

THE FUTURE OF DRUG POLICIES GLOBALLY - UNGASS 2008 and BEYOND: Reconciling Research with Reality, Rights with Responsibilities INTERNATIONAL CONFERENCE PROCEEDINGS



London, England

August 9, 2006



***The Future of Drug Policies Globally –
UNGASS 2008 and Beyond:
Reconciling Research with Reality,
Rights with Responsibilities***

London, England

9TH August 2006

CONFERENCE PROCEEDINGS:

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INTRODUCTION TO INTERNATIONAL TASK FORCE AND CONFERENCE



An introduction to the International Task Force and Conference

The International Task Force on Strategic Drug Policy (ITFSDP) is composed of drug policy experts from more than 23 nations, across Europe, North, Central and South America, the Caribbean, and Australia. Members include physicians, scientists, attorneys as well as those directly involved in drug policy and practice. A current list of members may be found by accessing the Task Force website at www.itfsdp.org.

Since its formation in 2001, the Task Force has met in Vancouver, Buenos Aires, London, several cities in the United States, and in the European Parliament in Brussels. Task Force members have supplemented their work in their home nations by travelling to other countries, to train and assist community leaders in sound drug policy and practice.

A definitive statement on drug policy, endorsed by all present, was one outcome of the Tampa, Florida conference in 2004. This was in due course expanded into the Technical Paper entitled "A New Global Approach to Reduce Drug Demand," which was formally adopted and published by the Task Force in February 2005. (This document now entitled "A New Approach to Reduce Drug Demand" can be obtained under the "Projects" section of the website – www.itfsdp.org.)

Other formal statements issued by the ITFSDP include a statement on drugs strategy generally, developed at the Brussels conference in 2005 and the statement on "Harm Reduction and Human Rights" developed and formally adopted at this latest series of ITFSDP meetings in London, August 2006.

The London Conference: 2006

In August 2006, some 60 members of the ITFSDP met in London for five days of study and discussion on a wide range of drug policy and practice matters. A high point in this gathering was the international conference held on 9th August, involving not only the 60 Task Force members but also approximately 50 U.K. specialist drug workers.

The conference was sponsored by specialist drug agencies from United Kingdom, Sweden, America and Europe. It was also supported by other drug agencies from U.K. and America, as well as international groups.

Twelve technical papers were presented by internationally eminent authorities in the field, and the full transcripts of these papers are given at the end of this document. A precis of the papers is provided for ease of access. The speakers included members of (or in many cases representatives of) international specialist bodies, government departments in Britain, Afghanistan and America, the United Nations, the International Narcotics Control Board, the European Parliament, and the British parliamentary system.

Sponsors:

London Drug Policy Forum
European Cities Against Drugs
International Scientific and Medical Forum
on Drug Abuse
MOTGIFT International

Supporters:

Drug Free America Foundation, Inc.
Drug Prevention Network of the Americas
International Task Force on Strategic Drug Policy
National Drug Prevention Alliance



CONFERENCE SCHEDULE AND PARTICIPANTS



AGENDA

THE FUTURE OF DRUG POLICIES GLOBALLY - UNGASS 2008 and BEYOND:

Reconciling Research with Reality, Rights with Responsibilities

August 9, 2006

Hotel Russell, London, England

Chairs: Maureen Kellett, Chair, London Drug Policy Forum, United Kingdom
Christy McCampbell, Deputy Assistant Secretary, International Narcotics and Law Enforcement Affairs, United States Department of State, United States

Co-Sponsors: European Cities Against Drugs
Institute on Global Drug Policy
International Scientific and Medical Forum on Drug Abuse
London Drug Policy Forum
MOTGIFT International

Supporters: Drug Free America Foundation, Inc.
Drug Prevention Network of the Americas
International Task Force on Strategic Drug Policy
National Drug Prevention Alliance

8.30 – 9.00 Registration

Morning Chair: Maureen Kellett, Chair, London Drug Policy Forum, United Kingdom

9.00 – 9.30 **WELCOME AND OPENING REMARKS**

Maureen Kellett, Chair, London Drug Policy Forum, United Kingdom
- Tomas Hallberg, Executive Director, European Cities Against Drugs, Sweden
- David A. Gross, M.D., Chair, International Scientific and Medical Forum on Drug Abuse, United States
- Torgny Peterson, Executive Director, MOTGIFT International, Sweden

9.30 – 10.00 **UNITED KINGDOM DRUG POLICY**

- Diana Coad, Member and former Parliamentary Candidate for Conservative Party;
Co-founder and Drugs Adviser/Spokesman for the “Kids Count” Charity

10.00 – 10.30 **UNITED NATIONS DRUG POLICY AND UNGASS 2008**

- Sandeep Chawla, Chief, Policy Analysis and Research Branch, United Nations Office of Drug Control, Austria

10.30 – 11.00 **PREVENTION, TREATMENT, AND JUSTICE: THE EMERGING INTERNATIONAL CONSENSUS AGAINST DRUG LEGALIZATION**

- John Walters, Director, Office of National Drug Control Policy, United States

11.00 – 11.30 Break



11.30 – 12.00 TACKLING DRUGS ON THE SUPPLY ROUTE: AN UNITED KINGDOM PERSPECTIVE

- Lesley Pallett, Head of Drugs and International Crime Department, Foreign and Commonwealth Office, United Kingdom

12.00 – 12.30 UNITED STATES FOREIGN POLICY

- Marc Wheat, Staff Director and Chief Counsel, Subcommittee on Criminal Justice, Drug Policy, and Human Resources Committee on Government Reform, United States

12.30 – 1.00 SWEDISH DRUG POLICY – IN SUPPORT OF THE UN DRUG CONVENTIONS

- Torgny Peterson, Executive Director, MOTGIFT International, Sweden

1.00 – 2.00 Lunch

Afternoon Chair: Christy McCampbell, Deputy Assistant Secretary, International Narcotics and Law Enforcement Affairs, United States Department of State, United States

2.00 – 2.30 FRONTLINE UPDATE: HOW AFGHANISTAN IS TACKLING THE DRUG PROBLEM

- Habibullah Qaderi, Minister of Counter Narcotics, Afghanistan

2.30 – 3.00 OVERVIEW OF DRUG POLICIES AND THEIR EFFECTIVENESS

- Professor Neil McKeganey, United Kingdom

3.00 – 3.30 DRUG EXPOSURE, ABUSE AND DEPENDENCE: *Lessons from Physicians, Addicts and Second-Hand Smoke*

- Mark Gold, M.D., Distinguished Professor, The Brain Institute, University of Florida, United States

3.30 – 4.00 Break

4.00 – 4.30 IS THERE ANYTHING SUCH AS E.U. DRUG POLICY?

- Raymond Yans, Director, Drug Unit (MFA/Belgium), former Chair, Dublin Group, Member, International Narcotics Control Board

4.30 – 5.00 US DRUG POLICY CONCERNS ON A GLOBAL BASIS

- Ambassador Anne Patterson, Assistant Secretary, International Narcotics and Law Enforcement Affairs, United States Department of State, United States

5.00 – 5.30 WHAT DOES THIS ALL MEAN FOR FUTURE DRUG POLICY?

- Dr. Hamid Ghodse, President, International Narcotics Control Board, Vienna

5.30 CLOSING REMARKS

- Christy McCampbell, Deputy Assistant Secretary, International Narcotics and Law Enforcement Affairs, United States Department of State, United States



SPEAKERS AND SPONSORS

This important conference held in London on the 9th August 2006 attracted sponsors, speakers and supporters from around the world. The proceedings were opened with a short comment from a representative from the sponsors, the London Drug Policy Forum, European Cities Against Drugs, the International Scientific and Medical Forum on Drug Abuse and Motgift International, Gotland, Sweden.

It is apparent from the biographies of all the sponsors and speakers that they have an interest and expertise in the subject of drugs – from the standpoint of the grassroots community, scientific researchers and academics, the Foreign and Commonwealth Office of the United Kingdom, political institutions, the United Nations, the Minister for Counter Narcotics in Afghanistan, the Drugs Czar of the USA. This conference has brought together speakers of the highest calibre with an unrivalled breadth of experience and knowledge.

The sponsors and supporters of this event wish to thank the speakers for their attendance and for sharing with the attendees information, opinion, research and hope for a future solution to the drugs problems facing the world.

The great majority of attendees, from the International Task Force on Strategic Drug Policy and from British drugs professionals, expressed that they were very satisfied with the conference. Some ninety-two percent were either very satisfied or satisfied with all aspects of the day, measured in terms of expectations met, adequacy of communications, relevancy of topics, quality of presentations, expertise of speakers, real world orientation, and ongoing usefulness of material. Comments received included “Don’t let matters rest here. These issues are too important to be left to chance.” Some wanted more details on specific subjects, or subjects other than those covered, but it was acknowledged that in one day, with 12 prestigious speakers, this was a utopian plea.





SPONSORS – ABBREVIATED BIOGRAPHIES:

Maureen Kellett JP

Chair, London Drug Policy Forum, conference morning proceedings

Maureen Kellett was appointed Chairman of the London Drug Policy Forum in 2004. She was elected to Common Council for the Ward of Tower on 1986 and in 1988 became a Magistrate on the City of London bench. She currently serves on the Committees of Governors for the City of London School, and the Barbican Centre. Mrs. Kellett was also Chairman of the City of London Drug Action Team, Drugs Reference Group, which looked into the problem of drugs in schools and in the workplace and was also partly responsible for establishing the City of London Arrest Referral Scheme. She now sits on the Steering Committee that oversees the Arrest Referral Scheme and has a particular interest in drug education and prevention.

Tomas Hallberg

Director, European Cities Against Drugs

Tomas Hallberg was born in 1961 is a married with two children aged 13 and 15 years old. In 1982 he joined the Police Academy. From 1987 to 1994, Mr. Hallberg served in the local drug squad in the central area of the City of Stockholm. In 1994 he became Detective Superintendent, Swedish National Police Board. From 1995-1998, Mr. Hallberg served as Vice Consul, Consulate General of Sweden, St. Petersburg, Russia; and Liaison officer for Nordic police and customs co-operation. In 1999 he was appointed Director of European Cities Against Drugs (ECAD) and has travelled tirelessly and extensively throughout Europe promoting ECAD. Mr. Hallberg's hard work has resulted in ECAD becoming a force to be recognised within Europe and globally.

Dr. David Gross

Psychiatrist, Chair, International Scientific & Medical Forum on Drug Abuse

Dr. David Gross is a psychiatrist and the Chair of the International Scientific and Medical Forum on Drug Abuse. Dr. Gross has devoted the bulk of his career to the treatment and prevention of drug abuse where he currently practises in a private practice in Delray Beach, Florida. He is a Distinguished Fellow of the American Psychiatric Society, and Past President of the Florida Psychiatric Society. Dr. Gross has lectured widely and published numerous papers and presentations which reflect his interests in the psychobiology of behaviour.

Torgny Peterson

Director, Motgift International

See Biographies for Conference Speakers on page 10.

Christy A. McCampbell

Deputy Assist. Secretary for Counternarcotics, Bureau of International Narcotics and Law Enforcement Affairs (INL), Chair, conference afternoon proceedings

Ms. McCampbell assumed her position with INL in March, 2006. She most recently served in the U.S. Dept. of Homeland Security as the Dir. of Public Safety Coordination and as the Law Enforcement Liaison in the Counternarcotics office. Ms. McCampbell is a 30-year career law enforcement officer who began her career as a San Diego, CA police officer. She holds a B.S. degree in Criminal Justice Administration, a Master's degree in Public Administration, and received her Juris Doctorate from San Francisco Law School. She is also a graduate of the FBI National Academy, 193rd session. She is the recipient of numerous law enforcement awards.



SPEAKERS - ABBREVIATED BIOGRAPHIES

Diana Coad,

Member and former Parliamentary Candidate for the Conservative Party; Co-founder and Drugs Adviser/Spokesman for the “Kids Count” Charity

Diana Coad has a long track record in politics. She has, at various times, been a councillor serving on the Town and District Councils in Stratford upon Avon. Ms. Coad has chaired many committees including the Chamber of Trade, Age Concern, Relate (marriage guidance), Crime and Drugs Prevention Youth Committee and more. She also has a number of important contacts with members of the European Parliament. As a natural extension of her political party work she has worked closely with Linda Lawrence to form Kids Count. This is a new charity with a think tank and advocacy function, the aim of which is to develop policies and solutions to put in front of politicians, lawmakers and opinion formers. The main age group addressed is children from birth to 25 years of age. It addresses issues currently of great concern in Britain such as drug and alcohol abuse, gun and knife crime, homelessness, bullying, and physical and sexual abuse.

Throughout her public life, Ms. Coad has had a strong interest in the field of illegal drugs, finding it to be a factor in so much of her political areas of interest. She has worked closely as a volunteer with a national drug prevention charity in the United Kingdom and has attended various conferences in Europe on drugs issues.

Sandeep Chawla, PhD

Chief, Policy Analysis and Research Branch, United Nations Office of Drug Control (UNODC)

Since 1994 Sandeep Chawla has led the development of UNODC’s research and analysis capabilities. The systematic publication of research findings, analytical studies, statistics and annual estimates of the extent of illicit drug production, trafficking and abuse, reflected in the *World Drug Report*, the annual illicit crop survey reports, all occurred during this period. He is Editor of the United Nations *Bulletin on Narcotics*, which is one of the oldest journals in the field, having been in continuous publication since 1949. Prior to joining UNODC, Dr. Chawla worked for the United Nations as a development policy advisor, specialising in social development. Dr. Chawla has lectured at universities in several countries and continues to teach international history and political economy at the university level in Vienna.

John P. Walters

Director, White House Office of National Drug Control Policy

John P. Walters was sworn in as the Director of the White House Office of National Drug Control Policy (ONDCP) on 7th December, 2001. As the United States “Drug Czar,” he coordinates all aspects of federal drug programmes and spending. Director Walters has directed critical changes to the National Youth Anti-Drug Media Campaign which have been credited with helping to change youth attitudes and behaviour towards drugs.



Under Director Walters' leadership, counter drug efforts in Colombia have generated dramatic progress, with a 33% decline in coca cultivation over the past two years. Director Walters has overseen the creation and implementation of the "Access to Recovery" treatment initiative announced by President Bush in his 2003 State of the Union address.

Director Walters has extensive experience at ONDCP. From 1989 to 1991 he was chief of staff for William Bennett and was the Deputy Director for Supply Reduction from 1991 until leaving office in 1993. During his service at ONDCP, he was responsible for helping guide the development and implementation of anti-drug programmes in all areas.

Lesley Pallett

Head of Drugs and International Crime Department, Foreign and Commonwealth Office, United Kingdom

Lesley Pallett has been a career civil servant since 1977. The majority of her civil service career has been spent in the Home Office covering policy issues such as immigration and police operations against organised crime. For the past ten years, she has been engaged in European Union cooperation on Justice and Home Affairs issues (immigration, asylum, police and judicial cooperation, counter terrorism and drugs).

Since July 2003, Ms. Pallett has been working as Head of the Drugs and International Crime Department (DICD) which leads for the Foreign and Commonwealth Office on the threat of international organised crime to the United Kingdom. DICD is responsible in the U.K. Government for improving the country's capacity to combat the threat of drugs, organised crime and illegal immigration by drawing up strategies for the top five international drugs and crime threats and by using the Drugs and Crime fund to build capacity in key countries to this end. These strategies lead to combating the threats to the United Kingdom of drugs, crime and illegal immigration by better coordinating HMGO's international effort both within HMG, bilaterally and multilaterally.

J. Marc Wheat,

Staff Director and Chief Counsel, Subcommittee on Criminal Justice, Drug Policy and Human Resources Committee on Government Reform, United States

The Subcommittee on which Marc Wheat serves has a primary focus on the \$12.4 billion drug control budget (this includes eradication, interdiction, prosecution, prevention and treatment), Food and Drug Administration, public health, federal cultural institutions, the President's faith based initiative and bioethics. Before joining the Subcommittee in August 2003, Mr. Wheat was a Bush appointee as the Senior Advisor for Senate Affairs at the U.S. Department of State. His responsibilities focused on enacting the Department's priorities for reconstructing Afghanistan and Iraq through the \$16 billion Foreign Operations Appropriations bill.

Prior to joining the State Department in October of 2001, he was Counsel to the House Energy and Commerce Committee since June 1995. As a member of the Committee's health team, Mr. Wheat worked in all areas of the Committee's health jurisdiction. His areas of responsibility



included public health, Medicare, bioethics, biotechnology, bioterrorism, National Institutes of Health, and the Centers for Disease Control and Prevention.

A sixth-generation Hoosier from Fort Wayne, Indiana, Mr. Wheat received his Bachelor of Arts degree (majoring in Spanish) from the University of Illinois at Urbana-Champaign in 1987, and his Juris Doctor in the Corporation and Securities Speciality Track at George Mason University. He frequently lectures on parliamentary tactics and strategy at the Leadership Institute.

Torgny Peterson
Executive Director, Motgift International, Sweden

After university studies in Sweden and England, Torgny Peterson served as the director of a community for adult drug addicts in Sweden in the early 1970s. In 1975, he was appointed Head of the Maria Youth Clinic in Stockholm – then the largest clinic for teenagers in Scandinavia. In 1985, Mr. Peterson was appointed Director of the Hassela Educational Foundation in Sweden, an NGO fighting drugs, oppression and social injustices. Mr. Peterson served as coordinator of the conference *European Cities Against Drugs – the Mayors’ Conference* held in Stockholm in April 1994. He served on the advisory board for the Atlanta-based American Cities Against Drugs and on the advisory board for Latin American Cities Against Drugs, which was initiated in San Paulo, Brazil in May 1997.

In July 1994, Torgny Peterson was appointed Director of the Stockholm-based co-ordinating office of the European Cities Against Drugs. In that function he has travelled extensively throughout Europe, North and Latin America, Asia and Australia to meet with politicians, law enforcement agencies, NGO’s and others to discuss and develop future drug policies. During the Swedish Presidency of the European Union, from May 3-6th 2001, Mr. Peterson hosted and arranged a high-level *World Conference on Drugs* which was opened in the presence of Her Royal Highness Crown Princess Victoria of Sweden. The conference was attended by delegates from 25 countries.

Since 2003, Mr. Peterson is the director for Motgift, a project targeting all citizens on the island of Gotland, the largest island in the Baltic Sea, and its international branch Motgift International, in order to decrease demand for and supply of drugs.

Habibullah Qaderi
Minister of Counter Narcotics, Afghanistan

Habibullah Qaderi obtained his Mechanical Engineering degree from Malaviye Regional Engineering College in Jaipur, India and then returned to Pakistan to serve his compatriots. He worked as Programme Logistic Officer in the United Nations High Commission for Refugees (UNHCR), and as a field officer in Chaman, Loriai and Dalbandin Refugee Camp.

After the book agreement and establishment of the interim administration under H.E. President Hamid Karzai (1381 solar year), Minister Qaderi returned to Afghanistan and started working as Senior Advisor to the Ministry of Refugees and Repatriation. He was an active member of the tripartite commission of Afghanistan with the United Nations, Iran, Pakistan, Denmark and the



United Kingdom. Habibullah Qaderi was appointed Minister of Counter Narcotics by President Karzai in January 2004 and is entrusted with this position both by the Afghan President and the Afghan Parliament.

Professor Neil McKeganey, BA, MSc, PhD, FRSA
Director, Centre for Drug Misuse Research

Professor Neil McKeganey is the founding director of the Centre for Drug Misuse Research (CDMR) which opened at the University of Glasgow in 1994. A sociologist by training, Professor McKeganey has carried out research on such topics as prostitution and HIV, drug injectors, HIV related behaviour, young people and illegal drugs, the impact of parental drug use on children, the evaluation of drug treatment services and the recovery from dependent drug use. Neil has written widely on issues to do with drug policy and provision and is committed to stimulating public and professional debate on the nature, impact and response to the problem of illegal drug use. In 2005, Professor McKeganey was asked by the United Kingdom Government Department of Trade and Industry to undertake an assessment of the likely impact of the U.K. drug problem in 20 years time. The report produced raised fundamental questions about the direction of drug policy and the importance of successfully tackling the drug problem. Neil McKeganey is the author of over 150 articles on aspects of illegal drug use and is the author with James McIntosh of “Beating the Dragon of Recovery from Dependent Drug Use.”

Mark S. Gold, M.D.
Distinguished Professor, The Brain Institute, University of Florida

Mark. S. Gold holds the post of Distinguished Professor at the University of Florida, College of Medicine's Brain Institute, Departments of Psychiatry, Neuroscience, Anaesthesiology, Community Health & Family Medicine, Vice-Chair for Education and Chief, Division of Addiction Medicine. Dr. Gold is a Distinguished Fellow of the American Psychiatric Association (2003), University of Florida College of Medicine 2003 Exemplary Teacher, Underrepresented Minority Mentor (2004), Up to Date's Addiction Medicine Section Editor, American Academy of Addiction Psychiatry (2005: Founder's Award), 24th Annual Nelson J. Bradley Career Life Time Achievement Award (2006), Teacher of the Year, researcher and inventor who has worked for 35 years to develop models for understanding the effects of tobacco and other drugs on the brain and behaviour. Dr. Gold has developed animal models which have led to new treatments for addicts and also conceptualized hypotheses which were more than novel but also yielded new approaches to treat patients. Under his leadership, the Division of Addiction Medicine at the University of Florida has grown from Dr. Gold in 1990 to one of the largest addiction medicine research, education and practice divisions in the United States. At the present time, the Division has major funded projects in proteomics, self-administration, functional imaging, public health, stem cells, impaired professionals, and nanotechnology.

Dr. Gold's work on the brain systems underlying the effects of opiate drugs led to a dramatic change in the way opiate action was understood. His work on cocaine led to a complete change in thinking about cocaine's addiction liability, acute and chronic actions. In addition to theory, his research has led to changes in the treatment of opiate and also cocaine addiction. Most recently he has made many contributions to the understanding of the second hand effects of



tobacco, and for that matter, all drugs smoked and the consequences of expired medications in closed spaces such as operating rooms. In 2005, Dr. Gold and his co-workers were first to demonstrate that intravenously administered anaesthetics and analgesics were exhaled and those controlled and dangerous substances are active in the air of operating rooms and other sites where administered to patients.

Since beginning his career in research at the University of Florida in 1970, Dr. Gold has been the author of over 900 medical articles, chapters and abstracts in journals for health professionals on a wide variety of psychiatric research subjects. He has authored twelve professional books including practice guidelines, ASAM core competencies, and medical text books for specialists and primary care professionals. He is the author of 15 general audience books.

According to a review in the *Journal of the American Medical Association* (JAMA 272: 18, 1996) “Mark S. Gold, M.D. the most prolific and brilliant of the addiction experts writing today....Dr. Gold has spent his career trying to bridge the gap in medical education and practice with the belief that addictions are diseases and that all physicians have a critical role in prevention and, if that fails, in early identification and prompt treatment.”

Raymond Yans

Director, Drug Unit, Belgian Ministry of Foreign Affairs, former Chair, Dublin Group, Member of International Narcotics Control Board

Raymond Yans was until July 2006, the Chairman of the Dublin Group – an international informal consultation and coordination mechanism for the implementation of UN Drug Conventions. The group includes the 25 member states of the European Union (EU) plus Australia, Canada, USA, Japan and Norway. He was an expert at the Belgian Ministry of Foreign Affairs on Narcotic Drugs Control since 1994 and headed the Ministry’s Drug Unit from 1995 – 1999, and since 2003. Mr. Yans was the Chair of the EU Drug Police Cooperation Working Group during the Belgian Presidency of the EU in 2001. He was active in the creation of the Cooperation Mechanism on Drugs between EU, Latin America and the Caribbean, based on the principle of co-responsibility from 1997-1999.

Mr. Yans has written many articles, made numerous speeches and participated in eight major international drug conferences between 1995-2005 – including *European Perspectives on Policies on Drugs* in Oslo 2005; *UNODC/PARIS PACT Round Tables* – Brussels, 2003, Teheran and Istanbul 2005, Doha 2006 and *Paris Pact Consultative Group* in Rome 2003 and Vienna 2005; and *Moscow Ministerial Conference on Drug Trafficking Routes from Afghanistan* in June 2006.

Ambassador Anne Patterson

Assistant Secretary, International Narcotics and Law Enforcement Affairs, United States Department of State

Anne W. Patterson became Deputy Permanent Representative to the United Nations in August 2004. She served as Acting Permanent Representative from January through July 2005. Prior to that, Ambassador Patterson was the Deputy Inspector General of the Department of State from



2000 – 2003 and Ambassador to El Salvador from 1997-2000. She has also served as Principal Deputy Assistant Secretary and Deputy Assistant Secretary of Interamerican Affairs; Office Director for Andean Affairs; Political Counsellor to the U.S. Mission to the United Nations in Geneva and as Economic officer and counsellor in Saudi Arabia. Other economic and political assignments include posts with the Bureau of Interamerican Affairs, the Bureau of Intelligence and Research, and the Bureau of Economic and Business Affairs. She received the Department's superior honour award in 1981 and in 1988, its Meritorious Award in 1977 and 1983, and a Presidential Honour Award in 1993. Ambassador Patterson has also received the Order of Congress from the Government of Colombia and the Order of Boyaca from the Government of Colombia for her work in that country. She was also recognised by the government of El Salvador with the Order of Jose Matias Delgado. Ambassador Patterson graduated from Wellesley College and the University of North Carolina. She is married and has two sons.

Dr. Hamid Ghodse

Former President, International Narcotics Control Board

Dr. Hamid Ghodse has been Professor of Psychiatry and of International Drug Policy at the University of London since 1987; Director of the International Centre for Drug Policy at St. George's University, London since 2003; President of European Collaborating Centres for Addiction Studies since 1992; Member of the Executive Committee of the Federation of Clinical Professors, United Kingdom since 1994; Member of the Scientific Committee on Tobacco and Health, U.K. since 2000; Director of the Board of International Affairs and Member of the Council, Royal College of Psychiatrists since 2000; Non-Executive Director, National Clinical Assessment Authority of England and subsequently Patients Safety Agency since 2001; Chairman, Higher Degrees in Psychiatry, University of London since 2003; Member of the Medical Studies Committee, University of London since 2003. Dr. Ghodse is also a member of the International Narcotics Control Board (INCB) since 1992, a Member of the Standing Committee on Estimates 1992 and President of the Board in 1993, 1994, 1997, 1998, 2000, 2001, 2004 and 2005.

Dr. Ghodse is the author or editor of over 300 scientific books and papers on drug-related issues and addiction including the following: *The Misuse of Psychotropic Drugs*, London 1981; *Psychoactive Drugs and Health Problems*, Helsinki 1987; *Psychoactive Drugs: Improving Prescribing Practices*, Geneva 1988; *Young People and Substance Misuse*, London 2004.

Dr. Ghodse has had a distinguished career and he is the recipient of many degrees and Fellowships. He has served on many expert committees and other working groups on drug and alcohol dependence all over the world from the U.K. to Australia and Beijing.



OVERVIEW OF PROCEEDINGS



PRECIS OF CONFERENCE PAPERS

Sponsors - Opening Remarks

Maureen Kellett, Chair of the London Drug Policy Forum and chairing the morning session, opened proceedings by describing her Forum's work with all the boroughs of London (a total population of around 8 million). A continuous challenge – in addition to supplying and managing drug-related services - was to counteract the sense that nothing can be done. In London it can currently be seen that fewer young people are using drugs, more people are being accommodated in treatment centres and deaths from drugs have fallen significantly.

Tomas Hallberg, Director of European Cities Against Drugs, spoke of the problems facing European countries – cynical attempts to convince the public that drugs are harmless, that needle exchanges are always successful, and that legalisation is a true solution. Factual responses are the best way of dispensing with these political gambits. The core goal is to show to the public and government that a prevention-based approach is best, not just for the general public but also for the users themselves. Humanitarianism does not involve facilitating the ingestion of toxic substances. Any member of society who can see beyond gratifying his or her immediate wants and pleasures, recognising responsibilities and obligations to others, is a whole person. Someone who is obsessed with and focussed on drugs is impeded from being whole.

Dr. David Gross, distinguished psychiatrist and Chair of the International Scientific and Medical Forum, has worked on drug addiction problems for some 30 years. He was instrumental in the founding of a new Internet Publication – entitled “The Journal of Global Drug Policy and Practice;” its aim is to bring out honest and realistic literature and research, helping to balance the more inflammatory material which too often catches the public eye. “The Journal” can be found at www.globaldrugpolicy.org. Despite being at the forefront of treatment, he has become convinced that the right way forward is a greater focus on prevention, and the development of more effective prevention methods.

Torgny Peterson, formerly director of the highly-regarded Hassela Nordic Network, now heads up a new organisation - Motgift (it means “vaccine against drugs”). In 1998 he was in the Swedish delegation to United Nations General Assembly Special Session (UNGASS), the largest ever international gathering on drug policy, and the countries attending signed a Declaration committing to eliminate or significantly reduce the growth of illicit drugs, as well as addressing other needs of the drug problem. The upcoming UNGASS – maybe 2008, maybe 2009, will come under even more liberalist pressure than the 1998 meeting, which is why prevention supporters must become more active now, in all possible ways and in every relevant setting. Politicians must be reminded that they have a responsibility for the well-being of all the electorate, not just the minority who abuse drugs – or sell them.



Remarks of Conference Speakers:

Diana Coad - *UNITED KINGDOM DRUG POLICY, full transcript on page 40*

Britain had no co-ordinated national policy until 1995 when, under a Conservative government but with all party support, “Tackling Drugs Together” was published. The policy focused on prevention, health risks and community safety. The core approach was to be free of drugs, or get free of drugs, and stay free. Harm reduction was mentioned, but the risk of it being diverted into liberalisation was recognised, and the policy reminded readers that the goal of any treatment was abstinence, and harm reduction should therefore be a means to this end - not an end in itself. It is interesting to note that this strategy gave birth to the merger between the Institute for the Study of Drug Dependence (ISDD) and the Standing Conference on Drug Abuse (SCODA), the offspring being DrugScope.

The change of government to Labour in 1997 did not, at first, produce any radical change of drug policy, and even the title “Tackling Drugs Together to Build a Better Britain” paid respect to its predecessor. A new initiative was the appointment of a “Drugs Tsar,” Keith Hellawell, a former Chief Constable. (A surprise for him was the Government’s last minute imposition of a Deputy, Mike Trace, from the treatment sector.) By 2001, under Home Secretary David Blunkett, more significant changes were apparent; Blunkett had already announced that he was inclined to downgrade cannabis, and his Drugs Minister, Bob Ainsworth, announced that “harm reduction” would be moved to the centre of policy. The Home Affairs Select Committee conducted a review of drug policy, while the Home Secretary continued to be guided by the Advisory Council on Misuse of Drugs; the net effect of this was that cannabis was downgraded, despite protests from police officers on the street.

One initiative from the Drugs Tsar's office had unintended consequences; cocaine and heroin were defined as the drugs “causing society (rather than the individual) most harm.” Presumably this was an attempt to focus the treatment sector, but instead it became almost a dominance of all policy; problem drug users who were not using Class A drugs found it near impossible to get residential treatment, and the implication of this initiative (i.e. that other drugs are of lesser concern) rippled through the whole strategy.

In exchanges in Parliament, the Conservative opposition had criticised the changes, and had pledged to reinstate cannabis to its former classification, but with the emergence of a new party leader, David Cameron, the policy became less assertive. (Mr. Cameron had been a member of the Home Affairs Select Committee which reviewed drug policy, the chairman of which - Labour MP Chris Mullins - subsequently became connected with The Senlis Council - an international pressure group for drug policy liberalisation.)

Outside government, most of the resources were in the hands of those with liberal inclinations: DrugScope, heavily funded by the government; the Police Foundation under Lady Runciman; and the Beckley Foundation. They enjoyed ready support from a mostly libertarian media, which had been particularly active since 1994 when the *Sunday Independent*, under the command of Editor “Reefer Rosie” Boycott, launched a campaign to legalise cannabis. Education and health sectors were largely in the hands of liberalisers. What had become a “treatment industry” seemed



to have forgotten its abstinence goal, spending around half of its annual budget on methadone maintenance. There was a clash of attitude between senior police officers and rank and file officers, but most of the power rested with the (more liberal) seniors. As for drug professionals working with drug users, in 2005 they voted in favour of drug workers being able to be drug users themselves - so much for the abstinence goal.

Any neutral observer in 2005 viewing all this cannot help but conclude that we are in a mess. We have lost our way - we have been persuaded to prefer “Acceptance + Harm Reduction” to “Abstinence + Prevention.” The pressure for more treatment is understandable, but what we really need much more of is prevention. A forward plan would include better balance between services; more prevention, and more prevention-focused education. We should learn to learn from others, forget obsessing over a “silver bullet,” inject more common sense into our approach - and expose and reject any hidden agendas.

Dr. Sandeep Chawla - *UNITED NATIONS DRUG POLICY AND UNGASS 2008, full transcript on page 49*

The title of this paper suggests that there is such a thing as a UN Drug Policy; strictly speaking no such item exists. There are 193 sovereign states in membership, and the international Conventions enjoy almost universal adherence, but this is some way short of a “universal policy.”

The first principle of drug control is protection of public health, to ensure that drugs are available for medical and scientific purposes only. Global problems stem from money, drugs and consumers crossing frontiers; any policy limited to national level has no chance of success - there has to be a global system. As developed by member states, the system has two particular strengths; the common interest/shared responsibility and the commitment that almost every country in the world has made in signing up to the Conventions. They are constraining themselves to ensure there is no conflict between national legislation and the principles of the drug Conventions.

One weakness is that cannabis legislation and policy has experienced extensive challenge - and even acrimonious debate, partly resulting from liberalisation lobbies attacking the extant policies. This has challenged the spirit of the UN Conventions and rendered the Conventions vulnerable, and it needs to be addressed by us all, collectively and quickly. There are three primary areas of argument: firstly, changes in the strength and therefore in the public health risks of cannabis use; secondly, the increase in numbers presenting for treatment, including more mental-health issues, and thirdly, a rational re-assessment of the cannabis market, its size and its nature.

Some adjustment of the Conventions may prove to be needed, to deal with these factors, but it is not readily clear what these changes should be. There is general agreement that the best overall strategy is to prevent the problem of drug abuse, but this still leaves us the problem of what to do about those who have chosen to use.



How we deal with these problems I do not know, I do not profess to know, and I will not offer any answers at this table. Some say we should change the Conventions, some say they should stay as they are, but our job in UN is to reflect what the nations say, and to achieve convergence.

