WHAT DOES “DRUG” MEAN ?

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Abstract: Despite being a modern and universal phenomenon, there is no precise definition of the word "drugs". Whether one approaches it in terms of its physiological effects or its prohibition, it seems we obtain only incomplete points of view, with the phenomenon as a whole remaining evanescent. The approach proposed here is to change our perspective and consider “drugs” as a universal total social fact. “Drugs” are a global social organization which, for the planet as a whole, distinguishes between the holy uses and lay uses of certain psychoactive substances. The article first describes the magical operation through which licit uses of “drugs” have been distinguished from illicit uses at a national level and then shows how this operation has continued at the international level in order to build a licit narcotic drugs economy that is separate from its illicit counterpart. This economic dimension is developed in the third part of the article in order to bring to light the monopolistic process that organizes the holy uses of “drugs”. The final section offers some lines of thought to explain why the legal dimension of “drugs” has been gradually and completely overshadowed by an exclusively prohibitionist reading of the phenomenon. Belief in the prohibition of “drugs” was undoubtedly necessary for the dissimulation of a reality even more unacceptable: the monopolization of licit customs.

Keywords: Drug Policy. International Drug Control. Pharmaceutical Companies. Physicians and Pharmacists.

Introduction

A modern phenomenon *par excellence*, the concept of "drug"[1] gained prominence in the 19th century with the industrial revolution and the development of a new sanitary and moral awareness. Psychoactive substances have of course been consumed for a long time and their uses have always been subject to more or less strict social control[2]. But it was only from the 19th century onwards that the consumption of certain psychoactive products was deemed to be a sanitary and social problem that required state action and the development of specific legislation[3]. In its modern acceptation, "drug" is inseparable from the public policies that are implemented to control its uses. The second specificity of "drug" is that of being a globalised problem, in the sense that whilst certain particularities exist, "drug" issues are not specific to individual countries and are necessarily part of a web of transnational interdependencies[4]. From the opium wars to the French Connection and on to the Columbian cocaine cartels, "drug" has always been perceived as a global phenomenon requiring multilateral solutions[5]. Finally, another aspect of its universal nature is that it concerns all populations and all milieus. If we include medical use, those who have never experimented "drug" are rare. Another particularity worth mentioning is the transdisciplinary phenomenon that has interested intellectuals from all horizons. Almost all scientific disciplines that deal with humankind have studied the "drug" problem[6]. We naturally think of medicine, from hygienics to psychiatry and the very

[1] I deliberately use inverted commas so as to underline the semantic indetermination of the word.

[2] MORTIMER ,W. G. *Peru*: History of Coca, "The Divine Plant" of the Incas. New York: J. H. Vail & Co., 1901; KRITIKOS, P. G. ; PAPADAKI, S. P. Le pavot et l'opium, leur histoire et leur extension dans la région de la Méditerranée orientale durant l'Antiquité. *Bulletin des stupéfiants*, v. 19, n. 3, 1967.

[3] BERRIDGE, V.; GRIFFITH, E. *Opium and the people*: opiate use in Nineteenth-Century England. New Haven; London: Yale University Press, 1987; VIGARELLO, G. La drogue a-t-elle un passé? In: EHRENBERG, A. (Dir.). *Individus sous influence*: drogues, alcools, médicaments psychotropes. Paris: Editions Esprit, 1991. Laws prohibiting the consumption of opium may have existed here and there, particularly in China, but it was not until the 19th century that more generalised public action was taken to restrict its use.

[4] KOUTOUZIS, M.; PEREZ, P. *Atlas mondial des drogues*. Paris: Presses Universitaires de France, 1996.

[5] LOWES, P. D. *The genesis of international narcotic control*. Genève: Librairie Droz, 1966. MCALLISTER,W. B. *Drug diplomacy in the Twentieth Century*: an international history. London; New York: Routledge, 2000; DUDOUET, F. X. De la régulation à la répression des drogues: une politique publique internationale. *Les Cahiers de la sécurité intérieure*, n. 52, p. 89-112, 2. trim. 2003.

[6] It is also important to mention the artistic dimension and the way in which artists and works of art have, in the literal sense, seized upon "drugs". Among the best-known, see DE QUINCEY, T. *Confessions of an English Opium Eater*. London: Taylor and Hessey, 1822 or BAUDELAIRE, C. *Les paradis artificiels:* opium et Haschisch, Paris: Poulet-Malassis et de Broise, 1860, or, more recently, Eric Clapton's song, *Cocaine*.

recent addictology, but we must also add pharmacology, neurosciences, botany, biology in general, chemistry of course, history and geography, sociology and law, ethnography and political science, criminology and geopolitics, and undoubtedly many more. As early as 1946, in his wonderful book entitled *Opium* and subtitled *general historical-geographical-chemical considerations relating to the manufacture and use of opium and economic, social and legislative studies*, Ihno Bensussan pointed out the plethora of dimensions surrounding this phenomenon[7]. Rare are the fields of knowledge that have not, at one time or another, produced knowledge on "drugs". This intensive effort of collective think might nevertheless prove to be a disappointment. More than a century after this phenomenon emerged, we are still finding it extremely difficult to accurately define "drug". There is no fully accepted definition of the word, which covers an entire range of representations that are not always suitable and not always consistent with one another. "Drug" is supposedly illegal, but we talk about "licit drug" and "illicit drug" and experts know that there are at least as many effects and uses of "drugs" as there are "drugs" themselves. "Drug" users themselves have an uncertain status which, depending on the contexts, shifts between addict, patient, user, deviant, delinquent and even criminal. Ultimately, we have no idea what "drug" means. Does it refer to a set of substances with similar physiological effects? Or something forbidden? A type of consumption? A social status? The more we try to isolate the phenomenon, the more it seems to slip between our fingers like fine sand. Among the many approaches that that have attempted to pinpoint the "drug" phenomenon, there are two that appears to be especially pertinent: that which focuses on the products, which one may call the substantialist approach, and that which focuses on what is prohibited, which one may call the moral approach.

The substantialist approach – essentially that of the medical profession – considers "drug" to be a set of substances with similar physiological effects that can cause intoxication. This representation of "drug" as a pathology factor was slowly constructed over the course of the 19th century by healthcare professionals who saw the consumption of certain substances as the cause of new pathologies[8]. With the increasingly widespread use of morphine

[7] BENSUSSAN, I. J. *L'opium*: considérations générales histoire-géographie-chimie fabrication et usage de l'opium et études économiques, sociales et législatives. Paris: Vigot Frères, 1946.

[8] MUSTO, D. F. *The American Disease*: origins of narcotic control. New York; Oxford: Oxford University Press, expanded édition, 1987; BACHMANN, C.; COPPEL, A. *Le dragon domestique*: deux siècles de relations étranges entre l'Occident et la drogue. Paris: Albin Michel, 1989.

in the United States and Europe, following the conflicts taking place on the two continents between 1850 and 1870[9], many doctors raised concerns about this new appetence, which they considered to be a misuse of the therapeutic act. In 1875, Berlin doctor Edouard Levinstein invented the term morphinomania – *morphinesucht* – the clinical definition of which stresses the morphine addict's uncontrollable craving for the "drug": his mania[10]. Imported into France, the future of his expression seemed bright, as it derived from the generic definition of "drug" addiction[11]. Medical attitudes towards "drug" of course vary from one country to another. American doctors developed the concept of *inebriety*, which refers to a sort of chronic drunkenness caused by alcohol or opiate abuse. However, these approaches have in common the fact that they focus mainly on the physiological effects of substances and on discovering their effects in terms of dependency. They very much dominated "drug" thinking throughout the 20th century and continue to be the most common manner of describing the phenomenon. So whilst the individual's character is at stake, it is always the dangerous nature of the substances that ultimately wins the day when it comes to describing the phenomenon.[12] To such an extent that "drug" are presented first and foremost and almost everywhere as substances and not as a social fact.

