

Development of the Convention on Psychotropic Substances, 1971

István Bayer

Unpublished manuscript

1989 Budapest, Hungary

Note: The author was an eyewitness of the events: he was UN officer (staff member of the Division of Narcotic Drugs) between 1967 and 1973, author of a number of documents of the Commission on Narcotic Drugs and the Plenipotentiary Conference, he was also joint secretary of the Technical Committee of the Plenipotentiary Conference.

Content

1. International actions before the 1961 Plenipotentiary Conference	p. 3
1.1 Amphetamines	p. 3
1.2 Barbiturates	p. 3
1.3 Tranquillizers	p. 4
2. The Plenipotentiary Conference adopting the 1961 Convention	p. 5
3. The road from 1961 to 1971	p. 5
4. The 1971 Plenipotentiary Conference	p. 21
References	p. 25
Chronology of UN and WHO statements and decisions	p. 26

Development of the Convention on Psychotropic Substances, 1971

1. International actions before the 1961 Plenipotentiary Conference

1.1 Amphetamines

Cases of amphetamine abuse were observed very soon after its introduction into medicine about 1935. Misuse of tablets led the Swedish authorities to place amphetamines under narcotics control regime already in 1944. In the United States abuse began with the oral ingestion of inhalers sold over-the-counter for relief of nasal congestion [1]. This phenomenon was followed very soon by the appearance of amphetamine tablets on the black market which were diverted from legal channels. In 1947, inhalers containing amphetamines were withdrawn from the American market.

The problem of the abuse of amphetamines was first raised in the WHO Expert Committee on Drugs Liable to Produce Addiction in 1954. The Committee recommended the introduction of national control measures (dispensing only on medical prescriptions, a prescription should specify the number of times it may be refilled or repeated, record keeping of prescriptions) [2].

In 1955, the Commission on Narcotic Drugs discussed "the possibility of including amphetamines among the drugs to be controlled under the proposed Single Convention, but it felt that the control measures at the national level as recommended by WHO would suffice for the time being, since it could not be said that these drugs were addiction-producing in the same sense as morphine or cocaine [3]. In 1956, an important change in the attitude toward amphetamines took place when the report of Professor Masaki on the amphetamine epidemic in Japan was presented to the WHO Expert Committee. The number of amphetamine abusers, many of them "mainliners", was estimated by Masaki to be between 500,000 and 600,000, half of them being dependent on this drug [4]. (A Central Stimulant Control Law was adopted in Japan in 1951.)

Under the influence of the 6th Report of the WHO Expert Committee, the Commission on Narcotic Drugs adopted a resolution recommending Governments to "provide adequate measures of control to prevent such (amphetamine) abuse" because "the Commission...found that they (amphetamines) possessed properties which made them analogous to addiction-producing substances" [5].

1.2 Barbiturates

The Report of the WHO Expert Committee on Drugs Liable to Produce Addiction on its meeting in 1951 is the first WHO document where addiction to barbiturates was mentioned [6] following Isbell's publication on chronic barbiturate intoxication [7]. However, it was a few years later, in 1956, when the Committee was presented with evidence on the abuse of barbiturates.

The situation in the 1950s was clearly described by Isbell, as follows [8]:

"... barbiturates are subject to uncontrolled and improper use by maladjusted persons. Such misuse takes many forms. The barbiturates may be used in suicidal attempts, they may taken to reinforce the effect of alcohol, or they may be used as antidotes for central nervous stimulants, such as the amphetamines. Finally, long-continued ingestion of large

amounts of these drugs leads to the development of 'true addiction' manifested by convulsions and a sudden withdrawal of barbiturates."

and

"The medical and pharmaceutical professions bear a heavy ethical responsibility in prescribing and dispensing barbiturates. Physicians must realize that these drugs are potentially dangerous and that they can, under certain circumstances, create a dangerous type of addiction. Simple insomnia alone is seldom a valid indication for use of barbiturates. Prescriptions should be limited in amount and the laws against refills without a new prescription should be strictly observed. Great care should be exercised in prescribing barbiturates for unstable persons, and such patients should be carefully checked and followed. One should not prescribe a barbiturate for strangers unless the indication for the drug is unmistakable."

In the light of this situation the WHO Expert Committee on Addiction-Producing Drugs expressed its opinion that barbiturates are habit-forming drugs. In the Committee's opinion, national control measures were sufficient at that time, but they needed close attention and in some instances definite strengthening (prescription obligation, specification of the number of times prescriptions may be refilled or repeated, record keeping of prescriptions) [9].

In 1957, the Commission on Narcotic Drugs noted that barbiturates were subject to special control in some countries only, and recommended - in a resolution - that all Governments take the appropriate legislative and administrative measures of control to prevent abuse [10].

It would be very difficult to assess the impact of WHO recommendations or Commission resolutions on the regulatory activity of Governments, however, it can be assumed that national control measures for barbiturates were not too much affected by these recommendations. National measures advocated by WHO experts had been already applied in industrialised countries, and developing countries were not in a position to introduce such methods due to the lack of the necessary administrative system and pharmaceutical infrastructure.

1.3 Tranquillizers

In 1956, the WHO Expert Committee on Addiction-Producing Drugs discussed the very rapidly increasing use of tranquillizers. The Committee was on the opinion that these substances must be considered as potentially habit-forming drugs. There was also evidence that their excessive use could lead to the appearance of characteristic withdrawal syndrome. The Committee concluded that in this respect tranquillizers resembled barbiturates, they should be subjected to national control, and their clinical use should be followed very closely [9].

In 1957, the Commission on Narcotic Drugs adopted a resolution noting the views of the WHO Expert Committee, and recommending that "Governments keep a careful watch for any abuse of these substances with a view to taking necessary measures of control"[10].

2. The Plenipotentiary Conference adopting the 1961 Convention

In 1961, at the Plenipotentiary Conference adopting the 1961 Convention there was no real move for the inclusion of amphetamines and barbiturates among the drugs controlled under the Single Convention. The discussions on the scope of control were focused on other drugs.

The 1961 Conference was so heavily involved in the discussions on cannabis, poppy cultivation, poppy straw, coca bush and coca leaves that the question of "psychotropic substances" (amphetamines and barbiturates, for the time being) remained in the shadow. A detailed scrutiny of the records of the Conference would also reveal the confirmation of the statements made by UN legal experts who declared that the Single Convention easily allows the eventual scheduling of any other substance, consequently discussions and decisions on amphetamines and barbiturates could be left without any legal problem for the futureLater (in 1968) this opinion was drastically changed by the UN Legal Office.