United Nations General Assembly Special Session (UNGASS) 1998 adopted a Political Declaration from all member states, to enhance demand reduction, and to eliminate or substantially reduce cultivation of coca, cannabis, and opium poppy. It also undertook to tackle the problems of amphetamines, precursor chemicals and money laundering.

Evaluating the effectiveness of this policy is very hard to do. Drug abuse has a cyclical nature, and consequential effects can change the trajectory of an epidemic, making the effectiveness measurement very difficult. If evaluation is done while use happens to be increasing, then policy will look like a failure - and vice versa.

Successful reduction in supply can be seen in regions such as the Golden Triangle and Andean countries. Qualifications on this success include the displacement of the problem to another area, and the fragmentary nature of some initiatives; there is a need to generate coordinated solutions.

At the 2008 UNGASS review, everybody in the world will ask “Did the drug problem get worse or better in the last 10 years?” No unequivocal answer can be offered; the truth is it got better in some areas and worse in others. It can certainly be said that prevalence has been contained to less than 5% of the adult population of the world; a significant success when you compare this figure with the unregulated open market for tobacco, where the prevalence is 30%.

Drug control, in various forms, has existed for around 100 years. Comparing the size of the problem at the beginning of the 20th century to the beginning of this century, there is what could be called proof of “containment.” In 1909 total world opium production was around 30,000 tonnes; right now it is around 5,000 tonnes. In the same period, world population has grown six times. Containment is clearly working and needs to be maintained.

John Walters - *UNITED STATES DRUG POLICY, full transcript on page 58*

The UN *World Drug Report*, given in June this year, gives a good measure of the worldwide drug problem, and gives a salutary reminder that cultivation and addiction levels are well below those of 100 years ago. It also defines a “global blind spot” around marijuana - the widespread perception of this drug as a “benign herb” undermines the truth – which is that it is a bad substance to use, especially for youth. Governments who lessen penalties only confuse the prevention message.

General prevention of all drug abuse is undercut by the overselling of harm reduction - this carries with it the implication that abuse is okay provided you keep an eye on the harm.

The International Narcotics Control Board stands out as a body which will not entertain injection rooms, and will not support injecting use or the use of prescription drugs for anything other than medicine or scientific research. In 1998 government heads agreed on the importance of demand reduction, and the need for more prevention, treatment and rehabilitation.



America has seen some success in recent years; youth drug use has fallen by 17% in the past three years, with an even greater reduction in the use of methamphetamines and ecstasy.

U.S. strategy is holistic and diverse, including increased investment in treatment and in addiction research. Screening/intervention programmes intercept early stages of abuse. Media campaigns have been seen to introduce positive effects on youth. Student drug-testing is making its mark, not only in deterring use but also in reacting non-punitively with any users discovered, helping them to cease. Drug courts now have many years of experience and have produced significant reductions in recidivism.

On the wider stage, America helped many other countries in their efforts. Afghanistan is just one of these, while Latin America is a primary focus for funding. Throughout their international exchanges, the United States confirms their basic commitment to the principles within the UN Conventions.

Control of precursor chemicals is another key activity, which has disrupted production of virtually every drug, with the exception of cannabis. Another core activity is to block the diversion and abuse of pharmaceutical drugs - this particular abuse is currently still escalating.

Much lies ahead, and surrender is neither a sensible nor a viable option. Balanced policies are the way forward, including ensuring that any measures aimed at reducing harm do not turn out to be “cures that are worse than the disease.”

Lesley Pallett - *TACKLING DRUGS ON THE SUPPLY ROUTE: AN UNITED KINGDOM PERSPECTIVE*, full transcript on page 65

The worldwide drug trade is worth more than \$300 million and it impacts society in social and security respects as well as economy and crime. It is now recognised that there is no single model that one can follow, and only a holistic approach has any chance of success. There is a need to engage at a number of levels which are co-ordinated and which send a consistent message. In dealing with other nations, it is essential that transit countries see themselves as full partners. To make an impact in these transit countries, one has to focus on key gangs, whilst government has to ensure that law-enforcement measures are intelligence-led. There is a need to look to like minded-countries to work in partnership, not only in Europe but also further a field.

One of the key features of this is working in partnership more than before with agencies such as the United States Drug Enforcement Agency, the Australian police, various European Union partners, and within regions such as the Caribbean. Relationships are also essential with key NGOs, academia and research institutions - in order that government may be better informed by empirical evidence as to what is effective. The creation of SOCA (Serious Organised Crime Agency) has added significantly to the United Kingdom's capability and intelligence-based approaches in tackling organised crime. The agency brings together key components of the law enforcement community. It is self-evident that organised crime is not going to go away - and that it will change as the “market conditions” change.



Marc Wheat - *UNITED STATES FOREIGN POLICY, full transcript on page 69*

After September 11th, 2001, in which he lost two friends aboard the plane that was flown into the Pentagon, Mr. Wheat was made a State Department Senior Adviser on drug aspects of terrorism, with one key subject being the extent and adequacy of international affairs on drug policy. Almost thirty years experience on “The Hill” (Washington) gives him a historical perspective on the relation of the illegal drugs trade to other activities, notably terrorism. If the connection was less apparent before 9/11, that terrible day propelled the United States into a more rigorous examination of the factors, and the significance of the drug trade came to the fore.

The USA’s drug policy is based on three pillars: Prevention, Treatment and Disruption. A paper Marc discussed concentrated on the third pillar. A first task was to identify countries where particular study and action were needed. It was not a short list; it included (in alphabetical order) Afghanistan, Bahamas, Bolivia, Brazil, Burma, Colombia, Dominican Republic, Ecuador, Guatemala, Haiti, India, Jamaica, Laos, Mexico, Nigeria, Pakistan, Panama, Paraguay, Peru and Venezuela.

Focus on three of these - Afghanistan, Colombia and Mexico - illustrates the diversity of U.S. foreign policy and practice.

We now live in a world that is full of contradictions and accelerating change. U.S. Government departments have had to change fast to keep pace with this change, and to greatly increase work with allies around the world. Key targets include narco-traffickers.

Those who continue to raise a ruckus in favour of drug legalisation or law relaxation are doing no more, and no less than deflecting attention from the more critical issues.

Afghanistan: The connection between heroin and terrorism in Afghanistan cannot be overstated. The disruption of border controls by drug traffickers plays into the hands of the terrorists. In the Helmand province, heroin cultivation has been especially severe, protected by the Taliban who formed an alliance with the growers. This is exactly what the FARC (Revolutionary Armed Forces of Colombia) did in Colombia.

Many people look at Afghanistan today and ask themselves in despair, “What does one do about a country where the rules of democracy are followed in the capital, but ignored in the rest of the country, where groups focus on making drug trade as profitable (for them) as possible?” We tend to forget that the same question was asked of Colombia ten years ago, and in our desperation and impatience we also forget that countering this situation is a (very) long game.

Colombia: Colombia has suffered internal warfare for some forty years now. Groups initially focused on political ideologies, but over time let this emphasis slide as they focussed more and more on making money from drugs. However, not all the news is bad. Last year saw improvements in all of the major “security indicators” i.e. homicides, kidnappings, terrorist attacks, and people driven from their homes. All of these were significantly less. People have expressed a safer feeling in their lives, and there has been police coverage of areas which have



not seen this in living memory. This suggests practices which could be usefully applied in Afghanistan.

Mexico: Methamphetamine is a major problem here. Ten years ago synthetic drugs were not a drug problem that ignited interest in the United States, but things are very different now, and some call this the most dangerous drug in America. Why the rapid growth? It is mainly because of very poor interception of transporting precursor chemicals.

The U.S. State Department and related offices have changed their configuration, giving greater emphasis to developing countries and building stronger links – what is known as “cultural diplomacy.” There is no country that enjoys uniformity of attitude across all government departments, and in America there are sections which favour so-called harm reduction. There will be genuine intentions behind this, but the net effect is to inappropriately encourage liberalising groups such as Drug Policy Alliance and Beckley Foundation, both of which receive funds from George Soros. Our focus should remain on the central goals of the drug situation, not allowing ourselves to be deflected by the legalisation circus.

Torgny Peterson - *SWEDISH DRUG POLICY – IN SUPPORT OF THE UN DRUG CONVENTIONS*, full transcript on page 76

At a 2003 conference in Rome, the Papal Nuncio quoted the Pope, who said “La droga non si vinci con la droga” – “Drugs cannot be fought with drugs.” Advocates of so-called harm reduction initiatives such as needle exchanges, prescription heroin and methadone maintenance programmes would do well to consider this. What was formerly a genuine practice to reduce the damage a drug user did in the period before they ceased their use has been hijacked into use as an apologia for continuing drug use.

Any country will get the drug problem it deserves, depending on the determination and leanings of its politicians and others in relevant professions – including the media. If the arguments of pro-drug campaigners drown the speakers for prevention, the result will be a drug-biased policy. Fighting against this requires sustained and organised input in four main areas: knowledge, strategy, coordination and leadership. It is not enough to address one or two of these.

Sweden did go through a period of accepting drug use – specifically in respect to amphetamines and opiates. Between 1965 and 1967 more than 4 million doses of amphetamines and 300,000 doses of opiates were distributed to drug users. It was found that this process was making things worse instead of better, and the process was terminated.

Some 20 years later the then-drugs minister, Margot Wallstrom, ordered an enquiry into the prevention-based approach. A committee worked for three years on the study, and in due course the Government decided to continue with a prevention-based approach. A “Drug Tsar” was appointed and is still in place today.

Swedish policy states that “... people are entitled to a worthy drug free life ...” and goes on to say that “...A society without drugs increases public health and well-being, and drugs policy is part of the Government’s public health policy to create a drug free society...”. The policy’s main



aims are to reduce the occurrence of new users, help users to stop using, and decrease supply. The policy has a massive support amongst citizens – including young people.

No injecting rooms are proposed by any of the political parties; there is a small needle exchange programme; only a small minority of long term addicts are prescribed methadone or buprenorphine, and there is a wide range of treatment centres – voluntary or mandatory. Drug testing is common in many workplaces.

Defending a prevention-based drug policy is as important - and as tough - as defending democracy. Fighting drug abuse is a matter of political will. Stamina and determination are essential fuels.

Habibullah Qaderi - *FRONTLINE UPDATE: HOW AFGHANISTAN IS TACKLING THE DRUG PROBLEM*, full transcript on page 80

Afghanistan suffers a very vulnerable economy; the Gross National Product (GNP) is 6 billion dollars but half of this comes from illegal opium. Theoretically, one could eliminate the opium problem in one quick hit - applying herbicides, bulldozers and bullets - but losing half of one's GNP in one year would be catastrophic for any country. Afghanistan is only five years out of a repressive dictatorship, and suffered 20 years of war with Russia before that. It is still at odds with the Taliban, and it is clear that they would exploit a stricken economy, recruiting destitute farmers and hungry city dwellers alike. (At this point Minister Qaderi asked if there was anyone in the audience who would like to take his job. There was laughter - but no takers.)

This year's spring opium harvest is at a record level - which might prompt some to ask, what has gone wrong with the Anti-Narcotics Ministry? The answer is that the Ministry has only existed for one-and-a-half years and is still building its operational structure. It started by developing a national strategy, one tailored to the socio-cultural history of opium cultivation which has spanned centuries of Afghanistan's history. The main target of the strategy is:

“...to secure a sustainable decrease in cultivation, production, trafficking and consumption of illegal drugs, with the end being complete and sustainable elimination.”

The strategy has four priorities: disrupt trade, diversify rural livelihoods, reduce domestic consumption, and develop central/provincial institutions to deliver the whole strategy. Part of the approach is to convey to Afghan farmers that Islam, the Afghan constitution and the new counter-narcotics law all prohibit poppy cultivation and could invoke crop elimination and/or imprisonment.

Domestic drug abuse is not heard of much in international media, but in fact 4% of Afghanistan's population abuse drugs; around 900,000 people. Most of them use hashish, but nearly 50,000 of them use heroin. The main response to this has been the development of treatment centres and improvement in drug awareness.

Afghanistan is landlocked, with open and accessible borders. It must develop co-operation with its neighbours, not only to reduce their suffering from the poppy crop, but also in the interest of Afghanistan's own health. Poppy cultivation effects are particularly severe in Afghanistan - not



just in that context of drug use direct consequences, but also because cultivation and trafficking underpin warlords and the Taliban.

Much thought has been given to what Afghanistan could do to replace the economic input of poppy cultivation. It is not that long ago in historical terms that Afghanistan used to grow the best pomegranates in the world - a crop now known to be even more valuable for its health benefits, which exceed other fruits, especially in respect to anti-oxidants. Many pomegranate groves were cut down during the 20 years of war, and these cannot be replaced overnight, but a determined start has been made. One dream might be that in 10 years time, a conference like this one would hear that Afghanistan is once again supplying 90% of a major world market - but this time it is not a dangerous drug, it is pomegranates!

Professor Neil McKeganey - OVERVIEW OF DRUG POLICIES AND THEIR EFFECTIVENESS, full transcript on page 87

The end of the 1980s and the emergence of HIV/AIDS saw a profound change in United Kingdom drug policy and practice. The ACMD (Advisory Council on the Misuse of Drugs) pronounced in 1988 that HIV was a greater danger to society than drug abuse. The period following saw HIV prioritised, a concentration on injecting use, and a recommendation that services be more user-friendly, not discouraging clients by challenging their behaviour. At this time methadone came into play as well, as a way of engaging with drug users and helping reduce risks of HIV.

This was the period in which “harm reduction” became a much greater proportion of drug policy and practice. In the name of HIV prevention, traditional drug worker practices - which formerly had aimed at limiting harm while working towards cessation - were transformed into limiting harm (mostly for the users themselves) but with little or no encouragement of cessation. The transformation of strategy was completed by the end of the 1990s, when Home Secretary David Blunkett not only endorsed “harm reduction” but also moved it to “centre stage” in his policy.

It is considered that three basic questions now need to be asked about this strategy: 1) Was the emphasis by ACMD on HIV right? 2) How successful have we been? and 3) Should we now change strategy?

An influential piece of research in Edinburgh in 1986 suggested that fully 63% of injecting users were HIV positive, but subsequently other studies showed much lower figures, averaging 12 %. In London by 2005, the figure was down to 2.3% and elsewhere was as low as 0.5 %. This poses serious questions about the wisdom of ACMD's recommendation.

As to success, claims in respect of HIV are arguable and there seems no evidence of “harm reduction” limiting hepatitis. Drug deaths have risen sixfold between 1983 and 2000. Overdose seems to be more of a function of social problems than of “harm reduction.” Prevalence actually accelerated in the years after “harm reduction” was introduced.

So it is that after 15 years of “harm reduction,” we have 40 percent of users suffering Hepatitis C, thousands dying, prevalence increased, drug-related crime increased and damage to families increased. “Harm reduction” quality control is rarely assessed. For those who suggest inadequate



investment in “harm reduction” was the cause, this seems quite implausible. Half of the current U.K. treatment budget of £500 million a year is spent on methadone - hardly starvation of funds.

At that time of moving “harm reduction” into prominence, it was said that if this paradigm was wrong, the consequences would be disastrous. This seems to have been the outcome, and the greatest shortcoming of the current policy is its preoccupation with “harm reduction,” along with great neglect of prevention. There is a clear need for more focus on prevention, and “harm reduction” needs to address more than just the user. Present prevalence is around 350,000 users; this is only one percent of the population between ages 15 and 55, so the potential increase could be huge - and catastrophic for the already-overloaded drugs services as well as for associated agencies.

A study has been made of possible developments over the next 20 years, considering scenarios for prevalence, ranging from a slight decrease on present figures up to a threefold growth. The impact on services has then been assessed. If the highest prevalence (which is by no means incredible) were to be reached, this would equate to around 1 million users. It would incur economic/social costs of some £35 billion per year; police forces would be overstressed, as well as drugs services; the public would be either fatalistic or antagonistic; and these and other factors might force national policies to change drastically.

The specific effect on treatment would be significant. Although there are already a wide range of treatment options, DTTOs (Drug Treatment and Testing Orders) often fail. More positive findings are seen for drug courts. An important factor is to link treatment and subsequent housing and employment. This often proves difficult due to the increasing extent of poly-use of drugs. This means that services must become more flexible, and services definitely need to give more help for others around the user. There is a strong possibility in the future of middle-aged or even elderly addicts, requiring a different approach. Alcoholics Anonymous and Narcotics Anonymous remain popular with many recovering users, notwithstanding their unfashionable image with some professionals.

Conclusions: Use is still growing, and could grow substantially over the next 20 years; particular potential for increased use relates to females, to rural settings, and to new drug markets prompted by different substances. There is a need for more research investment across the field, on the subject of “What works?”

Dr. Mark Gold - *DRUG EXPOSURE, ABUSE AND DEPENDENCE: Lessons from Physicians, Addicts and Second-Hand Smoke, full transcript on page 106*

The Florida-based Brain Institute has a budget of \$100 million to develop an infrastructure for multi-disciplinary research, involving neurologists, neuroscientists, neurosurgeons plus another 20 types of scientists.

The younger the use of drugs begins, the more likely the brain is to incorporate it and accept it as normal – and the more likely that the person will develop a lifelong, chronic relapsing illness.



Early use as an adolescent can change the brain's neural threshold, and the person will then need extreme thrills, like bungee jumping, to have the same kind of pleasure that a non-user gets from more gentle pastimes.

Research into second-hand smoke shows that anything that is smoked or cooked – tobacco, marijuana, methamphetamines etc., - adds pollutants to the environment. Children living in households where parents smoke anything from tobacco to heroin will have these substances active in their brains. (It is already known that babies ingest drugs their mothers are using while they are still in the womb.)

A drug is an “acquired primary drive,” addiction is a pathological attachment, and use continues despite adverse consequences. The brain changes after drug use and this makes relapse more likely.

Independent markers for addiction liability, addiction relapse and addiction-related changes in the brain will be established soon. They will definitely show a difference between pediatric-onset addiction and late-onset addiction

Cigarette smoking is amazing – it actually forms a new neural connection that suppresses the cough reflex. In animal research you cannot make a bird smoke, and only half of non-human primates can be made to smoke. If you put some in a chamber with smoke they will hold their breath, ignoring any “rewards” (like bananas.) It is a pity that humans do not show the same reservations over smoking that many animals do.

Second-hand smoke kills 35,000 people a year in the USA. If a child is in a car with the mother smoking you can measure cotinine in its breath – the child breathes it in and it is metabolised as if the child was smoking.

We have to protect people through laws related to “clean air.” With the advent of nanotechnology we have been able to look at the reasons why many addicted doctors are anaesthesiologists. In the course of giving opiate drugs to a patient, a certain percentage of drugs will be exhaled. Until recently, the air in operating theatres was not analysed, but we have now been able to measure fentanyl – an opiate 10 times stronger than morphine – in the operating theatre solely as a result of exhalation by the anaesthetised patient. (Fentanyl was the drug used in the Moscow theatre terrorism incident.) Addicted anaesthesiologists have high relapse rates because after treatment they usually return to the same environment in the operating theatre.

As well as the above effect, we now also know that nitrous oxide in operating rooms can cause spontaneous abortion. Fentanyl can be found in the air over sharps boxes and benzodiazepines can be found in the air in operating rooms where patients have been given them by intravenous injection.

Very small amounts of second hand drugs in the air can be detected from patients exhaling. There is a great need to evaluate workplace environments, especially in hospitals.



It is now agreed that second hand smoke is dangerous and we must have zero tolerance of it in the environment. How much more important then is it that we have zero tolerance of potent drugs – crack cocaine, heroin, methamphetamine? Children of drug-using parents have the highest rates of drug abuse and addiction simply because they have been using all their lives – against their will.

Raymond Yans - *IS THERE ANYTHING SUCH AS E.U. DRUG POLICY?* , full transcript on page 114

European drug policy flows from three institutions and is based on three pillars. The three institutions are the Commission, the Council and the Parliament, while the three pillars are Community Matters, Common Security and Justice/Interior Matters.

The Commission mainly handles the internal market. Its policy decisions may or may not influence member states. It guides the Union on drugs matters, but has no power to control the route taken. The Council decides on all drug matters, but again cannot enforce its decisions on member states. The Parliament could have become very powerful if the Constitution had been accepted, but it wasn't, and the alternative – harmonising 25 member states – is a forlorn hope. Influence within the member states is constrained by the combined controls of subsidiarity and proportionality, jargon words meaning that member states can do what they want in their own countries.

Post-Maastricht (1992), an attempt to improve coherence was the setting up of the Horizontal Drug Group. This enabled the 2005/2008 Drug Plan to be adopted. External bodies – particularly liberalising bodies – apply as much pressure as they can, and some internal bodies, for example the Catania Committee, add their pressure. The consultation process is weakened by the relative powerlessness of the European Union (EU) over member states' policies, and therefore the effect of such bodies is often to generate more heat than light, but they perform a valid contribution to the democratic process – and their main targets are more likely to be the media and the public, rather than the parliament.

The EU drug strategy aims comprise health protection by prevention, reduction of use and of harms; interdiction of drugs and precursors; stronger coordination mechanisms, and an ongoing clarification of EU's position in international forums. The strategy has no less than 46 objectives, but there are 5 that stand out: improved coordination, demand reduction, prevention and treatment (all 25 member states have needle exchange schemes) and supply reduction, including joint action with agencies such as Interpol; international cooperation, and information and research.

The fight for opinion is, as ever, vital. Conflicting messages come in from various EU sources or from such organisations as EMCDDA (European Monitoring Centre for Drugs and Drug Addiction.) Liberalisers are heard often, prevention lobbies are only rarely heard. The liberalising gambit is often to promote criticism of the UN Conventions within the EU. A Fourth Convention (which might be called "The Harm Reduction Convention") is currently under study in Strasbourg. In the short term the liberalisers may lose, but they know they are playing a "long game," and they know how to play the game.



For a positive, health-oriented strategy in the European context, there are a number of identifiable targets:

- short term/long term media strategy, independent of U.S. priorities
- strategy should focus on immediate winnable battles
- much more prevention should be advocated
- expose the dangers and myths about cannabis
- ditto for ecstasy and methamphetamines
- aim to limit first use, and
- encourage public opinion to conserve the UN Conventions.

Ambassador Anne Patterson - *US DRUG POLICY CONCERNS ON A GLOBAL BASIS*, full transcript on page 123

First-hand service in Colombia has allowed a clear understanding of events there. Colombia shares the common priority goals of all other nations: reducing drug cultivation, trafficking, and abuse, together with reducing the international effects such as organised crime, political instability and terrorism. The United States has strongly committed to these goals, and within the past decade, it has increased the International Narcotics and Law Enforcement budget from \$260 million to \$2.5 billion.

A holistic approach is seen as essential; any eradication and interdiction must be accompanied by lawmaking, ability to prosecute and convict, demand reduction, and public awareness. Key to any nation's long term success is the ability to assume full responsibility for a civil society. Beyond this, the consequences of drug abuse in one country upon its neighbours are, clearly, an essential consideration.

The notion that farmers benefit from drug cultivation has now been exposed as a myth; the real benefits go to traffickers, tribal leaders, insurgents and corrupt officials – and occasionally one encounters an individual who is in all of these categories! But 90% of the Afghan public believe that poppy cultivation is wrong, and President Karzai has stated that, “If we do not eradicate poppies, poppies will eradicate Afghanistan.” The United States has already donated \$330 million towards alternative livelihoods in Afghanistan, but no one views crop eradication as a pushover. It may yet prove to be the greatest challenge in the whole process.

Dr. Hamid Ghodse - *WHAT DOES THIS ALL MEAN FOR FUTURE DRUG POLICY?*, full transcript on page 132

As former President of the International Narcotics Control Board (INCB), Professor Ghodse has a clear overview of the historical perspective of drug control. Legislation started to emerge in 1909. Prior to that time there were some 50 years of legality all over the world. During the 19th century, opium was the equivalent of aspirin today – on sale at the grocery. By 1909, there were 20 million opium addicts in China, and the first Opiate Commission was formed prompted by the pandemic of drug use all over the world. UN General Assembly has been asked to designate 26th February 2009 as the Centenary of International Drug Control.



Of course, despite the development of legislation in 1909, there were still people who flaunted the controls, and between 1925 and 1929 over 100 tons of opioid analgesics were diverted into the illegal market. This is a failing that is almost non-existent today.

It was in 1925 that the Central Narcotics Board (CNB) was founded. This was the predecessor of the INCB. The CNB endeavoured to also regulate the international drugs trade, but this proved to be beyond its resources, and an additional body was set up to cover this aspect. Some time later the two bodies merged and in due course the INCB was born.

A key difference between the INCB and the UNODC (United Nations Office of Drug Control) is that the UNODC does not have a policy in its own right, having been formed to support the policies of the member states, but the INCB has a definitive drug policy, governed by international law and Conventions. Therefore, the INCB has to ensure that member states' legislation is kept consistent with the obligations each state has made to the UN. Although the Conventions themselves are inviolate, it is possible – subject to approval by the ruling bodies, including the World Health Organization (WHO) – to make changes to the detail. A current example is the proposal to shift Delta 9THC from Schedule 2 to Schedule 3 of the psychotropic convention.

INCB has to try to inject balance into member states' legislation. For example, many drugs in the illegal sector also have a medical or scientific use and 80% of the narcotic analgesics for cancer pain, terminal pain or chronic pains are used by just 6 countries. Therefore, the administration has to take account of these differences between one country and another. Even in highly developed countries, there are significant differences in licit use. Denmark uses 8 times more analgesics than Italy, France uses 3 times more hypnotics than the British, and Americans use 10 times more central nervous stimulants than European countries.

Precursor chemicals are a more prominent concern these days, and the 1988 Convention gives INCB full responsibility for control of these. Not every state has signed up to agreements covering precursors, but almost all have.

As well as cooperation within the UN, there is ongoing cooperation with bodies such as WHO, Interpol, UNODC, WCO (World Customs Organisation) and with regional organisations. INCB is not exempt from criticism by individual countries and, of course, there is unceasing criticism from the pro-drug lobbies. INCB is encouraged by this pro-drug criticism. Were this lobby to suddenly start praising the INCB's approach, this would suggest that things had gone seriously wrong.

INCB recognises the tremendous support that comes from the prevention community, especially in backing the board in its guardianship of the Conventions. Media focus may give the impression that it is only countries like Afghanistan and Colombia which are keeping the drug problem boiling. This is far from the truth, and the geographical spread of drug producers, precursor merchants and drug traffickers makes it essential that all countries continue to be active in countering this problem.

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Where do We Go From Here?

Some general conclusions from the conference speeches.

Coming as they did from different cities and different organisations, none of the 16 speakers at this conference had any opportunity to compare notes with each other before the event. The degree of consensus self-evident in the papers as delivered is, therefore, all the more impressive.

This chapter has been written by grouping together key remarks made by various speakers on any particular subject.

Prevention

Whether the speaker was a doctor, a government official, an academic, or a specialist, and wherever their home nation, a uniformity of recommendation could be heard throughout. On one matter they were unequivocally together - all advocated new and stronger emphasis on prevention.

It was agreed that there was a need to counteract fatalism and a need to encourage people to be free of drugs, or to become free if already using and to stay free. Prevention itself needed to learn from the latest research and from international experience. The guiding theme for prevention was informatively summed up in the Swedish drug policy:

"People are entitled to a worthy, drug-free life."

This theme mirrored the consensus found in the meeting of the International Task Force on Strategic Drug Policy that immediately preceded this conference. Based upon this consensus, the Task Force issued a Resolution Concerning Drug Abuse and Human Rights the day before the start of this conference wherein they stated:

"...all individuals have the right to live in a world with dignity, work, and a decent standard of living, as defined in Articles 22, 23, and 25, respectively of the Universal Declaration of Human Rights; and...these rights are seriously compromised in a world which would condone drug abuse..."

This Resolution has been appended to this report and can be found on the web site of the International Task Force on Strategic Drug Policy (www.itfsdp.org) in English, Spanish, and Portuguese.

Analysis of dependency and addiction can and should inform prevention, not least because treatment cannot claim to produce a complete solution. This is currently the subject of vigorous debate in the field, with serious doubts expressed as to whether the brain ever really recovers from drug abuse.

A holistic approach to prevention makes the best of sense; just as there is no "one-size-fits-all" treatment method, so also there is no "silver bullet" prevention system.



In the present atmosphere in the drugs scene, it is fair to observe that prevention is rarely mentioned - either in the professions or in the media - despite being one of the priority elements of virtually every nation's strategy.

What this indicates is a tendency, in many cases, to deliver a "user-dominated strategy." Moreover, there are some countries where the talk is mostly of the "rights" of users to be assisted to sustain their use (for example by methadone maintenance programmes) and to protect their health in the process, but with little or no mention of anyone else around the user who may be even more seriously affected. One would not argue against the principle of protecting a user's health, but one can and should argue against practices that do nothing to bring about health improvement.

The paper by Professor McKeganey included in these proceedings, under the heading "The Lure and Loss of Harm Reduction" gives a detailed analysis of United Kingdom drug policies having lost their way. When HIV/AIDS first became an issue, extremes of drug abuse damage limitation practices were brought into practice instead of the traditional prevention-focused approaches. There has now been at least 15 years experience of these so-called harm reduction measures, and whilst some degree of such measures can still be justified, an objective review of the gains and losses of the so-called harm reduction philosophy and approach is long overdue.

The historical position was that prevention and education would aim to minimise the number of people trying drugs at all; intervention would aim to divert people away from early stages of drug abuse; and treatment would aim to assist users (including dependent users) to progress into cessation of their abuse. Even in countries where so-called harm reduction is in the ascendancy, such as the United Kingdom, the stated goal of treatment is abstinence.

Within this historical approach it was always the case that drug workers would engage with drug users, discuss the nature and extent of their use, and work to minimise the harm occurring in the user over the period before abstinence was achieved. This practice should continue, but what should not continue is any so-called harm reduction practices which are not part of the route to abstinence and which time has exposed as cynical devices to underpin legalisation lobbies.

One of the best, unequivocal statements on "harm reduction" was published in Britain's first National Drugs Strategy, the 1995 "Tackling Drugs Together" document. In Appendix C, paragraphs 14 through 17, the Strategy said:

Harm Reduction

C.14 The Government has been asked to clarify where it stands in relation to the principles of 'harm reduction' or 'harm minimisation' in tackling drug misuse.

C.15 The Government starts from the basis that the ultimate goal of its drugs policies must be to ensure that people do not take drugs in the first place, but if they do, they should be helped to become, and remain, drug free.



C.16 In relation to 'primary prevention' (stopping people from taking or experimenting with drugs in the first place), the government would not support any initiatives that could be interpreted as explicitly condoning drug taking. Nonetheless, the Government acknowledges that there will be those who, through ignorance or for other reasons, will misuse drugs whatever the consequences. For these people, information and facilities aimed at reducing the risks should be provided because this may save lives. However, such information must be coupled with the unambiguous message that abstinence from drugs is the only risk-free option.

C.17 In relation to treatment, the Government continues to support harm reduction initiatives such as needle exchange schemes, that have helped the number of HIV infections amongst drug misusers. However, as with primary prevention, the Government views abstinence from drugs as the ultimate goal of treatment and rehabilitation services. Harm reduction should be a means to that end, not an end in itself.

(With regard to the C17 quote – it has now been shown that the provision of needle exchange schemes may not in fact have helped to prevent HIV infections – and the escalation of Hep. C infections has also been linked with such schemes.)

Prevention must have several phases to it, with adjustment in its elements according to whether the people engaged in the process are non-users (universal prevention), at risk of becoming users, (selected prevention), or are in early stages of use (indicated prevention). Clearly, there are also differences in delivery according to the age of the people involved.

The International Task Force on Strategic Drug Policy's report of February 2005 entitled "A New Approach to Reduce Drug Demand" - which can be accessed on the ITFSDP website (www.itfsdp.org) gives extensive details of the elements of effective prevention, and in particular in section C. "Effective Prevention Practices". Other sections (A. "Treatment System Prevention Practices" and B. "Justice and Enforcement System Prevention Practices,") give guidance on effective prevention in these specific settings.

Politics and policies

It used to be the case that most of drug work practice was free of politics, with all-party consensus on the majority of issues, but it is increasingly now the case that politics have entered the fray - and not always for the best. This is partly, but not wholly, because of libertarian pressure groups and "backbench" politicians politicising the issues. A particular, practical concern is that the libertarian side of the argument is generally much better financed and therefore, better resourced than the prevention side. When this imbalance is coupled with a media which inclines to support the libertarian stance more than any other, the net effect is that prevention is hardly ever heard of and media events that should have enabled prevention to be presented and explored become instead arguments about legalisation.



This is an issue that needs to be widely exposed. Media and general public discussions and debates need to be persuaded to raise the profile of prevention to its deserved level and to raise the understanding of what prevention is, and is not. Too many people, including the media, simplistically assume that prevention equals (i.e. is limited to) education. This is far from true.

It has become clear with time, that a major influence on drug behaviour (or attitude towards it) is the culture or, more accurately, cultures - in a society. This will include formal influences, such as schools, churches, workplaces, government departments and so on but will also include informal (and often more powerful) influences such as movies and TV, music, fashion, theatre, books and magazines, advertising etc. This illustrates the enormity of the prevention task.

The United Nations General Assembly Special Session (UNGASS) 1998 Conventions on drugs matters have always been targets for the libertarians and for most of the media. One important task for the International Task Force on Strategic Drug Policy must be to remind politicians of their responsibility to the whole population, not just that minority section of the population that abuses drugs or that other minority that espouses them.

In the same context, people should recognise that the goal of abstinence is almost universal. It follows therefore that a strategy based on “acceptance of use plus harm reduction” is counter-productive to this end and is, therefore, inferior to a strategy of “abstinence plus prevention.” The implication for drugs services is that a better balance is needed; more prevention-focused, more and better prevention, education which has a clear prevention goal, abstinence/cessation-based intervention and treatment, and hard-nosed investigation, exposure and removal of libertarian hidden agendas.

No one can realistically expect uniformity of approach across all nations. Not even the United Nations (UN), with all its resources and influence, has achieved total accord on the actual detail of its strategies even though most signatory nations have signed up to the broad principles within the Conventions. This, then, is the most likely form of progress - that national policies develop consistent with the UN Conventions, even though interpretation may differ from nation to nation.

Details covered by the Conventions may have to change, reflecting such aspects as new drugs (e.g. methamphetamines), new, more potent varieties of drugs (e.g. Skunk or Nederweed Cannabis) and variations in the nature of the drug market (e.g. greater trafficking in precursors and/or abuse of pharmaceuticals obtained without prescription via the Internet.)