The other approach, that we call the moral approach, is less concerned with substance properties than with the value judgements that form the basis for the social management of "drug" and with the public policies implemented to this end[13]. Here again, the "drug" problem was also founded at a moral level, through the combined action of the temperance movement, essentially in the United States and the United Kingdom, and of the health discourse of doctors[14]. Howard S. Becker

[9] In particular, the Crimean War (1853-1855), the American Civil War (1861-1865), the Austro-Prussian War (1866) and the Franco-Prussian War (1870-1871), all of which heralded the carnages of the 20th century and the massive use of morphine.

[10] VUILLAUME, D. La construction des pensées française et américaine sur la question des drogues. Du parallélisme des origines au tournant des années trente. *Médecines/Sciences*, n. 31. p. 921-928, 2015.

[11] See also YVOREL, J. J., Les mots pour le dire. Naissance du concept de toxicomanie. *Psychotropes*, v. 2, n. 2. p. 13-19, 1992.

[12] See among others: NAHAS, G.; LATOUR, C. (Ed.). *Physiopathology of illicit drugs:* Cannabis, cocaine, opiates. New York: Pergamon Press, 1991.

[13] I use "moral" where others might use "sociological" or "constructivist". BERGERON, H. *Sociologie de la drogue*. Paris: La Découverte, 2009. The reason is first of all that these approaches are not specific to sociologists, and secondly that "constructivist" is a relatively recent term that is not necessarily suitable when describing the thinking of the 1960s and 1970s. With "moral", I wish to stress the idea that for these approaches, "drug" policy is underpinned by a boundary between good and evil.

[14] BERRIDGE, V. Professionalization and narcotics: the medical and pharmaceutical professions and British Narcotic use 1868-1926. *Psychological Medicine*, v. 8, issue 3, p. 361-372, 1978; ACKER, C. J. From all Purpose Anodyne to

was certainly one of the first to encourage us, when looking at the "drug" issue, to discard all substantialist considerations and to focus on the strictly social aspect of the phenomenon[15]. It is not so much the effects of the substances that interest Becker – even though he devotes several pages to teach us about the sensations that marijuana produces – as what causes a person to become (or not) a deviant. It is neither the substance nor the individual that carries deviance within it or him, but rather the social relationship between the "drug" user and the person who is judging him. It is people who label others as deviants, just as it is moral entrepreneurs who create prohibitions. For Becker, the "drug" issue is not so much the substance as its prohibition and this can be explained by social reasons and not by the physiological effects of said substance. Thomas Szasz believes that it makes no sense to try to use the physiological effects of substances to justify the fight against "drug" abuse[16]. Prohibition, for whatever reason, stems not from science but from religion. What distinguishes kosher wine from non-kosher wine is not the chemical properties of the two wines, he says, because from a scientific standpoint they are the same wine. It is the religious ritual that modifies the status of the wine, and not the wine that changes the chemical composition. The difference between the two states is not one of its nature (chemical) but one of culture (ceremonial). He goes on to say that the same is true of heroin and cannabis in relation to alcohol and tobacco:

"Similarly, the important differences between heroin and alcohol, or marijuana and tobacco – as far as "drug abuse" is concerned – are not chemical but ceremonial. In other words, heroin and marijuana are approached and avoided not because they are more "addictive" or more "dangerous" than alcohol and tobacco, but because they are more "holy" or "unholy" – as the case may be.[17] »

There is no doubt that each substance has its own physiological effects, but these differences are not

Marker of Deviance: physicians' Attitudes Toward Opiates in the US from 1890 to 1940. In: PORTER, R.; TEICH, M. (Ed.). *Drugs and narcotics in History*. Cambridge: Cambridge University Press, 1995. p. 114-132.

[15]BECKER, H. S. *Outsiders:* Studies in the sociology of deviance. New York; London: Free Press of Glencoe; Collier-Macmillan, 1963.

[16]SZASZ, T. *Ceremonial Chemistry:* the Ritual Persecution of Drugs Addict, and Pushers. London: Routledge & Kegan Paul, 1974.

[17]Ibid. p. 4. The neurobiological similarity of the products was demonstrated a few years later by DI CHIARA, Gaetano; IMPERATO, Assunta. Drugs Abused by Humans Preferentially Increase Synaptic Dopamine Concentrations in the Mesolimbic System of Freely Moving Rats. *Proceedings of the National Academy of Sciences*, n. 85, p. 5274-5278, 1988. This discovery was mobilised in fights for the revision of drug consumption policies: see FORTANE, N. La carrière politique de la dopamine. Circulation et appropriation d'une référence savante dans l'espace des drug policies. *Revue française de science politique*, v. 64, n. 1. p. 5-28, 2014.

enough to explain the difference in treatment between heroin and marijuana on the one hand and alcohol and tobacco on the other. For Szasz, the problem was that the medical profession of his time itself maintained the confusion between the ceremonial (religious) dimension and the chemical (scientific) dimension of "drug", thus helping to create *Ceremonial Chemistry* – which aimed to use a clinical fact (the phenomenon of dependency) to justify a social fact (prohibition). Criticism has since been widespread and it cannot be denied that rare are those who still confuse policies on "drug" with substances and the physiological effects that they produce. The distinction is sufficiently accepted for it to be turned against so-called prohibition policies, on the basis that if it is not science that justifies prohibition, then prohibition is totally arbitrary. This can be seen in the expressions "legal drugs" and "illegal drugs". They reflect the notion that if products with similar physiological effects are authorised one minute and banned the next, then there must be more than just purely medical considerations behind such policies – i.e. a socially constructed arbitrariness[18].

Yet these two approaches struggle to explain the "drug" phenomenon as a whole. The substantialist approach fails to explain why similar substances such as cannabis and tobacco are subject to two different sets of regulations, or why, in modern times, the trend towards the liberalisation of the former would appear to run alongside a trend to prohibit the latter. If these substances have similar physiological effects, why are they not treated in the same way? It is all very well doctors worrying about the incoherencies of public policies, but they remain unable to explain them[19]. The moral approach suffers from a different type of problem. It is right correct in asserting that the "drug" policy is founded on a certain number of arbitrary factors based on values, or on the desire to control certain populations. But while this approach throws light on the incrimination of some of the most emblematic substances, such as cannabis and heroin, it does not take account of the regulations that apply to all narcotic drugs and psychotropic substances, such as codeine, barbiturates, benzodiazepines, etc. It says little about the legal uses of "drug". However, the main difficulty that these approaches have in common is that they

[18] BERGERON, op. cit. p. 5.

[19] See in particular Marc Kirsh's interview with Professor Roques in *La lettre du collège de France*, Hors-série 3, p. 50-53, 2012. https://lettre-cdf.revues.org/288#text Author of a famous report on the comparative dangers of numerous psychoactive substances, the only explanation that Bernard Roques could offer for the fact that alcohol was not on France's lists of narcotic drugs, was that this was due to the "alcohol lobby". But he produces no evidences for that.

remain prisoners of the notion of "drug" prohibition. Yet this is a fallacy. The law does not prohibit narcotic drugs or psychoactive substances, it controls their use. It is for this reason that one may perfectly legally misuse narcotic drugs, when they are presented in the form of medication, and even die in large number of such misuse, without this being too great a concern. In its 2015 report, the International Narcotics Control Board noted that "In the United States, federal authorities have reported that deaths involving controlled prescription drugs outnumber those involving heroin and cocaine combined" and even "those caused by motor vehicle accidents, thus constituting the single leading cause of "injury deaths" in the country"[20]. Is there any better proof of the fact that "drug" policy is not based on the fact that substances are banned, but on how their use is regulated?