At the very end of the Conference a resolution was submitted that amphetamines and barbiturates should be studied with a view to determining what action the international community should take with respect to them and how far it should go in the matter of control. The resolution was supported by 25 countries, and thus failed by one vote to obtain the required two-thirds majority. It could therefore not be annexed to the official records of the Plenipotentiary Conference.

3. The road from 1961 to 1971

In 1962, a draft resolution was presented to the Commission on Narcotic Drugs asking for a study of measures of international control of barbiturates. The draft resolution was rejected by a roll-call vote (10 votes to 8, with 1 abstention) [11].

At the same session a resolution was adopted by the Commission in which it recalled its resolution of 1957, considered the social dangers and the danger to public health arising from the abuse of barbiturates as reported by the World Health Organization, and recommended that Governments should take appropriate steps to place the production, distribution and use of such drugs under strict control.

The question of LSD had first been raised in the Commission in 1963 [12], and, consequently, discussed by the WHO Expert Committee on Dependence-Producing Drugs in the same year. The WHO Expert Committee had considered the problem of the abuse of hallucinogens, in particular LSD, as "a local one" and had expressed the opinion that "immediate measures with respect to distribution and availability are necessary". It had found that the abuse of other agents with related effects such as mescaline appeared to be "less wide-spread ... but a watch should be kept and corrective measures taken where necessary" [13].

In May 1965, the World Health Assembly adopted resolution WHA 18.47 requesting the Director-General to study the advisability of international measures of control of sedatives and stimulants [14].

In July 1965, the WHO Expert Committee on Dependence-Producing Drugs noted again "the increasing frequency of abuse of sedatives and stimulants not classified internationally as narcotic drugs" and "the epidemic-like spreading of this abuse

particularly among young persons in certain countries" as expressed in resolution WHA 18.47. The Committee recalled that it had repeatedly recommended the need for better control both of sedatives and stimulants at the national level. Realizing, however, that national efforts are still often insufficient, the Committee recommended the following measures:

1. availability on medical prescription only, as repeatedly recommended in earlier reports;
2. full accounting of all transactions from production to retail distribution;
3. licensing of all producers;
4. limitation of trade to authorized persons;
5. prohibition of non-authorized possession; and
6. establishment of an import-export authorization system.

The Committee felt that its last recommendations might be applied by national legislation, by amendments to the Single Convention under its article 47, or by a new international convention [15].

The Committee considered that in connection with these recommendations the terms "sedatives" and "stimulants" should include any drug that has been found to be dependence-producing and shown to be abused because of its sedative or stimulating effect on the central nervous system, but excluding alcohol or the substances under international control.

The Committee referred in its report to a paper in the WHO Bulletin which gave an expanded description of drug dependence of various types, including drug dependence of hallucinogen (LSD) type [16]. In the World Health Organization the terms "addiction", "habituation", etc. were replaced by "dependence". (It must be noted that the new terminology has never been "officially" accepted by the Commission on Narcotic Drugs due to objections raised by several delegations. In their opinion, the overall substitution of "drug addiction" by "dependence" could create difficulties in many countries familiar with the traditional expression "drug addiction" which term comprised medical and juridical aspects of the problem equally. There were also some doubts about the "dependence-producing properties" of such drugs as LSD.)

In 1965, the Commission on Narcotic Drugs reviewed the whole problem of barbiturates, amphetamines and tranquillizers. Individual statements were presented, there were discussions on resolution WHA 18.47 and on the 14th report of the WHO Expert Committee. The wording of the Commission's report that "...some differences in opinion on the extent of the measures that ought to be taken..." is an understatement of the divergences of views, but it is evident that several delegations were afraid of the administrative burden connected with the control of "millions of tablets". It was said that "there might be 200 or more manufacturers in a single country as well as hundreds of wholesalers and thousands of retailers".

To promote progress a "Committee on substances not under international control" was established by the Commission to be convened before the next session. This Committee (called "Special Committee") composed by the delegations of Canada, Federal Republic of Germany, France, India, Japan, Mexico, USSR, United Arab

Republic, United Kingdom and USA, assisted by representatives of WHO, PCNB, DSB and the Permanent Anti-Narcotics Bureau of the League of Arab States, had met in August 1966. Observers from Australia, Brazil, Denmark, Hungary, Italy, Spain, Sweden, Switzerland, and Venezuela had also attended the meeting. The terms of reference of the Committee was the "study of the question of substances not under international control, such as barbiturates, amphetamines and tranquillizers, and to report thereon to the Commission" [17].

In the following months, international alarm brought the problem of abuse of hallucinogens (especially LSD) in North America and Europe to the forefront of international attention. When the Special Committee was convened in August 1966, it singled out LSD "as presenting the most acute problem and showing signs of such spread as to demand immediate action...".

The report of the Special Committee was presented to the Commission at its 21st session in 1967. The report stated that "Taking into account the patterns of use and abuse, the immediate threat to public health and the potential accretion of traditional forms of addiction, the Committee concluded that immediate measures are necessary."

The Special Committee had recommended the adoption of the principles suggested by the WHO Expert Committee on Dependence-Producing Drugs as national control measures with the exception of the establishment of an import-export authorization system. The Committee concluded that "before the principle of import/export authorization could be endorsed, further information was desirable on this matter". There was, however, consensus that "import/export controls were desirable as a reinforcement to the measures of national control" ... and the Committee "recommended that, subject to a study of their feasibility, Governments should make provision for introducing them as soon as possible".

The Special Committee had recommended the adoption of principle 5 (prohibition of non-authorized possession) with the addition of the words: "for distribution".

The Special Committee considered whether, and in what form, it could recommend measures of international control. It was stated in the report that "the Committee was of the view that article 47 (e.g. the provision allowing the amendment of the Single Convention) might offer a convenient way of establishing a measure of international control in a much shorter interval than would be required for the conclusion of a new international treaty or other scheme of agreement. Provided that any new scheme was drafted with proper flexibility, there should be little difficulty in adapting it to the special problems presented by new drugs." .

"The Committee unanimously expressed the view that the establishment of a measure of international control, with the minimum of delay, was desirable, and suggested that the Secretary-General, in consultation particularly with WHO and PCNB, undertake, as a matter of urgency, a detailed study of the legal, administrative and other questions connected with the adoption of such international control."

The Special Committee pointed out the necessity of the "creation of a central source of expert advice on the risks presented by particular drugs". In that respect, its report contains the following paragraph:

"The Committee was made aware by the representative of WHO that reliable methods of assessment of the hazards in dependence-forming drugs were already

becoming available and likely to be further developed, and welcomed his assurance that WHO would be technically competent to undertake the task of evaluating the risks in stimulant and sedative drugs and of giving advice on particular substances. The Committee recommended that the Commission should request the Director-General to examine whether WHO would be willing to undertake this task."

