

PART XII

Law and Policy

Chapters 31–32

International Drug Policy

A shared global legal architecture — and a genuinely unsettled debate, presented here on its own terms, about how societies should respond to drugs like methamphetamine.

On the treatment of policy debates in this book

Drug policy is contested, and reasonable, well-informed people disagree about it. This chapter's aim is to describe the legal framework accurately and to present the strongest version of each competing position, not to advocate for one. Where evidence bears on a claim, it is reported; where the disagreement is fundamentally about values and trade-offs, that is said plainly.

International conventions

Three United Nations treaties establish the framework within which every country's drug laws operate. The **1961 Single Convention on Narcotic Drugs** (amended by a 1972 Protocol, and ratified by well over 180 states) governs the "narcotic" drugs — those with cannabis-, coca-, or opium-like effects. The **1971 Convention on Psychotropic Substances** was created precisely because the 1961 treaty did not cover the synthetic psychoactive drugs that proliferated after the Second World War, and it is the convention under which methamphetamine falls; it classifies substances across four schedules by weighing abuse potential against therapeutic value.¹ Amphetamine and methamphetamine are placed in Schedule II — reflecting that they "began life with medical use" — whereas MDMA, having virtually no accepted medical use, sits in Schedule I.¹ The **1988 Convention against Illicit Traffic** adds controls on precursor chemicals, trafficking, and money laundering.¹ Compliance is monitored by the International Narcotics Control Board, scheduling decisions are made by the 53-member Commission on Narcotic Drugs, and the World Health Organization provides scientific recommendations.¹ Much recent activity has concerned precursors: the Commission has added amphetamine-type-stimulant precursors to international control and, anticipating

that manufacturers substitute closely related chemicals to evade the rules, has moved to control families of related substances.² It is worth noting a longstanding critique that the very division between "narcotic" and "psychotropic" drugs — with cocaine under the 1961 treaty and amphetamines under the 1971 treaty — has, in the words of the UN's own former drug-control programme, no coherent conceptual basis.³

Comparative legal frameworks

Within this shared architecture, national responses span a wide spectrum. At one end lies strict prohibition enforced through the criminal law: the United States, for example, controls methamphetamine as a Schedule II substance with significant criminal penalties for illicit possession, distribution, and manufacture. Other jurisdictions retain prohibition on paper but reduce penalties (depenalization) or de-emphasize enforcement in practice. Further along the spectrum sits *decriminalization* of possession — retaining prohibition of supply while removing criminal penalties for personal use. Full legalization and regulated sale, which some jurisdictions have applied to cannabis, has not been applied to methamphetamine anywhere. These are not merely technical distinctions; they reflect deep disagreements about whether drug use is best understood as a crime, a health condition, or both.

Decriminalization debates

The decriminalization of drug possession — distinct from legalization, which it is frequently and unhelpfully confused with — is among the most actively contested questions in the field, and the evidence is genuinely mixed and hotly interpreted.

The case made by proponents. Advocates point primarily to Portugal, which in 2001 became the first country to decriminalize the possession of all drugs, replacing criminal penalties with administrative sanctions and referral to "dissuasion commissions," and coupling this with substantial investment in treatment and harm reduction.⁴ Over the following two decades Portugal saw reductions in drug-related overdose deaths and in HIV infections among people who use drugs, along with increased engagement in treatment — outcomes proponents attribute to re-

framing drug use as a health rather than a criminal matter, reducing the harms of incarceration and stigma, and channeling people toward care.⁴

The case made by critics. Skeptics point to more recent North American experiments. Oregon's Measure 110, passed by voters in 2020, decriminalized possession of small amounts of all drugs and directed funding to services; but amid rising overdose deaths, visible public drug use, and perceptions of disorder, it was rolled back by the legislature in 2024, with recriminalization of possession taking effect that September.⁵ British Columbia's decriminalization pilot, begun in 2023, was similarly curtailed in 2024.⁵ Critics argue these reversals show that removing penalties without more can worsen outcomes, and note analyses attributing increased overdose deaths to the policy change.⁵

Where the disagreement actually lies. A careful reading suggests the divide may turn less on decriminalization as such than on *implementation*. Portugal paired decriminalization with dissuasion commissions, mechanisms to steer people into well-funded and accessible treatment, and sustained health investment; Oregon and British Columbia, by most accounts, decriminalized without building comparable infrastructure — no equivalent dissuasion mechanism, and underfunded treatment capacity — while the arrival of fentanyl simultaneously drove overdose deaths upward, confounding any simple attribution.⁶ Meta-analyses of decriminalization (drawn largely from cannabis) tend to find little effect on rates of use.⁶ Some experts conclude that the North American failures were failures of execution rather than of the underlying policy; others conclude that decriminalization is unworkable in the American context without coercive leverage to compel treatment.^{5,6} This is a genuine and unresolved disagreement, and the honest summary is that the design and funding of the surrounding system appear to matter at least as much as the decriminalization label itself.