It is indeed very odd that no law exists to ban a phenomenon that is the object of a worldwide prohibition[21]. No international agreement bans "drug" – especially given that the word "drug" does not exist in international law[22]. The agreements that are currently in force refer either to narcotic drugs (the 1961 Convention) or to psychotropic substances (the 1971 Convention). Yet neither narcotic nor psychotropic substances are defined in terms of their chemical or physiological properties, but instead in an *ad hoc* manner through their entry of the former in Tables I and II of the 1961 Convention and of the latter in Tables I, II, III and IV of the 1971 Convention. So as I have shown in the past, the classification of substances within the various tables does not depend on medicinal or moral considerations or on how dangerous they may be, but on their economic interest in medical practice[23]. What makes a narcotic

[20] INTERNATIONAL NARCOTIC CONTROL BOARD. *Report of the International Narcotics Control Board for 2015*. New York: United Nations, 2016. p. 54.

[21] International laws do not prohibit drugs, but regulate their use. See DUDOUET, F.-X. *Le grand deal de l'opium*: histoire du marché légal des drogues. Paris: Editions Syllepse, 2009. Préface d'Howard S. Becker.

[22] Just like the term "drug" in English, the French word "drogue" only had legal existence between 1933 and 1964, i.e. between the date when the 1931 *Convention* came into force and the date when it was repealed by the Single Convention. Prior to 1931, the substances governed by international law were designated by their name; however, as from the 1930s, the French term "stupéfiants" and the expression "narcotic drugs" became more widespread. The first legal uses appeared in the 1936 Convention for the repression of the illicit trafficking of "harmful drugs", which never came into force. The new denominations of narcotic drugs were definitively adopted in the Single Convention, which replaced the previous treaties. In this paper I use French and English, which are the official languages of treaties. The Spanish translation of "narcotic drugs" is "estupefacientes". The word "drugs" in the plural form is commonly used by international organisations to to refer to all substances that are subject to international "drug" control, i.e. narcotics and psychotropic substances.

[23] DUDOUET, op. cit. Medical expertise, through the voice of the World health Organisation, is only called upon when a new substance is to be added to one of the tables. But it is never more

drug or psychotropic substance is the control regime that one decides to apply to it and which is specific to each table. It is not therefore its dangerous nature that makes the narcotic, but the extent to which the product is used in medical practice. The substances listed in table IV of the 1961 convention – the one for which it is recommended to prohibit all non-scientific uses – are not included because they have similar pharmacological properties, but because they are rarely used in medicine[24]. This is why, in table IV, we find both heroin and cannabis, while codeine – undoubtedly the most commonly used opiate in the modern pharmacopeia, appears in table II, which has far less strict control requirements. The derogatory regime can go even further and exempt certain preparations that contain narcotics from a wide range of controls, such as the obligation to be prescription only. This is the case for preparations listed in table III, among which we find those containing codeine. This is why, in countries that apply international conventions to the letter, it is possible to buy medicines containing codeine without a prescription, even though codeine is an opium derivative known to be extremely addictive. The link between "drug" and "prohibition" thus stems not from the law but from a belief based on a lack of understanding of the law.

These details are important, because they force us to re-examine the meanings frequently associated with the word "drug". "Drug" is not a synonym for narcotic or psychotropic substances. We think we are talking about the same thing but we are in fact describing two very different realities. First of all, what people usually mean by "drug" only partially relates to what the law means by narcotics and psychotropic substances[25]. Secondly, contrary to what the substantialist approach says, it is not physiological effects that determine what constitutes a narcotic or a psychotropic substance, but legal rules – so something of an arbitrariness. Finally, the law prohibits neither narcotic nor psychotropic substances, it simply regulates their use. We thus find ourselves with a legal rule that demolishes the most deeply rooted representations of "drug". So if "drug" is neither substances nor prohibited products, what are they?

In order to answer this question, not only do we need to forget our usual representations of "drug", we also need to take a sideways step. We must no longer ask what "drug" is, and instead ask

than advice. The final decision is made by the countries that are members of the United Nations Commission on Narcotic Drugs. See in particular p. 16-22.

[24] 1961 Single Convention on narcotic drugs as modified by the 1972 Protocol: article 2 § 5

[25] Alcohol and tobacco are not included, for example.

what "drug" does. In so doing, we return to the moral approach, which had already introduced such a constructivist process. Our approach will nevertheless differ, in as much as the objective of this study is no longer to explain prohibition, but instead to understand all aspects of the phenomenon, both licit and illicit - which means recognising that there are both lay uses and holy uses of drug[26]. In their famous article on primitive forms of classification, Emile Durkheim and Marcel Mauss clearly show the extent to which the taboos surrounding certain animals or places mimicked the social structures that organised the lives of aboriginal tribes[27]. And whilst the aborigines firmly believed it was forbidden to kill and eat this or that animal, it would never have crossed the researchers' minds to attribute these taboos to the very nature of the animals concerned, especially as what was forbidden for one, might be authorised for another. We must do the same with "drug" and must cease to think that when we talk about "drug" we are talking about the prohibition of certain substances, when we are in fact speaking about social structures within our society. What we call "drug" actually reflects a system of control of psychic states by modern health structures. "Drug" express above all a complex economic system between doctors, pharmacists, pharmaceutical industries and public authorities through which access to certain substances that can modify psychic states and relieve pain is regulated.

We therefore need to break away from the standard meanings routinely associated with "drug", whether as a substance or a prohibitions, and try to view them as an integral social fact[28], i.e. as a phenomenon which, to use Mauss's words, concerns the whole of society and its institutions. The urgency of a "total" approach is even more compelling in that it is undoubtedly the first entirely universal social fact, i.e. which affects all of humanity at the same time. Following the International Narcotic Control Board, the world consumption of opioids, for medical ends only, in 2016 was 11.6 billion of defined daily doses for statistical purposes[29], or just over one dose per capita per day. It is certainly difficult to find a social phenomenon that is both global and legally regulated. How the "drug" phenomenon has been socially constructed

[26] DURKHEIM, E. *Les formes élémentaires de la vie religieuse*: Le système totémique en Australie. Paris: Félix Alcan, 1912.

[27] DURKHEIM, E.; MAUSS, M. De quelques formes primitives de classification. Contribution à l'étude des représentations collectives. *Année sociologique*, n. 6. p. 1-72, 1903.

[28] MAUSS, M. Essai sur le don. Forme et raison de l'échange dans les sociétés archaïques. *L'Année sociologique*, seconde série, 1923-1924.

[29] | INTERNATIONAL NARCOTIC CONTROL BOARD. *Narcotic Drugs. Estimated World requirements for 2018. Statitics for 2016*. New York: United Nations, 2018. p. 113.

at the global level is what we will see in the following pages. We will particularly examine the way in which international institutions have separated the lay and holy spaces of "drug", or, to use technical terms, by distinguishing between licit and illicit uses of narcotics and psychotropic substances. Because when studying the magical operation that separates two apparently identical things, it is at this level that the "drug" mystery resides, making the phenomenon just as much a very real sanitary problem as a crucial moral issue.