The report of the Special Committee was endorsed by the Commission on Narcotic Drugs at its 21st session, including the recommendation on national measures for the control of LSD [18].

In 1967, the World Health Assembly, in its resolution WHA 20.43, recommended control measures for sedative and stimulant type drugs not yet under international control, and endorsed five of the original principles of national control proposed by the Expert Committee on Dependence-Producing Drugs at its 21st session [19]. At the same session, the World Health Assembly adopted also resolution WHA 20.42 recommending strict control measures for LSD and other hallucinogenic substances [20].

In January 1968, there was unanimous agreement in the Commission on Narcotic Drugs that Governments should be strongly urged to impose the strictest control on LSD and other hallucinogens (as it was already done by twenty-two countries), but the proposal to impose immediate international control on these substances using article 3 of the 1961 Convention was rejected by the majority of the members of the Commission. The reason of this rejection was explained in the Report of the Twenty-second session of the Commission, as follows:

"...The Representatives of Ghana, India and the USSR felt that it would be highly advantageous if, as a preliminary step, LSD and similar substances could be included in Schedules I and IV (of the Single Convention) since they were at least as dangerous as heroin. The majority of members, however, considered that that would not achieve the desired objective, because under the provision of article 2 (5) (b) a Party would have discretion whether to apply more severe restrictions than requested for substances in Schedule I. The result might be either that national controls were too severe or too lenient."

Finally a resolution was adopted, recommending Governments:

"(a) to prohibit all use of LSD and similar hallucinogenic substances except in medical and scientific institutions directly under its control or specifically designated by it;

(b) to restrict the use of such substances to approved medical and scientific purposes;

(c) to prohibit all import and export of such substances except between Governments or between authorities and organizations specifically approved by Governments for such import and export,"

and

"to consider also appropriate measures to prevent the use of lysergic acid and other possible intermediate and precursor substances for the illicit manufacture of LSD or similar hallucinogenic substances". [21]

One can assume that the rejection of the proposal to control LSD and other hallucinogens under the 1961 Convention was the consequence of the following considerations:

1. The 1961 Convention entered into force just a few years ago (in 1964) and many countries were not parties to this new convention. Many members of the Commission felt that an immediate extension of the scope of the 1961 Convention could withhold some Governments to join it.

2. Final decision was not taken on the course of action to be followed in respect of amphetamines, barbiturates and tranquillizers. Representatives in favour of a new convention and against the amendment of the 1961 Convention were afraid that the inclusion of hallucinogens in the 1961 Convention would have a "triggering effect". The application of the provisions of the 1961 Convention for the control of amphetamines was already strongly advocated by the representative of Sweden. This proposal, if accepted, would weaken the arguments about the necessity of a new convention and strengthen the position of delegations in favour of the accommodation of the provisions of the 1961 Convention with the control of the entire group of "psychotropic substances".

The divergence of opinions concerning the applicability of provisions of the 1961 Convention vs a separate international instrument was the reason why the Commission was unable to reach an agreement on the course of action in respect of amphetamines, barbiturates and tranquillizers. The Office of Legal Affairs of the United Nations did everything to persuade the Commission to commit itself for the creation of a new international treaty, using the following main arguments:

"As regards the application of article 3 of the Single Convention, the question whether the psychotropic substances under consideration are similar in respect of abuse and ill effects to the drugs in the Schedules of that Convention is one for determination by the World Health Organization. There would, however, be legal grounds for doubting the correctness of an affirmative decision by the World Health Organization if certain psychotropic substances were recommended for inclusion in the Schedules, but other substances having the same degree of similarity in regard to abuse and ill effects were not recommended for inclusion. Moreover, it was the general understanding at the 1961 Conference that article 3 of the Single Convention could not be applied to barbiturates, amphetamines or tranquillizers" [21].

It is evident that this opinion was the opposite of the view expressed by the same experts in 1961, described above.

The legal reasoning of the opinion of the UN Office of Legal Affairs was based exclusively on the "general understanding at the 1961 Conference". In the historical perspective, it is interesting to quote from a scholarly study of the late Dr Lande (former Secretary of INCB and drafter of the 1961 Convention, the 1971 Convention and the 1972 Protocol) who many years later (in 1973) revealed the background of this understanding, as follows:

".... this understanding was reached at the 1961 Conference particularly at the insistence of the American delegation. This delegation was obviously motivated in this by the opinion that the huge burden which would be placed on international and national control organs by subjecting amphetamines, barbiturates and tranquillizers to the narcotic regime would fatally weaken this regime in the campaign against addiction to narcotic

drugs and thus frustrate international efforts which had been made for more than half a century. The delegation also appears to have held that the narcotics regime was not suitable for those barbiturates and tranquillizers which were consumed in quantities which were a multiple of the amounts of even the most popular narcotics such as codeine which were prescribed for legitimate therapeutic purposes. One would have to keep a proper balance between the requirements of fighting drug abuse and those of facilitating legitimate medical use" [22].

It must be noted that in the 1960s the medical usefulness of amphetamines was overrated in several countries and the number of plain (monocomponent) and combination products on the American market (and in some other countries) was astronomical. Before the "cleaning" of the US materia medica from products with unfounded claims in 1968, hundreds of "mood modifying" preparations (mainly amphetamines + barbiturates) had been marketed and even more products were available for weight control purposes (amphetamines, frequently in combination with other drugs, for example with thyroid).

The difference in the amphetamine consumption between countries where amphetamines were placed under narcotics control regime and countries without strict control measures had become enormous. In Hungary, for example, the per capita consumption of amphetamine was of 0.0007 tablet in 1966, compared with 35 tablets in the United States in the same year.

In 1968, in the opinion of the UN Office of Legal Affairs, amphetamines, barbiturates and tranquillizers were considered as "psychotropic substances", but the problem and this term have been recently extended to LSD and other hallucinogenic substances. This extension of that term was also used by the UN Secretariat as a counterargument against the applicability of the Single Convention:

"The "special priority" asked by the Commission (in 1967) could only mean that thought should be given to finding a way of controlling LSD and other hallucinogens as quickly as possible by international agreement. It is evident that such a means of control can only be applied if LSD is made subject to a positive finding by WHO under article 3, para. 3 (iii) of the Single Convention; (a special treaty for LSD concluded and put into effect almost immediately, is out of question). But if such action were taken in respect to LSD alone, the omission of central nervous depressants and stimulants from the Single Convention would appear illogical and would be difficult to explain on legal and pharmacological grounds. The contradiction would be aggravated if LSD were included in the Single Convention, and later a separate treaty provision had to be made for stimulants and depressants by concluding a new treaty ..."

