remain to be seen.

98 Global Commission on Drug Policy (fn. 55), 11.

99 Andrew Kolodny et al., The Prescription Opioid and Heroin Crisis: A Public Health Approach to an Epidemic of Addiction, Annual Review of Public Health 2015, 559 ff., 560.

100 UNODC, Global Opioid Crisis (fn. 2), 10.

101 Burris/Davis (fn. 56), 9; Jelsma, Development (fn. 6), 13; Global Commission on Drug Policy (fn. 55), 11; Anderson/Davis (fn. 4).

102 UNODC, World Drug Report 2018 I (fn. 2), 23.

103 See the preambles of the Conventions.

104 Bewley-Taylor/Jelsma (fn. 60), 16 f.

105 See e.g. Victoria A. Greenfield/Letizia Paoli, If Supply-Oriented Drug Policy is Broken, can Harm Reduction Help Fix it? Melding Disciplines and Methods to Advance International Drug-Control Policy, International Journal of Drug Policy 2012, 6 ff.; Martin Jelsma, Harm Reduction for the Supply-Side: Its Time Has Come, International Journal of Drug Policy 2012, 20 f.

106 See e.g. Barrett (fn. 59).

107 See generally also Global Commission on Drug Policy (fn. 55), 21 f.; UNODC, World Drug Report 2018 I (fn. 2), 23; Nina Rehn-Mendoza, Are We Making Progress in International Drug Policies?, Nordic Studies on Alcohol and Drugs 2016, 223 ff.