To try to explain this magical operation that creates the "drug" phenomenon, we will proceed in four stages. First of all, we will return to the way in which the medicinal opium, morphine and cocaine issue was constructed over the course of the 19th century, as a reminder that it was never a case of totally banning its use, but of reserving its consumption for medical purposes alone. Secondly, w will provide a brief summary of the history of international "drug" policy and underline the fact that between 1912 and 1972 it created an airtight boundary between the licit and illicit "drug" economies. Thirdly, we will demonstrate the huge importance of the economic stakes and the oligopolistic direction that they gave to international "drug" policy. We will finish by trying to explain why, as from the 1970s, the perception of the problem increasingly focused on illicit uses alone, to such an extent that the licit aspect was forgotten. For the purposes of this article, we will continue to use the term "drug" in inverted commas in order to underline its lack of precision. On the other hand, we will use the term narcotic drugs and psychotropic substances to refer to substances covered by international laws.[30]

Holy uses, lay uses

The process leading to the distinction between holy and lay uses of certain psychoactive substances began in the 19th century with doctors and pharmacists developing a discourse on the dangerous nature of certain substances and asking to be granted the monopoly on the prescription and dispensing of those they used in their pharmacopeia. In France, for example, the monopoly of pharmacists had for a long time been limited to pharmaceutical compounds and not to the actual components which were used to prepare them and which were called "drogues"[31]. The latter concerned an entire

[30] The expression « narcotic drugs » appears for the first time in the Convention for limiting the manufacture of narcotic drugs (1931). It designates all substances covered by the Convention i.e. mainly opiates, cocaine and cannabis. The word is also used by subsequent traities except for the Convention of 1971 which introduces the expression of psychotropic substances.
[31] VIGARELLO, op. cit.

range of substances, including opium, which thus fell outside the pharmacists' monopoly. The term "drug" did not so much mean toxic or poisonous substances, as "the generic name of the raw materials with which pharmacists prepare their medicines"[32]. For the better part of the 19th century, opium, morphine, and later on cocaine, were not subject to any specific regulation restricting their consumption. For example, it was easy to find opium-based cordials in grocery shops or cocaine in fashionable aperitifs such as Mariani tonic.[33]

[32]Following LITTRE cited by PENCIOLELLI, Paul; VAILLE, Charles. *Code de la Pharmacie:* Livre V du code de la santé publique. Paris, Jean Baudet éditeur, 1954.
[33]MORTIMER, op. cit.

Figure 1: Advertisement for Mariani tonic

It was only gradually that their sale began to be regulated and restricted to medical uses alone. In France, the first law of national scope to regulate poisonous substances dates back to 1845, but it was not until 1916 that a regime dedicated to narcotics was clearly established, with their use being strictly reserved for doctors and pharmacists[34]. In the United Kingdom, the pharmacist profession was not accepted as a *numerus clausus* until 1852 and only obtained the monopoly to sell substances listed in the "Poisons Bill" in 1868[35]. At the same time, the status of doctors was being strengthened. Their authority to diagnose the physiological and psychological state of populations – which often involved healthcare considerations – was confirmed and became dominant[36]. From a status of one healer among many (physiotherapist, midwife, magnetizer, bonesetter), doctors of western medicine gradually monopolised the legal practice of medicine to such an extent that they subjugated other practices and even caused them to disappear. This victory over the medical act was largely due to the development of a health discourse concerning the non-medical consumption

[34] Voir VAILLE, C.; STERN, G. *La réglementation des substances vénéneuses:* les toxicomanies. 2. ed. Paris: Editions du Creuset, 1957. See also CHARRAS, I. Genèse et évolution de la législation relative aux stupéfiants sous la troisième République. *Déviance et Société*, v. 22, n. 4, p. 367-387, 1998. Non-medical uses are not sanctioned however. Which once again goes to show that the aim of the policy was not to ban "drugs", but to restrict access thereto.

[35] BERRIDGE. *Professionalization...* op. cit.
[36] Ibid. ACKER, op. cit.

of certain psychoactive substances – a discourse that coincided with the moralising discourses of temperance movements. These combined circumstances led to the authorities granting the monopoly for the prescription and dispensing of some psychoactive substances to doctors and pharmacists, because in addition to people's physical health, their moral well-being was also at stake[37]. So began a first distinction between "good" and "bad" consumption of "drug", i.e. between those prescribed and dispensed by duly authorised healthcare professionals, and those obtained by unauthorised means. But let there be no mistake, medical control is no guarantee of freedom from "drug" addiction, as can be seen nowadays with the medicalisation of addicts in substitution and support programmes, and with deaths caused by the abusive consumption of medicines containing controlled substances.

What ultimately differentiates the patient from the deviant is not the substance he consumes, but the social framework of said consumption. The magical operation through which we distinguish between the "good" and "bad" use of narcotics, has the effect of separating those who can legally benefit from such use from those who will be prosecuted for it. The oligopolistic structure of medical professions correlates with the various forms of monopoly from which they receive the principal material and symbolic benefits of their activity: diagnosis and medical act on the one hand, the prescription, preparation and dispensing of certain substances on the other. As a result, it is tempting to see this health-based discrimination policy as the construction of a monopoly on legitimate psychological constraint which would be a sort of modern equivalent of a monopoly on legitimate physical violence[38]. The development of relationships of interdependency that led to the advent of modernity significantly changed people's psychological economy and generated a set of self-constraints that are more or less difficult to bear. More generally, it is the very process of civilisation – in as much as it domesticates morals and imposes strict behavioural norms – that shapes the individual psyche[39]. Yet just like yesteryear's belief in salvation of the soul, the consumption of psychoactive substances can sooth the suffering caused by the interiorisation of social constraints. We know – thanks to Alain Ehrenberg in

[37] BERRIDGE. *Professionalization...* op. cit.

[38] This new model of psychological constraint replaces the Church's previous monopoly on salvation goods. WEBER, M. (1922). *Économie et société /1*: Les catégories de la sociologie. Chavy J. et de Dampierre E. (trad. dir.). Paris: Pocket, 1995.

[39] ELIAS, N. (1939). *La civilisation des mœurs*. Kamnitzer P. (trad.). Paris: Presses Pocket, 1990.

particular – the extent to which the consumption of these substances has become necessary for the mental well-being of modern man[40]. Pain relievers, sleeping pills, tranquillizers and anxiolytics are families of medicines that are all used on a daily basis to sooth the soul; and they all contain "drug". By limiting legal access to these substances to doctors and pharmacists, we *de facto* give them power over people's psychological states. They therefore found themselves in a position of authority, able to encourage certain types of consumption while proscribing others, i.e. prescribing psychological normality, even if this sometimes means producing collective blindness[41]. Healthcare professionals' authority to say what constitutes good or bad consumption of "drug" was consubstantial with the institutionalisation of their professions and played a large part in gaining recognition for their social utility. However, this victory of healthcare professions did not prevent the spread of non-medical consumption. Although doctors and pharmacists had the monopoly for prescribing and dispensing, the substances themselves continued to be freely produced and sold throughout the world. To such an extent that a given country might confine the consumption of morphine to the medical sphere, while at the same time allowing pharmaceutical firms to manufacture and export as much morphine as they wished, even when this meant that through the meanderings of international trade, it would return to said country to feed non-medical consumption. It was to resolve this problem that an international "drug" policy was created.

International narcotic control

Although healthcare professionals in the west were successful in demanding the monopoly on the retail distribution of some psychoactive substances (opiates, cocaine at the first), their manufacture remained totally unfettered. Pharmaceutical companies – especially those in the west – who produced and sold morphine, heroin and cocaine, fed both medical and non-medical consumption. Moreover, the consumption of opium for non-medicinal purposes remained perfectly legal in European dominions in Asia and indeed provided them with substantial revenues[42]. The

[40]EHRENBERG, A. *L'individu incertain*. Paris: Hachette, 1995. EHRENBERG, A. *La fatigue d'être soi*: dépression et société. Paris: Odile Jacob, 1998.