The divergence of opinions in respect of this issue is clearly reflected in the Report of the Commission on its twenty-second session, as follows:

para. 330: "Ghana, India and the USSR held that the 1961 Convention as a ready and existing instrument was capable of being used for the control of psychotropic substances...Article 3 as it stood, offered a means of imposing straight away on certain substances, e.g. amphetamines and LSD, which would be included in Schedule I and Schedule I and IV respectively ... As for other substances, belonging to the

group of barbiturates and tranquillizers, it was felt that where a different regime of international controls was found necessary, it could be obtained through an amendment ... adding one or two Schedules, if necessary."

para.331:" ...Sweden felt that control over the amphetamines should be applied immediately under the terms of article 3 of the 1961 Convention ..."

para.332: "Canada, France, Japan, Mexico, United Kingdom and USA considered that for legal and practical reasons article 3 of the 1961 Convention was not suitable to provide the necessary control for all psychotropic substances, and should therefore not be used, whether or not any legal basis could be found ..."

The representative of the PCNB (and DSB), Dr Lande, took a very firm position in favour of the conclusion of a new international instrument.

It was not possible to reach agreement in respect of the form of international action even in a working group which met during the twenty-second session. Finally, the Commission adopted a resolution on National legislative measures in which it "...recommends to Governments to adopt legislation ... to give effect to the following measures of national control over the above mentioned psychotropic substances..." (e.g. amphetamines, barbiturates, hallucinogens and tranquillizers).

The recommended control measures consisted of the principles of the WHO Expert Committee with the following changes:

- principle 6 (import-export authorization system) was abandoned;
- principle 5 (prohibition of non-authorized possession) was amended by the addition of the words: "distribution"; and
- principle 2 was also amended, as follows:

The original text proposed by the WHO Expert Committee "full accounting of all transactions from production to retail distribution" had been changed by the World Health Assembly, in its resolution WHA 20.43, for "supervision of ... ". Several delegations were on the opinion that the Commission should return to the original wording but at the insistence of the delegations of the United Kingdom and the USA, the amendment was accepted.

The Commission ended its discussion by noting that the "WHO Expert Committee on Dependence-Producing Drugs intended to give comprehensive study to the whole subject at its next meeting in October 1968" and "expressed the hope that that would lead to an expert assessment of those particular substances which WHO would advice for incorporation in the treaty action contemplated".

In the late 1960s it has become evident that the intravenous abuse of amphetamines (mainly methamphetamine) had taken alarming proportions in several countries. The situation in Sweden was described in a comprehensive review article by Goldberg [23] in the Bulletin on Narcotics, several papers were published on the new pattern in California [24], Pierce James[25] compared the stimulant mainliners to the Piccadilly

type heroin junkies and the symptoms of amphetamine dependence were clearly identified by Connell [26], who had drawn the attention to the dangers of the amphetamine psychosis already ten years earlier [27].

The amphetamine problem took a new dimension at the international level.

In 1968, Sweden, together with Denmark, Finland, Iceland, Norway and Yugoslavia, had moved a resolution asking the twenty-first World Health Assembly to recommend that the Commission on Narcotic Drugs include six amphetamines in Schedule I of the 1961 Convention. The representative of the United Nations to the World Health Assembly had informed the Assembly of the reiterated view of the UN Office of Legal Affairs on the matter. The World Health Assembly had not voted on the Swedish resolution but had proceeded to adopt resolution WHA 21.42 which took account of the steps being taken by the Commission on Narcotic Drugs in developing an international instrument for the control of psychotropic substances including the six amphetamine derivatives mentioned in the Swedish draft [28].

In 1969, a draft resolution was presented to the Commission on Narcotic Drugs by the delegation of Sweden asking that the Commission decide according to article 3, sub-paragraph 3 (ii) of the 1961, that "pending its decision as provided in sub-paragraph (iii) of the same paragraph, the Parties shall apply provisionally to the following substances - amphetamine, dexamphetamine, methamphetamine, methylphenidate, phenmetrazine and pipradol - all measures of control applicable to drugs in Schedule I of the said Convention" [29].

The Commission was also informed that the Secretary-General had received a notification from the Government of Sweden asking that the same amphetamines be controlled in terms of article 3 of the 1961 Convention.

The possibility of the adoption of the Swedish draft resolution was contested by the representative of the Secretary-General on legal grounds. The following excerpts from the reasoning of the representative of the Secretary-General (based on the opinion of the Office of Legal Affairs) were intended to convince the Commission that the adoption of the Swedish draft resolution was outside the competence of the Commission.

"...Article 3 of the 1961 Convention lays down the criteria for the inclusion of a substance in Schedule I, whose measures are proposed to be applied provisionally to six substances by the draft resolution. The criterion is that 'the substance is liable to similar abuse and productive of similar ill effects as the drugs in Schedule I'."

"In accordance with this criterion, WHO must first make a finding, and then, if the finding is affirmative, the question is brought before the Commission for decision. In connection both with the finding and decision, it is necessary to bring to bear any appropriate materials bearing on the interpretation of the criterion."

"The criterion is one of similarity in respect to liability to abuse and to ill effects. But there are widely varying possible degrees of similarity, and the question arises how similar a substance must be in order to be within the scope of the (1961) Convention. As this question is not clarified by the language of the Convention, the history of its drafting must be taken into account. It is not enough, as a basis for a finding or a decision, that there should be some degree of similarity as regards liability of abuse and ill effects; there must be the degree of similarity contemplated by the authors of the 1961 Convention."

The representative of the Secretary-General continued by enumerating the former decisions of the Commission and the 1961 Plenipotentiary Conference with the conclusion that " ... there was an understanding at all stages of the drafting of the 1961 Convention that it is not applicable to amphetamines, barbiturates and tranquillizers" ... "It results that there would be serious legal doubts regarding an affirmative decision that the required degree of similarity is present."

"If the substances in question are outside of the scope of the Convention and could not legally be placed in Schedule I, then they should not be under provisional control pursuant to article 3, sub-paragraph 3 (ii). It follows that it would not be legally correct for the Commission to adopt the resolution before it. From the legal point of view, the best method ... would be to advance as rapidly as possible toward the adoption of a new international instrument."