It would be a mistake to assume that problems for producer nations are limited to places like the Golden Triangle, Golden Crescent, Afghanistan and Latin America. What happens in those countries affects us all, in different ways. Our commitment therefore has to be that we become more aware of, and more active in relation to the global situation.

An alarm call was sounded in this conference when we were told that a “Fourth UN Convention” is being developed right now in Strasbourg and that its text has been described as “the Harm Reduction convention!” Whether we are Europeans or not, such a convention would have grave implications for all nations. We must, therefore, follow up on this and do so urgently!



Intervention and treatment

With the best will in the world, the drug problem is not going to self-destruct or evaporate overnight. Drug control measures have been on the table and in the community for almost 100 years now (in fact the one hundredth birthday of drug controls occurs in 2009.) Afghanistan progress towards ceasing cultivation of poppies will have to take its time, if it is not to bring about an implosion of their economy. Alternative agriculture will face practical, philosophical and economic problems. Similar comments could be made about Latin America.

Even when drug abuse is reduced to some irreducible minimum - perhaps one percent, or two percent, or... there will still be a need for intervention and treatment.

But unlike the fatalistic approach that too many assume in some countries, the ideal intervention/treatment will restate the long-term goal of abstinence (which some seem to want to forget.) Moreover, so-called harm reduction will be replaced by a genuine damage limitation as part of the intervention/treatment process, and will have the same over-riding abstinence goal that treatment has.

The too-easy deployment of "methadone maintenance" programmes in countries such as the United Kingdom should be replaced by a much wider use of "methadone reduction" programmes and a more rigorous questioning of whether methadone is the best approach in many individual cases.

The original introduction of so-called harm reduction measures such as methadone maintenance, needle exchanges, injection rooms and so on came at a time when the threat from HIV/AIDS looked much bigger than it turned out to be in western countries (clearly this is not the case in Africa, where a starkly different situation has developed.) Now is the time to reassess this whole issue, and produce a more balanced approach.

One particular concern, amongst many, is the effect on young people - either from their own drug abuse or from their involuntary ingestion of drugs, in the womb or in the home through passive (second-hand) smoke. The younger a person starts ingesting drugs, the more the brain becomes normalised in the intoxicated state. This can lead to a lifelong, relapsing illness. The kind of "zero tolerance" we are now applying in respect to tobacco smoke needs to be applied to all drugs in a wide variety of settings.

Children of drug/alcohol users have the highest rates of drug/alcohol abuse simply because they have been using it all their lives.

One form of intervention which also has great prevention value is Random Student Drug Testing (RSDT). In a recent survey in Scotland, 97% of parents said they wanted RSDT. This deserves to be expanded further, duly supported by the feedback from experience so far, and continually tested against research as it becomes available.



Media, Enforcement, Research

In the brief timing allowed in a one-day conference, there was little time to directly address these important subjects, but the International Task Force on Strategic Drug Policy fully values their input to drugs strategy and practice, and intends to continue its fruitful contact with people in all of these sectors. This matter is further addressed in the section below titled “Closing Recommendations.”

Conclusion

It is easy to take a short-term view of the drug problem, and demand to know if, for example, the various efforts in the name of the UNGASS decade 1998-2008 have made things worse or better. The honest answer is “some of each.” The notion of dissolving all drug abuse in 10 years was always going to be hopeful, but two findings are clear:

- The prevalence level of 5% of population clearly shows that "containment" is working. (Compare this figure with, for example, the 30% level for tobacco.)
- The prevalence of drug abuse is one-sixth of the value a century ago, despite the world population having grown in the meantime to six times what it was at the beginning of that period. In other words, prevalence today is around one-thirty-sixth of what it could have been if drug controls had not been established. Not an unqualified success, but a substantial one nevertheless.

Persuading governments to build on this is not easy given that persuasion, rather than imposition, is the extent of power in the UN and in regional bodies such as the European Parliament.

It has been said that defending your prevention-based strategy is as important as defending democracy. The key to success is for nations to all awaken to their responsibility for developing and cherishing a civil society and to do so not just in healthcare, but in the economy, in relation to crime, in addressing social issues, and in establishing adequate security at both the national and the international level. Greater co-operation between nations is essential, and must address transit nations as full partners in the general process, irrespective of the passage of drugs across their borders.

Just as drug abuse will be with us for long time, so too will pro-drug lobbies. We need to recognise that their activities are actually deflecting us from our own key work. And if governments bend to the pressure and relax laws, this only serves to confuse the general message to the public and to make prevention that much more difficult. We should not let the pro-drug circus distract us. Indeed, the single value of their criticism of what we are doing is to confirm that we are still doing the right thing!

And above all, we should keep in mind that any nation will get the policy and the problems that it deserves.

In summary, the strategy we promote will include the following:

Prevention
Education

that is pre-event
that is prevention-focused



Intervention
Harm reduction
Treatment

that is cessation-focused
that is cessation-focused
that is abstinence-focused

And social services, employment, housing that are in line with the above, and culture that encourages the above.

All decisions on specific actions as above should respect and serve not just the user, but also the many people around the user who are affected by his or her actions, up to and including society as a whole.

Closing Recommendations

Following the conference, the following recommendations for action were put forth by two of the conference speakers:

1. Recommendations for Public Relations and Media Campaigns in Europe: (which could be applied to other areas)

While it is believed that, in the present situation, no major shift is to be expected from European governments to reject the implementation of UN drug Conventions, we must ask if we are able, in the long run, to withstand the possible evolution of public opinion.

The political minorities and drug legalisation lobbies are skilled at “using the drums of communication” and media power: They skillfully obtain extensive media coverage of their press conferences. They have numerous press attachés that usually succeed in arousing interest among the mass (the hundreds) of journalists attending the daily Brussels European Press Centre briefings.

Are we able to do the same? Are you able to do the same?

True drug prevention advocates have been less than successful in getting equal or sufficient media attention to our issues.

We need to develop a short-term and long-term media strategy to counteract the harmful influence of pro-drug lobbyists on European public opinion and if such a strategy is to be effective in Europe, it must not rely on U.S. priorities.

For example, a straightforward media campaign in Europe against needle exchange programs or methadone treatment under medical control would be almost completely useless (in strategic terms) as all European Union (EU) governments already apply those techniques.

We must be active on themes where European governments and public opinion are still hesitating. There are three main fields open for media action, for drug prevention activists:

1. More primary prevention programs than those rooted in “harm reduction” should be demanded of authorities.
2. Develop and widely disseminate information about the toxicity and short term and long term ill-effects of cannabis.



- Organise more media coverage of scientific research in this field.
 - Organise scientific conferences in various European capitals.
 - Spread more information on the dangers of cannabis products with high THC levels that are exported from Holland.
 - Launch campaigns for banning businesses that promote and export cannabis seeds and other pro-drug type businesses.
3. Develop and widely disseminate information in a similar manner as described above on ecstasy or new amphetamine-type drugs and against the trivialisation of so-called fashionable drugs in the media.

To do this we need resources, professionalism, and knowledge of European realities, but by doing this, we can achieve two goals:

1. Limit the prevalence of “first drug use.” Prevent more young people from even “trying” fashionable drugs (which should be the primary target of any drug prevention policy).
2. Create for our politicians a more solid public opinion cover to convince them that rejecting UN Drug Control Conventions may finally be a very bad idea for their political future.

2. Recommendations to Prepare for the Next UNGASS:

Everybody should study the UNGASS Political Declaration 1998, not least Article 19 of that Declaration, which states that:

"Welcome the global approach by the United Nations International Drug Control Programme to the elimination of illicit crops, and commit ourselves to working closely with the Programme to develop strategies with a view to eliminating or reducing significantly the illicit cultivation of the coca bush, the cannabis plant and the opium poppy by the year 2008. We affirm our determination to mobilize international support for our efforts to achieve these goals."

So what does this mean? It means that governments all over the world agreed to develop strategies to get rid of "or reducing significantly" the coca bush, the cannabis plant and the opium poppy by the year 2008.

Have you checked with your government if they are fulfilling their commitment or was it just lip service on a solemn occasion? Request a copy of the speech given by the representative of your government at UNGASS and then make a thorough follow-up of the fulfilment of your government's commitment. If not fulfilled, tell the media about it - inform your people. If fulfilled or at least actively working in that direction, tell the media about it - inform your people. Never let politicians on the international level, or elsewhere for that matter, get away with empty promises.



We do not know yet for sure whether the next UNGASS will be held in 2008 or 2009, but be prepared for any of the alternatives and start making inroads to your government to become a member of your government's delegation to the next UNGASS. If they try to tell you that NGOs (non-governmental organisations) are not welcome, that is nonsense and might indicate that they do not want to have any input from organisations “on the floor,” who usually are very updated on the situation affecting people in their neighbourhood, region or country. Do not wait for your government to ask you to be a member of their delegation because they usually will not ask you.

Start writing articles, giving lectures, informing the media about the upcoming UNGASS and the scourge of drugs and how it is affecting people in your country - drug (ab)users as well as non-users.

Never forget that in a way we are business people, selling the idea of a better society for everybody - a society that will never allow drugs to become an integral part of that society, and if it already has, it is time to change that. Our opponents say that we should "stop the drug war." Our motto should be that they should "stop the war on people" by facilitating access to drugs, thereby sending hundreds of thousands of people to drug slavery.

If politicians have given up, opted for “harm reduction” or are even inclined to consider legalisation of certain drugs, remind them that any society has the drug problem it deserves. Remind them who is in charge of the major decisions affecting people in our countries - the politicians. The politicians must be held accountable for what they are or are not doing. We, as ordinary citizens in our respective countries, have a right and an obligation to question the politicians and the decisions made by them. We have also a right and obligation to praise them when praise is deserved.

To reach as many people as possible we have to realise the enormous advantages of modern technology. By using Internet and Internet-related devices we can reach an enormous number of people.

If you have not already done so, set up an Internet website focusing on the drug problem, the situation in your country, the need for international co-operation, UNGASS 2008 (or 2009) and the commitments by your government at the UNGASS 2008. Raise awareness!

Visit our UNGASS 08 website and sign our petition to protect the United Nations Drug Conventions! The site is located at:

www.UNGASSdrugs.org

Create blogs on the Internet for instant presentation of new facts and figures, speeches and pictures. A blog is a more “casual” way of interacting with your target groups and will, if you decide so, provide an opportunity for them to comment on what has been said, with or without you being a moderator of the blog. (However, it is recommended that the blog be moderated unless you want to run the risk of being overwhelmed by messages from the legalisers.)

* * * *



FULL TRANSCRIPTS OF PROCEEDINGS



United Kingdom Drug Policy

DIANA COAD

**Former Parliamentary Candidate,
Conservative Party, (United Kingdom)**



Ms. Coad applies many years of political activism at the grass roots level in reviewing past and present national policy and practice, under Labour and Conservative governments in the UK. The gradual but substantial shift towards more liberalism and away from prevention is described. Influences within government and in the voluntary sector are addressed. Suggestions for constructive change are offered.

Thank you to the International Task Force for inviting me to speak today.

I recently spoke at a drugs conference for politicians in Brussels – but where were they all? Apparently when they agreed to the conference they had forgotten that they would be in Strasbourg that week, not Brussels. Similarly when British M.P.'s expressed some enthusiasm about this conference they had overlooked that most of them would be on the beach. Here's a few of them now.

That essentially is why you are not seeing Vernon Coaker, who as Home Office Drugs Minister was the first to be asked. Later came and went Kate Hoey, Cheryl Gillan, Angela Watkinson and David Davis.

An advantage in my being here instead of paid up M.P.'s is that the Whips can't come after me!

I feel humbled before so many experts, I feel a little like the seventh husband of the much married actress Zsa Zsa Gabor on their wedding night. I know what to do but how on earth do I make it interesting and different?

My view on drugs and their damaging effect on all sections of society comes from years of voluntary work of all kinds, from around five years at local government level as a councillor and also from politics at a national level.

What I am going to try to do is to cover the history of UK drug policy, both in government and in other sectors of the community. That will lead me, I hope,



to an assessment of where we are now, and some thoughts on how today's situation might be improved.

Wandering the corridors of power

Britain did not have a broad structured drug policy before 1995, although a great deal of work was being done in various ways. In 1995 the then Conservative government conducted extensive consultation before coming up with a policy called "Tackling Drugs Together." This developed and was accepted in Parliament with a good deal of support from all political parties in the House – this was before drug policy became a political football.

The Statement of Purpose was to take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention, to:

- Increase the safety of communities from drug-related crime;
- Reduce the acceptability and availability of drugs to young people;
and
- Reduce the health risks and other damage related to drug misuse.

It is enlightening to compare these goals with those stated by the current government.

Very little was said in those days about "harm reduction" but the government was asked to clarify (by persons unknown) where it stood on the principles of "harm reduction."

Their answer was that "the ultimate goal of drugs policies must be to ensure that people do not take drugs in the first place, but if they do, they should be helped to become, and remain, drug free." The government went on to say that for people who do use, information and facilities aimed at reducing risks should be provided, but that this must be coupled with the unambiguous message that abstinence from drugs is the only risk-free option. They said "The government views abstinence from drugs as the ultimate goal of treatment and rehabilitation services. Harm reduction should be a means to that end, not an end in itself."

The Conservative plan was scheduled to run until 1998, but the Conservative Party did not survive as long as its plan! The New Labour Government entered the stage under Tony Blair in 1997 and expressed itself very keen on tackling the drug problem. Tony Blair's famous mantra was "Tough on crime and tough on the causes of crime." We all know that drugs are not only a crime but also a major cause of crime.



One of the first moves that Labour undertook was to appoint a Drugs Tsar. Their choice was Keith Hellawell, a former Chief Constable. Interestingly, on the eve of his appointment, Mr. Hellawell was given no choice but to accept a deputy, and this late runner turned out to be Mr. Mike Trace. More about him later.

A number of performance targets were made for the new 1998 strategy which was entitled “Tackling Drugs Together to Build a Better Britain.” The targets were very similar to the previous strategy, and included “helping young people to resist drug misuse in order to achieve their full potential in society.” In 2001, things changed at the Home Office. A new Home Secretary came in, David Blunkett, and one of his first moves was to effectively dispense with the office of Drugs Tsar. Mr. Hellawell took up a new and somewhat nebulous post related to International Drug Affairs.

Mr. Blunkett’s Drugs Minister, Bob Ainsworth set about the drug policy and produced what he termed “An updated Drugs Strategy” at the end of 2002. Also in this period a major review of drug policy was placed in the hands of a Home Affairs Select Committee in Parliament, and they were given a fairly vigorous steer by Home Secretary Blunkett in their first meeting, when he announced that he was “minded to re-classify cannabis.” Mr. Ainsworth was not without willingness to make radical proposals; at a conference in Ashford in October 2002. He was warmly received by a predominantly liberal audience when he said that “harm reduction” would be moved to the centre of UK policy. Meanwhile back in Westminster, the radicalism of Mr. Blunkett proved too strong a brew for the former Drugs Tsar, Keith Hellawell. Faced with the announcement that Mr. Blunkett was minded to re-classify cannabis, he gave his response on public radio, which was that he didn’t like it and he was resigning forthwith.

Mr. Hellawell felt that there needed to be a greater focus on the drugs heroin and cocaine, believing that these caused society the most harm. However, he clearly did not feel that this meant one should ignore all the other drugs. We can now see that Hellawell’s early prioritisation of heroin and cocaine has been converted by others into what is almost a policy dominance by them. It is, for example, the situation in Britain now that unless a person is using Class A drugs, they will no longer be funded for residential treatment. Anyone who knew Mr. Hellawell will know that this was far from his thinking.

I am sure he would be aghast at the latest chapter in this story, in which the Parliamentary Science and Technology Committee has suggested a complete rebuild of the classification system. There is nothing wrong with looking at where a particular drug is classified, but when it is known that the new proposal comes from two people - one of whom has long advocated



legalisation, and the other has been severely criticised by leading academics, then we have to view their proposals with suspicion.

And what of Mr. Hellowell's deputy, Mike Trace? With his treatment background, he had no difficulty in finding another post; he worked with both the National Treatment Agency and with the European Monitoring Centre in Lisbon. In due course an even more impressive post came his way, when he was offered the post of Head of Demand Reduction at the United Nations but on the eve of his taking up this post a UK National newspaper broke the story that Trace had been operating and was still operating as part of a pro-legalisation pressure group, Forward Thinking on Drugs, which was funded by George Soros. Trace had to accept that his position with the UN was untenable and he resigned. Since then he has done some more work with the National Treatment Agency, but also holds a significant post in the Beckley Foundation Drug Policy Programme, liberalising "think tank" which – by coincidence – is also funded by the aforementioned George Soros.

Some people would say that they wish he had lived up to his name and disappeared without trace.

Life at the Home Office has been a little unsettled in recent years. Home Office Minister Blunkett felt compelled to move on and Charles Clarke took over, only to suffer misfortunes of his own which eventually lead to his departure and replacement by John Reid. Shuffles at top levels tend to produce shuffles lower down and Drugs Minister Paul Goggins found himself replaced by Vernon Coaker, the present incumbent.

As additions to central government, there are a number of all-party M.P.'s committees on drugs and on alcohol that meet from time to time.

The Home Affairs Select Committee (HASC) of M.P.'s gets involved in major reviews covering several months. Their review of drug policy started after the election in 2001 and concluded in 2002 - and as if by magic they endorsed the opening suggestion minister Blunkett made to them, that he was minded to downgrade cannabis. The then-chairman of HASC now works for The Senlis Council, a European lobby group for legalisation.

The other body working closely on drug policy is the Advisory Council on the Misuse of Drugs (ACMD). This was asked to review The Select Committee's suggestion of downgrading cannabis. It was less than surprising when ACMD did so, in view of at least these 2 reasons:

- ACMD had been pushing for the same thing for years, and



- its membership of around 30 people had no prevention advocates but over a third of them were linked in some way to liberalising interest groups.

I have necessarily said a good deal about the Labour Government's approach, necessarily because it has been in government for the past ten years. But the Conservative Party has been active too, and sadly I have to tell you that I have become disillusioned with the way things have developed on conservative drug policy. It is worth noting that one of the members of the Select Committee which recommended downgrading cannabis and ecstasy, was the new Conservative Leader, David Cameron, who at that time had only been a member of Parliament for barely a year. During the proceedings of the Select Committee, it seems he supported not only downgrading of cannabis and ecstasy, but also the provision of injecting rooms, and other similar initiatives. Prior to his election as Leader, the Conservatives were determined to correct what they saw as a bad move in downgrading cannabis. As soon as Mr. Cameron was elected Leader, this idea was dropped and instead Mr. Cameron suggested we should be looking at injecting rooms as a good idea. To me, these moves sacrifice what the Conservative Party has advocated in the past, and they do not promise a good future.

Finally, there is the small matter of Britain's membership of the European Union. British MEPs are not known for their prominence on drugs policy matters, at least not since the time when Sir Jack Stewart Clarke was rapporteur of the Drugs committee. This short-sightedness may yet come back to haunt Britain.

History outside of government

Britain has always had a vigorous drugs service scene but not always heading in the right direction – you might say they are jolly good at rowing but don't always check the compass.

Treatment and intervention services had a strong voice for their field, called SCODA - the Standing Conference on Drug Abuse, whilst the research area had its own voice called ISDD – the Institute for the Study of Drug Dependency. There was nothing equivalent for education or prevention to be coordinated, so that when the 1995 Conservative strategy "Tackling Drugs Together" was being drafted, it was suggested that the Department of Education should create a similar body for education and prevention. As far as we can tell today, the Department of Health decided that drug policy was their territory, not Education's, and they funded a merger of SCODA and ISDD coupled with an expansion of their brief, to cover education and prevention. The new organisation was called DrugScope; its annual budget ran - and still runs – into millions.



What didn't seem to have been considered in the midst of the major funding of one charity was the possibility that the charity might have strong views of their own about drug policy. In fact, DrugScope fairly quickly emerged as an advocate for liberalisation – in effect attacking the very policy of those who were funding them.

DrugScope were of course not the only NGO favouring a libertarian agenda. The so-called Police Foundation (actually nothing to do with the police) under Baroness Lady Runciman, were heavily promoted in the media as a voice for liberalisation; they were one of the most-recorded voices in favour of relaxing laws on cannabis. Release provides legal advice on drugs matters, but its historic core goal, given that it was founded out of a campaign to legalise cannabis, was and is to do just that. Transform, based in Bristol, has kept going for several years on a small budget and has grown steadily in promoting its unequivocal agenda: "Legalise everything."

A more recent entry to the drug liberalisation field is the Beckley Foundation. Based in London and part-funded by George Soros, Beckley seems to have taken over as the pacemaker on liberalisation debates in the UK, particularly through its subsection, the Drug Policy Programme. A familiar face heads up this programme – Mr. Mike Trace.

Liberalising organisations have often joined together in spreading assertions which damage prevention efforts. For example, they assert that "the just say no approach doesn't work" - apart from this being very debatable, it is a convenient slogan which suggests to the media and others that prevention as a whole doesn't work.

This is reinforced by another assertion, that "you can inform people but you can't prevent their actions" - anti-smoking campaigns are but one example of what a big lie this is (even before you look into health promotion generally, outside of drug use.) For a final example of this cunning game-playing, there is of course the old one that claims "prohibition fails" - any student trying this assertion on would be sent packing by their tutor, and told to get out and obtain the evidence. Getting evidence is a painful process, of course, and it gets in the way of the media's deadline, and therefore rarely happens.

Whilst the liberalisation groups seem to be well resourced and therefore numerous, those who seek to promote a prevention approach and an abstinence focus on interventions and treatment, are fewer in number and struggling for funds. Such groups would include the Maxie Richards Foundation, Hope UK, Life Education, and the National Drug Prevention Alliance.



Media

Undoubtedly one of the biggest influences has been the media. Not content with just reporting drug debate, it has become directly involved, the most notable instance being in 1994 when the *Independent* newspaper campaigned to legalise cannabis. Editor Rosie Boycott was at the front of the charge. How interesting then, that some 10 years later, she admitted to having changed her mind, being especially worried about the stronger grades of cannabis.

Channel 4 ran its own pro-cannabis programmes, and countless others, in print or on screen, echoed this song.

Tony Blair, it is said, always used to worry about what the *Daily Mail* said on any subject - including drugs matters, of course; this was distasteful to those of more libertarian tendencies, and their tactic was to assassinate the *Mail* at every opportunity - a tactic still evident (and audible) today.

Education

Two organising groups for drug educators exist; the Drug Education Forum, and the more elevated Drug Education Practitioners Forum. Interestingly, many of their meetings have been held at the DrugScope offices. Both groups have shown themselves heavily weighted towards libertarian thinking. This attitude is not confined to drug education; it also relates to a sex education discipline, lesson choices and more – the extent of application being more prevalent in some schools than others.

Treatment

In 2001 the government funded the NTA - National Treatment Agency. This has the expected goals of helping drug users whilst lifting the practice standards of workers, but the increasing prevalence of drug use has raised difficult questions about NTA's effectiveness, and possibly also its direction. Is NTA listening too much to the libertarian voices, and has it forgotten that the government strategy is (as it always has been) that "the goal of treatment should be abstinence?" This is said, amongst other places, by HASC in their 2002 report. Another very significant question has to be - why is it that half their budget is spent on buying and distributing methadone; how does this harmonise with the overall abstinence goal?

NTA don't seem to be the only people who have lost their way. At a recent conference, drug workers voted in favour of allowing drug workers to be drug users. They were unimpressed by factors such as the illegality, it seems. I have been told of drug users quitting some agencies and going to others, because the



workers in the first agency just wanted to discuss their own drug use rather than address the drug use which the users had come along to terminate.

Enforcement

There seems to be a distinct split between some senior police officers and the ordinary policemen on the street. The seniors - at least those on the ACPO (Association of Chief Police Officers) drugs committee - advocate a relaxation of drug laws. This is in stark contrast with a conference of the Police Federation in Bournemouth at which 1000 of them engaged in a debate about legalising drugs – they voted 30 in favour and 970 against legalisation.

So, where are we now?

In a mess, essentially. With the exception of workplaces, which have good commercial reasons for encouraging abstinence and punishing use, the majority of the sectors in British society - and those governing society – have been reeled in like a fish on a line, towards liberalisation. I hope this will become more apparent to you from what I have said already, but to summarise what I mean by this, I would say that in my opinion our National Strategy and its delivery have lost their way and are now too focused on enabling users to continue with the least problems for them personally – but almost no focus on the problems that they cause other people. Increases in funding for intervention and treatment are welcome and I would support this principle, but it must be accompanied by a proportionate increase in prevention and a better focus on education; this is certainly not the case at the moment.

It is fair to credit the few but industrious prevention-oriented groups for impeding this decay. Without them things in Britain could have been much worse.

Any thoughts on improvement?

Well apart from us all moving to Sweden, there are a number of things we could do. It is not in my brief to offer a detailed future plan, but it does seem to me that a more successful future plan would include the following:

- A balanced approach for all services
- Much more prevention and prevention-focused education
- Learn from the success of others, regardless of where
- Stop looking for silver bullets
- Inject more sense into the processes, and
- Most importantly, expose and remove hidden agendas.



Then there are the things we can try to do personally. A good friend and colleague of mine Linda Lawrence, who is here today, came up with the idea for a “think tank” called “Kids Count” which I have been privileged to help with in its starting up and launching.

Why did we do this? Because our young people are being let down by politicians, lawmakers, and opinion formers. Our aim is to put policies before these people, relating to young people from birth to 25 years old, on issues such as alcohol and drugs, gun and knife crime, bullying, homelessness, educational failure, sexual abuse, mental and physical health.

You will all, of course, recognise that in many cases the use of drugs directly influences these issues.

I think we will all agree here today that the central plank of addressing these issues has to be prevention and abstinence, not “harm reduction” and acceptance – and we must get this through to the people at the top.

Let me finish by telling you of a cat called Humphrey who lived at No. 10 Downing Street until the Blairs moved in, when he disappeared. The British, being a nation of animal lovers disapproved, so he went looking for a new pet to Notting Hill (a liberal part of London) and saw a pet shop. He saw some beautiful puppies and called the owner to ask what they were. The owner said “these are very interesting and bred as part of a drugs experiment on dogs to show that illegal substances are not harmful. They are ‘Harm Reduction’ puppies.”

“Interesting,” said Tony Blair, “I shall bring Cherie to see these” - which he did about a week later. He said nothing and she looked around and saw the puppies. “Tony what lovely puppies - what are they?” Tony called the owner over to tell her what they were. “These are Drug Prevention puppies,” he said. Blair said, “But you told me that they were ‘Harm Reduction’ puppies.” “They were,” said the owner,” but now their eyes are open.”

Thank you.



United Nations Drug Policy and UNGASS 2008

SANDEEP CHAWLA, PhD

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Dr. Chawla challenges the notion that there is such a thing as “a UN Drug Policy,” given that 193 sovereign states are involved. Conventions are widely respected and honoured, and cooperation between nations is to some considerable extent achieved, albeit not universally. Changes in drugs abused – or in the nature of drugs already known – suggest intelligent review of the Conventions is justified, but the nature of change is far from clear. An evaluation of UNGASS achievements since 1998 is offered.

This is a fairly difficult subject to address. I have been asked to deal with UN Drug Policy and UNGASS 2008, UNGASS stands for a peculiar abbreviation for the United Nations Special Session of its General Assembly on countering the drug problem together which was held in 1998 and there is meant to be a 10 year review in 2008. But what concerns me and what I would like to start with is the first part of what I have been asked to speak on – the UN Drug Policy. I should start by posing the question is there such a thing? If there is I am not aware of it and I work for the United Nations. Let me try and characterise this or what people mean when they speak of UN drug policy and try and trace the contours of the beast.

The analogy of the beast is appropriate – it reminds me of a very famous and very ancient parable which many of you will have heard in many different versions because it comes out of so many different cultures.

The parable concerns six blind men who had never seen an elephant yet wanted somehow to get an idea of what the elephant was. And so, being denied the sense of sight and having the sense of touch and smell they were all put in front of an elephant and each one was asked to touch and feel the elephant and try to develop a characterisation. They developed six characterisations. The one who touched the side said the elephant was like a wall. The one who touched the leg said it was like a tree. The one who touched the trunk said it was like a snake. The one who touched the tail said it was like a rope. The one who touched the ivory tusks said it was like a spear, the one who touched the ears said the elephant was like a fan. Now there you have it – what is UN Drug Policy, is it simply – and the moral of this story of the parable is that the nature of the whole object is much more and quite different than the sum of its parts.



This story also illustrates for me, and I hope to be able to put this across, the fundamental paradox of the United Nations. Is the United Nations the sum total of its individual parts? Its individual parts are 193 sovereign states members, is it the sum total of these individual parts? Is it merely a mirror of its membership, is it something more? If so, what? I choose to believe, having worked for this organisation for a very long time, that it is a great deal more than simply a mirror of its membership – but what that more is, is extremely difficult to define because in popular debate and popular perception there are two polar extremes. Some people, detractors of the UN, have for the last 50-60 years maintained that it is an insidious attempt at creating a world government. Others on the other side maintain that the UN is nothing more than the passive reflection of the will of its individual member states.

Now, clearly there is something between these two extremes. Clearly there is some sensible way for this organisation to proceed in the world that we live in; the way I choose to see it is that the UN is nothing more than an ongoing attempt, 50 or 60 years old now, to resolve the basic paradox of our international system, of the world as we are organised in it, and that is the paradox of 193 sovereign nation states; some big some small, some rich some poor, some powerful some not very powerful; a lot who can control their national territory and some who can't, and representing interests which sometimes converge and sometimes diverge in quite different directions, but every single one of these 193 nation states is sovereign. That is the one thing that they all have in common and that is the one thing that they all try and maintain - their essential sovereignty.

Now if you have 193 different sovereigns, who can adjudicate between even two sovereigns? God perhaps. Not the UN, but God. In other words the only way to proceed pragmatically in this situation is to try and create a space, a reasonable working space. And that is precisely what the UN can do, should do and does do. It creates the space within which the diverging interests of the membership of the UN can be managed and also create the space in which the converging interests of the membership can be expanded.

Drug Policy is nothing more than an attempt to allow for that convergence between the interests of member states to be expanded. I don't think I need to explain to this audience the history or the rationale of the International Drug Control system. It is well known to all of you. It is based upon three International Conventions. It is a working system in terms of International exchanges and you are all familiar with the way the system works. Just to capture it in very broad contours, since these are international conventions which enjoy an almost universal adherence.

Drawing the analogy from individual governments, the closest one may come to characterising the system is, it has a parliament or a legislature of a fashion, the members of this legislature are the sovereign member states of the world represented in the General Assembly, or as far as drugs are concerned in a body called the Commission on Narcotic



Drugs. It has something like a Judiciary without judicial functions which is called the International Narcotics Control Board, some members of which are here and some staff of which are in this room. It has something like an Executive, but again, I hesitate with the word “Executive” which is supposed to be my organisation, The United Nations Office on Drugs and Crime, (UNODC). And it has something like an international collection of expertise in the areas where drug control is the first principle - which is Public Health represented through the World Health Organisation (WHO), which contributes its public health expertise to discussions on the way in which the drug problem is legislated against or dealt with.

Now, this is the first principle of drug control – indeed the protection of public health to try to ensure that drugs are available for medical and scientific purposes and not available for purposes other than those. The rationale of this system is also quite clear. It is a global problem – in the sense that drugs flow across frontiers, consumer patterns flow across frontiers, illegal money to finance the trade flows across frontiers. A solution taken at a purely national level within one country has no chance of success whatsoever and therefore there is a global system to deal with this.

Now the system is time tested and fairly old - the three International Conventions date from 1961, 1971 and 1988. The basic structure is with the 1961 Convention and is now nearly half a century old, things have changed, the world situation, patterns of consumption. The kinds of drugs and the way in which they are dealt with have changed and occasionally you need refinements of the system to keep it running. One such set of refinements was made in 1998 when a special session of the UN General Assembly came together to try and look at areas where specific refinements could be made to the system and I’ll spend the second half of my presentation on this event - UNGASS and what we make of it ten years down the road.

Before I go on to that, I’d like to spend 5 minutes on trying to raise a fundamental question about this system of conventions by which an international control system operates. What are, from the point of view of an insider working within this and keeping these conventions going, what are its strengths and weaknesses? I would point to two strengths and two weaknesses.

The most fundamental strength of the system is its multi-lateral nature. In other words, it is developed by all member states of the international system collectively, within a multi-lateral system which means they are all party to it, they all accept a common interest and a shared responsibility to the extent that they need something common to deal with it. The second strength is related to this and draws from it. For the UN drug conventions, adherence by member states – in other words ratification – is almost entirely universal. Practically every country in the world has ratified the three conventions with a few exceptions to individual protocols. This really shows you the strength and the power of the system that all the legitimately constituted governments of the world are willing to subscribe to a common system, to a common set of laws, rules and regulations. These they accept because the unique nature of these conventions is that they have a certain



obligatory element which is not always present in other instruments of international law. And the obligatory, the mandatory element, is that once a country signs up to it, it is obliged to make sure there is no conflict between its own national legislation and the principles of the drug conventions.

This question of the mandatory nature of the conventions brings me to the two weaknesses of the system. The biggest weakness of the international control system is cannabis. What do we do with cannabis? This is a weakness which has surfaced over time and has now assumed the status of a problem, which really makes the system vulnerable and needs to be addressed by all of us collectively and quickly.

Cannabis, as you know, is controlled under the 1961 convention in the international control system and the scope of control is the same as it is shall we say, for heroin or cocaine. Through the 1970s and 80s, there appeared across the world in different countries and different environments some sort of a difference of opinion about cannabis. Some countries began to break ranks from the consensus expressed within the conventions. The spirit of these conventions was challenged particularly as far as cannabis was concerned. The letter of the conventions was maintained but in some countries, in some areas, cannabis either began to be treated as something for which a new category of discourse was created – a soft drug rather than a hard drug. And in addition to this, the other thing which began to happen increasingly through the 1980s and 90s was that government policy and public opinion began to diverge on the question of cannabis.

Governments were saying one thing; public opinion was going in another direction. And a lot of the debates in the drug field were very often made extremely acrimonious by this ongoing problem of differences in perceptions between what government was expressing, what the conventions were expressing and what public opinion believed to be true – partly as a result of the efforts of some of the groups that were advocating liberalisation of drug policies.