[41] On the influence of doctors and their professional representations of the construction of drug-related policies, see in particular BERGERON, H. *L'Etat et la toxicomanie*: Histoire d'une singularité française. Paris: Presses Universitaires de France, 1999.

[42] DESCOURS-GATIN, C. *Quand l'opium finançait la colonisation en Indochine*. Paris: L'Harmattan ; Recherches Asiatiques, 1992;

world was thus facing a paradox whereby on the one hand the licit consumption of morphine, heroin and cocaine was increasingly monopolised by healthcare professionals, while on the other hand there was an unregulated supply of these substances and an Asian opium addiction that was encouraged by colonial powers. It was in this context that the first international opium conference took place in Shanghai in 1909, on the initiative of the Americans[43]. The conference resulted in no concrete agreement, but a series of resolutions was passed, encouraging the suppression of opium smoking and recommending the restriction of opium consumption to medical use alone. Although the question of morphine, heroin and cocaine was discussed as a growing problem, no commitment was made. It was not until three years later, following the Hague conference in 1912, that the first restrictive measures were introduced. These measures obliged countries to limit the availability of morphine, heroin, cocaine and medicinal opium to medical and scientific use only and to prohibit all other uses. It was a way of ensuring that international law recognised the monopoly that the majority of western countries had granted to doctors and pharmacists with regard to the regulation of opiates and cocaine consumption, and extended it to the rest of the world. This was the moment at which the fundamental principles of international "drug" policy came into being, with the aim of distinguishing between the lay and holy spaces of psychoactive substance use. What followed was no more than the division of this magical founding operation into specific economic activities – trade, manufacturing and culture. The very purpose of international "drug" policy, as organised under the auspices of the League of Nations and then the United Nations, was to develop a global system of control which would strictly tailor the licit narcotic substances offering to medical needs alone. The first conference organised to this end took place in the winter of 1924-1925[44]. It led to an international narcotics trade regulation that remains in force to this day. The control system that was introduced, known as the certificate system, meant that the international trade of narcotics would

RUSH, J. R. *Opium to Java*: Revenue Farming and Chinese Enterprise in Colonial Indonesia, 1860-1910. Ithaca: Cornell University Press, 1990.

[43] *Report of the International Opium Commission,* Shanghai, China, February 1 to February 26, 1909, Shanghai, North China Daily News and Herald Ltd, 1909, v.1 – Report of the Proceedings, v. 2 – Reports of the Delegations. The first international conference took place in 1906 between the Chinese and the British, resulting in an agreement to end the exportation of Indian opium and the eradication of poppy growing in China. See LOWES, op. cit.

[44] This conference was called the Second Opium Conference, due to another conference held at the same time and which dealt solely with opium for smoking. It led to the so-called 1925 Convention..

henceforth be subject to a system of prior authorisations issued by both the exporting country and the importing country. The issued certificates had to be sent to the Permanent Central Committee, made up of eight independent experts tasked with checking that the trade accounting was in order. This Committee, predecessor of the International Narcotics Control Board (INCB), was required to produce an annual report in which it set out an accurate statement of international trades and alerted the international community to the risks of deflection. These accounts made it possible to carry out panoptic monitoring of all narcotic durgs-related trade activities and to identify areas of the world that were likely to become hubs for illicit trafficking. The 1925 Convention drew the first ever global legal line between licit narcotic drug trade and illicit trafficking, but these first steps did not prevent trade deflections. For example, boxes of morphine bearing the brand names C. H. Boehringer Sohn, C. F. Boehringer and Soehne, Knoll A.G. (Germany) and T. and H. Smith were found among the narcotic drugs seized in China[45]. Other companies, such as V. Chemische Fabriek Naarden (Holland), Sandoz (Switzerland) and Société industrielle de chimie organique (France) were denounced and brought to the attention of the Advisory Committee on Traffic in Opium[46]. The members of the Commission formed the opinion that control of international trade would have no meaning until pharmaceutical industries were strictly limited to medical and scientific needs. This was the task undertaken at the Geneva conference from May to July 1931. For the first time ever, the resulting convention – the Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs – imposed a direct limitation on the manufacture of narcotic drugs, depending on medical and scientific needs. These needs had been established beforehand by the Control Board[47], which had been created for this very purpose and which had fixed the global quantity that could be manufactured for each substance and the maximum amount that could be imported into each country. Consumption estimates were calculated by the countries themselves, but if they failed in this duty or were not part of the convention, the Board

[45] League of Nations, Advisory Committee on Traffic in Opium and other Dangerous Drugs, *Report to the Council of the Work of the Ninth Session of The Committee*, Geneva, February 3rd 1927. C.29.M19.1927. XI. Annex 3: Labels detached from Packages containing Narcotics seized during the Period September 16th, 1926, to December 15th, 1926, to be sent to the International Anti-Opium Association.

[46] League of Nations, Advisory Committee on Traffic in Opium and other Dangerous Drugs, *Report to the Council of the Work of the twelfth Session*, Geneva, February 2nd 1929. C.33.1929. XI. p. 5-6.

[47] In 1967 the Control Board was merged with the Central Committee to form the International Narcotics Control Board.

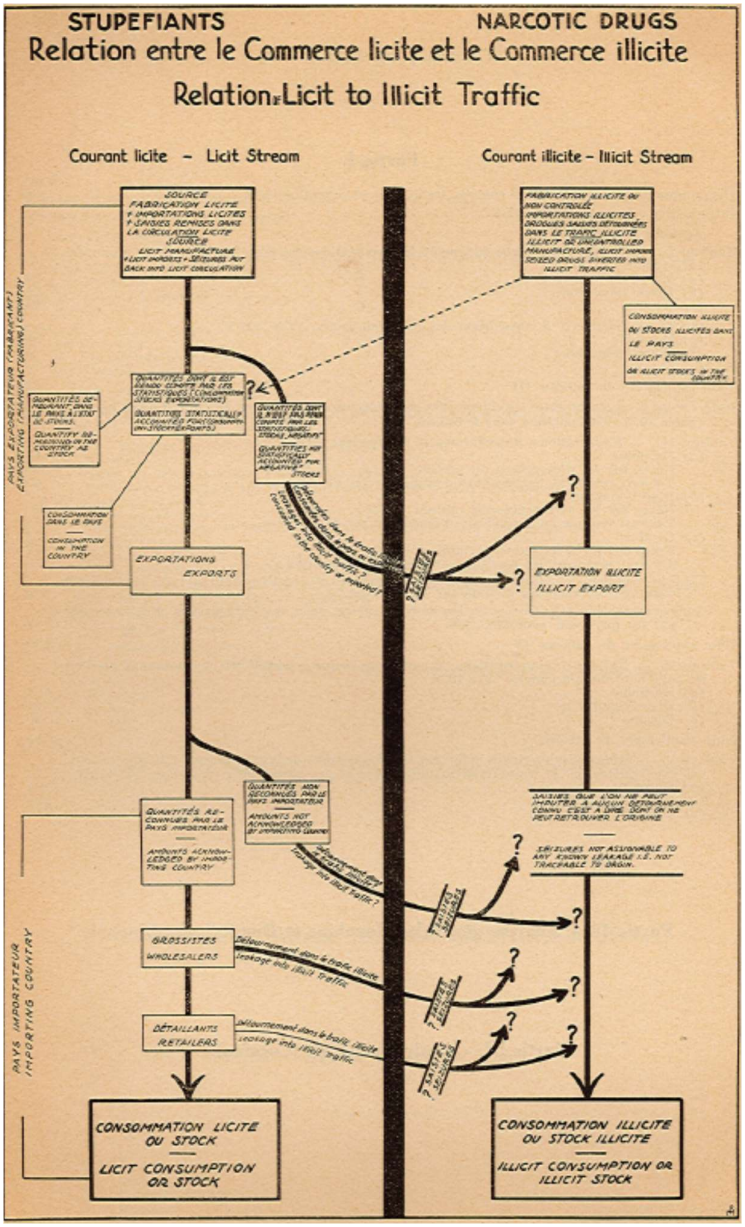
would make an estimate on their behalf. Each country's manufacturing limit was henceforth limited on the basis of the overall evaluation of its medical needs, in such a way that the Permanent Central Committee would be able to raise concerns about any excess production[48]. Moreover, any quantity imported over and above estimated needs would be deemed suspicious and might lead to the Permanent Central Committee decreeing an automatic embargo. A clear distinction was henceforth made between the entire licit narcotic drug offering and the illicit offering. Figure 2, taken from the preparatory documents for the 1931 conference on limiting manufacture shows quite clearly how, in real terms, the creators of international "drug" control viewed the problem and its solutions. The diagram clearly illustrates the two distinct spaces that emerged as the various conferences took place: one represents the licit narcotic circuit, the other shows the illicit circuit. The first thing to note is the mirrored construction of the two spaces: manufacture – international trade – consumption. This shows that it is not the substances that are licit or illicit, but rather the uses to which they are put. We can then see that "consumption" is conflated with stocks. This technical consideration tells us that end consumption does not fall under the jurisdiction of international control and that from an accounting standpoint can be conflated with the stocks that countries build up for their own purposes – military in particular.