There were three different sets of opinion in the Commission:

Some representatives, including those of India and the USSR, stated that the interpretation of the Secretary-General was not binding, because under the terms of the treaty it was for the Parties themselves to determine its scope. They did not accept arguments about the understanding at the time of the drafting of the 1961 Convention and repeated their arguments in favour of the application of the existing Convention. In their opinion, as regards the administrative and practical difficulties, which appeared to be underlying justification for anticipated legal obstacles, these difficulties had been unduly exaggerated and were far from insuperable.

The representatives of Sweden and Yugoslavia felt that it was entirely appropriate to bring the six notified amphetamine-like substances under the control of the 1961 Convention, but that other psychotropic drugs should be reserved for a new international instrument.

The representatives of Canada and the United States, among others, "found themselves in full accord with the interpretation made by the Secretary-General: in their view the 1961 Convention could not, and should not, be extended to the psychotropic substances".

It was an important element of the discussions the argument of the representative of Canada who, among others, stated that "if the (Swedish draft) resolution was adopted, and Parties were put under the obligation of applying for the stimulants specified by Sweden provisional control under the terms of article 3 of the 1961 Convention, this was very likely to cause some Governments, who were in the process of becoming Parties to the Convention, to withhold their adherence".

The Commission finally adopted a resolution drafted by Canada, the Federal Republic of Germany, France, Mexico, Peru, Switzerland, the United Arab Republic, the United Kingdom and the United States, on the "application of urgent control measures to certain stimulant drugs", recommending that "pending the entry into force" of the international instrument for the control of psychotropic substances being prepared by the Commission, "Governments shall use their utmost endeavours:

(a) to apply to the (enumerated 6 substances) national control measures corresponding as closely as possible to those provided by the 1961 Convention for the substances in Schedule I of that Convention;

(b) to assist each other in so regulating the movement of these dangerous psychotropic substances as to provide effective safeguards against their misuse [29].

In 1969, the opposition of the minority of the delegations against a new international instrument came to an end: they agreed that the Commission should begin the consideration of a draft Protocol which was submitted to it by the Secretariat.

The Secretary-General had drawn up and circulated to 146 Governments a detailed questionnaire "Psychotropic substances not under international control" (amphetamines, barbiturates, tranquillizers and hallucinogens). The replies of the questionnaire had been analysed by the Secretariat in a document. This document contained, in its annexes A and B, two alternative drafts for the Protocol with a commentary on the whole Protocol and on its individual articles.

Concerning the two draft of the Protocol the Commission had taken the decision to choose draft A. This was a very important decision because draft B gave Parties the right of rejecting the Commission's decisions to apply control measures to certain substances. Draft B was supported by several delegations, first of all by the representative of the USA, but the majority of delegations were against the inclusion of the right of rejection in the new instrument.

The Commission decided that the term "psychotropic substances" be used in the draft Protocol, decided also to delineate four regimes of control and, to propose accordingly, four Schedules. The selection of substances, and their apportionment to the Schedules, were mandated to a technical committee on the basis of suggestions to be made by WHO. [29]

In response to the Commission's request, lists of drugs recommended for control were established by the WHO Expert Committee on Drug Dependence. In August 1969, the Expert Committee reviewed its sixteenth report in which criteria for classification of individual drugs were already suggested [30]. The principles and criteria were adopted by the Expert Committee with some amendments.

The Expert Committee had before it an extensive compilation of data on 226 psychoactive drugs and herbs. Included in the compilation were 13 chemical and other categories of central nervous system depressants, 4 such categories of central nervous system stimulants, and 6 categories of hallucinogens, as well as some precursors of a few of hallucinogens. The data assembled on each of the drugs included information on the following: (a) name, (b) structural chemical formula, (c) symptoms of intoxication, (d) tolerance, (e) psychic dependence, (f) physical dependence, (g) certain pharmacological characteristics, (h) major dangers of abuse, and (i) a tentative abuse-potential rating, together with appropriate references. The compilation was presented to the Expert Committee by Professor Isbell [31] and later published in an edited form by Isbell and Chrusciel [32]. The Dependence liability of "non-narcotic" drugs is a valuable source of information and a scholarly assessment of the scientific knowledge at that time.

The following tables are the reproductions of the four lists of substances which were recommended for control by the WHO Expert Committee on Drug Dependence in its 17th Report [33]. In order to assure better overview and better comparability, the original titles (group a, b.1, b.2 and c) were replaced by "recommended schedule I, II, II and IV" respectively, and the chemical names were omitted.

Table I

Recommended schedule I

Drugs recommended for control because their liability to abuse constitutes an especially serious risk to public health and because they have very limited, if any, therapeutic usefulness

INN	Other nonproprietary or trivial names
1.	DET
2.	DMHP
3.	DMT
4. LYSERGIDE	LSD, LSD-25
5.	mescaline
6.	parahexyl
7.	psilocine, psilotsin
8. PSILOCYBINE	
9.	STP, DOM
10.	tetrahydrocannabinols, all isomers

Recommended schedule II

Drugs recommended for control because their liability to abuse constitutes a substantial risk to public health and because they have little to moderate therapeutic usefulness

1. AMPHETAMINE
2. DEXAMPHETAMINE
3. METHAMPHETAMINE
4. METHYLPHENIDATE
5. PHENMETRAZINE

Recommended schedule III

Drugs recommended for control because their liability to abuse constitutes a substantial risk to public health, although having moderate to great therapeutic usefulness

which there was insufficient evidence to permit a firm recommendation to be made but whose inclusion in the group (e.g. the respective schedule) was believed to be justified "by analogy".

It was stated in the report of the Expert Committee:

"The expression 'by analogy' implies that, with respect to chemical structure, pharmacodynamic properties, therapeutic indications, or routes of administration, these drugs showed such close similarities to the drugs recommended for control that they were believed to be likely to present a comparable combination of risk to public health and therapeutic usefulness. It must be emphasized, however, that direct evidence of the dependence liability of 'analogous drugs' is to some extent deficient because certain relevant studies have not been undertaken or are not yet complete. Consequently, further research and observations are needed on these drugs."

It should be noted that it was never stated by the WHO Expert Committee that the dependence potential of the "analogous drugs" would be lesser than that of the "recommended drugs". In reality, the WHO Expert Committee admitted only that the "analogous drugs" were not investigated in such a way than the others, and, consequently the same scientific evidence was not available.