Approach	Description / example
Strict prohibition (criminal)	Criminal penalties for possession/supply (e.g., U.S. Schedule II)
Depenalization	Prohibition retained; reduced penalties or de-emphasized enforcement

Decriminalization (possession)	Supply prohibited; personal possession not a crime (e.g., Portugal 2001; Oregon 2020–2024, since reversed)
Legalization / regulated sale	Applied to cannabis in some places; <i>not</i> applied to methamphetamine anywhere

Healthcare Policy

Beyond the criminal-legal question lies a set of healthcare-policy choices — about treatment access, harm reduction, and public-health strategy — that are evidence-informed but also value-laden and contested.

Whatever a society decides about the criminal status of methamphetamine, it must also decide how to treat the people who use it and how to reduce the harms of use. These healthcare-policy questions are shaped by evidence, but they are not settled by it alone, because they involve value judgments about which this book takes no side. What follows describes the policy landscape, the evidence where it exists, and the points of genuine contention.

Access to treatment

The central difficulty in treating methamphetamine use disorder, established in Part VIII, is that there is no FDA-approved medication for it; the best-evidenced treatment is the behavioral intervention of contingency management.⁷ This shapes the policy problem in a specific way. Because the opioid-treatment system is organized around medications like buprenorphine and methadone, people who use methamphetamine are frequently underserved even when they are connected to care — studies find that individuals well engaged in treatment for opioid use are still often undertreated for a co-occurring methamphetamine use disorder.⁷ Access is further constrained by limited insurance coverage of stimulant treatment, workforce shortages, and rising demand reflected in a steep increase in amphetamine-related hospitalizations and costs.⁷ Contingency management itself has faced a distinctive policy barrier: federal rules have historically capped the value of incentives that programs may offer at levels far below what the evidence indicates is effective (meaningful results generally require incentives on the order of a few hundred dollars over several months), though states have used their own funds and opioid-settlement dollars to support programs, and federal caps have more recently been loosened.⁸

Harm reduction services

Harm-reduction policy is where the evidence and the politics diverge most sharply. The public-health evidence, reviewed in Part VII, is strong: syringe services programs are associated with roughly a 50 percent reduction in HIV and hepatitis C transmission and connect people to care, and naloxone and fentanyl test strips reduce overdose deaths.⁹ Yet these interventions have long been politically and legally contested in the United States. A federal ban on using federal funds for syringe services programs, enacted in 1988, was only partially lifted in 2015 — permitting federal support for program operations in at-risk jurisdictions but still prohibiting the purchase of the syringes themselves — and some states continue to classify syringes as drug paraphernalia, preventing sanctioned programs from operating.⁹ Other harm-reduction measures have advanced (naloxone has become widely available, and the federal waiver formerly required to prescribe buprenorphine was eliminated), while supervised consumption sites remain legally contested, with the first officially recognized sites in the United States having opened in New York City in 2021 against the backdrop of a federal statute long used to prohibit them.⁹ The underlying dispute is real and value-laden: proponents regard harm reduction as evidence-based public health that keeps people alive and connected to care, whereas critics regard some of these services as facilitating or condoning drug use — a disagreement visible in recent federal budget proposals to cut harm-reduction funding on precisely those grounds.^{9,10}

Public health strategies

At the broadest level, the debate concerns whether methamphetamine should be approached primarily as a public-health problem or as a criminal-justice one — and, increasingly, how the two might be combined. Several strategic threads recur. Because the illicit stimulant supply is now widely contaminated with fentanyl (Parts VII and IX), effective treatment of stimulant use disorder is itself a form of overdose prevention, and overdose strategies that address only opioids will miss the people who use stimulants.^{7,10} The social determinants explored in Part XI — housing above all — are increasingly recognized as central rather than peripheral to any effective response. And a persistent point of contention concerns coercion:

some experts advocate expanding voluntary, low-barrier, non-stigmatizing access to treatment and harm reduction, while others argue that courts and the justice system must retain leverage to compel people with severe addiction into treatment, pointing to Portugal's use of non-criminal pressure as a model.^{5,10} The evidence reviewed throughout this book supports the proposition that expanding treatment access, contingency management, and harm reduction reduces death and disease; it does not, by itself, resolve the value questions about coercion, funding priorities, and the proper balance between public-health and criminal-justice responses — questions on which citizens and their representatives, not this reference, must ultimately decide.