So the main concern for those promoting international "drug" control was not to take direct action on consumption, but to avoid the various forms of upstream deflection (the black arrows), especially the one affecting illicit traffic. Careful observers will have noticed that the diagram begins with manufacturing operations, but makes no mention of poppy or coca cultivation, or of the harvesting of opium and coca leaves. The "drug-related" agricultural operations – what the jargon of international law calls "production" – still escape the limitation devices. A draft convention was rapidly drawn up, but the conference planned for 1940 was adjourned due to the outbreak of the Second World War[49].

[48] Société des Nations, Section du Trafic de l'Opium du Secrétariat de la Société des Nations, *Convention pour limiter la fabrication et réglementer la distribution des stupéfiants du 13 juillet 1931*: Etudes historique et technique. C.191.M.136.1937.XI.

[49] See the Archives of the Society of Nations in Geneva, Series: Advisory Committee on Traffic in Opium and Other Dangerous Drugs: confidential documents. O.C./Confidential 1-56 (1933-1940).

Figure 2: Relation of licit to illicit traffic[50]



[50] Society of Nations, Traffic in Opium and Other Dangerous Drugs, *Conférence sur la Limitation de la Fabrication des Stupéfiants visés par l'Article 4 (b), (c) et (g) de la Convention de Genève sur l'Opium*, *Analyse du trafic international de morphine, diacétylmorphine et cocaïne pour les années 1925-1929*. Partie I. Genève 1931. C.587.M.228.1930. [Conf. L.F.S.2. (1).] p. 3.

The project was taken up once again after the war, leading to the so-called 1953 Protocol which gave six countries[51] the monopoly for the global production of opium, establishing in exchange a principle of limitation equivalent to that for manufactured narcotic drugs. However, having been passed with serious misgivings, the protocol was slow in coming into force[52] and was very rapidly overthrown by the 1961 Convention, thus marking a major backward step in production control. It was not until the 1972 protocol - which replaced the 1953 protocol and amended the 1961 Convention – that opium production was brought under the jurisdiction of international "drug" control. It can be considered that with the protocol coming into force in 1975, the system of international control reached full maturity. From a legal standpoint, the licit "drug" economy was henceforth a completely closed space, from cultivation to manufacture, trade, distribution by pharmacists and doctors and consumption. It is a fact that since that date, no legal text has been approved to strengthen or extend control of the licit "drug" offering. The only text to have been passed is the 1988 convention against illicit traffic in narcotic drugs and psychotropic substances, which, as its name suggests, essentially relates to the control of the illicit offering. So it took just over half a century to enact, at a global level, a clear separation between the holy and lay uses of narcotic drugs.

The economic stakes of drug policy

As this rapid overview suggests, international "drug" policy was driven more by economics than by moral or health considerations. We can try to measure its effect through the role that pharmaceutical industries played in building the system of control and in the impetus they provided in favour of a monopolisation of the licit narcotic and psychotropic substances offering[53]. Evidence of the presence of pharmaceutical industries in the development of international "drug" policy can be found as early as 1920 in a letter from the firm of Hoffmann-Laroche to the Secretary-General of the League of Nations, offering to create "a universal syndicate for the industry of opiate and cocaine preparations […], which would place itself by contract under the control of the League of Nations"[54] [55](our

[51] Bulgaria, Greece, India, Iran, USSR and Yugoslavia.

[52] It was only in force from 1963 to 1975, i.e. only until the 1972 Protocol came into force.

[53] DUDOUET, F.-X. L'industrie pharmaceutique et les drogues. *Studia Diplomatica*, v. 55, n. 5-6, p. 145-170, 2002.

[54] ASDN. 12A Section sociale. Sous-section : Opium Traffic, côte 12A/36370/36970. *Lettre de*

translation). This syndicate, said the letter, would take care to divide among its members the quantities of narcotic drugs to be manufactured, so as to avoid any risk of deflection and thus "reconcile the health requirements put forward by those who inspired the Hague International Opium Convention, […], with the private and public interests of industry and the different countries concerned"[56] (our translation). Far from creating a stir, the industries' proposal was backed by The Advisory Committee on Traffic in Opium, which, during its sixth session in 1924, encouraged manufacturers to come to an agreement between themselves regarding the division of production quotas. Although a cocaine manufacturing cartel had existed since 1924, the morphine and codeine cartels appeared somewhat later, during preparatory work for the 1931 Conference, with a view to limiting the manufacture of narcotic drugs. The relationship between companies and State representatives was so close that preliminary negotiations between manufacturers[57]. The prevailing opinion within entities of the League of Nations was that the best way to achieve a generalised limitation of narcotic drugs manufacture was to constitute an international monopoly which would guarantee the chosen companies a monopoly on the medical market, in exchange for which they would cease feeding the illicit demand. An export quota-share system had even been set up between the main European manufacturers (France, Germany, Holland, Switzerland, United Kingdom) and should, in principle, have been accepted as it stood by the 1931 conference. At the end of the day, the companies' project was not approved, due to opposition from certain manufacturing countries which had been excluded and, more broadly, to the movement of rejection that it provoked among numerous non-manufacturing countries[58]. The cartels nevertheless continued to function up until the Second World War, and while we find no trace of them afterwards, the principle of an oligopolistic organisation of the

la firme Hoffmann-La Roche adressée au Secrétaire général de la Société des Nations le 2 juillet 1924. Carton R. 787. The firm Hoffmann-Laroche acted as spokesperson for European manufacturers.

[55] Original text in French: "un syndicat universel de l'industrie des préparations opiacés et de la cocaïne […], qui se soumettrait par contrat au contrôle de la Société des Nations"

[56] Original text in French: "concilier les desiderata sanitaires des inspirateurs de la Convention de l'opium de La Haye, […], avec les intérêts privés et publics des industries et des différents pays"

[57] Society of Nations, Traffic in Opium and Other Dangerous Drugs, *Rapport de la réunion préliminaire des représentants officiels des pays manufacturiers, Tenue à Londres en octobre - novembre 1930,* C.669.M.278.1930.XI.