Table II

Drugs analogous to those in "recommended schedule III" which were not formally recommended for control

INN	Other nonproprietary or trivial names
1. ALLOBARBITAL	
2.	alphenal
3. APROBARBITAL	
4.	barotalum
5.	brallobarbital
6. BUTALBITAL	
7.	butobarbital
8.	butylallenal
9.	cyclopentobarbital
10.	diberal
11.	dormovit
12.	dormupax
13.	eldoral
14.	enallypropymal
15.	ethallobarbital
16. HEPTABARB	
17.	hexethal
18. NEALBARBITAL	
19.	pentenal
20. PROBARBITAL	
21.	propallylonal
22.	propylbarbital
23.	rectidon
24.	reposal
25. SECBUTABARBITAL	
26.	spirobarbital
27. TALBUTAL	
28. TETRABARBITAL	
29. VINBARBITAL	
30. VINYLBITAL	

Drugs analogous to those in "recommended schedule IV" which were not formally recommended for control

INN	Other nonproprietary or trivial names
1. AMFECLORAL	

2. AMINOGLUTETHIMIDE	
3. BARBEXACLONE	
4. BENZPHETAMINE	
5.	bromal
6.	bromal hydrate
7.	butylchloral hydrate
8. CARBUBARB	
9.	chloralformamide
10.	chloralimide
11. CHLORALODOL	
12. CHLORPHENTERMINE	
13. CINPERENE	
14. CLOBENZOREX	
15. CLORACETADOL	
16. CLORAL BETAINE	
17. CLORETATE	
18. FENFLURAMINE	
19. FLUDOREX	
20.	heptobarbital
21. HEXOARBITAL	
22. MEFENOREX	
23. MEPHENTERMINE	
24. METHARBITAL	
25. METHYLPENTYNOL	
26.	narcobarbital
27.	nicotinyllamphetamine
28. NITRAZEPAM	
29. ORTETAMINE	
30. OXAZEPAM	
31. OXIFENTOREX	
32. PEMOLINE	
33. PENTOREX	
34. PETRICHLORAL	
35. PHENDIMETRAZINE	
36. PHENTERMINE	
37. PHETHARBITAL	
38.	trichlorethanol
39. TRICLOFOS	

In 1970, the text of the Draft Protocol on Psychotropic Substances prepared by the Secretariat in the light of the discussions at the twenty-third session was examined by the Commission on Narcotic Drugs at a special session. The text of the draft had been previously circulated by the Secretary-General to Governments for comments. The background document contained the comments of 55 Governments and of WHO and

INCB; this document as well as the report of the WHO Expert Committee and the report of INCB were also taken into account by the Commission.

Without entering into the analysis of the Commission's position in respect of the Draft Protocol, attention is drawn to some decisions which determined the future of the new treaty, as follows.

1. The WHO Expert Committee raised objections against the adoption of the term "psychotropic substances" by stating in its 17th Report that "...Noting that the term "psychotropic substance", as used in the Protocol, applied only to substances specifically listed in one of the ... Schedules, the Committee observed that (a) since the term "psychotropic" has come to be widely applied to a large class of drugs used extensively in medical therapy, and (b) since many of these drugs do not produce drug dependence, there was considerable likelihood that the use of the unqualified broad term "psychotropic" to designate only the dependence-producing members of that larger class would lead to confusion and misunderstanding on the part of persons not familiar with the details of the Protocol. The Committee suggested that consideration be given to the addition of a qualifying term, such as "dependence-producing", when speaking of psychotropic substances to be controlled under the Draft Protocol."

The suggestion of the WHO Expert Committee was not accepted by the Commission. One can assume that there were several reasons leading the Commission to this attitude. First of all, the Commission had never accepted the term "dependence" which was generally used by WHO as a substitute for the terms "addiction" and "habituation". This would already explain why the Commission did not occur with the WHO proposal, but the Commission might be motivated also by other considerations, as follows.

There were some doubts about the "dependence-producing properties" of hallucinogens. Even WHO was reluctant to endorse the definition of "drug dependence on hallucinogenic type drugs" published by some WHO experts in the WHO Bulletin [16], and it was pointed out by the WHO Expert Committee that "the dangers of these drugs (e.g. hallucinogens) include harm to the person himself or other people as a result of the drug-induced psychosis..." without mentioning "dependence". If hallucinogens were not dependence-producing psychotropic substances how to place these drugs under the control of an international instrument bearing such a label?

The adoption of the qualifying term "dependence-producing" could also lead to an illogical situation in respect of barbiturates and other sedatives, because the rationale of the WHO Expert Committee recommendation concerning those barbiturates which were later included into Schedule III of the 1971 Convention was formulated, as follows:

"The fact that good documentation is available for these four compounds (e.g. amobarbital, cyclobarbital, pentobarbital, secobarbital) should not be construed as indicating that their dependence potential is greater than that of the other hypnotic barbiturates. It probably means only that they have been popular drugs, have had large sales and, therefore, have been available to more people than the other hypnotics."

In the light of that factual statement nobody would be able to declare that the "other" barbiturates which were left out from the schedules of the new treaty are not "dependence-producing psychotropic substances".

It seems that the Commission preferred the use of a less controversial term.

2. Another decision affected the role of WHO in the scheduling mechanism. Under the 1961 Convention the Commission has the right to adopt or reject the recommendations of the World Health Organization, under the 1971 Convention - and this decision was taken at the first special session - the rights of the Commission were extended to the taking of a decision on a schedule which is different from the WHO recommendation.

3. The Commission decided to add to the Draft Protocol the four lists of drugs as recommended by the WHO Expert Committee, leaving the decision on individual substances to the Technical Committee of the Plenipotentiary Conference. The two additional lists in the 17th Report of the WHO Expert Committee which contained the "analogous" drugs were omitted...This decision is a clear sign of the intention of the majority of the members of the Commission to reduce the number of the substances under control to the minimum.

4. The 1971 Plenipotentiary Conference

The Conference was deeply influenced by the confrontation between two obstinate parties. The most important manufacturing and exporting countries tried everything to restrict the scope of control to the minimum and weaken the control measures in such a way that they should not hinder the free international trade in Schedule III and IV (or even Schedule II) substances. Many developing countries who were importers of these drugs insisted on such control measures which could not be implemented by themselves. The discussion on **prescription obligation** is the clear demonstration of the absurdity of the situation: industrialised countries in which all of the hypnotics, sedatives and tranquillizers were prescription drugs denied the necessity of the provision that all psychotropic substances should be dispensed on medical prescriptions, and such developing countries where pharmaceutical preparations, including the most toxic antibiotics, are freely available on the village markets, insisted on the prescription obligation...

There were long-lasting and heated discussions on the **scope of control and scheduling criteria**.

The basis of placing a new substance under international control is the recommendation of the World Health Organization. The criteria for such a recommendation are very simple in the 1961 Convention (article 3, para.3, sub-para.(iii)):

"If the World Health Organization finds that the substance is liable to similar abuse and productive of similar ill effects as the drugs in Schedule I or Schedule II ...".