References — Part XII

Listed in order of first citation within Part XII. Numbering restarts each installment; the apparatus is to be consolidated on final assembly. Sources current as of 2026; policy status is time-stamped in text and subject to change.

1. The three United Nations drug control conventions — 1961 Single Convention on Narcotic Drugs (amended 1972; >180 states party), 1971 Convention on Psychotropic Substances (amphetamine and methamphetamine in Schedule II; MDMA in Schedule I; four-schedule system by abuse potential vs. therapeutic value; in force 1976), and 1988 Convention against Illicit Traffic (precursors, trafficking, money laundering; in force 1990); roles of INCB, the Commission on Narcotic Drugs, and WHO. (UNODC, "International drug control: how it works," 2026; International Narcotics Control Board; Wikipedia, "Convention on Psychotropic Substances"/"International drug control conventions.")
2. INCB / Commission on Narcotic Drugs scheduling of amphetamine-type-stimulant precursors — APAA added to Table I of the 1988 Convention (2019); INCB recommendation of 18 fentanyl and ATS precursors (2023, with CND vote 2024); control of "closely related substances" to anticipate circumvention. (INCB press releases, 2019 and 2023.)
3. Critique of the narcotic/psychotropic distinction as lacking a coherent conceptual basis (UN International Drug Control Programme, as cited by Transform Drug Policy Foundation, "Global drug policy").
4. Portugal's 2001 decriminalization of possession of all drugs (administrative sanctions, dissuasion commissions, treatment and harm-reduction investment) and associated reductions in overdose deaths and HIV infections and increased treatment engagement over two decades. (Comparative reviews including Reason Foundation, "Drug Decriminalization in Oregon: Measure 110's Impacts Compared to Other Countries"; academic and policy literature.)
5. Oregon Measure 110 — passed November 2020, effective 2021 (decriminalized possession with a citation/fine model; funded services), rolled back by the Oregon Legislature in 2024 with recriminalization of possession effective September 2024; British Columbia decriminalization pilot (2023) curtailed in 2024; analyses attributing increased overdose deaths to Measure 110 (Spencer NM, *J Health Econ*, 2023). (Brookings, "Clarifying debates about drug decriminalization," 2026; Deseret News; Oregon Public Broadcasting; Lake Forest College; City Journal.)
6. Interpretive debate on decriminalization — the role of implementation (dissuasion commissions, coerced/incentivized treatment, treatment investment) versus the policy itself; meta-analytic findings (largely cannabis) of little effect on use rates; differing expert conclusions (e.g., K. Humphreys). (Brookings, 2026; Reason Foundation; Scheim AI et al. decriminalization meta-analysis.)
7. Stimulant treatment gap and undertreatment — no FDA-approved medication for stimulant use disorder; contingency management as best-evidenced treatment; undertreatment of methamphetamine use disorder among care-engaged individuals; rising amphetamine-related hospitalizations and costs. (Care-engaged polysubstance cohort, PMC8474730; see Part VIII.)

8. Contingency management policy — federal incentive caps historically below effective levels (effective programs require incentives on the order of \$200–\$300/month for 3–6 months); use of state and opioid-settlement funds; recent loosening of federal limits; California Medicaid "Recovery Incentives" demonstration. (Johns Hopkins "Opioid Principles"; Massachusetts DPH stimulant-use report feedback; clinical-trial documentation.)
9. Harm-reduction policy — syringe services programs' ~50% reduction in HIV/HCV; 1988 federal funding ban, partially lifted in 2015 (operations funded, syringe purchase still excluded) following the Scott County, Indiana HIV outbreak; state paraphernalia laws as barriers; naloxone expansion and removal of the buprenorphine waiver; contested legal status of supervised consumption sites (first officially recognized U.S. sites, New York City, 2021; federal "crack house statute," 21 U.S.C. § 856). (PMC7596878; AHRQ PSNet harm-reduction perspective.)
10. Political contestation of harm reduction and public-health strategy — proponents' evidence-based-public-health framing versus critics' "facilitating use" objection, including federal budget proposals to cut harm-reduction funding (2025–2026); treatment of stimulant use disorder as overdose prevention given fentanyl contamination; and the coercion-versus-voluntary-treatment debate. (Addiction Center, 2025; PMC4490612; PMC11186154.)

End of Part XII — Law and Policy (Chapters 31–32)

*Part XIII — Research Frontiers (Chapters 33–35: New Treatments; Artificial Intelligence; Future Directions)
continues the volume.*