[58] Society of Nations, *Actes de la Conférence pour la limitation de la fabrication des stupéfiants Genève*, 27 May–13 July 1931. Two Volumes: Volume I. *Séances plénières. Comptes rendus des débats* et Volume II. *Séances des Commissions et de la Sous-Commission pour le Contrôle*. C.509.M.214.1931.XI.

"drug" offering was never denied. Between 1925 and 1999, thirteen countries shared almost all legal opioid production[59]. In alphabetical order, these countries were: Australia, Belgium, France, Germany (East and West), Holland, Hungary, India, Italy, Japan, Spain, Switzerland, United Kingdom, USSR (including Russia). Table 1 shows the cumulative share of these thirteen countries in the global manufacture of the principle opioids between 1925 and 1999.

Table 1: share of global manufacture of main producing countries

Opioid	Global production
Morphine	88%
Codeine	89%
Heroin	85%
Pholcodine	92%
Dihydrocodeine	100%
Methadone	99%
Pethidine	95%
Dextropropoxyphene	100%

As we can see, the concentration of global opioid production is phenomenal. Of course, not all of these countries participated in this oligopoly in the same way and at the same time. Germany was the biggest producer of opiates before the Second World War, but disappeared from the market in the 1970s. The USSR took Germany's place after the war, but by the 1990s its production was no more than residual. On the other hand, three countries maintained a large market share throughout the period, between them totalling almost half of the global production of the principle opioids: the United States, the United Kingdom and France (Table 2) – in other words the three countries that dominated the global political scene throughout the 20th century.

This monopolisation of the licit opiate offering must be viewed in relation to the composition of the controlling bodies set up to monitor the world's "drug" economy[60]. A study of the members of these bodies reveals an over-representation of manufacturing countries. They made up 60% of the mandates of chairmen and vice-chairmen over the period between 1929 and 1999, as opposed to 29% for consumer countries and 11% for opium and coca producing countries. Here again, the

[59] Data collected by the author based on statistics produced by international institutions. 1925 was the first year for which we have almost complete figures for the world as a whole; 1999 was the final year of the study.

[60] By "control body", we mean the bodies created by international conventions to monitor proper application and, above all, to control on a day-to-day basis the licit drug economy worldwide: international trade, manufacture, agricultural production. We are referring to the International Narcotics Control Board (since 1967) and its predecessors: the Permanent Central Committee (1929-1967) and the Control Board (1934-1967). Another count by nationality of the number of years spent in control boards gives similar results, with the USA: 89 years, France 76 years, the United Kingdom and India: 55 years each, Turkey: 43 years, Switzerland: 33 years, Yougoslavia: 32 years, etc. DUDOUET. *Le grand...* op. cit. p. 200-201.

United Kingdom (21.3%), France (13.9%) and the United States (13%) accounted for almost 50% of the mandates. The strong correlation between shares of global narcotic drugs manufacturing and the occupation of positions of power within control bodies suggests that international "drug" policy involves the licit narcotic drugs market being carved up between the countries most committed to the repression of illicit uses.

Table 2: the United States', United Kingdom's and France's combined share of global production

Opioids	Global production
Morphine	49%
Codeine	50%
Heroin	38%
Pholcodine	82%
Dihydrocodeine	35%
Methadone	73%
Pethidine	78%
Dextropropoxyphene	50%

This observation is not unlike what Elias said about the formation of modern states, pointing out that the gradual construction of monopolies that constituted them went hand in hand with the development of a monopolistic elite that shared the resulting benefits[61]. International "drug" policy can thus be seen as an effort to give a handful of countries and companies the monopoly of the licit narcotic drugs economy and allowing them – just like healthcare professions – to reserve the legal benefits of thes substances for themselves. This process of monopolisation nevertheless has the particularity that it immediately takes place at a global level. It is certainly a unique precedent in the history of humanity, for as far as I am aware, no other field with the potential to affect everyone on the planet has ever been subject to such comprehensive regulation, to such an extent that we have to see it as the first truly universal public policy. We then have to ask why this policy is so little known.

The myth of prohibition

While international drug policy is certainly the first planned economic experiment at a global level, it is surprising that prohibition remains the main angle of approach to "drug". Even studies that claim to describe international "drug" policy continue to focus on the repressive aspects and pay no attention to the regulation of licit activities[62]. There are doubtless many reasons for this collective

[61] ELIAS, N. (1939). *La dynamique de l'Occident*. Kamnitzer P. (Trad.). Paris: Pocket, 1990.

[62] BENTHAM, M. *The politics of drug control*. London: MacMillan Press Ltd., 1995; BEWLEY-TAYLOR, D. R. *International Drug Control*: Consensus Fractured. Cambridge: Cambridge University Press, 2012.

blind spot and I would like to mention two of them. The first reason is the most well-known. It is the idea that between the end of the 1960s and the beginning of the 1970s[63], the world began to wage a sort of all-out "war on drugs". Although it is difficult to put a precise date on the outbreak of this war, there are a certain number of events that mark a stronger clamp-down on illicit uses, particularly those aimed at consumption. First of all, in many countries ratification of the 1961 convention led to legislative devices being reinforced. Whilst this convention was not strictly speaking a repressive text, it nevertheless encouraged governments to severely clamp down on all activities relating to illicit supply and to take charge of treating and reinserting "drug" addicts. The laws introduced in the 1960s and 1970s were thus representative of more repressive public policies[64] particularly regarding non-medical consumption, which was sometimes directly penalised[65]. This legislative dynamic may have created the impression of a global movement towards "drug" prohibition. However, the most famous event in favour of a repressive representation of "drug" policy was undoubtedly the action taken by the United States, whose President declared "drug" abuse to be public enemy n°1[66]. In the process of withdrawing from Vietnam, Richard Nixon conveniently found a new conflict and announced a whole series of measures designed to tackle "drug" trafficking. He created the Office of Drug Abuse Law Enforcement, which in 1973 merged with the illustrious Bureau of Narcotics and Dangerous Drugs to form the Drugs Enforcement Administration. The dismantling of the French Connection, which took place during the same period and which was widely publicised, was part of this global offensive. Another consequence, albeit less well-known, of this all-out war against "drugs" was the sudden cessation of poppy growing in Turkey in 1972. The main effect of this

[63] NADELMAN, E. A. Global prohibition regimes: the evolution of norms in international society. *International Organization*, v. 44, n. 4, p. 479-526, 1990; SHEPTYCKI, J. W. E. The drug war. SHEPTYCKI, J.W.E. (Ed.). *Issues in Transnational Policing*. London; New York: Routledge, 2000. p. 201-223. The role that these two authors attribute to the United States with regard to the development of international drug policy is greatly exaggerated.

[64] See in particular CESONI, M.-L. *Etude comparative sur les politiques législatives en matière de prévention des toxicomanies en Europe*, Université de Genève, Travaux du CETEL, n. 39, 1993.

[65] This is especially the case in France: BERNAT DE CELIS, J. *Drogues*: consommation interdite: La genèse de la loi sur les stupéfiants. Paris: L'Harmattan ; Logiques sociales (Coll.), 1996.

[66] See President Richard Nixon's speech 17 June 1971 https://www.youtube.com/watch?v=g3j4xJzlMas Consulted: 13 sept. 2017. A similar indictment can be found at the end of the Cold War, regarding certain drug lords such as General Noriega or Pablo Escobar, who were seen as true enemies of the State.

decision, made under pressure from the Americans, was to totally disrupt the licit opium market, in which Turkey was one of the main actors. The initial withdrawal of Turkish opium, followed by its return a few years later in the form of poppy straw, caused a series of crises of opium poppy underproduction and overproduction in the licit market which came close to sweeping away the entire system of international control[67]. Conversely, despite their formal separation, this readily ignored episode shows just how much the two spaces were interdependent. All of the ignorance and indifference of political decision makers was required to question the line that separated them.