Now, what's the situation now? In June of this year, my organisation produces its annual flagship publication called The World Drug Report. We produced the one for 2006 – we devoted a special chapter to cannabis drawing attention to this problem. In this chapter on cannabis we had primarily three arguments, the first one was that under our very eyes, over the last twenty or thirty years, the nature of the substance available on the market place had changed. If you go down the street in London to buy yourself a joint of cannabis today, you are very likely to be buying something very different to what was used at the time of the Beatles. It is much stronger, much more potent, and therefore the public health risk is much greater than it was before.

The second argument was that now, for the first time, we were beginning to get evidence from some countries and some markets that where earlier people hadn't presented themselves for treatment or emergency room episodes for cannabis, they were now beginning to do so because the substance was that much more powerful. And the third



argument, most difficult one of all, was that we had to – as the United Nations Office on Drugs and Crime, as the repository of all this data and information on drugs, we had to admit to the world, somewhat shamefacedly that we knew far too little about the cannabis market. About the drug itself, about the size of production, about how many people were consuming, about the way in which the market had changed, and unless we got this evidence together quickly it would be very hard for the world at large to take an informed, evidence-based policy decision on cannabis.

Now this was greeted in public discussion in different countries in very different ways. It became a factor of national debate in some countries....so evocative, but essentially what it pointed to was the need to do something about this and to address the problem of cannabis much more seriously than we had dealt with it before. Because it does create vulnerability and a weak spot in the international control system which we are all committed to supporting. For how we deal with it, I do not know. I do not profess to know and I will not offer any answers at the table. We clearly need to adjust the conventions to deal with this challenge. How we do it, as I said, I do not know.

Some people advocate changing the conventions, some people advocate staying with them as they are and merely making adjustments to them. We don't advocate one thing or the other, because as the UN, we have to try and reflect collectively the wishes of our membership. We have a lot of experience and a lot of expertise, almost a genius, I would say at finding consensus where there is very often very little. We've been doing it as an organisation – that's what we are supposed to do. But the one thing we can't do, we cannot convert divergence into consensus and there is in our membership, in the membership of the UN, there is divergence on these issues. We need to resolve that divergence, otherwise, we will not move forward and we will stay caught in a vicious circle of an international system which works – but only just, and we need it to work much better.

The second problem that I'd like to illustrate, as far as the limitations and weaknesses of the control system as we know it today, is the problem of ways of dealing with the different dimensions of the drug problem. I will not speak about prevention specifically here because all of you have a great deal of expertise on the subject and I think all of us are agreed that there is no better way of treating the problem than to prevent it. I think that is common sense and that doesn't need to be asserted. In the whole drug field, there continues to be sometimes the perception of an internal conflict between strategies which tackle the supply of illicit drugs and the strategies which tackle the demand for them.

Let me express it to you this way – how do we face a situation such as the following: We tell a farmer in the Rif in Morocco that we will eradicate his livelihood because he happens to grow cannabis and do what, in popular parlance, would be cutting a poor man's stomach. We have nothing to answer this farmer if he tells us "why are you eradicating my livelihood," when you can walk into a legitimate coffee house shall we say in downtown Amsterdam and consume without the consumer or the seller being in any way punished for this transaction?



Now all of you are familiar with this example – why I've stated it is because it continues to represent the fundamental divergence in this field. Where the response has always been, yes, an effective drug control policy necessarily implies balancing supply with demand – balancing strategies to reduce supply with reducing demand. The problem with this is not that it is not true, it is absolutely true. It is perfectly valid. It's been said now for thirty years and unfortunately the perpetual statement and restatement of it doesn't make a great deal of difference to moving the debate forward because it gets caught in perpetual slinging matches of divergent national interests. Country A has a producer problem, Country B has a consumer problem; Country C has a transit problem of drugs going through them. And most of the time, most international exchanges on drugs happen when Country A says its problem is driven by Country B. Country B says its problem is sustained by Country A. Both Country A and Country B blame Country C for being the transit area through which the drugs go and a lot of international exchanges end up stopping here. I think we need to do more.

The only way we can do more is if we use all of the new studies and literature developing all across the world about how we can tackle epidemics, how epidemics actually progress and how we can ensure that our interventions come at the right point – the appropriate point. For example, everybody is aware of the fact that epidemics go through phases in which they go on an upward trend, they plateau at a particular stage, they go downward afterwards and there are feedback loops in these epidemics.

If you try and have a lot of treatment at the beginning of an epidemic, it's pointless because there are not a large group of users. If you have a lot of enforcement at the beginning of an epidemic, it's very effective because it deters people. By the same token if you have too little treatment and too much enforcement at the plateau stage of an epidemic, it's not very helpful. You need much more treatment and much less enforcement. We don't always plan these interventions in the appropriate sequence and we continue to compartmentalise the field into either geographical categories or thematic categories. We say something is a problem of a particular region or something is a problem of treatment or prevention or of enforcement.

What we need to do is to pull all of this together into a set of sequenced interventions going well beyond the limitations of geographical or sector approaches to the drug problem. Unless we do this, the system will continue to suffer from these crucial weaknesses.

Finally, to the last bit of what I wanted to say on the UNGASS 1998 Special Session of the General Assembly of the United Nations. This session adopted a political declaration of all the member states present to intensify efforts to solve the drugs problem, to have by 2003, enhanced demand reduction strategies in place and to have for these strategies measurable results by 2008. It also agreed to eliminate or significantly reduce the cultivation of coca, cannabis and the opium poppy. The Special Session adopted guiding principles for demand reduction – the first time this was done internationally. And it adopted a set of action plans and strategies to tackle the problems of the amphetamine



type stimulants, of pre-cursors, against money laundering, in favour of judicial cooperation and in favour of eradicating illicit cultivation and having what a peculiar term in the UN has always been, “alternative development.”

The Special Session reiterated to all principles of drug control, a holistic approach - balancing supply and demand as I’ve just discussed and the idea that everybody, every country, had a shared responsibility to deal with the problem. It articulated three new ideas new to drug control and those are the ones which will concern us in 2008. The first new idea was that it adopted fixed goals and targets in each sector that it dealt with. The second new idea was to measure progress. To measure results against a given target needed more data, more evidence and policy was meant to be based more upon these things than it had been traditionally. And the third thing that UNGASS argued for was that policy and interventions had to be evaluated. Now these three new things are what is going to drive the process forward in 2008. And that is the last question I am going to address.

How do we deal with the assessment of the decade 1998-2008, and how will this assessment be done? There are lots of different views at the moment within the membership of the UN; many views are being advocated and a lot of discussion is going on. A process is forming, is consensus based, and I can tell you something about the raw contours of that process.

There are two ways to evaluate progress between 1998 and 2008. The standard way is to evaluate the process. What was the process by which international cooperation for drug control was enhanced and expanded - and for that, there is an existing instrument and a way of evaluation which is ongoing? Member states of the UN represented in the Commission on Narcotic Drugs designed a questionnaire which goes out to all member states, all signatories to the conventions every two years, and the last cycle of it will happen in 2008. This is called the Biennial Reports Questionnaire in the peculiar and arcane UN terminology, and governments report back on what they have done under the UNGASS goals and targets over the last two years. An assessment report will pull all this together but it is a process assessment it is not an outcome evaluation.

This is the second thing which needs to be done, and that is to evaluate the outcomes of drug policy over the last ten years – this is very difficult indeed. There are three places where you can evaluate outcomes. One is to use the best measure we have so far – it is not perfect, it is far from perfect but it is the best and only workable measure we have so far for assessment of outcomes and that is to look at the prevalence of drug abuse in the world at large. The only measure we have for international comparison is annual prevalence – the number of people who have consumed a drug in the 12 months prior to the time of the survey.

There are some limitations with this. The first and biggest limitation with prevalence data is we have no baseline data to measure against. We do not have a fixed absolute estimate, that in 1998 the number of drug abusers in the world was “X” million. We have an



estimate – it was about 180 million people but it was an estimate. Unless you have a baseline, it's very difficult to measure a trend. We have order of magnitude calculations but we don't have categorical ones. We have another difficulty with annual prevalence – it doesn't really get to the heart of the problem because the heart of the problem is often concealed as problem drug use or hard core drug use and for that we do not have any real numbers worldwide – our latest estimate from the UN was 25 million problematic drug users worldwide but it's not a very robust number. The third problem is prevalence does not measure the consequences of illicit drug abuse. It does not measure injecting drug use. It does not measure the diffusion of HIV/AIDS. It does not measure crime. It does not measure the collateral effects of drug abuse and that is again a particularly difficult question. So yes, prevalence measures are available and outcome evaluations must deal with prevalence and we will try and pull them together globally to the best we can but we have to be aware of these limitations.

The second question which can deal with an outcome evaluation is to evaluate the effectiveness of policy; this is also particularly difficult, it's very hard to do. I spoke earlier about the problems of epidemics and feedback loops, there is in a certain sense a cyclical nature to these things because feedback loops tend to change the trajectory of an epidemic all the time and we have sometimes real difficulty with measures of policy effectiveness, particularly dependent upon the time the evaluation is done.

If you evaluate a particular policy when an epidemic is on the upswing, I think it is common sense to conclude that any policy at that time will be deemed a failure. If you evaluate a policy at a time when an epidemic is plateauing, or coming down, by definition any policy will be a success. The problem is to track the relationship between the policy and the spread of the epidemic. All of us are familiar with this not, only in the drug field, but in the field of economic cycles. Very often elected politicians come into government at a time of the economic cycle when it had nothing to do with their particular government and yet if the cycle is on the upswing they benefit and if the cycle is going downward they lose from it. Now this is something which is part of the nature of the system and needs to be looked at when we deal with this very difficult question of evaluating the effectiveness of particular policies.

Finally - the third area, which is the question of actual documentable successes in reducing the supply of illicit drugs. We have had documentable successes in the Golden Triangle, in the Andean countries with the coca cultivation, and with the cultivation of opium in the Golden Triangle – these can all be documented. These can all be upheld and maintained as genuine outcomes of our policies, with two limitations, and that is that a supply side policy success in one area is no guarantee against the displacement of the problem to another area. And in the drug field, the production side you are familiar with this, and the other I spoke of earlier; of fragmented interventions where we will deal very well with the problem in one area, in one country but we won't deal with all of the other things that we should be doing to make that a success. For instance, dealing with prevention or treatment or demand all across the spectrum of that area and that I already offered an argument for sequenced interventions which we need to deal with.



So in short at UNGASS, at the review in 2008, we are bound to be asked the question by everybody at large in the world “well did the drug problem get better or did it get worse over the last ten years?” I am not a politician, so I cannot give you an answer which a politician would give – but I can give you an answer of the most measured and balanced kind that I can offer with all the evidence and data that I have to deal with.

Number one, the question is too big and too complex to allow for an unequivocal answer. Number two, the drug problem indeed did get better in some areas, but indeed it did get worse in others, and that is as fair and honest and balanced an assessment that can be offered at the moment. There is one way of tackling it and that is to say the one point which we have tried to maintain in our official publication in the World Drug Report 2006 and in our various public utterances. This is to develop an argument that “we may not have solved the drug problem but we have certainly contained it.” And we have contained it to less than 5% of the adult population of the world. This is no mean achievement and there are various ways in which you can compare and contrast this. The best example to be offered as a comparison would be if you compare this with the relatively unregulated open market for tobacco, where annual prevalence for tobacco consumption covers about 30% of the adult population of the world – illicit drugs is no more than 5%. But for the control system, that 5% would probably have been much greater.

This argument doesn’t only apply to the ten year period, and this is something which is very important to maintain, and I’d like to conclude with. The UNGASS decade 1998-2008 is important but it is only symbolically important. Drug control was around for 100 years before and will probably be around for a long time after, therefore our focus ought to be on more than just that one decade. And if we turn the focus to half a century or to a century, then the argument of containment becomes even more powerful because if we track drug control or the drug problem from the beginning of the twentieth century to the beginning of the twenty first century, then there is very good reason to believe that it has been contained. It could have been much worse *but* for this control system. I think some of you are familiar with the analogies which we have put up several times before, but I put up just two of them (again).

In 1909 total opium production in the world was 30,000 tons. At the moment in 2006, total opium production – illicit as well as legitimate for medical use – is 5,000 tons. In a world six times larger population-wise, the total production of opium from which you make heroin is six times less. This is the best argument I can offer for a long term containment of the problem. You can use some of these other data from 1909 that would be looking at consumption, looking at other data, but in this sense containment is an unequivocal success and it needs to be maintained.



Prevention, Treatment and Justice: The Emerging International Consensus Against Drug Legalisation

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Director Walters describes U.S. progress against the international background. The undercutting effect of so-called harm reduction on prevention-based policies is reviewed. Specific U.S. progress relates to all drug services – prevention, education, treatment, enforcement and research. Student drug testing is described, as is America's cooperation with other countries, not only in policy/practice, but in the key activity that is precursor trafficking.

Introduction

The United States realises that the problem of drug trafficking and abuse threatens not only our society, but also those of our neighbours across the globe. Challenges abound in our international efforts against drugs and there is much work to be done.

I would like to thank the many organisations that have come together to address the world drug problem today: MOTGIFT International, European Cities Against Drugs (ECAD), London Drug Policy Forum, the Institute on Global Drug Policy, the International Scientific and Medical Forum on Drug Abuse, Drug Free America Foundation, Inc., the Drug Prevention Network of the Americas, and the International Task Force on Strategic Drug Policy. It is organisations such as these who have demonstrated that balanced policies, sustained over time, work to control and reduce the drug problem.

Global drug threat

In June, the UN released its annual World Drug Report, providing policy makers with a good barometer of the current status of the worldwide drug problem. This year the UN reminded us that the world has much lower levels of drug cultivation and drug addiction than 100 years ago. Since the Political Declarations at the UN General Assembly Special Session on Drugs (UNGASS) in 1998, we have seen improved international efforts to fight against illegal drugs.

The latest UN World Report states that a “global blind-spot has developed around cannabis.” We agree. Marijuana potency has dramatically increased over the last 15



years. Today's marijuana is at least twice as strong as it was in the mid-1980s. Our National Institute on Drug Abuse found that the average levels of THC in marijuana seized in the United States has doubled between 1985 and 2003. New indoor growing techniques have now raised the average THC content of marijuana seized in the United States to around seven percent, with some strains containing as much as 20 percent THC. Marijuana use in the United States fuels treatment demand among teenagers, impairs driving, and is fostering the growth of acute health episodes, leading to increased mentions of marijuana in emergency room visits. Scientific studies are also now documenting the links between marijuana use, mental health issues such as schizophrenia, thoughts of suicide, and depression.

Indeed, the widespread perception that marijuana is a benign, natural herb seriously detracts from the most basic message our society needs to deliver: it is not OK for anyone - especially young people - to use this or any other illicit drug. In fact, efforts by governments to lessen the penalties for cannabis, advocate for its so-called “medical use” have confused young people by sending a message that cannabis is not a serious drug of abuse.

It is no longer acceptable to base drug control policy on anecdote and press sensationalism. It must be based on fact, science, research and evaluation. But above all, our efforts rest on an unwavering commitment to reduce drug use and its consequences.

Other nations have harkened to voices that all too often amount to a counsel of despair. Under the rubric of “harm reduction,” they suggest we abdicate our responsibility to fight against the suffering caused by the disease of addiction.

The U.S. remains committed to fighting the drug problem and believes that the legalisation of marijuana is not the answer. Rather, the solution lies in prevention and treatment through well-researched scientific evidence. More children use marijuana than any other illicit drug, by far. Many of them are in search of the “natural high” their friends promised and think that marijuana use is only “harmless fun.” They don't realise that the purchase and use of this illicit drug can have negative consequences - triggering acts of violence that shatter lives and affect communities close to home and around the world. Unfortunately, marijuana is still readily available in drug markets throughout the United States.

Continued value of UN drug conventions

The global threat posed by illicit drugs requires a global response. The unity we seek exists in the form of three international agreements known collectively as the UN Drug Conventions - which carry the force of law: the 1961 Single Convention on Narcotic Drugs as amended in 1972, the 1971 Convention on Psychotropic Substances, and the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances.



There is no question that the overwhelming majority of our nation's bodies support these agreements and reject actions that are incompatible with them. For instance, the International Narcotics Control Board (INCB), guardian of the Conventions, has consistently rejected programmes such as government-approved or supported injection rooms, government fostering or sustaining injection drug use, and the dispensing of drugs for anything other than medical or scientific research purposes - consistent with standards for ethical treatment of human subjects. The question is not whether our pledges are supported - I think we all know that they are, the question is whether we can expand our partnership to make it even more effective.

With hard work, we have developed a strong international consensus that the drug trade threatens all nations and it is the mutual responsibility of all states to combat drug cultivation, trafficking and use as mandated by international law. In 1998, the heads of governments of the United Nations met at the General Assembly in New York. They set out to stress the importance of demand reduction as being an integral part of a comprehensive drug control strategy and gave more prominence to prevention, treatment and rehabilitation. UNGASS also called on the States to implement diverse efforts including: information and educational awareness, prevention, treatment, consideration of alternatives to incarceration, data collection, and research.

U.S. progress in reducing drug use at home

In the U.S., we have experienced a significant reduction in use drug use over the last three years – “past month cannabis use” rates falling 18 percent, overall use of any drug down 17 percent. These are declines that we haven't seen in a decade. Strikingly, youth use of methamphetamine fell fully 25 percent. Even more compelling is the decline of MDMA (Ecstasy) which plummeted by 60 percent between 2001 and 2004.

Through a balanced drug control strategy, we have set goals to reduce teen drug use by 10 percent in two years, and 25 percent in five years. We exceeded the two-year goal, with an 11 percent reduction and over the past three years there has been an historic 19 percent decrease in teenage drug use. The U.S. National Drug Control Strategy takes a long-term, holistic view of the drug problem and recognises the devastating effect drug abuse has on the country's public health and safety. The Strategy maintains that no single solution can solve this multi-faceted challenge. Our efforts include:

Investment in treatment

The U.S. spends \$3.5 billion a year on drug abuse treatment and research. This does not include the additional funds spent by state and local governments and private individuals. We have embarked on a new programme that seeks to make our treatment system more accessible, accountable, and effective. Using vouchers that empower individuals by allowing them to choose amongst various drug treatment programmes, including Faith-Based programmes, President Bush's “Access to Recovery” initiative is intended to serve



some of the approximately 100,000 individuals who seek drug treatment each year and are put on a waiting list or are otherwise unable to get help.

Addiction research

We have learned that addiction is a fundamental disease of the brain, according to the best medical science. It is a disease caused by repeated drug use. Science and extensive experience also tell us, however, that drug use is both a preventable behaviour and one that we can intervene against and stop. We need effective drug treatment resources that lead to full recovery and re-integration into society for millions (of individuals.)

Screen and intervene

We also have drug screening and intervention programmes as part of the nation's existing network of health, education, law enforcement, and counselling providers. Focusing on this nexus is cost-effective and limits the spread of drug use by individuals who are in the early stages of use, before the negative effects of continued use and addiction are compounded. Early intervention interrupts the continued worsening of a person's drug use trajectory, getting them help at a time when that help is most likely to be successful.

Media campaign

We implement effective prevention campaigns, turning young people away from a life of drugs at moments when they are most vulnerable. Exposure to anti-drugs advertising has had an impact on improving youth anti-drug attitudes and intentions, and increasing perceptions of risk in drug use. Among all three grades surveyed, such ads have made youth view drugs less favourably and less likely to use them in the future.

Student drug-testing

The disease of addiction spreads from non-addicted users, from peer to peer. Schools test for tuberculosis and other communicable diseases because of the public health threat; testing for drug use extends those same protective factors. Parents, school administrators, and educators are not powerless against the drug problem. Random drug testing of high-school students give students who are under peer pressure from drug-using peers an excuse to say “no” and provides parents with help in keeping their children drug-free. Random testing deters students from using dangerous, addictive drugs, and identifies those who may need help or drug treatment, early and in a confidential way. It is a powerful public health tool and just one component of a school's overall drug prevention programme.

In addition to deterring the spread of drug use, this testing is non-punitive - positive test results are never provided to police. The goal is to both serve as a deterrent and to identify and get help for those early in dependency. It is not a “one size fits all”



programme or a federal mandate - communities and schools need to build unique programmes to meet individual challenges.

In the U.S., random testing for drugs in schools has not discouraged extra-curricular participation. In fact, high-schools with Random Student Drug Testing programmes exceeded the state average, both for test scores on the state-mandated graduation test and for the graduation rates themselves. In addition, 46 percent of schools with Random Student Drug Testing programmes reported increases in student participation in athletic activities and 45 percent reported increases in extra-curricular activities.

Drug courts

We use the criminal justice system as an ally in achieving treatment referral and recovery, enlisting the power of the courts to effect supervised treatment rather than jail. Drug Court programmes reduce recidivism. A National Institute of Justice study compared re-arrest rates for drug court graduates with individuals who were imprisoned for drug offences, and found significant differences. The likelihood that a drug court graduate would be re-arrested and charged for a serious offence in the first year after graduation was 16.4 percent, compared with 43.5 percent for non-drug court graduates. By the two-year mark, the recidivism rate had grown to 27.5 percent, compared to 58.6 percent for non-graduates. Today there are 1,621 Courts currently in operation in all 50 states - an increase of more than 400 courts just in the past year.

U.S. support for international drug control

UNGASS goals recognise that we need both domestic and international efforts to stop the widespread damage to our communities caused by the production, trafficking and consumption of illegal drugs.

In the U.S., we have waged a battle against those who produce and traffic in drugs, against the narco-terrorists who destroy nations, and against the street-corner pushers who destroy neighbourhoods and families. We support more international supply control efforts with a strategy to target networks by attacking entire business sectors, such as the transport sector. The strategy includes destroying the economic basis of the cocaine production business in South America by fumigating the coca crop, seizing enormous and unsustainable amounts of cocaine from transporters, and selectively targeting major organisation heads for law enforcement action and, ultimately, extradition and prosecution in the United States.

No nation has done more to control illicit drugs than Colombia. Colombia is a country being freed from decades of narco-trafficking and narco-terrorism. We are seeing the restoration and the expansion of democracy, the rule of law, and human rights. Further, we are witnessing the economic revitalisation of a nation too long under the threat of drug organisations that threatened the country's future. After years of steady increases, cocaine production in the Andes is - for the third straight year - headed in the right



direction: down. An aggressive programme of eradication has cut Colombia's potential cocaine production by one third since the inauguration of President Uribe in August of 2002.

The Karzai government in Afghanistan has made remarkable progress to reduce opium cultivation through sacrifice and courage. The CY2005 annual U.S. Government estimate for opium poppy cultivation in Afghanistan shows that approximately 107,400 hectares of poppy were cultivated during the crop season in 2005 - a decline of 48 percent over the 2004 level. The decrease in poppy cultivation was widespread, four of five regions, nineteen of Afghanistan's twenty-six poppy growing provinces down from 2004. Eight provinces had no visible poppy cultivation. A reduction in cultivation is attributable to several factors including voluntary restraint by farmers. What is most important to remember is that farmers are not getting rich.

The path our nations support in the Conventions, to which we are bound ourselves, is the right one. Let us here use that unity to move farther and faster against our common threats. When we push back against illegal drug use, we help to establish these fundamental principles more securely for all our nations.

This is a tough fight that is not yet over, but we are on the winning path, and surely the fight must not be abandoned now. At stake are Columbia's and Afghanistan's futures, as well as the well-being of many other nations in these areas of the world.

Control of precursor chemicals remains a challenge. In conjunction with our efforts, key international bodies like the Commission on Narcotic Drugs and the 1998 UN General Assembly Special Session (UNGASS) have addressed the issue of chemical diversion. With the exception of cannabis, every illicit drug requires chemicals in order to be refined to its final form (e.g. the coca plant to cocaine, the poppy plant to heroin), or is purely a result of chemical synthesis (e.g. methamphetamine, MDMA, etc.) Chemical control offers a means of attacking illicit drug production and disrupting the process before the drugs have entered the market.

International efforts to control precursor chemicals are key. In March 2006, the United Nations Commission on Narcotics Drogues (CND) adopted a resolution, proposed by the U.S. and sponsored by a number of nations, on international cooperation in the control of pseudoephedrine and other precursor chemicals used to make synthetic drugs. According to the agreement, the United Nations Commission on Narcotic Drugs accepted voluntary provisions that will assist the international community in the oversight and regulation of precursor chemicals.

The diversion and abuse of pharmaceutical narcotics, depressants, and stimulants are another challenge we face. Surveys show that the non-medical use of prescription drugs, particularly narcotic painkillers, continues to rise in several populations. Because they are legal and have legitimate medical uses, prescription drug abuse poses a different threat than that of illegal drugs and therefore requires a unique strategy. Prescription drugs are



increasingly acquired over the Internet, often without a doctor's supervision. What is needed is continued improvement in the surveillance of practices like "doctor shopping" coupled with more careful and responsible medical oversight, preserving legitimate access to needed medicines while at the same time deterring unlawful conduct.

Conclusion

As noted in the UN World Drug Report, there has been great progress in our global fight against drugs. But we still have much work to do. Part of this work is continuing to make a case for drug control and to counter the voices of surrender. Experience demonstrates that balanced policies, sustained over time, work to control and reduce to drug problem. "Harm reduction" initiatives that encourage or facilitate drug use will inevitably lead to more drug addiction and more despair for our most vulnerable citizens.

We have much to be proud of over the past ten years, and much more to accomplish in the next ten.

Thank you for your continued work against drugs and for the opportunity to address you today.



Tackling Drugs on the Supply Route: An United Kingdom Perspective

LESLEY PALLETT

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The Foreign and Commonwealth Office (FCO) has a wide range of issues to address which are related to drug production, trafficking and consumption. The FCO recognise that a holistic approach is the only strategy. International cooperation has to be intelligence-led rather than intuitive. As well as enforcement agencies, the FCO works with academia and research bodies. The Serious Organised Crime Agency (SOCA) has proved a significant addition to the total resource.

Phrases such as “from source to street,” suggest two neat circles on the map - one point of origin and one destination for drugs. However, as we all know, this simple catchy phrase belies a very complex issue - UNODC has put the value of the worldwide drug trade at \$321 billion - which is felt in all of our societies, from a security, to an economic, to a social impact.

So, although traditional perspective has been that tackling drugs and crime is a domestic issue, the international nature and extent of organised crime has shown that this is no longer appropriate. It affects all countries worldwide, and as such, we have to engage internationally as well as domestically.

The UK has engaged seriously in tackling the supply of drugs at every stage along the supply chain. We employ a variety of techniques and mechanisms to engage at diplomatic, operational and practical levels. We know all too well that only a holistic approach has any chance of success. We cannot do this alone, and need to work with key partners, not just in the UK but externally too.

So, who is involved in tackling organised crime (OC) in the UK? There is a range of departments and agencies - Home Office, CPS (Criminal Prosecution Service), Customs, police, SOCA are the obvious ones. But think also of MOD (Ministry of Defence) because of their involvement in peacekeeping, including the rule of law, in places such as the Balkans and Afghanistan; DFID (Department for International Development) because of their work in developing institutions and the rule of law in poor or post-conflict countries, and HM Treasury, who have the lead UK government interest in regulation of



the financial sector and tackling financial crime in its broadest sense. Not to forget the FCO (Foreign and Commonwealth Office) - we can add our country-specific knowledge to the analysis and suggest what levers can be pulled to make a difference. We know what are the wider issues in the UK's relationship with a particular country or region and we can suggest how best to improve the situation. OC has been identified as one of the FCO's nine strategic priority areas governing its work around the world.

What does our strategy comprise? We need to recognise the issues for the source and transit countries. At a very basic level, criminals need to get the drugs from the source country to the consumer and they are endlessly creative in finding routes to beat law enforcement's efforts. Failed and failing states are easy targets for criminal activity and they may simply not see it as "their" problem and so take little or no action to tackle it.

In order to tackle this, we need to engage at a number of levels, which are co-ordinated and send a consistent message. One key interaction is via diplomatic/political engagement. We need to encourage the political will to tackle organised crime, to include encouragement and to pass relevant legislation e.g. AML/POCA (Anti-Money Laundering/Proceeds of Crime Act). We emphasise that this impacts on our relationship with that country, and need both to address the crime and the impact on the law-abiding communities that the supply route has on the country itself and the UK.

We put a lot of emphasis on capacity building. This is a joint problem and needs joint working to ensure a joint solution. We need to help countries develop their expertise at a practical level to have a law enforcement capability which can adequately address this challenge, and reduce the impacts on each individual country on the supply route.

It is essential that transit countries see themselves as partners in tackling criminal activity, with necessary legislation, resources, etc. We can help with expert advice. Many of the key countries through which drugs and crime pass, simply do not have the capacity to fund the development of the necessary skills. DCF funds projects as diverse as infrastructure for border check points on the Bulgarian/Turkish border, computer software training for police in Latin America, maritime interdiction in Caribbean, effective court systems in Pakistan, border controls and cooperation on the Tajik/Afghan border, UKSAT, Ionscan in Caribbean & Pakistan, container profiling in L.A. (These initiatives are done in partnership with the host country, our own LE agencies and other key partners in the region.)

Operational cooperation is another essential tool. UK has a network of over 160 LOs around the world, who work with host & partner LE agencies to share intelligence and support operational actions against criminals. To make an impact in transit countries, it's clear that we have to focus on key gangs and HVTs. No point in taking action only against the transporters. That means improving intelligence picture on those people – and then using that intelligence to direct and target interdiction/arrest operations. We have to ensure law enforcement is intelligence-led.



Jamaica as illustration of the success which can result: Blockage of the supply and arrests of the kingpins has resulted in a 70-80% reduction in cocaine transiting Jamaica over the last 2 years and a doubling of prices. Early blockade of transit routes has now gone but the supply has not resumed, because the kingpins are gone. But we have to have an integrated policy. Shortage of cocaine means that criminals are turning to extortion to fund their activities. The Jamaican government is holding firm as part of a longer-term strategy to restore security to Jamaica.

Partners: We can't do this on our own. Nor is it sensible for another developed country – U.S., France or Spain for example - to be doing exactly the same as us in the same or similar countries. We need to look to like-minded countries to work in partnership. EU countries are an obvious ally but we also work closely with U.S., Canada, Australia. There is no single model – we work with all partners, in specific areas, dependent on spheres of interest and influence. But what it does mean is that we have to understand too what are the drivers of our allies' interests and again this is where the FCO's broad knowledge of host countries can bring something to the party. So we can make joint demarches to a government to encourage it to pass the necessary legislation to facilitate action against OC, we can operate in joint investigation teams at law enforcement level and we can jointly fund capacity building projects - or at least have visibility as to what we are each doing so that we don't provide overlapping or incompatible equipment or skills.

In the case of Afghanistan, international co-ordination of effort is key to success. We work closely with Germany which has the policing lead and Italy which leads on justice. We coordinate closely with the U.S. which has a key role on security there. This applies in the region too. A good example is Tajikistan where we, the EU and U.S. are investing heavily in both money and skills terms in establishing an effective border control.

Partners don't need just to be operational colleagues. We need to develop further our relationships with key NGOs, academia and practical research institutes so that we can be better informed by empirical evidence as to what is effective.

Creation of SOCA has added significantly to UK's capability and intelligence-based approach to tackling OC. The real bonus is that it brings together key parts of the law enforcement community. SOCA's aims are to improve our knowledge of the OC groups and how they operate so that it can tackle them, not just through seizing the drugs or other commodity, but also in innovative ways such as their financial assets and by hindering their activity in any other way which can be effective. One of the key features of SOCA is working in partnership more than before. So if the U.S. DEA or Australian police are already engaged in a particular country, SOCA may attach a local officer (LO) to that unit or simply ask them to help. It has to be reciprocal of course, so SOCA will be able to help the U.S. or Australians where we are strongly represented. Joint working with our EU partners will be likely to increase - we already enjoy very good working relations with France, Spain, Italy and NL for example and in a region such as the



Caribbean we all have practical interests and connections which we can use jointly to advantage.

And the threats? OC is not going to go away and it is going to change. The new threat can be that it involves countries, which haven't hitherto been involved in OC. Afghanistan did not use to be an opium-producing country (rather the Golden Triangle) but during the Taliban period and beyond, it now produces over 90% of the heroin consumed in UK. Taliban imposed an opium ban which they achieved by means of threats, which we wouldn't be able to accept, but all that did was push up the price and increase their profits. Success by law enforcement on cocaine trafficking routes means that it is now starting to find new routes through new countries - Mexico and West Africa - so we have to adapt our focus and engage with the host governments in these countries, while not easing up our efforts on the routes which we've disrupted.

So key messages are that:

- We need a co-ordinated, complementary approach with partners at each stage in the supply chain – this is not a competition!
- All stakeholders (i.e. politicians, officials, LE agencies, Think Tanks, Academia) need to work to a single agenda
- Can't compartmentalise key domestic issues such as OC separately from foreign policy
- We need to remain alive to the new threats, the countries in which they are perpetrated, and how we can best respond.



United States Foreign Policy

MARC WHEAT



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U.S. State Department operates within the nation's drug policy, which covers prevention, treatment and disruption. Drug abuse is often found to be linked to terrorism, and 9/11 heightened American sensitivity to this issue. International cooperation is widespread, and within the general cooperation America sustains a particular cooperation with some 20 other countries. Afghanistan, Colombia and Mexico are three such "High-emphasis" countries; activity in these three countries is described in detail.

Good Morning it is a very great privilege to be here today. I have met many of you earlier in Brussels and it is a delight to be back and meet you and others who are making a very big impact in your communities all over the world.

Since 1987, I have been off and on Capitol Hill working for Congress and in the Administration. About six weeks after 9/11, I had the honour to go to the State Department to work as the Senior Adviser for Senate Affairs. We were moving toward re-configuring the United States Government and our Foreign Policy in light of a war on terror that we did not know we were in until we had tremendous and damaging attacks on our country.

Since August 2003, I have been back on the Hill working for the State Department, particularly for the International Narcotics and Law Enforcement with John Walters at the ONDCP at the White House and others who really work and concentrate on what we are doing internationally on drug policy. I find myself oftentimes not speaking about what we are actually doing or providing suggestions – usually my role is to raise hard questions. And sometimes it's a little difficult that we have to ask very hard questions of our own friends and allies, but I ask them to be of good cheer and I remind them of something that Senator Cicero said in the first century B.C. He said:

"It's a shameful thing to be weary of enquiry when what we search for is excellent."

First of all, let me restate that the United States National Drug Control policy is based on three principle pillars: prevention, treatment and disruption of the drug markets.



Each of these three pillars supplement one another. They provide a balanced approach to taking advantage of the best tools that we have to disrupt the drug market and to keep people from initiating use and working to get them off drugs if they have started to use. The third pillar is what I am going to focus on today – disruption of the drug market and how that is addressed with diplomatic posturing.