The consequences of the systematic application of these criteria are well known: a huge number of substances which are similar to morphine or codeine were placed under international control because they are liable to similar abuse, etc. The majority of these drugs has never been marketed. In other words: in the case of opioids, the 1961 Convention has become a functional preventive instrument.

This "similarity concept" - and the preventive role of the international conventions - was abandoned in 1971. This change in the philosophy and approach constitutes the source of the problems in respect of scheduling under the 1971 Convention.

The criteria for a WHO recommendation in the 1971 Convention (article 2, para. 4) are complex and confusing:

"If the World Health Organization finds:

(a) That the substance has the capacity to produce

(i)(1) A state of dependence, and

(2) central nervous system stimulation or depression, resulting in hallucinations or disturbances in motor function or thinking or behaviour or perception or mood, or

(ii) Similar abuse and similar ill effects as a substance in Schedule I, II, III or IV, and

(b) that there is sufficient evidence that the substance is being or is likely to be abused so as to constitute a public health and social problem warranting the placing of the substance under international control ... "

It is not by chance that every word in this paragraph was carefully analysed by Dr Lande in his legal Commentary [34] on 15 pages....

There were long-lasting discussions on various drafts of sub-paragraph (a) clause (i). Several delegations were on the opinion that clause (i) is sufficient but this view was contested by other delegations who were not convinced that LSD and other hallucinogens were "dependence-producing" substances. This discussion led to the drafting of a clause (2), "tailored" to amphetamines and barbiturates and a clause (ii) allowing the scheduling of such hallucinogens which are not covered by clause (i). As the provision in sub-paragraph (a) does not constitute a "safeguard" against the scheduling of a large number stimulants and sedatives, the Conference adopted a sub-paragraph (b) requiring WHO that, in addition to the evaluation of the abuse-liability of a new drug, it should present "...sufficient evidence that the substance ... is likely to be abused so as to constitute a public health and social problem...". It is obvious that this requirement was unrealistic.

The adoption of the controversial and arbitrary criteria in paragraph 4 of article 2 of the 1971 Convention can be explained by "pragmatical" reasons. The standpoints of the different delegations were too far from each other to allow a compromise. At the same time, delegations were obliged by their Governments to conclude a new treaty without abandoning the instructions given by the same Governments. Under the pressure of time, opposite views were put together in one paragraph at the plenary meeting where agreements were facilitated by the absence of most of the professionals who worked in technical committee only... This explanation is supported by the following example: The four Schedules were already adopted by the plenary meeting when it was realised by the secretary of the technical committee that, due to a technical error, the note concerning the salts of the substances in the Schedules have been omitted. His request that the plenary meeting should amend the text with this note was rejected as a minor issue... As a consequence of this omission salts of amphetamines and barbiturates (representing about 90 per cent of those compounds!) were not under international control ... This fantastic mistake was corrected later by the Commission on Narcotic Drugs by an amendment.

The ambiguity of the criteria for scheduling has become evident already during the 1971 and also exploited by those delegations who wanted to limit the number of substances under international control to the minimum. Every attempt to add a new drug to the draft schedules of the World Health Organization was refused by the Conference but several substances were deleted from the WHO list.

The Australian delegation insisted that allobarbital, aprobarbital, butobarbital, heptabarb, secbutabarbital, talbutal and vinbarbital should be added to either Schedule III

or IV because these are "either intermediate or short acting barbiturates and, as has been documented, these generally present a greater abuse potential than the long acting barbiturates already included in draft Schedule IV". It is interesting that the refusal of that Australian proposal was not followed by the automatic deletion of barbital and phenobarbital from the Schedules. The explanation is very simple and sad: barbital and phenobarbital were old drugs, they had no "protectors" anymore, consequently, despite the fact that there were no reports, in 1971, on their abuse, they remained on the list. On the other hand, due to the very strong industrial lobbying, chlordiazepoxide and diazepam were omitted from Schedule IV. It is interesting to note that the proposal of the US delegation to delete methaqualone from Schedule IV - with the argument that there is no need for its international control -was not accepted by the Conference in 1971, but a few years later the Commission on Narcotic Drugs agreed to move methaqualone from Schedule IV to Schedule II , following the request of the Government of the United States....

Finally, the Conference had adopted the WHO draft schedules with the following changes: phencyclidine was transferred from Schedule IV to Schedule II, and aminorex, chloral hydrate, chlordiazepoxide, diazepam, methohexital and paraldehyde were deleted from Schedule IV and all of the proposals to add other substances to the Schedules were refused.

Unfortunately, the problem of **isomers** was treated in 1971 in a contradictory manner; it is not clear in which cases and which kind of isomers are under the control regime of the 1971 Convention.

There were discussions on the eventual necessity of the **control of plants** containing psychotropic substances. The problem was limited to some Schedule I substances which are ingredients of hallucinogenic plants. The control of Lophophora Williamsi and peyotl or mescal buttons (containing mescaline) was objected by the Mexican and US delegations, consequently they were left out from the scope of control and the Conference decided to leave out completely control measures for the cultivation or production of psychotropic substances, As a consequence of this decision cultivation of Psilocybe fungi is a legal activity ...

In order to limit the number of substances under the control regime of the 1971 Convention the Conference refused to accept the WHO proposal to control lysergic acid and some other LSD **precursors**. As a consequence of this decision, LSD precursors, first of all ergotamine and ergometrine remained available for the illicit manufacture of LSD for the next 17 years... and, in addition, the lack of the provision of previous international treaties for the control of substances which are "convertible into a drug", hindered also the scheduling of any precursors of psychotropic substances. The further consequence of that decision is the obvious contradiction that precursors of narcotic drugs are included in the Schedules of the 1961 Convention, but precursors of psychotropic substances must be scheduled in the 1988 Convention instead of the 1971 Convention

The intention of many industrialized countries to limit the number of substances under the control regime of the 1971 Convention was motivated mainly by the huge number of pharmaceutical **preparations** containing amphetamines and barbiturates, most of them combination products. It must be reminded that in 1971 the therapeutic usefulness of amphetamines was overrated in many countries and there were also a large

number of preparations containing analgesics and barbiturates in combination due to the traditional belief that they are "synergists". In many industrialized countries it seemed to be impossible to place under international control thousands of such preparations. This is the reason why several delegations were on the opinion that the scope of control of the new Convention should not be extended to preparations at all... . This view was not accepted by the Conference and it was decided that preparations should be controlled as the substances but Governments are authorized to exempt preparations from control measures " ... if a preparation containing a psychotropic substance other than a substance in Schedule I is compounded in such a way that it represents no, or negligible, risk of abuse and the substance cannot be recovered by readily applicable means in a quantity liable to abuse, so that the preparation does not give rise to a public health and social problem". These criteria were unrealistic already in 1971, because of the following facts:

The preparation must be compounded in such a way that the risk of abuse is minimal and the active ingredient cannot be recovered by readily applicable means, etc. . These criteria are identical with those in the 1961 Convention which led to the exemption of Reasec in which atropine can be considered as a counteracting agent against the abuse of the opiate-type component of that preparation, but it is impossible to draw a parallel with any preparation exempted by national authorities under the 1971 Convention ... The second criterion (e.g. the substance cannot be recovered by readily applicable means) is outdated as a safeguard against the extraction and isolation of the drug in a world in which codeine is extracted from a tablet containing 3 other ingredients and converted into heroin by a schoolboy.