Another factor that in my opinion is part of the foreclosure of the holy "drug" space is the transformation of the international institutions themselves. Up until the 1960s, the bodies in charge of international "drug" control were essentially the Commission on Narcotic Drugs, the Permanent Central Committee and the Control Board, along with their respective secretariats[68]. For these bodies, the fight against illicit uses went hand in hand with the organisation of the licit market. The two aspects were never fully separated[69]. This situation changed radically as from the 1970s. Under the impetus of the Americans, the United Nations Fund for Drug Abuse Control (UNFDAC) was created in 1971. It operated using voluntary contributions from member countries and was resolutely oriented towards fighting "drug" abuse through various programmes of assistance and eradication. Its high level of exposure swiftly made it the preferred body for governments wishing to engage in their chosen policies whilst at the same time and above all demonstrating their commitment to the fight against "drugs". Between 1984 and 1987 alone, the Fund's annual budget increased by 300%[70], while the INCB's resources were constantly being worn away. Forced to reduce the duration of its sessions, the Board even found it hard to recruit the statisticians that formed the very foundation of its control mission[71]. This difference in resource allocation demonstrates the extent to which management of the licit narcotic drugs

[67] See International Narcotics Control Board's report for 1973. E/INCB/21, and the International Narcotics Control Board's report for 1980*: Supply and demand of opiates for medical and scientific purposes.* E/INCB/52/Supp. See also DUDOUET. *Le grand...* op. cit. p. 174-175.

[68] Among which I include the Division of Narcotic Drugs reporting to the Secretary-General of the United Nations.

[69] See in particular the reports of the League of Nations Advisory Committee on Traffic in Opium and those of the United Nations Commission on Narcotic Drugs up until 1960. The same joint concern remains in the reports of the International Narcotics Control Board.

[70] International Narcotics Control Board, *Report of the International Narcotics Control Board for 1987*, Vienna, United Nations. p. 4.

[71] Ibidem., p. ii

economy had become a lower priority. In 1990, UNFDAC became the United Nations Drug Control Programme (UNDCP), henceforth officially overseeing the various previous administrations, including the Commission's and the Board's secretariats. In 1997, the UNDCP merged with the International Centre for the Prevention of Crime (ICPC) to form the United Nations Office for Drug Control and Crime Prevention (ODCCP). This merger was, *per se*, a way of hiding international control if licit "drug" uses which, from an organisational standpoint, was obscured by the fight against illicit uses[72]. In 2002, the ODCCP became the United Nations Office on Drugs and Crime (UNODC). "Drug" is placed at the same level as crime, and its licit aspect (now without any reference to control) became totally invisible. "Drug" was henceforth a purely criminal matter. The acceleration in institutional metamorphoses and the avalanche of acronyms are a sign of the deep dereliction affecting international bodies at the beginning of this 21st century. Ignorant of their own past, international "drug" control bodies are finding it increasingly hard to respond to critics who denounce the failure of "drug" prohibition[73]. And this for a very good reason: prohibition does not exist.

All of these aspects contributed towards the collective repression of the origins of international "drug" policy and to a focus on licit aspects alone. This oversight (or "hiding" – call it what you will) left the door wide open for an exclusively repressive vision of "drug" policy, to such an extent that everyone – doctors included – came to believe, with absolute certainty, that "drug" is prohibited[74]. People thus took the new priorities for "drug" policy to be its raison d'être and found its bases (prohibition) in its consequences (repression).

Conclusion

The term "drug" is the fruit of a magical secular operation which, between the end of the 19th century and the second half of the 20th century, saw a distinction being made between "lay space" and "holy space". Analysis of the process that separated the licit uses from the illicit ones shows that "drug" cannot be viewed simply as something forbidden and must be seen as differentiated treatments of the

[72] While preparing my thesis in the late 1990s and early 2000s, I was struck by the extent to which the management of licit drug activities was ignored by international drug control agents. The members of the INCB – because it was their job – were fully aware of this. Yet they were physically separated from their colleagues at the UNPCD by a door with a digital code that isolated their corridor.

[73] See in particular the Global Commission on Drug Policy https://www.globalcommissionondrugs.org/

[74] In this regard, the vast majority of scientists who continue to talk about drug prohibition bear a high degree of responsibility.

same group of substances. We might then challenge the common belief in prohibition and ask whether it does not simply make the "drug" phenomenon more acceptable than it would otherwise be. Perhaps we prefer to believe that "drug" really is prohibited, rather than having to accept that their licit uses are monopolised by doctors, pharmacists and a small number of companies. It is this globalised and highly specific social organisation that prevents us from seeing the prohibition. By believing that "drug" is forbidden, we ignore the holy space in which licit uses are confined and we forget the principles that legitimise the whole of "drug" policy. In the same way that "no power can be satisfied with existing just as brute force […] and must thus justify its existence […] or at least make sure that the arbitrary nature of its foundation will be misrecognized[75], so "drug" as a universal system of power must conceal the principle of its existence; i.e. the worldwide and monopolistic organization that separates lay uses from holy uses, the licit from the illicit. It then becomes easier for both beneficiaries and victims of the norm to think that "drug" is quite simply forbidden, rather than admitting that this is the case for some people but not for others. At the end of the day, belief in "drug" prohibition allows the system as it was created to continue in its pervasive ignorance. If the term "drug" is a name for something, it is certainly not the name of a substance, or of something forbidden, but rather of a belief which, by concealing them, manages to allow the holy and lay uses of certain psychoactive substances to coexist at a global level. Indeed, is this not Durkheim's definition of religion?[76] From this standpoint, "drug" is certainly the new religion of modernity. What is truly magical about "drug" is not so much their artificial paradises as their capacity to be humanity's first common myth.

[75] BOURDIEU, P. *The State Nobility. Elite Schools in the Field of Power, Stanford, Stanford University Press : p 265.*

[76] "A religion is a unified system of beliefs and practices relative to sacred things, that is to say, things set apart and forbidden--beliefs and practices which unite in one single moral community called a Church, all those who adhere to them." DURKHEIM. *Les formes...* op. cit., p. 65.

Table of international texts

Title	Adoption	Main purpose	Came into force
International opium convention, the Hague	1912	International recognition of doctors' and pharmacists' monopoly on the retail distribution of narcotic drugs	1920
Agreement concerning the Suppression of the Manufacture of, Internal Trade in, and Use of, Prepared Opium, Geneva	1925	Eradication of opium smoking in Asia	1926
International opium convention, Geneva	1925	Control of international trade	1928
Convention for limiting the Manufacture and regulating the Distribution of Narcotic Drugs, Geneva	1931	To limit the manufacture of narcotic drugs	1933
Agreement concerning the Suppression of Opium Smoking, Bangkok	1931	Eradication of opium smoking in Asia	1937
Convention for the Suppression of the Illicit Traffic in Dangerous Drugs, Geneva	1936	Fight against illicit uses	1939
Protocol bringing under International Control Drugs Outside of the Scope of the 1931 Convention […], Paris	1948	Application of the 1931 Convention to certain synthetic opiates	1949
Protocol for Limiting and Regulating the Cultivation of the Poppy Plant […], New York	1953	To limit opium production	1963
Single Convention on narcotic drugs, New York	1961	Unification of previous agreements	1964
Convention on psychotropic substances, Vienna	1971	Extension of control to cover new substances such as barbiturates, benzodiazepines and amphetamines.	1976
Protocol amending the Single Convention on Narcotic Drugs, 1961, Geneva	1972	To limit opium production	1975
The United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988, Vienna	1988	Fight against illicit uses	1990