What we have done through Congress, and working with the Administration is that we have required the Administration to identify those countries where we have the most difficulty – where we need to be placing our assets and diplomatic efforts. In September 2005, the President's major list were the countries of Afghanistan, Bahamas, Bolivia, Brazil, Burma, Columbia, Dominican Republic, Ecuador, Guatemala, Haiti, India, Jamaica, Laos, Mexico, Nigeria, Pakistan, Panama, Paraguay, Peru and Venezuela. What I would like to do is bring a little more focus in on three of those countries as an example of some of the different approaches the U.S. Government has brought to bear on some of those problems. Primarily Afghanistan, Columbia and Mexico.

So let me ask a hard question – what does the world do for a country that follows the forms of democratic government in the environs of its capital, but elsewhere is controlled by extremist networks focused on making drug trafficking as profitable as possible in order to finance their objectives and operations? This is a question that we ask ourselves today about Afghanistan and people tend to just throw up their hands in exasperation because we just don't know what to do. But let me remind people, especially those of us who have not been engaged for most of our lives on this - that that's the same question we asked about Columbia - maybe ten years ago. And we forget that we are in a very long game – and that sometimes what doesn't happen the first couple of years after trying, doesn't mean that it's a failed strategy. We need to keep working in that direction; so there's a good foundation for hope and I salute the excellent and brave public servants like Habibullah Qaderi (who will be speaking later today), the Minister of Counter Narcotics in Afghanistan.

The United States knows first hand the cost of ignoring countries that are undergoing the agony of drifting into lawlessness as their societies collapse because the rule of law is no longer a functioning institution. On September 11th 2001 the World Trade Centre in New York was destroyed by two hi-jacked aircraft. I lost two friends who were on the plane that crashed into the Pentagon and more friends of mine and my wife were endangered by a fourth plane that may have been targeted at the White House or the U.S. Capitol Building. These attacks were perpetrated by evil men who operated in a country where the government could not, or would not keep them from setting up their headquarters and training facilities for these operations. As a consequence of 9/11, the United States government underwent its most dramatic reorganisation since the Second World War. The most visible change in the U.S. government was the establishment of the Department of Homeland Security which consolidated many of the counter drug agencies and other agencies which related to securing our borders, providing security for maritime waters and airspace. Since then, the Department of Defence has also augmented resources for the setting up of the U.S. Northern Command, and its quadrennial defence revue



accelerated the Department of Defence's transformation to contend with the new realities of asymmetric warfare and the posture to take pre-emptive strikes against our enemies when there is imminent danger of attack.

The impact of 9/11 on our State Department and our foreign policy initiatives has also been dramatic. Under Secretary Colin Powell and now Secretary Condoleezza Rice, they have had to coordinate the President's policies and build diplomatic relationships throughout the world to coordinate intelligence and law enforcement actions against those who are planning terrorist operations. We now live in a world that is full of conflict, contradictions and accelerating change. The most dramatic change of all is with our allies throughout the world in processing the exponential increase in the number of targets that we have to identify, track and analyse. In addition to hostile nation states, we are focusing on terrorists groups, proliferation networks and narco-traffickers. I think it's important to know that as we contend in our own lives with people who are advocating the legalisation or de-criminalisation of drugs - that just takes us away from focusing on this critical mission. The connection between heroin production and terrorism in Afghanistan cannot be overstated.

The booming drug trade has given a second wind to stubborn insurgency being waged by the Taliban and Islamist War Lords. The booming dope trade is rapidly creating narco-states in central Asia and destroying what little border control exists making it easier for terrorist groups to operate. In August 2005, the UN reported that opium production had decreased 21% from its 2004 level, but even with this decrease Afghanistan still ranks as the world's largest opium supplier – accounting for 87% of the world's supply. We've heard this week that in another few weeks we are anticipating the release of new figures on Afghanistan where we may be again at record levels of opium production. There is reportedly evidence from the Taliban that they, and other fighters, are ordering increased poppy production from Afghan farmers in remote regions beyond the government's control as a means to make money to finance their operations and also to weaken the Afghan government. In Helmand Province, where we have seen the largest dramatic growth in the cultivation of the opium poppy, the Governor stated earlier this year that the Taliban had forged an alliance with the drug smugglers providing protection for drug convoys and mounting attacks to keep the government away from the poppy fields. This is a similar path to that followed by the FARC in Columbia, which initially was established as a Marxist-Leninist guerrilla organisation, but they since have largely put aside their ideological predilections in order to make massive amounts of money in the coca trade. The counter drug efforts in Afghanistan have failed to prevent the explosion of heroin production and trafficking, if all of Afghanistan's opium were converted to heroin it would be approximately 526 metric tonnes. The United States' consumption for heroin is about 80 metric tonnes and only about 5% comes from the Central Asia area, the rest of it comes from Mexico and Columbia. So this is largely a problem for Europe, Central Asia and its neighbours – Iran having the largest addiction rate in the world.

One thing that we have been very frustrated with in Congress is that the Department of Defence has been very, very slow on the uptake in recognising the threat of drugs in



Afghanistan in financing of a lot of the counter government we are facing along with the Afghan government. So we are occasionally surprised and pleased when this is pointed out as a difficult problem by the Department of Defence and a great quote we have here is: "For my money, the number one problem we have in Afghanistan is drugs," said U.S. Marine Corps General James L. Jones in testimony before the Senate Armed Services Committee. Recently, Secretary of Defence Rumsfeld said similar things and we were delighted to see that he has lately come to our party. In 2005, the Department of Defence increased its counter narcotics role in Afghanistan but did not become actively involved in counter drug operations on the ground.

The U.S. military in Afghanistan supported efforts by Afghan and U.S. agencies such as the DEA – but reluctantly and very lately. We asked multiple questions multiple times on how much support DOD was giving to the Drug Enforcement Administration to help do investigations and analysis of intelligence on the ground after taking down a drug processing laboratory – time and again we were told there was no support given.

But we have to look at the bright side on this – although we are in a very difficult time in explaining why we have enormous increase in opium production in Afghanistan given the levels of investment, we have to remember this again is a long process. We have almost from ground zero worked with the Afghans to rebuild a judicial system, to construct a narcotics prosecution task force, establish border crossings and border strong points - training and equipping the counter narcotics police force through a multi-national effort between the U.S., U.K., the Germans, Italians, Dutch, Lithuanians, Canadians. It's a remarkable effort but it is going to be very, very difficult to maintain the majorities in many of these parliaments for the level of support that we will need to give to Afghanistan over a long period of time. With the issue of Columbia - which I never thought I would have to say that Columbia is the bright spot - but this occupies a unique role in the U.S. government's position in the global war on terror in that its targeted groups are Marxist rather than Islamic based and they have no reported ties with Al Qaeda.

But in Columbia, each one of the foreign terrorist organisations, as identified by the State Department, has been fighting a war for about 40 years. The first two groups, The Revolutionary Armed Forces of Columbia (the FARC) and The National Liberation Army (the ELN) started in the 1950s as Communist organisations. When the Colombian military was not able to protect the people from these guerrilla groups, a third guerrilla group organised which was called the United Self Defence Forces of Columbia, which is now a conglomerate of illegal self defence groups, which is now starting to fall apart and being disbanded. All three of these groups have really set aside any ideological differences they may have in order to just reap enormous profits from the drug trade in Columbia. Currently in Columbia, we have about 200 Special Force soldiers who are working on providing a great deal of support for the government of Columbia in their counter-insurgency efforts, as well as, training for going after some of the areas that are not yet under the control of the central government where a great deal of the coca is being



produced. We have an enormous investment in spray operations that do aerial eradication of the coca crops and include heroin.

The result of this – and this is how we have to put this into perspective with Afghanistan – after about a billion dollars of investment, primarily from the United States although we’ve also had support from other countries throughout the world, in Columbia – is that we don’t have a great story to tell on coca being eliminated in Columbia. But part of the explanation for that is that where we have been looking, the coca production has been going down but as we get better control and the rule of law takes more effect in Columbia, police forces and the military are able to get out into areas where they didn’t have access before. In those areas we are able to find more coca – that’s part of the explanation as to why we had such a bad report this year on crop estimates. Compare that with the estimates we are going to be getting in another few weeks out of Afghanistan – they’ll be bad numbers – but the thing to bear in mind is that the crop estimates are not the only measure of success. In Columbia, although we have bad figures on coca production, the major security indicators all improved last year: homicides were down 13%, kidnappings were down 51%, overall terrorist attacks were down 21% and the number of internally displaced persons was down 15%. We know that Columbians feel safer when they are travelling by automobile between major cities – it’s a dramatic reversal, where now in 1,098 of all of Columbia’s government municipalities, there’s now police protection - that has not been true at any time in Columbia’s history. So we think that Columbia is largely a success story and that is the model we should be looking at when we look at what we need to be doing in Afghanistan.

Now, on Mexico, let me focus in on a drug that has been extremely problematic for the United States and it may not be a problem yet in your country but it gives us an example of what we have been able to do in Mexico with the issue of methamphetamine. My boss, Mark Souder who is the Chairman of the Drug Policy Sub-Committee, was at a conference in Asia and the Japanese and the South East Asians wanted to focus the agenda not on cocaine and heroin, which was the major problem for the United States at that time, but on the synthetic drugs – primarily methamphetamine. This was not a priority for the U.S. ten years ago. We knew we had some problems in Hawaii and California, but overall it was not a serious issue. It has been just a tremendous epidemic in the last several years in the United States. This last year Attorney General Alberto Gonzales stated that in terms of damage to children and to our society, “meth” is now the most dangerous drug in America. Probably 80-85% of the methamphetamine consumed in the United States is manufactured in Mexico or is made in California controlled by Mexican drug gangs. The reason methamphetamine is a remarkably dangerous drug is that it can be made in your own homes using readily available chemicals that you can find in an auto supply store or a drug store and it is very, very easy to make. The problem is that when you make it you could blow yourself up or burn your house down and you’ll certainly create a toxic waste site wherever it is being manufactured. This has been an enormous burden on American law enforcement because it takes a great deal of time to secure an area where methamphetamine has been produced. It takes a lot of time to clean it up, it’s very expensive, sex abuse of children goes through the roof wherever meth is



produced and it is the leading driver for children being placed in foster care in most counties of the United States now. Why did this problem grow so remarkably and what are some of the things we could be doing in our own countries? There is not enough control on the pre-cursor chemicals that are used to make methamphetamine.

Pseudoephedrine is used in common cold tablets for example and they are being made into pills and being shipped all over the world with no tracking or control. Many nations are importing them - far more they can legitimately consume. For example, Mexican imports of pseudoephedrine, which is the primary meth pre-cursor, rose from 100 tons in 2001 to nearly 224 tons two years later. Mexican authorities estimate that their legitimate demand for pseudoephedrine is only about 70 tons a year, so it is an enormous issue and an enormous problem. I know that the State Department has worked valiantly with the Mexicans to provide them with assistance on tracking and identifying their pseudoephedrine imports and providing assistance with respect to import controls. And in fact, when we recently passed the Combat Methamphetamine Epidemic Act which was signed into law earlier this year, which Director Walters referenced this morning, some of the best elements of our law we took from Mexican statutes and we are applying them to ourselves and so that's some of the value of the interaction with one another.

Let me just touch on a couple of other issues that you might be seeing come out of Washington and that is how we are re-configuring some of the diplomatic efforts out of the State Department. There are two initiatives - one is called transformational diplomacy, where we are moving more assets out of Europe into developing nations, and the other one is greater emphasis on cultural diplomacy - public diplomacy. I wanted to flag with respect to that - it's great that many of the things we are doing on cultural diplomacy and reaching out on democratisation but there still seems to be a great deal of support within the bureaucracy for the whole "harm reduction" movement.

We have heard, and read, and know about how George Soros has invested a great deal of money into the "harm reduction" movement. What we may not know is that under the Bush administration, he has received from the U.S. Federal government, he has received about \$27 million for various efforts throughout the world that may be democracy building, but it substitutes for money he would otherwise be using for "harm reduction." So, when you read about how Soros spent \$25 million in the 2004 elections in the United States, he is still up \$2 million and that's something we would like to see terminated immediately and it hasn't happened yet but we would like to see that happen.

Diana Coad spoke earlier this morning about the "legalise everything" movement which is sponsored by the Soros financed Open Society Institute, the Beckley Foundation and other organisations that push their "Utopian" agenda. I think it's kind of amusing that Utopians who follow 20th century ideologies tend to be much more loving of humanity in the abstract rather than the people who live next door or across the street. The people who are here in this room are the people who work with addicts struggling with their own addiction, or they are working with families who have lost someone from addiction and



they know that the real concrete things need to be done – some of the ideologies just get in the way.

Let me close with this. Reinhold Niebuhr, a Christian theologian, was struggling with the rising tide of Nazism in his own country and he wrote:

“When the mind is not confused by Utopian illusions it is not difficult to recognise genuine achievements of justice and to feel under obligation to defend them against the threats of tyranny and the negation of justice.”

....and so I salute you, who are the cultural diplomats of the 21st century, who are working everyday to overturn these Utopian illusions and bring in justice and mercy to our fellow men.



***Swedish Drug Policy –
In Support of the UN Drug Conventions***

TORGNY PETERSON

Executive Director MOTGIFT International



Sweden has first hand experience of both liberal and restrictive drug policies, concluding after detailed analysis that a restrictive (prevention-oriented) approach is the best strategy. The core value is that “people are entitled to a worthy, drug-free life.” There is all-party consensus rejecting so-called “harm reduction” initiatives as injecting rooms and methadone or buprenorphine prescriptions in all but a small minority of cases.

At the ITF (International Task Force) 2003 conference in Rome, the Papal Nuncio quoted the Pope as saying, “La droga non si vince con la droga” (Drugs cannot be fought with drugs) - a straightforward statement summarising the criticism against so-called “harm reduction” in a very concise way.

Proponents of so-called “harm reduction” are working hard to convince politicians, law enforcement agencies and citizens about the advantages of providing drug users with free needles, easy access to substitution therapies, including heroin, drug injecting rooms - you name it.

Those in favour of a more tolerant stance on drugs have hi-jacked the expression “harm reduction” and given it a completely new meaning. It is no longer primarily a question of minimising supply and demand for drugs, but rather trying to convince people that drugs are here to stay and we should accept that “fact” and teach people how to use drugs in a “safe” way. However, there are no safe ways of using drugs. It is rather like Russian roulette - if you are “lucky,” you might survive several “games.” If you are less fortunate you might end up with major injuries or death during the first “game.”

So-called “harm reduction,” as the term is used by advocates of a more tolerant attitude towards drug use, is what you practice when you have failed in prevention. It is important to note that so called “harm reduction” has nothing to do with prevention of drug use. On the contrary, promoting injecting rooms, mass distribution of needles and methadone/buprenorphine could rather be regarded as harm production as it “helps” the drug addict to continue dependence on drugs.

Defending a restrictive drug policy is as important as defending democracy. There is no time for complacency. Fighting drugs is a matter of political will. Any country with a



major drug problem has the drug problem it deserves because there are too many politicians who are cowards, who are too comfortably seated, or too afraid to stand up to the “challenges” from those who have given up the fight against drugs, from those who promote legalisation, or from organised crime groups, or ignorant journalists demanding changes. Among these politicians we also find those who are more interested in being re-elected rather than making a difference.

Such politicians think they are “innovative” and “pragmatic” (favourite terms among harm reductionists) when they follow the trail of the legalisers or the wishes from drug addicts to get free access to drugs through legalisation and taxation of drugs.

Fighting drugs requires stamina and determination and the way forward could be summarised in four words:

Knowledge - You need adequate knowledge about the problem you want to solve, which also means that you have to be extremely well updated. Knowledge valid a couple of years ago, or even a month ago, is often outdated. Make sure you have access to the latest information on drug related issues, not least information about the international “scene” as trends and tendencies in one country are rapidly “exported” using new technology.

Strategy - Without the proper knowledge, you cannot develop a strategy involving the proper authorities, NGOs, users and their relatives and other citizens. Without proper knowledge, you cannot influence politicians or “guide” the media. Worst of all - you won't be able to convince your local neighbourhood, your region or your country as a whole about the necessity to fight drugs without a proper strategy based on proper knowledge.

Co-ordination - There are too many projects and too many organisations doing a lot of good work but without co-ordination. Co-ordination of measures is not only a matter for local authorities but for everybody involved in the work against drugs. Consequently, every local and/or regional community should develop methods to co-ordinate their efforts in order to save money, manpower and duplication. We are living in a world where access to money directs various projects. Unfortunately this has resulted in competition to get the money, leaving matters of co-ordination to suffer as the system quite often requires that you don't reveal what you intend to do as your ideas might be stolen by somebody else and your “project” might be “jeopardised.” This is a completely wrong way to move forward. Before trying to find money, you should approach other organisations in your field working towards the same goal as yourself in order to create maximum input and strength when you go looking for money together.

Leadership - No work will be successful without competent leadership. You must always ask, without looking at yourself as the best and most appropriate leader, who will be the most competent leader with a drive to move things forward in the direction that you all have agreed upon. You must make sure that there are no hidden agendas involved



with the leadership role, no corrupt links to politicians and/or others who might want to see your work go in another direction.

When it comes to knowledge, strategy, co-ordination and leadership, it is no good having one without the other. No matter how much knowledge you have - unless you are able to make that knowledge work for you when creating the strategy. No matter how good a strategy is if you are not able to communicate it and co-ordinate it.

Those in favour of a more tolerant attitude to drugs - liberalisation and/or legalisation - say we should “stop the war on drugs.” I say, they should stop the war on our people - a war where they want to allow drugs to infect the very fabrics of our societies, creating misery for individuals, families and others, causing mayhem and creating major threats to democratic societies. That cannot be accepted.

So what about Sweden?

Sweden once made the mistake of providing drugs to drug addicts. Between 1965 and 1967 some 4 million does of amphetamines and more than 300,000 doses of opiates were distributed to drug users. Luckily enough the project was terminated in 1967 and since then no serious attempts have been put forward about providing drug addicts with the drug of their choice.

Since the beginning of the 1970s Sweden has promoted a restrictive drug policy, regardless of what political party/parties has/have been ruling the country. Even if politicians in Sweden might have different views on most political problems, there has been and still is consensus about keeping and developing the restrictive drug policy.

Following a slight increase in drug use during the early 1990s, the then minister responsible for drug related issues, Margot Wallstrom (today an EU Commissioner) ordered an inquiry into all aspects of Swedish drug policy and a Parliamentary Committee on Drugs was established. The committee worked for three years and presented their result in a work entitled “Vagvalet” (“At Crossroads” in English) - the title indicating that Sweden had to decide whether or not to proceed with a restrictive drug policy or not. After discussions in the Parliament and the Government, it was decided that Sweden would continue to adhere to a restrictive drug policy, develop it, increase funding and create an office with a National Drug Coordinator. The “Drug Czar’s” office was established in 1991 and is still in place with the same Drug Czar, Mr. Bjorn Fries.

Not long ago the Swedish Government presented the National Drug Plan for the years 2006 to 2010.

The National Drug Plan states:

Swedish drug policy is built on the fact that “people are entitled to a worthy life” - a society without drugs increases public health and well-being and drugs policy is part of the government's public health policy to create a drug free society.



The main “ingredients” of achieving such a goal are to reduce recruitment of drug users (prevention), help people to stop using drugs (care and treatment) and decrease supply (law enforcement).

Several surveys, also recent ones, clearly indicate that the restrictive drug policy has massive support among citizens, even among the younger generation.

Sweden has needle exchange programmes. However, they are very small compared to those in most other countries with such programmes. There are no needle exchange programmes in prison. Of course not, I would say. If you cannot create a drug free environment in prisons then how would you expect drug free environments to be possible elsewhere? There are a few ways to get drugs into prisons, all of which could be fought successfully if the will is there. Sometimes I suspect that certain prison officers are quite “happy” with the drug situation, as access to drugs within the prison walls keeps things and nerves “under control.” I also suspect that there are certain prison officers involved in providing prisoners with drugs.

Sweden does not have any injecting rooms and there is no intention from any political party to introduce it. With the new government, the likelihood of such proposals is even more unthinkable. (Oslo in Norway is the only city in Scandinavia with an injecting room.) Sweden has a fairly small number of drug addicts receiving methadone or buprenorphine.

As for treatment, there are quite a few options in Sweden - voluntary as well as compulsory. Drug testing is quite common in many middle-sized and large firms throughout the country.

I will be happy to provide more information to anybody interested in further details. Thank you for your attention.



Frontline Update: How Afghanistan is Tackling the Drug Problem

HABIBULLAH QADERI

Minister of Counter Narcotics, Afghanistan



Minister Qaderi describes Afghanistan's vulnerable economy, in which 50% of the GNP comes from poppy cultivation. This can only be reversed at a steady pace, if the nation's economy is not to be jeopardised. Eighteen months ago, the Anti-Narcotics Ministry was established, guided by a new national strategy which aims to achieve a "sustainable elimination." Domestic drug abuse is a small but significant part of the equation. Cooperation with neighbouring countries is another. Crop substitution is easy to talk about; harder to realise – but Afghanistan sees this as a key part of the long-term solution.

Your Excellency, Madam Chair and Honourable and respected guests...thank you for giving me this opportunity to speak today. I would like to express a special thanks to you, Ms. Calvina Fay, for inviting me here.

First, before I begin, I want to be sure that you are all relaxed and calm - is everyone relaxed?

In Afghanistan, my country, my homeland, we grow lots of opium poppies. In fact, our opium crop supplies eighty five percent of the world's supply of heroin.

Oh, no shock? No surprise? Of course, you already know that - if not the actual figure of eighty five percent, but that the words poppies, opium and heroin appear in nearly every media story about Afghanistan.

Did you know that my country's gross national product for this year is projected to be six billion dollars, and that about half of that, roughly two point nine billion dollars will be from the illegal opium harvest?

You will note that I said "illegal." Illegal opium harvest. It is written in our constitution, "the state prevents...cultivation and smuggling of narcotic drugs..."

Afghanistan supplying ninety percent of the world's heroin....fifty percent of Afghanistan's economy based on opium....



You can see that I, as Afghanistan's Minister of Counter Narcotics, am not in an enviable position. How to counter a product - an illegal product - that is fifty percent of your economy?

With international help we could eliminate the poppy crop as soon as next year.....through the point of the gun – force - arresting, perhaps even killing, farmers and processors and smugglers. We can do it with enough manpower driving tractors and bulldozers through the poppy fields, even perhaps most cost-effectively, through aerial spraying of defoliants. By next harvest season, with enough money, equipment and technical assistance, next April - done, no more poppies, no more opium crop, no more heroin coming from Afghanistan.

Yes, it could be done.....but at half of our economy, what would be left of the country? Take any economy in the world - a nation's, a state's, a province's, a city's and eliminate half, destroy, get rid of half of it...and you will have the collapse of that society....anywhere.

I don't know if we would even care to imagine what would happen to a nation that has seen twenty years of continuous war and is just five years removed from a stifling, repressive dictatorship. My nation. Afghanistan. Destroy and eliminate the poppies overnight, and those farmers then with their barren fields, and the hungry city dwellers enraged that their government would allow half of its own economy disappear.....they would be willing, quick, new recruits to a Taliban force that would rampage through this then desolate land. And then, what would we have left?

I mentioned, didn't I, that I am the Minister of Counter Narcotics for my country? Is there anyone here who would like the job? No takers?

All right, then, as long as President Karzai allows me, I will keep the job. You should realize now by what I have admitted that first and foremost I am a practical person, a realist. I do not believe in fantasy worlds or in living under illusions. I could stand here and assure you that the Ministry and all Afghanistan is approaching this massive illicit drug cultivation head-long - that we are battling it, and that we are beating it, that we are winning.....and you'd probably wonder if I were a liar or just plain crazy, because as the well-publicized accounts in the media worldwide are reporting about Afghanistan, this last spring's opium harvest is said to have been a record crop.

I am a realist, remember? This year's harvest probably was a record crop. So, you have a right to ask, "There's a Ministry, you're the head of the Ministry, what's gone wrong?"

Were it diamonds that we were producing in abundance, or oil, or timber or steel - or pomegranates, even, yes pomegranates - the world would be applauding us - and I would not have been an invited speaker here.



Perhaps, though, it is not quite fair to ask "what's gone wrong?" After all, the Ministry has only been up and running, for all practical purposes, for a year and a half. We had to acquire a headquarters building and make it useable, and then had to find a talented, professional staff. As important, we had to coordinate funding and technical assistance from our international friends to function and begin setting up and staffing provincial offices.

And one does not just form a ministry and run out and start solving problems. What we did first was to formulate a comprehensive national drug control strategy. An essential part of that was in looking at the history of the opium poppy in the country and approaching our strategy with that in mind, knowing that it would be impossible to eliminate overnight a behaviour and way of life that is centuries old. More so, it is a way of life that has expanded with the country's economic chaos that began with the Soviet invasion and continued through our twenty years of war.

In one sentence, the goal of the Ministry and the Afghan government is "to secure a sustainable decrease in cultivation, production, trafficking and consumption of illicit drugs with the end being complete and sustainable elimination."

To obtain this goal, we have established four priorities.

- first, disrupting the drug trade by targeting traffickers and their backers....
- then, strengthening and diversifying legal rural livelihoods...
- also, reducing the demand for illicit drugs within Afghanistan and the treatment of problem users...
- and finally, developing state institutions at the central and provincial level to put the strategy into effect.

To achieve the first, disrupting the drug trade by targeting traffickers, we are focusing on those who profit most from opium rather than on the poor farmers who usually have little choice but to grow it. We realize that targeting the farmer with excessive eradication will have a detrimental impact on our wider security as well as our economic stability. Remember, eradication of fifty percent of an economy would bring the end of that country, but we have begun. Now, it's only a start, I know, but in the past year we have convicted over one-hundred-fifty traffickers.

The second priority is to strengthen and diversify legal rural livelihoods. We know that Afghan farmers do not grow poppy simply to maximize profit. There is the availability of easy credit from the smugglers, the lack of fertile land for other uses, the lack of alternative employment - factories, industry and such....the lack of markets for alternative crops....and the lack of infrastructure to grow and transport produce - that is, irrigation canals, roads and highways. Our strategy is not only to bring different crops to the



country - the alternative livelihoods, but to bring cash-for-work programs, to construct roads and renovate irrigation systems, to improve access to finance and credit and to research and develop new crops and markets.

To strengthen and diversify legal rural livelihoods, two of our top priorities are community based alternative livelihoods, needs assessment and social compact. You might think what the relationship would be between needs assessment and social compact with strengthening and diversifying rural livelihoods. Doing needs assessment is to enable the government to engage in provision of alternative livelihoods in a pragmatic manner and give the communities an opportunity to think strategically and come up with their priorities that not only help them in the ultimate destruction of the poppy, but also help them in their longer term development goals.

At the interim stage, our focus to provide alternative livelihoods lies on three sectors: agriculture development, infrastructure, and agricultural credit, however we understand that fighting narcotics in Afghanistan requires inputs in all sectors.

Now, why social compact when we have identified the needs? We believe that any inputs to strengthen and diversify legal rural livelihoods will not bring a considerable decrease in cultivation and change to the attitudes of farmers. Unless the illicitness of what they grow is reiterated and a moral compact is built between the government, farmers and their communities.

We envision to clearly indicate to Afghan farmers that Islam, the Afghan constitution, and the new Afghan counter narcotics law prohibits cultivation of poppies. And if cultivated, severe consequences such as eradication and imprisonment are to follow.

Our third priority, to reduce the demand for illicit drugs and to treat problem users, may seem strange to many of you who may think that Afghanistan does not have a drug problem - that it exports its entire product. Not true. About four percent of our population abuses drugs - for the most part our own home grown hashish, but nearly fifty thousand of those nine-hundred thousand overall drug abusers use heroin. Of course, drug treatment centres are not foremost on the minds of citizens who see a dire need of hospitals first, along with basic health care rural clinics, but our goal is to establish community-based and residential treatment centres as well as to target would-be users with effective drug awareness P.R. campaigns.

Our ability to deliver on the previous three priorities will be severely limited without success in our fourth priority: strengthening state institutions at both the central and provincial level. We need strong, effective and accountable law-enforcement institutions. We have established my Ministry as well as a counter narcotics division of the Interior Ministry, and we have created the counter narcotics police of Afghanistan, the Afghan Special Narcotics Force, the Counter Narcotics Criminal Justice Task Force and the counter-narcotics trust fund. These are all on the central, national government level. Now we need to be able to extend the reach of these institutions to the provinces. Without



strong, respected state institutions there can be no enforcement - that is, prosecution and punishment. Without strong, respected state institutions there can be no way to make traffickers and growers accountable for their illegal activities.

So, we set our priorities - reduce the trade, diversify rural livelihoods, reduce internal demand for drugs, and establish strong state institutions. To achieve these goals we established eight pillars upon which they sit - eight measurable, workable tactics.

Public awareness is one. That is, informing the people of the government's policies, legislation and available alternatives to opium cultivation and making the public aware that we mean business, that we are serious and can back that seriousness with action.

Demand reduction is another pillar, that is, to reduce Afghanistan's own drug use.

Then there is law enforcement. This is the establishment of law enforcement agencies - such as the Ministry of Interior, the counter narcotics police, the border police and the customs police - all staffed and equipped and working to investigate drug offenders. You can make all the laws in the world, write them in big bold print in the books, but without the power to enforce them they are useless - just words on paper.

Along with law enforcement is a criminal justice system, we need to be able to utilize the criminal justice task force and the tribunal and penitentiary facilities to prosecute, convict and imprison offenders. Again, laws without investigation, prosecution and punishment are simply empty words on paper.

Institution building is so essential that it is a pillar as well as a priority. As I mentioned earlier, without effective central and provincial institutions - housed, staffed and funded, there can be no effective counter narcotics strategy. Without strong, respected institutions, again, these laws are unenforceable.

Another pillar is alternative livelihoods. This encompasses all rural development that provides legal economic alternatives to farmers.

Which goes hand-in-hand with the next pillar - eradication. We know that we cannot destroy a farmer's field, his crop, his livelihood, without first providing him with a viable alternative crop or employment to feed himself and his family. Eradication for the sake of eradication, without an alternative, will be completely counter-productive. The enemies of the state - rogue warlords and the desperate Talibs love a violent, un-thought-through eradication program, because they use it to recruit and build their own militant forces.

A final pillar is international and regional cooperation. This is the process of cooperating with neighbouring countries as well as the international community to align our counter narcotics policies and actions. Afghanistan is landlocked, surrounded on all sides by other countries - open, accessible borders over which, for three thousand years have made our country a smuggler's crossroads. It is imperative that we sit down with our neighbours



and coordinate a counter-drug policy.....as it is imperative that we coordinate actions with our international friends for whom the ready availability of heroin from Afghan poppies is a scourge upon their populations.

So, you see, we have our hands full. For us, this battle against opium and hashish as well, is not just to please our international partners, but it is for the long-term health of our own country.

To be sure, to eliminate the opium trade today when it represents half of our gross national product would be disastrous for the economy and the country. But this illicit trade presently provides money, power and sanctuary for local warlords who refuse to consider the central government supreme, and to the Taliban, who want very much to turn Afghanistan away from its progress and shove it once again into darkness. To do nothing at all now will ensure the anger of our international friends and, with the warlords and Taliban strengthened, will guarantee that Afghanistan remains unstable and on the brink of a return to the horrors of the only recent past.

So, if you did not know it before, you know it now.....in Afghanistan we grow hashish and opium poppies. Lots of both, but so much of the latter that one might say it is the backbone of our economy.

But you also know now that we have established a Ministry of Counter Narcotics which has drawn up a complex strategy to reverse this....not overnight, we realize, but in a detailed process over time.

Earlier, I mentioned pomegranates. Did you also know that in Afghanistan we grow pomegranates? The richest, many agree, the best in the world. Perhaps you were not aware that recent medical research has shown that the health benefits of pomegranate juice - in particular, its anti-oxidant powers - are many times stronger than any other fruit. Watch the reports of ongoing medical studies worldwide. You're going to see a lot more about the miracle fruit, the pomegranate.

We still grow and harvest pomegranates in Afghanistan, but so many of our groves were destroyed in the twenty years of war - through deliberate cutting down or through neglect - either way, destroyed, gone. You can understand that we can replant those groves that can be one of the many alternative livelihoods to replace the poppy. But you don't plant a pomegranate sapling tree today and expect it to bear fruit next year. It takes time. It takes money, it takes assistance, it takes rebuilding the irrigation canals, paving roads, building processing plants and packaging and bottling plants, which, of course, require electricity, lots of electricity, which means power plants and hydroelectric dams.....and on and on....

All doable. All possible.



Wouldn't it be wonderful if in a similar conference in ten years, what a triumph it would be if whomever is then in my position today as Afghanistan's Minister of Counter Narcotics is standing up here where I am today and proudly tells you, "relax, be calm, take a breath in, let a breath out, because what I'm about to tell you will shock you. In Afghanistan today we supply ninety percent of the world's pomegranate juice. Now, I'm sorry, I don't have more of a speech today because my job has been eliminated, there is no longer an Afghanistan Ministry of Counter Narcotics but please, won't you enjoy the pomegranates there on the tables in front of you which I've brought as gifts from my homeland...."

Wouldn't that be wonderful? That is our hope.

Thank you.



***Overview of Drug Policies and Their Effectiveness (UK)
The Lure and the Loss of Harm Reduction in UK Drug
Policy and Practice***

PROFESSOR NEIL MCKEGANEY

**Professor of Drug Misuse Research
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Since the late nineteen eighties drug policy and practice within the U.K. has been heavily influenced by the idea of reducing drug related harm. The paradigm of harm reduction which has shaped drug treatment services grew out of the fear that HIV may spread rapidly and widely amongst injecting drug users. This paper looks at the extent to which drug use or HIV have had the greater impact on individual and public health within the U.K. and the extent to which it has been possible to reduce drug related harm in the face of continuing drug use. The paper concludes that in the face of the growth in the prevalence of problem drug use over the last ten years and the persistence of an array of drug related harms including: the extent of Hepatitis C amongst injecting drug users, the extent of drug related crime and the impact of drugs on communities and families that it may be appropriate now to make drug prevention, rather than harm reduction, the key aim of drug policy and practice.

Introduction

In 1988, the Advisory Council on the Misuse of Drug published the results of its enquiry into the growing problem of AIDS and HIV in the U.K. Contained within the council's "AIDS and Drug Misuse: Pt 1" report (1988) was a sentence which proved to be more influential than any other in the history of U.K. drug policy. That sentence identified the need for a fundamental shift in drug policy and provision as a result of the belief that the:

“...spread of HIV is a greater danger to individual and public health than drug misuse” (ACMD 1988:17)



In the wake of that statement the principal priority for services working in the drugs field, as well as for drug policy more broadly, became one of reducing drug users' risks of acquiring and spreading HIV infection.