In the light of the experiences it can be concluded that (1) none of the preparations exempted by Governments are in conformity with the first exemption criterion and (2) in respect of the second exemption criterion, it is impossible to detect any difference between exempted and non-exempted preparations...

From the point of view of **international trade**, the 1971 Convention consists of two treaties: one for "street drug" hallucinogens in Schedule I and one for pharmaceuticals in Schedule II, III and IV. There are extremely strict control measures for Schedule I substances and very weak ones for Schedule II and III substances and nothing for Schedule IV substances. The provisions of the 1971 Convention do not allow the monitoring of the movements of international shipments which are necessary for the prevention of their diversion. (This gap was partially filled by ECOSOC resolutions.)

References

1. Monroe, R.R. - Drell, H.J. (1947):
Journal of the American Medical Association 135, 909
2. WHO Technical Report Series (1954), 76
3. Report of the Commission on Narcotic Drugs (1955), 10th session
4. WHO Technical Report Series (1957), 116
5. Report of the Commission on Narcotic Drugs (1956), 11th session

6. WHO Technical Report Series (1952), 57
7. Isbell, H. - al. (1950): Chronic barbiturate intoxication: experimental study.
Arch. Neurol. and Psychiat. 64, 1 - 28
8. Isbell, H. (1956): Abuse of barbiturates.
Journal of the American Medical Association 162, (17), 660 - 661
9. WHO Technical Report Series (1957), 116
10. Report of the Commission on Narcotic Drugs (1957), 12th session
11. Report of the Commission on Narcotic Drugs (1962), 17th session
12. Report of the Commission on Narcotic Drugs (1963), 18th session
13. WHO Technical Report Series (1964), 273
14. World Health Assembly (1965) Resolution WHA 18.47
15. WHO Technical Report Series (1965), 312
16. Eddy, N. - al. (1965): Drug dependence: its significance and characteristics.
Bulletin of the World Health Organization 32, 721 - 733
17. Report of the Commission on Narcotic Drugs (1965), 20th session
18. Report of the Commission on Narcotic Drugs (1967), 21th session
19. World Health Assembly (1967) Resolution WHA 20.43
20. World Health Assembly (1967) Resolution WHA 20.42
21. Report of the Commission on Narcotic Drugs (1968), 22nd session
22. Lande, A. (1973): The international drug control system (in: Drug Use in America: Problem in Perspective. Appendix: The technical papers of the second report of the Commission on Marijuana and Drug Abuse. Vol. III. pp. 6 - 132
23. Goldberg, L. (1968): Drug abuse in Sweden
Bulletin on Narcotics 20, (1) 1 - 31, (2) 9 - 36
24. Kramer, J.C. - al. (1967): Amphetamine abuse, pattern and effects of high doses taken intravenously.
Journal of the American Medical Association 201, (5), 305 - 309
25. Pierce James, I. (1968): A methylamphetamine epidemic?
Lancet 1, (7548), 916
26. Connell, P.H. (1968): Amphetamine dependence
Proc.Roy.Soc.Med. 61, 178 - 181
27. Connell, P.H. (1958): Amphetamine psychosis.
Chapman and Hall, London
28. World Health Assembly (1968) Resolution 21.42
29. Report of the Commission on Narcotic Drugs (1969), 23th session

30. WHO Technical Report Series (1969) , 407
31. Isbell, H. (1969): Technical data on selected psychoactive substances. WHO/DGD/WP 69.3 with two addenda
32. Isbell, H. - Chrusciel, T. (1970): Dependence liability of "non-narcotic" drugs. WHO, Geneva
33. WHO Technical Report Series (1970), 460
34. Commentary on the Convention on Psychotropic Substances. Done at Vienna on 21 February 1971 (E/CN.7/589). United Nations, New York, 1976.

Chronology of UN and WHO statements and decisions

- 1956:** amphetamines are dependence-producing drugs (Commission on Narcotic Drugs)
- 1957:** barbiturates are dependence-producing drugs (WHO)
- 1961:** proposal to study the problem of barbiturate abuse rejected (Plenipotentiary Conference)
- 1962:** proposal to study the problem of barbiturate abuse rejected (Commission on Narcotic Drugs)
- 1963:** LSD abuse is a local problem (WHO)
- 1965:** proposal to study the possibilities for the international control of sedatives and stimulants (WHO)
proposal for international control measures for sedatives and stimulants, including import/export authorization system (WHO)
- 1966:** immediate action is necessary for the international control of LSD (Special Committee of the Commission on Narcotic Drugs)
- 1967:** immediate action is necessary for the international control of LSD (Commission on Narcotic Drugs)
proposal to control LSD under the 1961 Convention (Special Committee of the Commission on Narcotic Drugs)
- 1968:** proposal to control LSD under the 1961 Convention rejected (Commission on Narcotic Drugs)
proposal to introduce an import/export authorization system for sedatives and stimulants rejected (Commission on Narcotic Drugs)
proposal to control 6 amphetamine-type stimulants under the 1961 Convention rejected (WHO)
- 1969:** proposal to control 6 amphetamine-type stimulants under the 1961 Convention rejected (Commission on Narcotic Drugs)
list of 226 drugs and herbs and precursors to be considered for inclusion in the new international treaty (WHO)
- 1971:** 32 drugs selected for inclusion in the new international treaty (Plenipotentiary Conference)

control of plants under the new treaty rejected (Plenipotentiary Conference)
control of precursors rejected (Plenipotentiary Conference)
prescription obligation for all psychotropic substances rejected (Plenipotentiary Conference)
control or monitoring of international trade in all psychotropic substances rejected (Plenipotentiary Conference)