Whilst the ACMD's report was not the first to articulate the need for a "harm reduction" focus on the part of those working in the drug field, the report was a key step along the road to the development of harm reduction as a distinct area of professional practice. Stimson, writing in 1990, outlined what he saw as the development of a new paradigm on the part of those working within the drugs field. At the centre of the new paradigm was the focus on HIV:

"A key issue in shaping drug policies is the choice that has been posed between two targets - between the prevention of HIV transmission and the prevention of drug abuse....Preventing the physical disease of AIDS has now been given priority over concern with drug problems....In this paradigm prevention takes on a new meaning - the key prevention task is not the prevention of drug use, but the prevention of HIV infection and transmission." (Stimson,1990:333-334)

Further aspects of this new paradigm involved the concentration on injectors and injecting drug use as opposed to those using illegal drugs by other means; a recognition that given the means (sterile injecting equipment, condoms) injecting drug users would seek to reduce their chances of becoming HIV positive; and the importance of ensuring that drug treatment services were as accessible and as user friendly as possible. This latter element contrasted markedly with the previous paradigm of drug abuse treatment in which the focus had been on addressing client's drug dependency needs. Challenging drug users about the impact of their drug use as well as testing individuals motivation for recovery (which were aspects of the prior paradigm focused on meeting individuals drug dependency needs) was now seen as antithetical to the view that services should be doing all they could to attract clients and retain contact with clients as a way of reducing their HIV related risk behaviour.

It is difficult to overstate the impact of these ideas on the world of drug abuse treatment within the U.K. In the period following the publication of the ACMD report there was the growth of an entirely new form of drug agency in the form of needle and syringe exchange clinics. There was also, at this time, a substantial growth in the use of methadone prescribed on a maintenance basis as a method of engaging and retaining drug users in contact with drug treatment services and reducing their HIV related risk behaviour.

Some ten years after the publication of the ACMD report, the ideas and practices of harm reduction have become a key part of the "drug treatment establishment" within the U.K. national drug strategy. "Tackling Drugs to Build a Better Britain," published in 1998, identified the importance of "harm reduction" within the treatment pillar of the strategy:

"There is growing evidence that treatment works. In particular, harm reduction work over the last 15 years has had a major impact on the rate of



HIV and other drug related infections” (Tackling Drugs to Build a Better Britain, 1998:aim,iii)

Similarly, David Blunkett, the then Home Secretary, further endorsed the importance of harm minimisation initiatives in his introduction to the “Updated Drug Strategy” published in 2002:

“All problematic users must have access to treatment and harm minimisation services both within the community and through the criminal justice system” (Updated Drug Strategy 2002:3)

So central were the ideas of harm minimisation to drug treatment policy that the updated drug strategy even re-named the fourth pillar of the strategy “Treatment and Harm Minimisation” in contrast to its previous designation simply as “Treatment.” The updated strategy summarised how widespread the ideas of practices of harm reduction had become by 2002:

“Nearly all DAT area (97%) have harm reduction services and 87% provide access to drug prescribing services.” (Updated Drug Strategy 2002:52)

Within these terms there can be little doubt that the ideas of harm reduction/harm minimisation have had an enormous impact on the world of drug abuse policy and treatment within the U.K. What I would like to do in the remainder of this paper, is to ask three related questions. First - was the ACMD right in asserting that AIDS and HIV represented a greater threat to individual and public health than drug misuse? Second - how successful have we been in reducing HIV and other drug related harms within the U.K? Third - whether the time is right to shift the major focus of direction of policy and provision within the drugs field in the U.K. from reducing the harm of continued drug use to reducing the incidence and prevalence of drug use itself?

AIDS and HIV a greater threat than drug misuse?

At the time that the Advisory Council on the Misuse of Drugs “AIDS and Drug Misuse” report was produced, the thinking within the U.K. around the issue of drug users and HIV was influenced by one study more than any other, namely the results of research involving drug users attending a general practice surgery in Edinburgh. This research, carried out by Roy Robertson and colleagues, showed that a staggering 63% of injecting drug users attending the practice were HIV positive (Robertson et al 1986). The results of this research sent a shock wave through those planning and delivering drug services in the U.K. as well as those working within the public health field more broadly. For the first time there was real evidence that the U.K. might experience an epidemic of HIV amongst injecting drug users that was equal to, if not greater than, that experienced by sections of the gay community within parts of the United States. Moreover, the Edinburgh results opened up the possibility of widespread heterosexual transmission of HIV, first to the sexual partners of injecting drug users and then on to the wider heterosexual non-drug injecting population.



In the wake of these fears, research was rapidly commissioned to assess the extent of HIV infection amongst drug injectors across a broader range of locations. For example, on the basis of research carried out with drug injectors drawn from across Edinburgh (as opposed to the clients of a single general practice sample as was the case with the Robertson research), the prevalence of HIV infection amongst injecting drug users was found to be 19.7% (Davies et al 1995). In Glasgow, similar research involving interviewing and drug testing city wide samples of drug users found that only 1.8% of injecting drug users were HIV positive (Rhodes et al 1993). In London research using the same methods identified 12.8% of injectors to be HIV positive (Rhodes et al 1993). Finally, Haw and Higgins reported that 26.8% of injecting drug users in Dundee were HIV positive compared to 3.7% in the surrounding rural area (Haw and Higgins 1998). Further research in Glasgow and London with female drug using prostitutes - a group who at that time were seen as key in terms of spreading HIV beyond the injecting drug using population to the wider heterosexual non drug injecting population - identified low levels of HIV infection and high levels of condom use with commercial partners (McKeganey et al 1992, Ward et al 1993). Cumulatively this research lowered the fears of an impending public health crisis involving drug users and HIV within the U.K.

By December 2005 there were thought to be 21,898 AIDS cases in the U.K. (of whom 1,234 are thought to be as a result of injecting drug use) and 76,765 cases of HIV infection (of whom 4,381 are thought to have acquired infection as a result of injecting drug use). The prevalence of HIV infection among injecting drug users attending drug treatment agencies and taking part in the Unlinked Anonymous Prevalence Monitoring Programme was 2.3% in London and 0.5% elsewhere in England (Health Protection Agency 2004). Despite these low levels of infection, very recent research has indicated that there may have been a small increase in the prevalence of HIV infections amongst injecting drug users in London although the possible increase is still well short of the level of infection feared in the late nineteen eighties (Hope et al 2005).

The figures on the prevalence of HIV infection and AIDS amongst injecting drug users contrast markedly with the prevalence estimates for problematic drug use within the U.K. Within England, Frischer and colleagues used the multiple indicator method to estimate a total problem and drug injecting population in 2001 of 287,670 (Frischer, Heatlie and Hickman 2004). From Scotland, Hay and colleagues used capture recapture statistical methods to estimate the prevalence of problem drug use (defined as heroin and benzodiazepine use) in 2003 to be around 51,582 (Hay et al 2004). From Northern Ireland McElrath estimated the prevalence of problem drug use to be of the order of 828 (McElrath 2002). On the assumption that the prevalence of problem drug use in Wales (where there is no current or recently equivalent estimate) is on a par with that in England, the overall prevalence of problem drug use in the U.K. as a whole may be in the region of 356,000 - i.e. some eighty times greater than the number of HIV positive injecting drug users within the U.K. On the basis of these figures alone it is difficult to avoid the conclusion that it is problematic drug use, not AIDS and HIV, which is having the greater impact on individual and public health within the U.K.



In the next section I look at the degree to which it can be said that we have been successful in reducing drug related harm including that related to HIV amongst drug users in the U.K.

Reducing Drug Related Harm

There are a number of areas in which it is possible to consider the issue of how successful we have been in reducing drug related harm - some of these pertain to the individual whilst others relate more to the impact of drug use on families and communities.

- **HIV Infection**

It is evident from the foregoing that the U.K. has not witnessed anything like the rapid rise in HIV infection rates amongst injecting drug users that was feared in the initial “AIDS and Drug Misuse” report from the Advisory Council on the Misuse of Drugs. One reason for this may well have been the success of the very harm reduction measures (needle and syringe exchange, methadone maintenance programmes and advice on safer injecting) which that report gave impetus to. This is the thrust of the submission from the U.K. Harm Reduction Alliance to the Home Affairs Select Committee’s enquiry into drug policy:

“Between 1987 and 1997 Britain led the world in developing a harm reduction approach to drug use. The clearest achievement was in the prevention of HIV infection among people who inject drugs (by heeding the advice outlined in the report of Advisory Council on the Misuse of Drugs). The UK has thus averted an epidemic of HIV infection associated with drug injecting and there is evidence that harm reduction has resulted in lower rates of hepatitis C virus (HCV) infection than found in comparable countries.” (UKHRA 2001:2)

Whilst HIV has certainly not spread to anything like the extent feared in the ACMD’s report, it should not be assumed that this was due solely to the development of a harm reduction approach on the part of drug services within the U.K. It may have been the case, for example, that the number of cases of HIV infection amongst injecting drug users simply did not reach the critical threshold or “tipping point” to generate widespread transmission of HIV. However, having said this is unlikely that the development of such harm reduction initiatives as needle and syringe exchange had no impact on reducing the spread of HIV infection amongst injecting drug users. Setting this issue aside though, the claim that harm reduction initiatives within the U.K. have been relatively effective in preventing the spread of Hepatitis C is a good deal less convincing.

- **Hepatitis C**

By the end of 2003 there had been a total of 38,352 cases of Hepatitis C diagnosed in England, over 90% of which are thought to have been acquired as a result of injecting drug use (HPA 2004). In Scotland, in 2003, there were a total of 18,109 cases of HCV



infection, amongst the 12,166 cases where information was available on route of transmission 90% were known to have injected drugs (HPA 2004).

In 2003, 41% of injecting drug users taking part in the Unlinked Anonymous Prevalence Monitoring Programme of drug users in contact with drug treatment agencies were known to be HCV positive (HPA 2004). High as these percentages are, the extent of HCV infection amongst injecting drug users may be even higher in some cities. Bloor and colleagues, for example, have recently reported that as many as 60% of injecting drug users in contact with drug treatment services in Glasgow may be HCV positive (Bloor et al 2006). The high prevalence of Hepatitis C amongst injecting drug users within Glasgow is all the more striking when one considers that for much of the nineties to the present day Glasgow has had a well supported, city wide, network of needle and syringe exchange schemes (EIU 2003). It is difficult to see how the level of Hepatitis C in Glasgow could be any higher even in the near total absence of such harm reduction measures, or indeed how the provision of such services over many years has in any way reduced the spread of infection amongst injecting drug users.

- Deaths

Data on drug related deaths in the U.K. are collated by the Office for National Statistics. In 2001 there were a total of 235 AIDS deaths in the UK and 1,192 deaths amongst drug users involving heroin, cocaine or methadone (Health Statistics Quarterly 13). Between 2000 and 2004 there were a total of 5,551 deaths of drug users involving heroin, cocaine or methadone (Health Statistics Quarterly 29). On the basis of these figures there is little doubt that the level of drug related mortality within the U.K attributable to HIV/AIDS is only a fraction of that associated with drug misuse more broadly. Whilst there has been a decline in the number of drug related deaths in England and Wales, with the number of heroin and morphine related deaths falling from 926 in 2000 to 744 in 2004, that reduction is hardly commensurate with a successful harm reduction campaign that still leaves hundreds of drug users dying prematurely each year (ONS: 2006). Indeed, for the period 1993 to 2000 (a key period in the impact of harm reduction ideas within the U.K.) deaths from heroin and morphine in England and Wales actually increased from 187 in 1993 to 926 in 2000 (ONS: 2002).

- Overdose and Life Problems

Over the last few years there has been a growing interest in the extent and the factors associated with non-fatal overdoses amongst drug users. This research has identified the extent of problems characteristic of the life circumstances of long term drug users. The National Treatment Outcome Research Study found that 15% of respondents had overdosed in the three months before accessing treatment (Stewart et al 2002). From Scotland, Neale and Robertson (2005) reporting on the results of the Drug Outcome Research in Scotland study, found that 11.5% of drug users initiating treatment had experienced an overdose in the last three months and 2.4% had experienced more than one overdose during that period (Neale and Robertson 2005). Within this Scottish study 32.9% of drug users had experienced a recent relationship breakdown, 34.4% had



financial problems, 34.5% had accommodation problems and 30.3% had experienced the death of a close relative or friend. This array of life problems was significantly associated with an increased risk of overdose on the part of drug users included in the DORIS research.

- Homelessness

Whilst the extent of homelessness amongst those using illegal drugs has not been widely studied within the U.K. previous research has shown that in many instances those who have developed a significant drug problem are also often living in very unstable conditions. For example, a study of 1000 homeless young people in hostels and days centres in London found that 88% were taking at least one drug and 35% were using heroin (Flemen 1997). Also from London, Downing-Orr found that 85% of homeless young people in London were using illegal drugs (Downing-Orr 1996). In a study of 200 drug users admitted to hospital following a non fatal drug overdose Neale (2001) found that 32% were currently homeless and 68% had been homeless in the past. Of the 136 individuals in this study who had been homeless in the past, 82% had experienced a non fatal drug overdose compared to 66% amongst those who had never been homeless. As Neale points out these findings suggest that the “combined experience of homelessness and drug use increased life threatening behaviour (Neale 2001:363).

- Dual Diagnosis

Within the last few years there has been increasing attention focussed on the nature and extent of mental health problems experienced by dependent drug users. Marsden and colleagues, reporting on the sample of 1075 drug users included within the National Treatment Outcome Research Study, found that 32.3% of females and 17.5% of males had experienced anxiety symptoms, whilst 29.7% of females and 14.9% of males had experienced depression. Fully 26.9% of females had experienced paranoia compared to 17.1% of males (Marsden et al 2000). From Scotland, McKeganey and colleagues have reported that 61% of female drug users contacting drug treatment services had experienced physical abuse and 35% reported having been sexually abused. In the case of male drug users contacting drug treatment services 22% had experienced physical abuse and 7% had been sexually abused (McKeganey et al 2005). On the basis of these figures it is evident that a substantial proportion of drug users are experiencing serious mental health problems associated with past, and in some cases continuing, abuse.

- Prevalence of Problem Drug Use

There has never been a series of drug misuse prevalence studies carried out within the U.K. that would enable an assessment to be made of the increase in problem drug use over the period in which the ideas of HIV prevention and the reduction of drug related harm have been influential. Nevertheless, De Angelis and colleagues have sought to analyse data on drug related deaths over the period 1968 to 2000 to estimate the possible growth in the incidence and the prevalence of problem drug use over that period. On the basis of this work De Angelis and colleagues suggest that with regard to the incidence of



opiate use/drug injecting there may have been a ‘.... threefold increase in the incidence between 1975 to 1979 and a five to six-fold increase between 1987 to 1995’. With regard to the prevalence of opiate use/drug injecting over this period De-Angelis and colleagues suggest that this has “..continued to rise since the early 1970’s doubling between 1977 to 1982 and rising more than fourfold from 1987 to 1996” (De-Angelis et al; 2004).

Identifying possible changes in the prevalence and the incidence of problem drug use in the absence of successive prevalence estimation studies is a complex and inexact science. However, the research from De-Angelis and colleagues does at least illustrate the very real possibility that during the period in which attention was shifting from the prevention of drug abuse to the prevention of HIV that the prevalence drug use increased substantially within the U.K.

- Children of Dependent Drug Users

Whilst the impact of problem drug use is most evident in terms of the individual drug user the harms of dependent drug use often extend well beyond the individual user to other members of his or her family. The “Hidden Harm” report from the Advisory Council on the Misuse of Drugs estimates that there may be between 205,300 and 298,900 dependent children in England and Wales with a parent using illegal drugs. The figure for Scotland is thought to be between 40,800 and 58,700. Large as these figures are the authors of the Hidden Harm report add the caveat that “In the light of the assumptions we have made we believe these are very conservative estimates and the true figure may well be higher (ACMD:2003:25). The Hidden Harm report notes further that amongst 77,928 drug using parents on whom information was available only 46% of parents were actually living with their dependent children and 54% of drug using parents had children living elsewhere most often with other family members. These figures give an indication of the continuing destructive impact of parental drug dependence upon families and of the harm to both adults and children associated with parental drug use.

Although not all of the children with drug dependent parents are likely to suffer serious adverse effects research has indicated that many of these children will experience a range of short term and long term problems arising from amongst other things: their neglect, their exposure to their parents drug use and associated criminality, disruption to their household routines (Hogan & Higgins, 2001 Hawley et al., 1995, McKeganey et al., 2002, Kroll & Taylor, 2003, Forrester, 2000, Barnard 2007). To a large extent it is only with the publication of the Hidden Harm report in 2003 that drug treatment agencies have become aware of the importance of meeting the needs of children within drug dependent households.

- The Impact of Drug Use on Communities

Whilst communities represent one of the four key pillars of the U.K. drug strategy there has been remarkably little research that has charted the evolving impact of drug abuse on communities within the U.K. or which has looked at the way in which communities are able to respond to local drug problems. Where research has been carried out the picture



that emerges is one of communities that have been profoundly influenced by their local drug problems. Qualitative research in one such community in Scotland identified that drug abuse had become a major fault line amongst local residents with many of those interviewed and surveyed identifying drug abuse as one of the worst aspects of their local area (McKeganey et al 2004). Similar qualitative research carried out for the Joseph Rowntree Foundation in England has explored the development of drug dealing markets within local communities and has identified something of the complex relationships that exist between local drug markets and their surrounding community. In some instances the drug markets studied arose within a context of widespread social dissolution, in others the local drug market was sustained within the context of socially cohesive local relationships. Both types of drug markets though were to be found in circumstances of widespread local poverty and deprivation. One of the shocking findings of the research team undertaking this work was the involvement of young people within local drug markets:

“Young people’s involvement in drug market activity caused concern among professionals in all our sites. In Byrne Valley, the market relied on young people to connect seller and buyers....In Sidwell Rise and Etherington young people actively tried to be part of the drug market but found it hard to gain acceptance from the more established sellers. It was reported to us that young people in these two sites often offered to work for free in an attempt to gain a foothold in the market....Just under a third of our professional interviewees and just under half of four police officers thought that young people were more likely to work as runners than any other position....” (May et al 2005:23)

The researchers in this study sought to identify the views of local residents as to how their local drug problems should be tackled. Over a quarter of respondents stated that there needed to be more of a police presence on the streets with only 10% feeling that the police were doing all they could. However, three quarters of respondents felt that tackling the local drug problem was a responsibility that needed to be shared by the whole community. There are though likely to be certain requirements for communities to be able to tackle their local drug problem:

“For this to occur, a local community needs to be cohesive and to have mutual trust and shared expectations. In short there needs to be a collective sense of efficacy if residents are to be able to exercise any form of informal social control over the areas in which they live.” (May et al 2005:29)

Other research carried out for the Joseph Rowntree Foundation is rather more pessimistic about what it sees as the prospects for successfully tackling local drug problems. On the basis of their own qualitative study of the impact of local drug problems on communities Shiner and colleagues concluded, for example, that:

“Widespread drug use has given rise to a seemingly intractable set of problems dating back to the middle of the last century and there is little sign



that these problems are abating. Despite the best efforts of the police, and the medical establishment, illegal drugs continue to be readily available and widely used. Even when the police are able to identify and arrest major drug dealing operations this has little if any discernible impact on price and availability” (Shiner et al 2004:48).

On the basis of these studies one would have to conclude that we have had only limited success within the U.K. over the last ten to fifteen years in tackling the impact of drug abuse on local communities.

- Drug Related Crime

Information on the nature and the extent of drug related offending has been provided in the U.K. through a range of studies including work involving interviewing and drug testing arrestees. The ADAM and the New ADAM (Arrestee Drug Abuse Monitoring) programmes in the U.K have provided a means of systematically measuring the proportion of arrestees using illegal drugs and the extent of the link between drug use and offending (at least that element which involves a police arrest). Holloway and colleagues have produced an overview of the results of having interviewed and drug tested over three thousand arrestees in England between 1999 and 2002. In year one of their research 25% of arrestees tested positive for opiates (n=1434), by year three this figure had increased to 28%. Similarly, in year one 15% of arrestees tested positive for cocaine, whilst by 2002 this figure had increased to 23%. In terms of the link between drugs and crime the New ADAM research team were able to report a number of significant reductions in drug related offending over the study period. For example, the proportion of cocaine users reporting one or more property crimes in the last 12 months fell from 59% in year one to 51% in year three, overall the proportion of arrestees reporting property crime in the last 12 months fell from 53% in year one to 48% in year three. The link between drugs and crime was very evident in this research with, for example, 17% of non drug using arrestees in year three reporting one or more property crime in the last 12 months, compared to 85% of those who had used crack cocaine or heroin.

Similar research carried out in Scotland in 2000 found that fully 71% of arrestees tested positive for at least one controlled drug, 31% tested positive for opiates and 33% tested positive for benzodiazepines (McKeganey et al 2000). Within this Scottish research 43% of injectors had shared needles within the last three days, 25% reported that they had been in receipt of an illegal income in the last 30 days. Amongst current injectors 61% reported having been in receipt of an illegal income in the last 30 days whilst amongst those arrestees who had not used any illegal drugs over the last 12 months only 5% reported having been in receipt of illegal income over the last 30 days. These figures confirm the close association between illegal drug use and crime and the challenge which we still face within the U.K. of breaking the link between problematic drug use and offending. Crucially, within the Scottish research only 44% of female drug using arrestees and 19% of male drug using arrestees, had had prior contact with a drug



treatment agency. These findings indicate the shortfall in access to treatment of a significant proportion of drug using arrestees within Scotland (McKeganey et al 2000)

Discussion

In the light of the previous section one would have to say that the harm reduction approach within the U.K. appears to have had only modest success in reducing the breadth of drug related harms. With approaching fifteen years experience of harm reduction initiatives we have a situation in which around 40% of drug injectors within the U.K. are Hepatitis C positive, in which thousands of drug users are dying from drug related causes, in which the prevalence of problem drug use has escalated substantially, and in drug use continues to fuel high levels of offending and to undermine communities and families throughout the U.K. It is worth considering in the discussion section of this paper why we have not had more success in reducing these various drug related harms.

- The level of harm reduced in the face of continuing drug use is less than it needs to be

The principle of reducing drug related harm has an immediate and almost unquestioned appeal. However, whilst the notion of reducing harm is very appealing this is not the same thing as saying that it is possible to reduce drug related harm to a sufficient degree, in the face of continuing drug use, to enable drug users and those around them, to avoid a range of adverse outcomes. The effectiveness of harm reduction initiatives in this sphere may lie not with the question of whether it is possible to reduce drug related risk behaviours per se, but by how much such behaviours can be reduced. Within the U.K. Unlinked Anonymous Prevalence Monitoring Programme 29% of a total of 1677 drug injectors studied in 2003 reported sharing injecting equipment within the last month. In Scotland in 2003/4, 34% of injecting drug users reported on the Drug Misuse Database reported sharing needles and syringes in the previous month. This figure compares to 32% to 36% during the period 1998 to 2002 (HPA2004). These figures indicate then that despite a plethora of initiatives aimed at increasing drug injector's awareness of the risks of needle and syringe sharing, and of providing drug users with access to sterile injecting equipment, that around a third of injectors are still sharing injecting equipment. Whilst the level of sharing identified in these studies may not be sufficient to generate epidemic spread of HIV infection the level of sharing identified may well be sufficient to generate further spread of Hepatitis C infection given that it is already more prevalent than HIV amongst injecting drug users within the U.K.

Existing initiatives aimed at reducing drug related risk behaviour are not able to exert sufficient control over injectors risk behaviour

Another reason why existing harm reduction measures may have had only modest success in reducing the level of drug related harm may have to do with the degree to which these initiatives have been able to exert control over individuals' injecting behaviour. A good illustration here may well be the provision of sterile injecting



equipment to injecting drug users. This is an initiative which, on the face of it, should reduce the risk of drug injectors acquiring HIV and other blood borne infections. However, if a sterile needle and syringe is used in a highly un-sterile environment (for example a toilet or derelict building) to inject highly toxic substances, the drug user is likely to experience serious adverse health effects irrespective of the cleanliness of the injecting equipment provided. For services to be successful in further reducing the risks of continued drug injecting it may be necessary to intervene much more directly in the injecting event, for example by providing advice on injecting technique, by supervising or administering injections to naive users, by providing drug users with a setting where they can use their street drugs under some level of medical supervision and ultimately by providing drug users with the drugs which they are injecting or using by some other means. At the moment there are no services within the U.K. that are developing such an intensive array of harm reduction measures although in fact anything short of such an array may well leave considerable areas of injecting risk behaviour intact and leave substantial numbers of injecting drug users experiencing a range of harms associated with their continued drug use.

Shortcomings in the quality of harm reduction work

There have been surprisingly few attempts to assess the quality of harm reduction initiatives within the U.K. Recently, however, the National Treatment Agency has undertaken an assessment of needle and syringe exchange services. Whilst the results of this research have not yet been published, an early report provided by Abdulrahim and colleagues (Abdulrahim et al 2005) gives considerable cause for concern at the quality of harm reduction work within at least some needle and syringe exchange schemes. On the basis of survey of needle and syringe exchange clinics across the U.K. the authors found that 16% of needle and syringe exchange clinics did not discuss issues to do with needle and syringe sharing in their assessments of clients, 30% did not discuss issues to do with safer injecting techniques, 35% did not discuss injecting hygiene, and 61% did not discuss issues to do with the clients possible registration with a general practitioner. These are all areas which bear directly upon improving drug users' health. The fact that substantial numbers of needle and syringe exchange clinics were not discussing these areas gives an indication that the quality of professional work within a significant number of clinics is falling below the level that would be needed to significantly reduce array of drug related harms.

- A lack in the quantity of harm reduction work

Another possible explanation for the persistence of serious adverse harms associated with illegal drug use may be the fact the level of investment in harm reduction initiatives is itself less than it would need to be for those initiatives to be successful in reducing drug related harm. It is difficult to assess the weight of this explanation because of the lack of detailed information on the funding of harm reduction initiatives within the U.K. However, on the basis of some of the statements made about harm reduction on the part of both advocates and commentators, as well as official government policy, it is difficult



to accept that the level of investment within harm reduction has been so modest as to fall well short of that which would be required to bring about a major reduction in drug related harm. The updated U.K. drug strategy, for example, refers to the fact that ‘Nearly all DAT area (97%) have harm reduction services and 87% provide access to drug prescribing services’ (Updated Drug Strategy 2002:52). With regard to substitute prescribing, although there is a lack of clear costing data with which to assess the level of funding for substitute prescribing services.

Peter Martin has reported that approaching half of the total U.K. drug abuse treatment budget (itself estimated to be in the region of £500m a year) is now being spent on providing substitute medication to dependent drug users (Martin 2004). Within Scotland whilst there are no accurate data on the number of drug users being prescribed methadone, recent research undertaken by the Scottish Executive has estimated that as many as 19,000 drug users (more than a third of the total estimated addict population within Scotland) now receiving methadone (ISD 2004). On the basis of these sorts of proportions then it cannot be said that there has been a lack of support for harm reduction initiatives within England or Scotland.

- The focus on reducing drug related harm has been directed too much at the individual drug user

Another possible reason why there has been the persistence of drug related harm within the U.K. may be that the harms that have been targeted in policy and practice have been too closely associated with the individual drug user. Again it is difficult to judge the degree to which this is the case. However, if one focuses on the children of drug dependent parents there are, by 2006, relatively few drug services oriented towards supporting the children within drug dependent households. Indeed it can be argued that it was not until the publication of the Hidden Harm report in 2003 that there was even significant official recognition that children living within drug dependent households were in need of care and support. Further, whilst within the last few years there has been a growing awareness of the impact of parental drug use on children there remains hardly any official awareness of, or provision for, children affected by their siblings drug use despite the findings of recent research which has shown that the lives of children can be seriously adversely affected by sibling drug use (Barnard 2005). It may well be the case that in relation to reducing the harms experienced by families members our efforts have been impeded by too great a concentration on the individual drug user (Barnard 2007).

The Impossibility of eliminating drug related harm

Finally, our limited success in reducing drug related harms may arise from the fact that illegal drug use, drug dependence etc are intrinsically harmful in and of themselves. Whilst one may reduce some of the harms of dependent drug use, nevertheless it may well be the case that so long as the drug use itself continues there will be a continuing element of harm arising as a consequence. For example, whilst it is possible through judicious prescribing of methadone to reduce individuals’ needs to turn to crime to



support their drug use, nevertheless to the extent that some level of illegal drug use persists there may be a continuing though lowered involvement in criminal activities to support that drug use. Indeed both tautologically and literally it may only be with the complete cessation of illegal drug use that the harms of such drug use can themselves be eliminated.

CONCLUSIONS

Whilst in the late 1980's there were good grounds for fearing that AIDS and HIV might become a national epidemic amongst injecting drug users in the U.K. and for suggesting that HIV and AIDS represented a greater threat to individual and public health than drug use itself in fact the reverse has been the case. HIV/AIDS has remained a relative rarity amongst injecting drug users whilst problematic drug use has become widespread in communities across the U.K. Further, on the basis of the evidence assembled within this paper, one would have to conclude that in the face of substantial support for harm reduction policies and practices within the U.K. nevertheless substantial drug related harms remain. What might one conclude from this with regard to policy and practice within the drugs field?

Writing in 1990 Gerry Stimson recognised that over time the shifts in policy and practice heralded by the AIDS and Drug Misuse Report from the Advisory Council on the Misuse of Drugs might themselves be vulnerable to challenge in the face of escalating levels of HIV infection and continuing drug related harm:

“For how long will agencies and their staff be able to sustain this new image of the drug user, when (to be realistically pessimistic) they will be faced with recalcitrant injectors many of whom will not change their behaviour? How long will the doors remain open to all comers, and for how long will staff cope with the stress of such working conditions. For how will drug workers agree to give up on dependence and other chronic drug problems? How acceptable will these policies and practices appear when there are substantial numbers of HIV positive sick injectors? How much concern will there be for the injector when the epidemic becomes established in heterosexual populations?”

Stimson further observed that in relation to the shift in drug policies and practices within the U.K. that:

“The stakes are high, if the paradigm turns out to be wrong or ineffectual, the consequences will be disastrous” (Stimson 1990:338)

Whilst for Stimson the key challenge to the harm reduction approach appeared to be the possible failure to curb the further spread of HIV infection in fact it could be said that a greater challenge has come from the limited spread of HIV amongst injecting drug users combined with the persistence and escalation in drug related harms and prevalence. In



the light of this it is possible to conclude that it is the prevention of drug use rather than the reduction of drug related harm which now needs to become the central direction of policy and provision within the drugs field in the U.K.

Given the current extent of problem drug use within the U.K. however it would clearly be inappropriate to entirely switch attention from reducing the harms of continuing drug use to preventing drug abuse itself - such a policy would seem to be a classic case of locking the stable door long after the horse has bolted. Nevertheless, high as drug user prevalence is within the U.K. the potential for further increases in prevalence remain. At the present time the estimated 350,000 problem drug users within the U.K. still only represents around one percent of the U.K. population aged 15 to 55. On this basis then one would have to say that the potential for further spread of illegal drug use is considerable and the need for effective means of drug prevention greater now than at any time in the past. Within these terms there needs to be a renewed focus upon drug prevention within the U.K. In addition, however, there will be a need to continue our efforts directed at reducing the harms of continued drug use. Crucially though the notion of the harms that need to be reduced have to be extended well beyond the individual drug user.

Such an extension will present a substantial challenge to the harm reduction movement since it cannot be assumed that a commitment to reduce the harms experienced by those continuing to use illegal drugs will be equally applicable to those who are affected by others drug use. The clearest example of this challenge lies in relation to the children affected by their parent's drug use/dependency where agencies may increasingly have to identify whose needs are paramount (those of the child or those of the parent) in seeking to reduce the impact of parental drug use on children. There is though a further reason why prevention rather than harm reduction may need now to become the major concern of drug policy and practice which is that at the current level of prevalence many of the drug related harms which we have become aware of over the last few years are already so burdensome that it is beyond the capacity of our existing services to meet the needs of the individuals involved.

Again the best example of this has to be children within addict households. It is currently estimated that there may be in excess of 350,000 children with one or both parents dependent upon illegal drugs (Hidden Harm 2003). If only a quarter of those children are in need of support then meeting the needs of these children is already well beyond the capacity of social work services within the U.K. For many of these children the only prospect of reducing the harm associated with parental drug use may actually be the reduction of parental drug use itself. Much the same case can be made in relation to many of the other drug related harms (Hepatitis C, overdose, dual diagnosis, etc) such that it may well be only by reducing the extent of problem drug use that one can bring about a substantial reduction in the array of drug related harms within the U.K.



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Note: The following is an extract from the whole paper, covering points which Professor Neil McKeganey delivered in support of his main paper at the ITF Conference in London on 9th August. The whole paper can be obtained by applying to Professor McKeganey at the Centre for Drug Misuse Research, Glasgow.

Sociology and Substance Use

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Executive summary

This report looks at the contribution of sociological research on substance use and misuse within the UK and considers possible future developments in this area over the next 20 years.

In the case of illegal drug use, there are indications that the prevalence of abuse has increased dramatically in the last 50 years. In 1955, for example, there were 46 new cases on the Home Office Addicts Index. By 1995 this figure had increased to 14,735.

With regard to the future, we have identified a number of scenarios covering possible increases in the prevalence of problem drug use. These range from a high-prevalence scenario of around 1 million problem drug users by 2025, to a medium-prevalence



scenario of around 750,000 problem drug users, a low-prevalence scenario of around 500,000 problem drug users, and a reducing-prevalence scenario of around 300,000 problem drug users. On the basis of the longer-term trend of problem drug use of the last 40 years, it is certainly not beyond the bounds of credibility that the number of problem drug users could increase three-fold to the 1 million level by 2025.

The impacts of a possible three-fold increase in prevalence, if it occurred, could be considerable. For example, the number of drug related deaths per year could increase from around 2,000 to around 6,000 per year. There could be around 400,000 drug users who are Hepatitis C positive and 10,000 who are HIV positive.

The economic and social cost of drug abuse could increase to around £35 billion a year.

To date, the proportions of drug treatment clients over 35 has been low in the UK and elsewhere. It is possible that, in future years, society will find itself dealing with large numbers of middle-aged and even elderly 'difficult-to-treat' addicts.

It is possible that over the next 20 years the illegal drug problem in the UK will expand beyond the capacity of society to cope.

Nobody knows whether illegal drug use will expand to the worst-case scenario of a three-fold increase in problem drug user numbers in the UK or whether it will reduce.

If we are to avoid the point where drug abuse reaches a level that is beyond the capacity of society to cope with it (and we have no way of knowing what that point may be) there will be a need to substantially increase funding in the areas of drug prevention, drug treatment and drug enforcement and to ensure that interventions in each of these areas are maximally effective.

An evaluation of DTTOs concluded that there was a low completion rate which probably reflected the challenges faced by local services in keeping chaotic drug users on an intensive and highly structured programme (Audit Commission, 2002).

Increasingly, service provision for both illegal drug use and alcohol problems is being delivered in the form of integrated packages of care that incorporate general health, social and other forms of support, as well as drug misuse treatment (National Treatment Agency, 2002). This is resulting in an expansion of 'wraparound' housing, education, training and employment services. Although such developments have yet to be thoroughly evaluated, the complexity and extent of problems accompanying addiction is likely to mean that enabling service users to achieve relatively simple goals, such as moving into paid employment or retaining secure accommodation, will prove very difficult.



Looking to the future in drug treatment research

In the future, sociologists must build on existing research evidence to increase understanding of how services might better help vulnerable and marginalised subgroups of drug users, the families and carers of drug users, and the communities in which drug users live. Equally, it will be necessary to investigate and evaluate a broader range of drug treatments than has been the case hitherto.

Both of these possibilities highlight the importance of future research into the prevalence and treatment needs of older drug users. However, at the opposite end of the age spectrum, society must deal with ever-younger drug users. It is here that the boundary between treatment and prevention is most blurred. Although the effectiveness of drug prevention programmes has been widely contested, research indicates that drug education – if delivered in the proper context and in the appropriate way – can reduce drug misuse or at least delay the onset of experimentation. (DrugScope, 2004) Building on this evidence, the Department for Education and Skills (2004) now provides detailed guidance on what schools should be doing in this area and efforts are being made to equip young people with core life skills that will protect them against drug taking.

The importance of mutual aid in recovery processes is clearly reflected in the popularity of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). But mutual-aid practices are increasingly varied. For example, there are trends toward the political organisation of addicts, the professionalisation of mutual aid movements and the globalisation of recovery mutual aid via the Internet.

Finally, it is important to highlight the role that local communities might play in tackling drug problems in the future. While community-based responses to drug problems are to be welcomed, the success of such initiatives may depend upon first re-establishing a sense of safety within local neighbourhoods and, secondly, increasing understanding and trust between local people who use drugs and those who do not

While it is not possible to say with any certainty what the level of illegal drug use will be in 2025, we can speculate, on the basis of past increases in prevalence, that the next 20 years may witness a three-fold increase in prevalence.

The result of such a development could be that within the next 20 years the prevalence of problematic drug use in the UK could increase from around the 350,000 to 1 million.

It is possible that any significant expansion in the use of heroin, cocaine and any new drugs yet to be developed might occur among new social groups whose “risk profile” is very different from those who are currently using these drugs.

In the next 20 years there may also be marked changes in the nature of drug treatment services, with less focus on addiction and more focus on intoxication (Caulkins et al., 2003). There may be a need for drug treatment services to be much more responsive to



the greater consumer power and knowledge of a large group of users who do not have the traditional risk profile which includes abuse and social exclusion. Equally, there will be a need to identify exactly what 'treatment' means for individuals who are not yet addicted but who may be on the road to addiction. Other demographic changes are also likely to influence the nature of drug treatment, including the decreasing age of onset of illegal drug use as well as individuals who have remained drug dependent into their 60s and 70s.

The field of prevention might also undergo dramatic change. Drug prevention technology today is somewhat underdeveloped. It is possible that the introduction of cheap, non-invasive, drug-testing kits might fundamentally change the terrain of drug prevention, allowing services to focus directly on those who are using specific substances at a point well before they get into difficulty with those substances. Similarly, it may be that widespread drug testing itself reduces the overall prevalence of drug use. We might see widespread erosion of the rights of individuals as a result of their drug use (McKeganey, 2004).

There will be a growing need to support professional practice in each of these areas to ensure that professional practice is based on clear evidence of “what works.” This will necessitate much greater investment in research to establish the effectiveness of different approaches to tackling society's drug problem.



Drug Exposure, Abuse and Dependence: Lessons from Physicians, Addicts and Second-Hand Smoke

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Mark. S. Gold holds the post of Distinguished Professor at the University of Florida, College of Medicine's Brain Institute, Departments of Psychiatry, Neuroscience, Anaesthesiology, Community Health & Family Medicine, Vice-Chair for Education and Chief, Division of Addiction Medicine. Dr. Gold is a Distinguished Fellow of the American Psychiatric Association (2003), University of Florida College of Medicine 2003 Exemplary Teacher, Underrepresented Minority Mentor (2004), Up to Date's Addiction Medicine Section Editor, American Academy of Addiction Psychiatry (2005: Founder's Award), 24th Annual Nelson J. Bradley Career Life Time Achievement Award (2006), Teacher of the Year, researcher and inventor who has worked for 35 years to develop models for understanding the effects of tobacco and other drugs on the brain and behaviour. Dr. Gold has developed animal models which have led to new treatments for addicts and also conceptualized hypotheses which were more than novel but also yielded new approaches to treat patients. Under his leadership, the Division of Addiction Medicine at the University of Florida has grown from Dr. Gold in 1990 to one of the largest addiction medicine research, education and practice Divisions in the USA. At the present time, the Division has major funded projects in proteomics, self-administration, functional imaging, public health, stem cells, impaired professionals, and nanotechnology.

Dr. Gold's work on the brain systems underlying the effects of opiate drugs led to a dramatic change in the way opiate action was understood. His work on cocaine led to a complete change in thinking about cocaine's addiction liability, acute and chronic actions. In addition to theory, his research has led to changes in the treatment of opiate and also cocaine addiction. Most recently he has made many contributions to the understanding of the second hand effects of tobacco and for that matter all drugs smoked and the consequences of expired medications in closed spaces such as operating rooms. In 2005 Mark and his co-workers were first to demonstrate that intravenously administered



anaesthetics and analgesics were exhaled and those controlled and dangerous substances are active in the air of operating rooms and other sites where given to patients.

Thank you it's a pleasure to be here. Minister Qaderi – I want you to know that I drink pomegranate juice every day and I would like to thank you for your talk. Researchers don't often get out and this invitation has helped me to think about things in a different way. The thought today is the relevance of second hand smoke research and second hand drugs. Before I do that a thought about needles and harm reduction – in animal research we have basically an animal protection group that oversees our work to be certain that we don't allow animals a harm reduction approach; giving them their drugs and self-administration modules is regulated and would be seen as cruel. So some of the very same protocols that have been applied to humans if you were to present them to a basic scientist they would be appalled.

I work with the Brian Institute and thanks to a Department of Defence grant and a series of other grants, McKnight family included, we have had over \$100 million to develop an infrastructure for research. And that research is multi-disciplinary with neurologists, neuroscientists, neurosurgeons and our group and if my wife were here she would say that even in Florida I work too late – the light's still on. No one knows where Gainesville is, but three hurricanes found us and the New York Times declared us the hurricane capital of Florida, so mostly I was ducking as my trees were falling down. Coming to England I thought I would bring with me this – “Don't worry about avoiding temptation - as you grow older it will avoid you” and Churchill had a brilliance about him and this really has to do with the role of pleasure and pleasure cells and their decline over time.

The bottom line is that people who image brain reward and reinforcement centres say that the peak is somehow in your teens and progressively you lose the substrate from which intense drug reward or intense pleasure derives. This is a troubling subject for me – I'm 57 years old and I said to the Director of NIDA who shows me this graph – “You know, Nora, I don't feel I have a pleasure problem – I feel that I have a joy in every day life.” After 50 she can hardly show any pleasure cells and her answer to this was, “I was operating on the basis of euphoric recall.” It wasn't that it was secondary pleasure – my mind reminded myself and then occupied the pleasure circuits...I won't go into the details! When you speak after lunch you need a few jokes to start –and one of the ways to keep working in this field after 30 years and to write as I do, is to keep a sense of humour.

So the converse of Churchill's statement is true – the younger that use begins, the more likely the brain is to declare it normal. The more likely the brain is to incorporate it and the more likely it is that a person develops a life long, chronic relapsing illness. That's very clear from tobacco research, and the whole basis of tobacco research is to delay initiation - because if you start smoking at 12 you will end up smoking a pack a day, but if you start smoking at 40 you only smoke 3 cigarettes a day. Again, it's a substrate issue and a timing issue – it takes a while for the brain to develop.



Prevention focuses on the young for that reason. I joked but it's true that I spend most of my time with rats. We teach them to self-administer drugs, we look at their brain reward threshold and we have a whole host of projects far beyond what I can discuss today. But I will tell you this – given unlimited access to cocaine, rats self administer cocaine to death, the parasite kills the host. That's the bottom line. As for adolescents, what are they thinking? Their brains are developing and use at that time is misconstrued as part of adolescence. Or their brain may say "Gee, maybe I'm supposed to have X amounts of marijuana in my brain at that time," and it could change the brain's reward threshold that the person was born with - change it so that they need bungee jumping to have the same sort of pleasure that they might have from singing in the church choir. And this is a very real prognostication from our animal work. The brain takes a long time to develop and you can kind of see brain imaging, suffice it to say that the female brain is not even fully developed until the age of 21 – meaning the outside crevices and what it looks like, and the male brain may never fully develop – an interesting notion ...

In our current research work, we have over 20 scientists and a large number of projects ongoing and I could talk about any of them. In fact today, at lunch, I was talking about our project comparing club drugs to a football head trauma where a person becomes amnastic, and we have nice work published on that as well. A little more University of Florida trivia – University of Florida is called "The Gators" because we invented Gatorade – thanks to Robert Cade we have turned out two Gatorade professors a year. We are also number one in the States in basketball, and in the "Best College Town in America" competition, we're ranked number three.

But, we are also ranked number one by *High Times* magazine for having the most drug use. And Florida is an importation area as well as a growing area. Gainesville has its own marijuana called "Gainesville Brain" and we have a number of people who were recently in the citrus industry who have moved into marijuana cultivation. So we are ranked number one unfortunately, both for basketball and by *High Times*. Which brings us to marijuana. In the United States, they have a saying about the "other white meat" – meaning pork. Marijuana is the "other smoke," and part of the second hand discussion is where does marijuana smoking fit into the Safe and Clean Air Act? And so we consider marijuana and anything that can be smoked, methamphetamine and anything that's cooked, as a source of environmental contagion and a pollutant that needs to be avoided.

In part because many of the second hand drugs are active in the brain, the child oftentimes is the involuntary recipient of those drugs. In other words, children of cigarette smokers smoke cigarettes at an alarmingly high rate, not just because of modelling or access, but because they have been smoking their entire life – but against their will. Their parents have filled up the atmosphere with cigarette smoke which they inhale and the same applies to the children of cannabis smokers, the same applies to the children of crack smokers, same applies to children of opium smokers – the same applies to anyone who lives near a person making methamphetamine.



Think, how ridiculous is it that when police figure out that there's a meth lab, they go in there with hazmat gear. But everyone's been living there all along – breathing second hand and toxic materials. So a lot of good prevention comes out of understanding the science. It's the drug. The “harm reduction” assumes that the drug is not the problem, but the drug is the problem and it's not withdrawal that's the problem. It is addiction and dependence that's the problem.

A drug is an acquired primary drive in the dependence model so that a human, or an animal, that had no previous interest in any drug is given the opportunity to self-administer it. They do and develop a life long pattern of use – they acquire the drive to that drug. It's a tragic but very easily obtained outcome in all basic scientific research. Addiction is pathological attachment – it's like a bad love object and you acquire the desire to take the drug and you continue to use despite consequences. That has led us to a variety of treatments, but most of them have been related to overdose and/or detoxification, yet it's a chronic relapsing disorder and people chronically relapse. So people in my area have always said you have to focus on prevention because treatment is, at best, incomplete and there is, as you will see later, an active debate as to whether there is such a thing as full recovery. Does the brain really fully recover? And that's an argument we need to have. Prevention is the only complete treatment and we should use science for prevention.

Cocaine is a dangerous drug - and the brain changes after drugs of abuse in a way that makes use more likely and that makes toxic side effects more likely. And after all, won't brain research come to the point where it says, “It's not what the person says after their de-tox, it's what their brain says?” Think about it – if, God forbid, you were to have a heart attack, your doctor would measure a heart enzyme that's in the blood and then tell you whether it's time to leave the hospital. Rather than you saying “I'm fine, I want to get up and leave.” The independent markers for addiction liability, addiction relapse and addiction related brain changes will be here soon enough and they may prove that certain people may not recover the way we think. They are definitely going to show the difference between paediatric onset addiction and late onset addiction. Given unlimited access to potent drugs of abuse – “harm reduction” is an oxymoron - it's really not possible.

A couple more things – the United States is on the verge of a new cocaine epidemic. The drugs are in the state of Florida and the DEA has looked at the medical examiners reports for cocaine, as well as, student reports. And drug use has gone up again in Florida overall, in high schools and in the Universities and now cocaine deaths are at levels that are almost unheard of. So we should keep an eye on this because we are seeing a great deal of it. By the way, it occurs in the most affluent areas and in areas with students, so that per capita the number one areas in Florida are Tallahassee, Gainesville and Sarasota.

There are limits to rat research and I have a paper coming out on the limitations to rat research. A rat is not a person. If rat research was perfect, we could treat addicted rats with AA (Alcoholics Anonymous.) But, they don't actually go to AA meetings and



there's no process addiction in rats – you can't get them to gamble and they're not interested in pornography.

Back to tobacco - not all animals will smoke. I tried to train my cockatiel to smoke – people are very concerned about animals smoking. I wish we had the same concern about people using the drugs I give to animals. We don't generally have this, but the moral of this story is - you can't make a bird smoke. You also can only make half of the non-human primates smoke - that's even with giving them rewards like bananas and saying "Good monkey!" They don't want to smoke and even if you put them in a chamber with smoke, they hold their breath. That's a big difference between some primates and humans. Think about how amazing cigarette smoking is – you actually form a new neuronal connection that suppresses the cough reflex, and it's there for ever. It's remarkable – brand new nerves that say "forget that smoke, don't worry about that smoke." Well it's only been very recently that people have said "Well gee – what about the smoke?" How did we get a smoking epidemic in the United States?

Let's consider doctors. Doctors helped to promote cigarette smoking – 20,000 physicians said "Luckies are less irritating." In one Luckies advert, if somebody coughed, a "good doctor" would say, "I hear that cough – you should switch to Luckies because that's throat protection against irritation." Another doctor figure said, "Many people smoke and I never saw a throat irritation." The moral of this story really is that physicians have been very poor role models – worse than that, they are uneducated in general when it comes to tobacco, alcohol and other drugs and relate most experiences to themselves.

They have very little core competency. We demonstrated in an experiment that they cannot even identify the foetal alcohol syndrome. If you actually set up a competency test, they will uniformly fail. So people will turn to physicians who will say "drugs of abuse are safe until proven dangerous, but new medications are dangerous until proven safe" and with that suspension of reality "every drug of abuse is safe until we prove it dangerous" – and that's been the conundrum. Our group put together the American College of Obstetrics and Gynaecology's guidelines. Think about how sad that is – I'm not even in that college but I know that their drug guidelines say no performance enhancing drugs. If you could take a drug during pregnancy and give birth to Einstein, people would do it. Or if you could take a drug during pregnancy and get Shaquille O'Neal, people would. But in reality, you only get decrement from a base line. Since you are not born with a flash card that says "I'm going to be a nuclear physicist," you can't tell that a person didn't achieve their potential because they're teaching physics in high school. Nevertheless it's clear there's no performance enhancement.

Second hand smoke – in the United States there are 35,000 deaths a year due to second hand smoke. As a result, the Surgeon General has declared that not one molecule of second hand smoke is allowable in the air – not one. Okay, what about other things in the air? If tobacco is so bad – and you can see why it's so bad, by the way – then the second hand effects can be dramatic. Every organ of the body can lose enzyme activity and, of course, the brain can change after second hand smoke. Our group showed that you could



take a child driving in a car with the mother who is smoking and get that child to breathe and measure cotinine in its breath. So the child in the car with the mother, who is smoking, inhales the smoke and it is metabolised as if the child was smoking all along.

The moral of this whole thing is that we should see how the drugs we are concerned with relate to clean air, and relate to the laws which are on the books right now to protect people from second hand smoke. I looked at other things, given nanotechnology, and one of the problems I was trying to understand was why is it that doctors who are drug addicts are anaesthesiologists? I asked the Chairman of Anaesthesiology at the University of Florida and he gave me a slide – a slide that they show during orientation to the new anaesthesia house staff (slide jokes about correlation between anaesthesiologists and drug addiction). So it's a well kept secret amongst themselves that being an anaesthesiologist carries a great deal of risk. I had to say "Why would that be," and so I asked people and they said it was because they have the best drugs.

I called Floyd Bloom at Scripps and said "do you have a drug problem at Scripps?" and he said "no, of course not." They have the best drugs. They give drugs to animals in trials. They have drugs all over the place. How about oncologists? - no. But anaesthesiologists? - yes. So I proposed this hypothesis that said that just because we had bad technology before and couldn't measure it, there may be exhalation of drugs that are inhaled. I think this is going to be demonstrated as well in these common public shooting galleries, where if somebody is injecting themselves with heroin, there will be exhaled morphine in the environment.

Our hypothesis was in the course of anaesthesiology, in giving opiates. There would be a certain percentage of it that would be exhaled that you could detect now. There is a rich history of all this and the moral of the story is that this does help us to explain why 25% of the state of Florida's addicted doctors are anaesthesiologists - because the environment of the operating room is rarely analysed. When we went into the operating room with PhD students and engineering students and took air samples, what we found were the drugs that they were giving the patient that are supposed to be in a closed loop. In other words, they gave them IV fentanyl and we measured it in the air. We said how could it be in the air? Is it because of leaks? With open heart surgery it was the same. Is it active? Yes, it's so active it could change the brain through second hand exposure.

That's fentanyl in the air, in the cardiovascular suite – an opiate about ten times more powerful than morphine. And in the hallway, we didn't have any. This was fentanyl from a person breathing. Keep in mind as doctors got better drugs for anaesthesia analgesic – fentanyl rather than morphine - the air handling systems have not kept up. So if you check with your own hospitals you may find that the air handling systems are circa 1985, but the drugs being given to people in surgery are 2006 potency. Fentanyl also is the potent drug that was used in the theatre episode in Moscow when the Chechyns pumped in fentanyl gas.



So one of the original arguments against my hypothesis was “Okay Dr. Gold, but how do you know it is active in the air?” Well the answer comes from Moscow, and it is that if you aerosolise fentanyl you can put a whole theatre to sleep. I agree that we have to pause and ask ourselves – how much clean air do we really need? Does clean air just refer to second hand tobacco – but how about second hand narcotics? Don’t the nurses in the operating room deserve some protection from second hand anaesthetics? In the United States by the way, it was only after spontaneous abortion rates were calculated by public health officials that they put nitrous oxide detectors in the operating rooms. So do we need to have spontaneous abortions before they do something?

We are expanding this work – I am now measuring fentanyl over the sharps boxes. Anybody who works in a hospital knows that doctors open the vials and throw things away and they don’t have a hood in the operating room. So, they don’t have a hood and they put them in a box – the box serves as a source for fentanyl dissipation all over the air.

The next question is how much is enough? We don’t know – we know it’s very potent and it’s certainly a sensitising dose. But if the Surgeon General says any second hand tobacco smoke is dangerous, can get into the body and can change the person’s physical risk factors and their brain against their will - certainly the same would apply to anything that’s smoked. Another thing – if you know anyone who is a fentanyl abuser, they are 90% certain to be a surgeon or an anaesthesiologist of the doctor addicts. Anaesthesiologists always have the highest relapse rate. This has always been troubling to people who run professional programmes, but if you are an addict and they don’t realise that there are second hand drugs in the operating theatres, they put you back in the operating room. One addict literally threw up when they put him back to work in the operating theatre.

I am happy to send anybody a summary of this work which has been covered in the USA and also in *Nature* in the UK.

What else is in the air? We are measuring second hand benzodiazepines in the air. So in an emergency room, where they give a person benzodiazepines intravenously, the patient exhales it into the air. It is a work risk and I have recently met with our Centre for Disease Control - they have an Occupational Workplace division for hospitals and they haven’t really analysed all this. I have also been doing casual explorations, deploying the med students. I make them go into the operating room with alcohol wipes and I have them wipe down the surfaces. They show there is fentanyl and other drugs on the walls and on the surfaces where the anaesthesiologists work – because without anyone specifically thinking that they are there, no one is specifically removing them. Think about how long it takes to get methamphetamine out of a building, once the police have been in. Another area of concern is of course surgeons. People often pick on psychiatrists but this is an area where psychiatrists are more mentally stable than surgeons or anaesthesiologists, and the same for paediatricians.



I see I am out of time. Next time I come, I would like to tell you about head trauma versus club drugs, but I just did want to tell you there is a whole world of nanotechnology. It has been used by famous perfume makers - I met with a perfume manufacturer who was interested in nanotechnology as it might relate to the best fragrances and cosmetics.

But we have neglected protecting children in the households and people in the workplace by not insisting that the same technology be applied to evaluate what drugs are in the air - because you can measure all kinds of things if you look. Believe me, I am looking. We are now sampling the exposed skin of the anaesthesiologists. Some of you may know that some of them wear short sleeves, others after they put the IV in the person take their gloves off and my medical anthropologist had pictures of an anaesthesiologist who would rub his hair with his gloves and then scrub out. There again - hair exposure, on the skin, in the air - and we are calling for the evaluation of workplaces.

Let me summarise the work. We can detect very, very small amounts of second hand drugs and we have to decide how much clean air is enough. If the decision has already been made for second hand tobacco and it is zero tolerance, how much second hand cannabis, how much second hand methamphetamine, how much second hand crack should we tolerate? No wonder children of drug using parents have the highest rates of drug abuse and addiction – they’ve been using drugs, I believe, for their entire life – but against their will.



Is There Anything Such As E.U. Drug Policy?

RAYMOND YANS

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Mr. Yans was until July 2006, the Chairman of the Dublin Group, an international informal consultation and coordination mechanism for the implementation of UN Drug Conventions. The group includes the 25 member states of the EU plus Australia, Canada, USA, Japan and Norway. He was an expert at the Belgian Ministry of Foreign Affairs on Narcotic Drugs Control since 1994 and headed the Ministry's Drug Unit from 1995 – 1999, and since 2003. He was the Chair of the EU Drug Police Cooperation Working Group during the Belgian Presidency of the EU in 2001. Raymond was active in the creation of the Cooperation Mechanism on Drugs between EU, Latin America and the Caribbean, based on the principle of co-responsibility from 1997-1999.

Raymond has written many articles, made numerous speeches and participated in eight major international drug conferences between 1995-2005 – including *European Perspectives on Policies on Drugs* in Oslo 2005; *UNODC/PARIS PACT Round Tables* – Brussels, 2003, Teheran and Istanbul 2005, Doha 2006 and *Paris Pact Consultative Group* in Rome 2003 and Vienna 2005; and *Moscow Ministerial Conference on Drug Trafficking Routes from Afghanistan* in June 2006.

Good Afternoon, European Union (EU) policy is settled by 3 different institutions. Its implementation is based on 3 pillars.

As many of you come from the American continent, I believe it will be useful to give you first a quick description of EU's functioning. I already present my excuses to my British listeners who will be obliged to listen to a presentation about the EU by someone coming from Brussels - two terms which are not very popular in this island....

I shall start with the 3 institutional powers of the EU.

1. Commission (Brussels)

Its main responsibilities are, of course, about the internal market. It also contributes to a wider set of goals, from employment and cohesion to research and innovation. Its policies may strongly influence national policies, for the best and for the worse.



In drug matters, the role of the Commission is to guide EU health references in addiction, prevention and treatment matters. Another important asset of the Commission is its very important budget for EU assistance to third world countries in drug prevention, alternative development, and law enforcement matters.

But all in all, the Commission has very little power in drug policy. It prepares the drafts and the evaluations of EU Drug Strategies and EU Drug Action Plans, but eventually, the contents of those documents are decided by member states (MS).

2. EU Council (Brussels)

Those are the MS, headed every six months by a new chair. From July 1, 2006, Finland is chairing us, following Austria's chairmanship and just before Germany takes the chair in January 2007. Eventually the Council decides almost about everything in EU drug matters. But as the rule of unanimity still prevails - it is not empowered to decide a lot together because, unanimously, in drug matters, the Dutch and the Swedes together...is a difficult story...

To make the matters slightly more difficult, I shall ask you not to confuse the EU Council (Brussels) with the Council of Europe (meeting in Strasbourg), which is an older institution created a few years after World War II (WWII). The Council of Europe is completely independent from European Union structures and it includes non EU member states such as Switzerland, Russia, Norway, Turkey, Croatia, Ukraine, Armenia

3. European Parliament (Strasbourg/Brussels)

The European Parliament could be - or could have been - a very important institution (because based on direct democracy - which the Commission is NOT). But it is an institution en devenir (in a state of evolution), a Parliament to be. So, it is actually a very expensive forum with hardly any direct power at all. Its main competence is control over European Commission budget.

But it has at the best, a consultative role in the European community drug policies. Had the European Constitution been adopted, the European Parliament would have had more power and some co-decision competences to be shared; however, with Council and Commission. But presently, this is political fiction.

Those are the 3 powers (Commission, Council and Parliament.) Now let's go to the substance and the 3 pillars.

First pillar

Community matters (which are not controlled by MS any more): Those matters are ruled by the Commission, with consultation of member states (mainly the internal market but also some other important tools, for example in health and research matters).

In drug matters: the Commission (and not the MS) has the sole authority about precursor (drugs) control. It also gives indications and support in drug prevention and treatment



schemes, including harm reduction programs and of course the Commission co-rules (with MS) the Lisbon Drug Monitoring Centre. (EMDDA)

Second Pillar

This is a responsibility of MS and is about Common Security and relations with third States. In drug matters, this pillar works rather smoothly. On bilateral level, the 25 MS of EU do indeed have very common views about our policy towards Afghanistan, Peru, Bolivia, Russia, USA, etc. All this is much helped by our coordination work inside the “Dublin Group”.

On a multilateral level, we prepare whenever possible, our common positions for common presentations in international forums such as the UN Drug Commission, the UN General Assembly, Economic and Social Council (ECOSOC), The Dublin Group, the Paris Pact, and various official international drug conferences.

Third pillar (Justice and Interior Matters)

This is also a total responsibility of the Council, of MS. In this field, we have many difficulties of coordination in drug matters: how could we possibly harmonize our national legislations and our national drug policies? How can we cooperate over the still existing borders inside the EU? How can we adjust the development of EUROPOL, EUROJUST...?

After the adoption of the Maastricht Treaty and in order to try and improve EU coherence in drug policy, the Council decided in 1997 to establish a drug inter-pillar working group: the Horizontal Drug Group (HDG).

And now, we come more to the point: this HDG adopted in December 2004 the EU Drug Strategy for 2005-2012, which consists of 2 consecutive 3-year action plans. In June 2005, we adopted the EU 2005-2008 Drug Action Plan. In that period of time, drug lobbies were of course overactive in order to try and influence our work.

Some of you might remember the hearings organized in 2005 inside the European Parliament. You might remember the famous “Catania Report” presented by Mr. Catania who chairs a Commission of the European Parliament (EP); this report criticizing UN Drug Conventions and the so-called “War on Drugs” has been widely spread around the whole world.

But what is the influence of such reports or hearings on the decisions taken actually by Member States during the EU Council meetings?

To understand the (non) influence of such European Parliament reports on the EU Council, we must first remember that Catania is a senior member of a small – even if very vocal - Italian political Party. That party is a very tiny minority in the European Parliament; however, with a few other small European parties, they formed a tiny “technical political group” in the Parliament, which enables them to receive rather



important financial and human resources and support from the Parliament (such as translation facilities and meeting rooms for organizing meetings or hearings inside the Parliament, recruitment of advisors and communication specialists, travel expenses, and so on). They also have the right to chair one Commission of the EP. They chose the civil rights commission, for obvious purposes: drug policies can be discussed there.

Second thing we should remember: EU is not a federal State, it is not even a State at all - and the European Parliament unlike the US Congress has almost no decision making powers except for budget matters, as I said earlier. Besides, such reports, or hearings held in the buildings of the European Parliament in Brussels, are not really meant to influence MS national policies. Those texts are not even sent to the “National Drug Coordinators” of EU States or to the national delegates of the HDG.

Actually the work of our “anti-prohibitionist” members of Parliament is not aimed at influencing the decision-makers: their main target is the media and the European public opinion.

After the rejection of the European Constitution, today, only the older EU Treaties (Maastricht and Nice Treaties) apply. Without any European Constitution, the European Parliament will therefore still remain for years what it is now - a useful Assembly debating about European future- but also, a sometimes vocal and rather impotent body which is sometimes used or manipulated skillfully by political minorities, sometimes very active and competent.

EU strategies and action plans are not allowed to go beyond the limits set in the European Treaties, which are actually limits set to European Power itself.

Our work in the Council is based on the EU theological principles of proportionality and subsidiarity - two EU jargon terms, understood by only a few highly specialized academics in modern semantics. They mean in clear language that anyway, national drug policies in EU are what individual MS will want them to be.....

Our EU strategies and plans are consequently only what we agreed to do together besides what we are doing alone, inside our national borders... EU drug action plans are therefore only a small part of EU Drug policies, which remain widely national.

I will nevertheless try to explain to you what we are trying to do together, 25 independent MS, together.

EU Drug Strategy

Basic aims of this strategy are:

- 1). Achievement of a high level of health protection by complementing Member States' action in preventing and reducing drug use, drug dependence and drug related harms to health and society.
- 2). Improve actions against cross-border trafficking in drugs and diversion of precursors



through enhanced law enforcement cooperation embedded in a joint approach.

- 3). And of course strengthen EU coordination mechanisms to ensure that action taken at national, regional and international levels is complementary and contributes to the effectiveness of drug policies within the EU and in its relations with other international partners.

The strategy also, quite rightly, calls for a more clearly identifiable European position in international fora, such as the UN, the Dublin Group, and so on, reflecting EU's dominant position as a donor in drug control international cooperation.

EU Drug Action Plan 2005-2008

The action plan itself is about hundreds of actions based on the 46 objectives of the strategy. Each of those items includes the type of action, the timetable, the responsible party as well as the assessment tools and the indicators.

Globally, the Action Plan includes 5 big chapters:

1. **Better coordination**, including also the obligation for the Commission to issue a Green Paper on ways to effectively cooperate with civil society.
2. **Demand reduction**:
 - a) improving access and effectiveness of school-based prevention programmes
 - b) developing more early intervention programs
 - c) developing more prevention, treatment and harm reduction services, including in prisons, with due regard to national legislations.

Needle exchange programmes, under medical control, and substitution treatment - for example Methadone - under medical control, have been developed in all 25 MS. Let us remember that INCB does not consider such practices (under medical control) to be contrary to the UN Conventions.

On the other hand, the other 2 harm reduction options, the so-called “safe injection rooms,” or shooting galleries, as well as heroin distribution programmes (even under medical control) are rightly condemned by INCB and are admitted in only a few EU countries. There is certainly no common EU policy in this matter.

3. **Supply reduction**:
 - a) We are reinforcing the promotion of joint investigation teams between MS and of joint customs operations especially in order to strengthen controls of EU's external borders.
 - b) We want to improve the consistency of intelligence given by MS to EUROPOL.



- c) We also want to develop cooperation in the information exchange between MS Financial Intelligence Units.

4. International Cooperation:

- a) EU's positions at international meetings to be prepared on EU Council level.
- b) Mainstream projects in the drug field into EU cooperation with third countries: Those receiving EU assistance are mostly the countries on our Eastern border and the Balkans, as well as Afghanistan and its neighbours, including Iran, Morocco and Latin America countries.

5. Information and Research:

- a) We develop further compatible methodologies between MS.
- b) And we are increasing research in the field of drugs.

Those actions may be under the responsibility of MS alone, of MS in joint actions, of the 25 MS together, of the Commission, of The Lisbon Drug Monitoring Center (EMCDDA), of EUROPOL, of the Dublin Group, of EUROJUST, of the European Agency for Evaluation of medicinal products, and I hope that I have forgotten nobody.

The coherence of this all is not very striking; that is unfortunately what Europe may be becoming if it has no political unity - flesh without a skeleton.

The situation on EU political and institutional levels is, as you know blocked. The only thing we seem to be still able to do is enlargement. Today 25 States, tomorrow 27 or 28, and later 32, 34, 40??

Ladies and gentlemen, as you know, in drug policy matters, the important fight is opinion information:

MS are broken ideologically in these matters, the Commission and the Lisbon Monitoring Centre are far from giving any clear message on cannabis and ecstasy primary prevention. Recreational drugs are becoming a reference, especially in the UK and the Netherlands. Demand reduction is being transformed into "harm reduction" and in the EP, as I said earlier, only those who favour drug legalization make themselves heard and listened to.

And to crown it all, civil society in Europe is most vocal in favour of drug legalization and is heavily lobbying national governments and European institutions for that purpose.

I think it is most useful to give here a few comments over those groups and their priorities. Some of them might be very familiar to you.

- DRUG POLICY ALLIANCE - of course, with offices in various European capitals, including Brussels. Brussels where all those groups are also present,



actively lobbying the European Commission, national delegations as well, of course, as the European media.

- BECKLEY FOUNDATION (UK) - very active in criticizing the UN drug Conventions, while its official purpose is (let's smile a little): "to promote objective debate on the effectiveness, direction and contents of drug policies."
- TRANSNATIONAL INSTITUTE (Netherlands) - very tough and competent Dutch quasi-official lobby in drug matters, going beyond the promotion of the so-called "Dutch Drug Model" and calling openly for legalization of all drugs.

I say this is a quasi official Dutch institution, because the Drug Policy Director of the Transnational Institute (Mr. Martin Jelsma) was an official member and advisor of the Dutch national delegation during the last United Nations Drug Commission in March 2006.

- IDPC (International Drug Policy Consortium) - of 24 NGOs including Beckley Foundation (UK), Drugscope (UK), Drug Policy Alliance (USA), International Harm Reduction Association, Civil Liberties Union (Hungary), Transnational Institute (Netherlands) and many others, coordinating the strategy against UN Drug Conventions.
- SENLIS COUNCIL - financed by the "Avina Foundation," very wealthy NGO seeking to "provide the ground for building a new effective drug policy model beyond the UN Drug Conventions approach."
- ENCOD - European coalition of 30 associations, militating actively in favour of drug legalization.

All these groups, which include some fashionable society people and numerous British trendy drug consultants, are now mobilizing policy and lawmakers, academics and mostly the media to re-evaluate what they call half a century of failed policy.

As you know, in 2008 or most probably in 2009, ministerial representatives of all UN member states will reconvene a special session of UN General Assembly on drugs. In 1998, the UN General Assembly had decided that UN should meet again - ten years later - to evaluate the results of the decisions made in 1998.

The strategy of those lobbies, and also of the Dutch official delegates in EU drug coordination meetings, is to develop a criticism of UN Drug Conventions inside EU, in order to create some kind of "new consensus" (this is their word) within the EU to replace what they call "the ineffective United Nations approach."

Their ambition is to develop a dynamic move by a majority of EU MS to reject the global implementation of UN Drug Conventions which should be replaced by what they call the "Fourth Convention," promoted by the British Institute of International & Comparative Law. This Convention project, based on health principles and not on drug control, is now very seriously being studied and analysed by the Council of Europe in Strasbourg under



the provisional name of “Convention for Drug Policy, Promoting Public Health Policies.”

We may also call it the “Harm Reduction Convention Project.” The anti-drug-control lobbies and governments hope that this Convention will be open to signature and ratification by 2008.

Ladies and gentlemen, I am convinced that in the present situation, no major shift is to be expected from European governments to reject the implementation of UN drug Conventions. But are we able, in the long run, to withstand the possible evolution of public opinion?

Those political minorities and legalization lobbies really know how to “use the drums of communication” and media power. They obtain, very skillfully, extensive media coverage of their press conferences. They have numerous press attachés who usually succeed in arousing interest among the mass - the hundreds of journalists attending the daily Brussels European Press Centre briefings.

Are **we** able to do the same?

Are **you** able to do the same?

I remember the Conference some of you organized in Brussels in March 2005. I attended it and found it most interesting, with some very high-level speakers and scientists. But its impact on European media was very unfortunately almost below zero.

What we need is to develop a short-term and a long-term media strategy to counteract the harmful influence of pro-drug lobbyists on European public opinion. If such a strategy is to be effective in Europe, it must not rely on U.S. priorities.

For example, a straightforward media campaign in Europe against needle exchange programs or methadone treatment under medical control would be almost completely useless, in strategic terms, as all EU governments already apply those techniques.

We have to be active on themes where European governments and public opinion are still hesitating.

I took a long time to think about what a good strategy could be to win this media battle in Europe. I see three main fields open for media action, for preventionists:

1. Require from authorities more primary prevention programs, more priority in this than in new harm reduction developments.
2. Develop widely, information about cannabis toxicity, short term and long term ill effects of cannabis. Organize more media coverage of scientific research in this field. Plan scientific conferences in various European capitals Spread more information on dangers of high THC cannabis types exported from Holland. Launch campaigns for banning cannabis seeds business, and so on.



3. The same should be done on ecstasy or new amphetamine-type drugs, and against the trivialization of those “fashionable” drugs in the media.

To do this you need resources, you need professionalism, you need a good knowledge of European realities, but I think sincerely that by doing this we can achieve two goals:

1. Limit the prevalence of “first drug use.” Prevent more young people from even “trying” fashionable drugs (which should be the primary target of any drug prevention policy).
2. Create for our politicians a thicker public opinion cover to convince them that rejecting UN Drug Control Conventions may finally be a very bad idea for their political future.

Note: The ideas developed in this presentation are personal and not official.



U.S. Drug Policy Concerns on a Global Basis

AMBASSADOR ANNE W. PATTERSON

**Assistant Secretary of State, Bureau of International Narcotics
& Law Enforcement Affairs, US Department of State**



Ambassador Ann Patterson joined the Foreign Service in 1973 as an Economic Adviser and is a Career Minister in the Foreign Service. She was sworn in as Assistant Secretary of State for INL on November 8th 2005. From 2004 to 2005 she served as Deputy Permanent Representative and then Acting Permanent Representative at the United States Mission to the UN. Prior to that Ambassador Patterson was the Deputy Inspector General of the Department of State from 2000–2003 and Ambassador to El Salvador from 1997–2000. She has also served as Principal Deputy Assistant Secretary and Deputy Assistant Secretary of Inter-American Affairs; Office Director for Andean Affairs; Political Counsellor to the U.S. Mission to the UN in Geneva and as Economic officer and counsellor in Saudi Arabia. Other economic and political assignments include posts with the Bureau of Inter-American Affairs, the Bureau of Intelligence and Research, and the Bureau of Economic and Business Affairs. She received the Department's superior honour award in 1981 and in 1988, its Meritorious Award in 1977 and 1983, and a Presidential Honour Award in 1993. Ann has also received the Order of Congress from the Government of Colombia and the Order of Boyaca from the Government of Colombia for her work in that country. She was also recognised by the government of El Salvador with the Order of Jose Matias Delgado. Ambassador Patterson graduated from Wellesley College and the University of North Carolina. She is married and has two sons.

Distinguished Conference Organizers, Speakers and Guests:

I am honoured to participate in this important gathering as the 2008 United Nations General Assembly Special Session on Narcotics draws nears. First, let me thank Christy for her introduction. I am enormously pleased to have her on our team in the State Department, with her vast and very practical experience in the fight against drugs. Let me also thank Betty Sembler and Calvin Fay not only for bringing us together, but speaking as the parent of a teenager, for working tirelessly to keep our children off drugs.



I am pleased to discuss with you the international drug problem, from the perspective of U.S. foreign policy.

The calibre of this meeting's public and private sector participants – among the most noted experts in the field – is a testament that stopping illegal drug cultivation, trafficking, and abuse is a top priority for every nation.

The United States not only wants to keep drugs out of our own country, but we also want to reduce their international effects as well, such as: organized crime, political instability, addiction, and the funding of terrorism. Progress against these threats is essential to other critical goals like health, economic development, democracy, and respect for human rights. As Christy mentioned, I was ambassador to Colombia and saw first hand how corruption and the corrosive effects of drugs can almost destroy a society. In short, unless the drug trade is contained, international stability is at risk.

My government has increasingly recognized that reducing illegal drugs is pivotal to our domestic and foreign policy interests. Certainly, this fact is clearly demonstrated by the surge of funding from the U.S. Congress to the State Department's Bureau for International Narcotics and Law Enforcement Affairs (INL). Less than a decade ago, my Bureau's budget was about \$260 million. Now, around the world, we carry out programs valued at over two and a half billion dollars to combat illegal drugs and crime and develop civilian police.

We have learned over the years that fighting drugs overseas is closely tied to reform of legal and judicial systems: eradication and interdiction alone will not be successful without new laws, the ability to prosecute, convict and imprison, demand reduction programs, and public awareness of the dangers of drugs.

In keeping with the "way ahead" theme of this conference, there are two primary programs that I would like to discuss with you. These include the multiple-year Andean Counter Drug Initiative (ACI), and policies and programs with our international partners, particularly the United Kingdom, to roll back the illegal drug trade in Afghanistan. I would also like to discuss U.S. efforts to control precursor chemicals used to make amphetamine-type stimulants, such as methamphetamine. The United States has begun to get a handle on its meth problem, but addiction is growing elsewhere, particularly in Asia.

The Andean Counter-drug Initiative

Colombia – the focal point of the nine-country Andean initiative – still supplies over 90 percent of the cocaine and almost 50 percent of the heroin which enters the United States. During the next few minutes, I want to address candidly the controversy about our counter-drug policy in Colombia. My own view, I suppose, is predictable. I believe that progress over the past six years has been remarkable within Colombia.



Like everyone else, I would have liked to have seen a more dramatic impact on price and purity on cocaine in the United States, but I am convinced that this will come if we persist in Colombia.

The United States government has spent over \$5 billion to combat drugs and build government institutions in the Andes, mostly in Colombia, in the past six years, which is a substantial sum in terms of our foreign assistance but a small amount relative to the damage caused by drugs in the United States. It is worth remembering that the United States sharply intensified its efforts in the Andes in 2000 because of concern about the runaway drug cultivation in Colombia. In 2000, cultivation was soaring; prices had dropped; and cheap cocaine threatened to swamp treatment programs in the United States.

We assist the Colombians in eradication, law enforcement programs, and helping farmers grow legitimate crops. Human rights awareness and development has been an important part of our program. In 2005, the U.S.-supported Anti-Narcotics police eradicated through spraying a record 138,775 hectares of coca and 1,624 hectares of opium poppy. Additional unprecedented amounts of coca and opium poppy were manually destroyed the same year. This effort has prevented billions of dollars worth of cocaine from reaching the United States and Europe.

Colombia's success has required a careful balance of anti-narcotics education, forced and voluntary eradication, law enforcement, prevention and treatment, as well as development of alternatives for reformed coca farmers. In 2005, the International Narcotics Control Board described the importance of alternative development as an essential element when combined with "law enforcement, and the threat of penalties and/or forced eradication."

In keeping with this understanding, the United States has already provided nearly \$280 million in alternative development assistance to Colombia, and the U.S. Government is one of the top contributors to such projects through the U.N. Office on Drugs and Crime. Thousands of Colombians have been helped.

We have focused our efforts not only on eradication but also on helping the Colombians with law enforcement. After all, the citizens of my home state of Arkansas do not grow coca, marijuana, or poppies in our huge expanses of rural land not because it will be eradicated, but because the state police will arrest them if they do. As Alvaro Uribe now settles into his second term as president of Colombia, his government is aware that continued progress depends upon its ability to extend government authority to the many parts of Colombia which previously lacked a government presence. In this vein, a programme to put police in every Colombian municipality has been particularly effective in establishing the government in every town.

Also, thanks to aggressive prosecutions and military action, the once solid link between terrorist and paramilitary groups like the AUC and the FARC, and drug dealers has been



weakened. Colombia has extradited more than 300 criminals to the United States since the beginning of the Uribe Administration. And thanks to correctional system reforms, these criminals can no longer run their trafficking operations from inside prison walls.

Last month, I accompanied ONDCP Director Walters to Bogotá. I had not been there for three years, but I was gratified to see first-hand the enormous drop in violence, including kidnappings and murders, and the improvement in the economy, as Colombians have brought home their expertise and their money. I was also amazed to see that the government had regained control of parts of the country where guerrilla leaders used to walk freely through the centre of town.

But we also came away aware that Colombians are concerned that the country's efforts against illegal drugs during the last half decade have not been as successful as they should have been. At the same time, every Colombian leader we met stated his or her resolve to redouble counter-narcotics efforts on all fronts, and especially on eradication of illegal crops.

Much of the concern in Colombia and in the United States that we are not making progress as quickly as we should is a result of the recent crop estimates, which showed an increase in cultivation. Crop estimates for Colombia and surrounding countries are sometimes a moving target, depending on the sources of data, the extent of surveys, and the varying statistical calculations used by different institutions. In 2005, U.S. investigators found more coca than in 2004 simply because they looked in more places. At the same time, the U.N. estimates for the region showed that Colombia, Peru, and Bolivia have reduced their overall coca cultivation over the past five years.

Our critics say our policy is not working because we have not seen dramatic drops in cultivation in Colombia nor dramatic drops in price and purity on U.S. streets, although there are positive signs in this regard which Director Walters outlined in a press conference last fall. What is clear is that traffickers are opting to fight it out in Colombia, because the narcotics business is dominated by terrorist groups who need the revenue. What is clear is that tons of potential cocaine is eradicated in the field, not reaching the United States and Europe, and not fuelling violence in Colombia. What is clear is that Alvaro Uribe recognizes the fight against narcotics not only consists of eradication, but also law enforcement, social programs, and human rights.

We are always concerned about the possibility of a "balloon" effect. For example, the counter-narcotics performance of the new government in Bolivia led by President Evo Morales can only be described as lacklustre. The Morales Administration's effort to find so-called "commercial" uses for coca directly contradicts Bolivia's pledges in the 1988 U.N. Convention to attack the drug trade and to gradually phase out traditional uses for the coca leaf.

The six-year term of Plan Colombia ended last year, but our financial and political support has continued. In the next few years, we will begin to turn over control these



programs to the Colombian government, but we are committed to staying the course until Colombia is able to assume full responsibility for a civil society, free of narco-terrorist influence.

Confronting the Afghan Opium Poppy/Heroin trade

Let me turn to Afghanistan, the world's leading producer of illicit opium and heroin, which accounts for 90 percent of the global supply.

As far as I know, there has never been a producer on the scale of Afghanistan, certainly in terms of economic output, in Latin America or in Asia. The drug trade now accounts for somewhere between 30 and 50 percent of the country's gross domestic product and had an export value estimated at \$2.7 billion in 2005.

The United States has been working closely in Afghanistan with the United Kingdom, the lead nation on counter-narcotics. The United Kingdom is also a consumer of Afghan heroin. While there is no evidence, yet, that Afghan heroin has entered the U.S. market in any sizeable amount, I predict it will. The United States is the world's largest market for almost every product, and the potential revenues will be enormously tempting to traffickers.

Like Colombia, the cultivation, production, and trafficking of drugs is a destabilizing influence, but it is especially dangerous in a nascent democracy like Afghanistan. Support for anti-drug efforts is an essential component of the international community's strategy for Afghanistan and is tied to the nation's economic development, rule of law, democratic processes, the fight against corruption and, importantly, defence against a resurgent Taliban.

The United States and our international partners are also very concerned about the spill-over effect from heroin production in Afghanistan. Leslie Pallett and I attended a conference in Central Asia in May, and addiction rates amongst Afghanistan's neighbours are soaring. In Tajikistan, for instance, there is outstanding international collaboration with the Europeans, the United Nations, and the United States to counter this threat. My bureau supports an excellent counter drug agency, run by the sort of brave individual you meet in this business. However, I am forced to wonder how long a country like Tajikistan, one of the poorest in the world, can beat back the corruption and violence associated with drug trafficking. Addiction rates are also increasing rapidly in Iran and Russia, and drugs are bound to be transiting through Iraq. In Pakistan, I visited a doctor who runs a successful demand reduction facility in Peshawar. She too said addiction rates were increasing and with it the need for treatment programs. So, we are not just concerned about the destabilizing effects of drugs in Afghanistan, but also its effects on the entire region.

For those who say that the farmers have no other source of income, it is important to remember that very little of the drug profits actually benefit Afghan farmers. The beneficiaries are drug traffickers, some Afghan tribal leaders, the Taliban insurgency, and



corrupt local government officials. As we have discovered, these four categories of people can blur and converge into single corrupt individuals of considerable influence that are hard to arrest and prosecute. Nevertheless, we are taking the lessons we have learned from other successful programs and modifying them to address the challenges presented by the nexus of corruption, drug trafficking, and terrorism in Afghanistan.

In December of 2005, the Afghan government laid a legal foundation to combat illegal drugs by enacting the comprehensive Anti-Narcotics Law. Implementing this law requires collaboration between our international partners and for the Afghan government to implement and refine its five-pillar strategy for combating narcotics. These include public information dissemination, alternative livelihoods to create alternatives to poppy cultivation, eradication, including discouraging planting poppies in the first place, interdiction, and law enforcement and justice reform to support Afghan efforts to arrest, prosecute and punish traffickers and corrupt officials.

The public information campaign – using media outlets and community leaders – seeks to raise awareness of the negative consequences of poppy cultivation and promote changes in behaviour. Public opinion polls show that some 90 percent of Afghans believe growing poppy is wrong. A central theme of the campaign is the oft-repeated sentiment of President Karzai who says, “If we do not eradicate poppies, poppies will eradicate Afghanistan.”

The United States is a strong supporter of alternative livelihoods programs, but also recognizes that such programs can only be successful in changing farmers’ behaviour if the risks and costs of poppy cultivation are simultaneously increased through other elements of counter-narcotics policy. Recent increases in poppy cultivation have been driven not simply by rural poverty, but also by efforts of large landowners, corrupt officials, and drug traffickers to take advantage of weak government institutions for personal gain. We know that a strong effort to eliminate opium poppy can cause economic dislocation for some farmers and make the Afghan central government unpopular. But the long-term pay-off is that Afghanistan’s future generations will benefit from economic stability and development – free of the violence and corruption that accompany the opium trade.

Furthermore, at the same time that we are working with the Afghan government to eliminate poppy, we are providing funding for rural development. The United States has so far allocated roughly \$330 million specifically for alternative livelihoods programs, in addition to hundreds of millions of dollars more for road construction, agricultural development, and other efforts to rehabilitate and strengthen Afghanistan’s rural economy.

There is a great deal at stake in eliminating the opium trade in Afghanistan. I mentioned the spill-over effect earlier. Drug money not only fuels a growing insurgency in Afghanistan, but has made the border region between Afghanistan and Pakistan a major transit route for heavily armed drug convoys that provide funding for marginalized



groups on both sides of the border and fuel a growing drug abuse problem. Moreover, the size of shipments – one single shipment recently interdicted by the Pakistanis was sufficient to supply the entire U.S. market for a year – indicates that drug traffickers are confident that no one will intercept them and thus there is no need to break shipments into smaller quantities with multiple carriers. DEA is working with both Afghan and Pakistan law enforcement to address this threat.

Drug convoys cross the Iranian border and have engaged in fierce fire fights with Iranian police units that have suffered significant casualties intercepting these convoys. We faced the same threat in the Andes when the FARC and AUC in Colombia and the Shining Path in Peru drew upon the proceeds of drug trafficking to expand their power base, hold the countryside hostage, and attack central governments. But the political will of these same governments to sustain a campaign against these narco-insurgents made a difference.

Similarly, in Afghanistan, we must keep all options on the table, even the hard ones, like forced drug crop eradication. We understand eradication is extremely controversial in Afghanistan and among donor nations. Indeed, successful eradication is possibly the most difficult challenge of the entire counter-narcotics program in Afghanistan.

We will work with Afghanistan and the international community to find common ground to conduct eradication programs which target criminals rather than ordinary farmers. We will also work with our partners to expand the benefits of legal and sustainable agriculture to ever wider areas of the country by confronting large landowners, traffickers, and corrupt officials who promote the cultivation of illegal crops.

With the British in the lead, the ability of the international community to confront the drug trade in support of the Afghan government requires a dynamic international response. In this vein, we are heartened that the vast majority of the Afghans fully understand the threat posed by narcotics to their broader national goals.

Production and trafficking of methamphetamine

The final issue I want to review with you is methamphetamine production and trafficking, which is a problem not only in the United States, but also increasingly in Asia. Meth addiction has affected parts of the United States, like my home state of Arkansas, that historically have not had serious drug problems. Pictures of children in these dangerous meth labs and the risks to law enforcement personnel – Christy moderated a video for the State of California that showed first responders how to avoid contamination from these labs – have shocked Americans. In response, last month, ONDCP launched the first-ever U.S. Synthetic Drug Control Strategy. In March, a U.S.-sponsored resolution entitled Strengthening Systems for Control of Precursor Chemicals Used in the Manufacture of Synthetic Drugs was adopted unanimously by the U.N. Commission on Narcotics Drugs.

The U.S. Congress also enacted the Combat Methamphetamine Epidemic Act, which gives us important new tools by requiring the President to identify in the International Narcotics Control Strategy Report the top five exporter and top five importer countries



with the highest rate of diversion of meth precursor chemicals. The new law also requires a certification for these countries.

As governments, we are building an international consensus to confront the common threat posed by methamphetamine, a drug which is easy to produce and enormously profitable. Through the International Narcotics Control Board, the United States participates in Project Prism, working with international partners to monitor suspect shipments of meth precursors. Project Prism and other mechanisms lead to important bilateral investigations that result in seizures and arrests.

The United States also collaborates with many countries to help them control the precursor chemicals which are needed to make these toxic drugs, and we are making special efforts with our immediate neighbours – Canada and Mexico – in this important area.

Beginning in 2003, Canada implemented new legislative controls and law enforcement strategies that have curbed the illegal diversion of methamphetamine precursor chemicals, especially to the United States. Bilateral investigations resulted in the destruction of several major illegal pseudoephedrine tablet operations in Canada and the dismantling of nine U.S./Canada-based Middle Eastern criminal gangs involved in illegal chemical trans-shipments. These police actions and new domestic restrictions have resulted in a reduction of precursor availability in the United States and a significant decrease in the number of labs.

These successes in Canada and the United States have largely pushed the precursor problem into Mexico, which has much weaker institutions and established drug cartels. With respect to Mexico, we are collaborating on a wide range of training and other assistance to specifically target meth production and trafficking. This training includes specialized techniques for investigating and prosecuting illegal traffickers in precursor chemicals. Mexico has done a good job of curbing the diversion from its large legal pharmaceutical market. Mexico has taken to regulate imports of precursors and the pharmaceutical products that contain them. As a result of these efforts, Mexico saw about a 40 percent reduction in precursor chemical imports between 2004 and 2005. The Mexican government has committed to reducing such imports even further in 2006. We will be working very closely with the Mexican government – and Christy is working to redesign some of our assistance programs – to ensure that meth precursors do not enter into the distribution chains of the major drug trafficking cartels.

Conclusion

The 1998 U.N. General Special Session on Narcotics (UNGASS) set an extremely ambitious goal of eliminating production and abuse of illegal drugs by 2008. In the last several years, we have seen remarkable achievements – many of which are highlighted in this year's U.N. World Drug Report



For example, today, Thailand, Pakistan, and Laos are virtually opium poppy free; in the Andes, significant strides have been made against illegal cultivation; seizures, arrests, and convictions against many of the biggest traffickers are on the rise; and all over the world young people have a better understanding of the perils of illegal drug use and are acting accordingly.

The policies, programmes, and challenges I have discussed today remind us of our mutual responsibility to counter drug cultivation, trafficking, and abuse. It is fitting that Colombian drug control experts recently travelled to Kabul to meet their Afghan counterparts to share their drug-control expertise to combat similar problems albeit in different environments.

This international consensus is guided by the three U.N. Drug Control Conventions, especially the 1988 Convention. Together, we must work against attempts to undermine the conventions. They embody our common will to safeguard our communities from the harm of illegal narcotics. Any attempts to broaden the supply or legalize drugs would undermine the conventions and imperil the health and well-being of our citizens and future generations.

As called for in the 2006 U.N. Annual Drug Report, we must continue our international cooperation to reduce the threat posed by international drug production, trafficking, and abuse. For its part, the United States will carry on, whole- heartedly, until the drug blight is substantially contained.

Thank you, again, for the opportunity to participate in this important conference and for the chance to learn from so many accomplished international experts in the field of narcotics control.



What Does All This Mean for Future Drug Policy?

DR. HAMID GHODSE

**Member and Past President, International Narcotics
Control Board, Vienna**



Dr. Ghodse has been Professor of Psychiatry and of International Drug Policy at the University of London since 1987; Director of the International Centre for Drug Policy at St. George's University, London since 2003; President of European Collaborating Centres for Addiction Studies since 1992; Member of the Executive Committee of the Federation of Clinical Professors, UK since 1994; Member of the Scientific Committee on Tobacco and Health, UK since 2000; Director of the Board of International Affairs and Member of the Council, Royal College of Psychiatrists since 2000; Non-Executive Director, National Clinical Assessment Authority of England and subsequently Patients Safety Agency since 2001; Chairman, Higher Degrees in Psychiatry, University of London since 2003; Member of the Medical Studies Committee, University of London since 2003. Dr. Ghodse is also a member of the INCB since 1992, a Member of the Standing Committee on Estimates 1992 and President of the Board in 1993, 1994, 1997, 1998, 2000, 2001, 2004 and 2005. Dr. Ghodse is the author or editor of over 300 scientific books and papers on drug-related issues and addictions including, for example, the following: *The Misuse of Psychotropic Drugs*, London 1981, *Psychoactive Drugs and Health Problems*, Helsinki 1987; *Psychoactive Drugs: Improving Prescribing Practices*, Geneva 1988; *Young People and Substance Misuse*, London 2004. Dr. Ghodse has had a distinguished career and he is the recipient of many degrees and Fellowships. He has served on many expert committees and other working groups on drug and alcohol dependence all over the world from the UK to Australia and Peking.

Good afternoon. I am going to address some of the issues focusing on the responsibilities of the INCB and the way in which we are facing some of the difficulties and also some of the challenges ahead and perhaps looking at some of the possible solutions. Before doing so I would like to thank the co-sponsors and supporters of this meeting. We traditionally, over the past few years, we have always responded positively to the anti-drug NGOs and because of this we usually get lots of invitations but we do not participate in areas in which there is a conflict of interest and on behalf of the Board and the Secretariat of the



Board and also for the NGOs who are not here. I thank you for the support of the International Conventions.

I would like to take you to some of the highlights of my presentation this afternoon and look at the historical perspectives because it is very important. We actually had drugs that were legalised for over 50 years - from about 1858 to 1909 drugs were legal not only in China but all over the world. Some of the figures were mentioned this morning of the 30 tons of opium which was exported to China, from Turkey, from Iran, from India but in addition to what China was producing, there were also the opium dens. They were all around Europe - the last one was closed in France in 1916.

You can think about injecting rooms now replacing opium dens. When you look at some of the figures which one of our colleagues mentioned this morning, that when we look at what were pharmaceuticals of the day in the market and it was more than 50,000 pharmaceuticals in the United States of America which contained some opioids or cocaine. The opium during the 19th century was the aspirin of today. You were buying it over the counter at the grocers, not even from the pharmacy. Therefore, drugs were legalised for a very long period of time. But because they created 20 million opium addicts, not just users, in China - that is only why the Civil Societies (NGOs of the day), one should give the credit to where it should go - to the United States, when the Bishop Brent and the late President Theodore Roosevelt, they became very worried – of course with other people helping them in Europe also – they arranged the very first International Opiate Commission in Shanghai in 1909.

In case I don't have any time to come back to this, because of the rest of the presentation, I want at this point to say that I have spoken with Kofi Annan a few months ago. I have written to and talked with the President of the General Assembly – to say we have asked formally that the General Assembly will mark the 26th February 2009 as the centenary of the International Drug Control and we are hoping that in the next session of the General Assembly, it will be discussed and the day will be marked for that purpose. As NGOs you might think from now how you are going to celebrate that day in 2009 because that gives an opportunity not only to look at UNGASS because many aspects of UNGASS very likely will be going to make a 10 year evaluation and therefore it will be a very good time to mark the centenary. My gratitude to you is for your support of the International Conventions. That is my role – as a member of the board to be a guardian of the conventions. The INCB, perhaps you will be interested to know of some of its activities – of course this would be a bit patronising or arrogant that we believe that our ancestors and the people who made the conventions knew less than we know. They had the experience of the pandemic drug problem all over the world without any regulation – that is why they made the 1909-1912 conventions etc. And, of course, Conventions always have been dynamic in responding to what has happened. In 1925, when the Central Narcotic Board was created (originally called the Central Opium Board and that was the predecessor of the INCB therefore the life of INCB goes). Back to 1925 – pre-dates the United Nations and very, very technically the INCB is not part of the United Nations. UNODC, which does an excellent job, does not need to have a policy because it is basically the governments which dictate what should happen. Whereas the INCB has a



100% definitive policy and that is determined by the law – international law and convention. Therefore, INCB has to make sure that the issues that the governments have signed up to comply with their obligations.

In 1925, the predecessor of the INCB, was really about regulating international trade but it was proven not to be very effective on its own because between 1925 and 1929 when the Central Opium Board came to function – in that 3 years, 100 tons of opioid analgesics, mostly opiate analgesics and cocaine was diverted from the licit manufacturers in Europe to the illicit market. Therefore you can see how important it was to make the decision to regulate the international trade. But it was not good enough, and in 1931 a supervisory body was organised and countries had to say how much they needed. Therefore an estimate system could be set up. These two bodies worked together until 1961 - then they merged eventually. There is a nice historical background which we don't have time to cover it all, but I refer for the issues of the situation during the 19th century to the Board's Report of 2000 and also to the historical background of the development of the conventions which we are dealing with - 1961, 71 and 1988. These conventions are complementary to each other and they also do not need to stand still because they through resolutions and through ECOSOC. You can have, actually have some substances added – methamphetamine is a good example. When we faced this problem, we immediately tried to get some sort of resolution through ECOSOC, making an estimate for pre-cursors for methamphetamine and for the import and export - exactly what we did with the psychotropic drugs - which did not have the same sort of regulations as the narcotics had - through the resolutions that have now been in place and are working very well. I am glad to say that diversion of the international trade from the licit to the illicit is almost non-existent - it is so insignificant that we do not need to mention anything about it.

The board is a quasi-judicial board and the analogy that Professor Chawla used this morning is a very good one – it is like running a country in a democratic fashion. You have the Executive of the UNODC and the Legislature of CND and the quasi-Judiciary of the INCB and the WHO has a major contribution to make in recommending, but does not necessarily means recommendation of the WHO would always be approved by the CND. There are, for example, recommendations for the next Commission that Delta 9THC to be removed from Schedule 2 of the psychotropic convention to Schedule 3 of the psychotropic convention - you can make your own judgement on what that means. The rule of the INCB is work in six major areas in making sure that cultivation, production, manufacture, utilisation of drugs are limited to medical and scientific purposes. One should not forget that these drugs are extremely effective in the practice of medicine, even today – many of them if not all of them, and many of them are very effective. Therefore with the question of making a limit to the medical and scientific purposes, we want to be quite sure that limitation does not make any shortage of narcotic, analgesic and psychotropic substances when there is a medical need for them. INCB has been extremely active on that to remind the countries that some of the countries, they overdo on their national controls so that availability of some of these drugs is very scarce. For example, 80% of narcotic analgesics for cancer pain, terminal pain or for chronic pains are used in six countries only which means that the rest of the world, over 120 countries, are using them very little or not at all. That is not because of the controls, or a variety of



cultural factors etc., etc. For example, even in very highly economically developed countries such as in Europe, Denmark uses eight times more than Italians in analgesics. The French use three times more hypnotics than the British and the Americans use ten times more central nervous stimulants, not illicitly but licitly than the Europeans – and they use four times less hypnotics and anxiolytics. Why do the Americans want to be so alert and active and why do the Europeans want to be so sedated and relaxed? These are not always the question of the controls or the economy, also something to do with the culture and the practice of medicine, which is very diverse even in the same country and the same culture.

Of course there is the question of precursor chemicals, which according to 1988 conventions has been solely given to the INCB. In fact, for that control does not need any WHO input and as Prof. Chawla was rightly saying, one of the three conventions is amongst those which have been ratified by most of the countries, but still we are not there with a universal ratification of the Conventions. There are loopholes - therefore it is my mandate to get it to that point by 2008, therefore that is why we have been very active. For example, I had meetings with a number of the Ambassadors in New York a few months ago when I was then President, and I am delighted to say that afterwards Butan, Democratic Republic of Congo and Samoa ratified the convention. I have done a few trips over the past few months to the individual countries to make sure we have universal ratification. If that happens, then we can celebrate in 2009 that now after 50 years from 1961 we have universal ratification. Of course it is no good to just have a piece of paper.

For implementation you need to have a range of national legislation for the policy, the whole spectrum of international drug control which is not only the control of the law enforcement, which is very important, but also demand reduction, prevention etc. INCB works very closely with WHO, Interpol, UNODC, WCO and regional organisations and also receives other information which we get from a variety of sources. Therefore we have two Annual Reports; ours which we have to produce for Narcotics and Psychotropics and one specifically for Article 12 of the 1998 Convention on Precursor Chemicals. We have major press conferences in many parts of the world when we address the media and we present to them. Of course we are very much criticised by some countries; sometimes we are continually criticised by the pro-drug NGOs and I am delighted that we are criticised because the day that the pro-drug NGOs like us will be the day that we haven't done our job. I do not see that as a negative, I see it as very positive. In fact when I was confronted by some Ambassadors in Vienna and there was some criticism of the Board's Report and of the Board, I said again that the day they were all happy with us would be the day we hadn't done our job. But we are not there just to get at the governments, we are there to help to rectify the problems which they have and we do that using very quiet diplomacy, behind closed doors. The Board has certain instruments in their possession - Article 14 of the 1961 convention, Article 19 of the 1971 Convention, and Article 22 of the 1988 Convention. If a country does not comply and fails, even with all the help and support that the Board has given and technical assistance by ONDCP, then the Board can ask for sanctions against Import/Export. This powerful instrument has been used in half a dozen countries over the past 10-15 years but you do not know because in the early stages of invoking those articles, it is confidential and bi-



lateral, and all of those countries, almost overnight, rectified the situation. So I am glad to see that it is effective. Only one country in the world, which we made public, was Afghanistan which Article 14 is invoked and will continue to be invoked until the situation in Afghanistan is rectified.

The Board is there to take remedial action to help the governments, rather than to get at the government. There are technical bodies of the INCB – in fact many of my colleagues, the highly qualified doctors, the pharmacists, the drug regulators do not know that the international trade of narcotics and psychotropics is one of the most regulated international trades in existence. We have done the bookkeeping over the past 70 years – we have to know about production, import and export. Therefore when we make the documents public each year, it is quite clear how much for example, the UK imported opium from India to make morphine to export to Zambia. Therefore we know all of that and because the importing country cannot import and the exporting country cannot export without the Board knowing, you will see it is highly regulated and it is extremely difficult for the Board to do.

If you allow me, because His Excellency the Anti Narcotics Minister from Afghanistan is here with his delegation, there was something he said which worries me and the Board very much. Firstly, the production in Afghanistan is predicted to be even higher this year than it has been. Secondly, in the statistics he showed I noticed immediately there are some drugs which are alien to their culture which were seized - 6 kilogrammes of cocaine – that might not mean very much in the United States but it is a lot in Afghanistan. There were some seizures of amphetamines which illustrates how drug issues have become pandemic in the context of overriding the culture and endemic use which we discussed. And the second thing he mentioned is a very good example for any country that wants to be preventive in the drug problems. If 50% of your economy is based on illicit activity, the government is hostage to drug traffickers and that is exactly what the world community wants to prevent. If you are hostage to drug traffickers, then you can imagine the rest of the criminal issues, whether it is terrorism, insurgencies etc., etc. that can flourish in that context. The government can be changed by the drug traffickers if 50% of your economy is in the hands of the illicit drug producers. I think Afghanistan needs to do something about it drastically, very soon, rapidly. It cannot be done overnight. We appreciate that is why we haven't done anything about Article 14, more than just trying to help them as much as we can - as well as asking the world community to help and support them. All of us wish his pomegranates to become a reality.

Finally I would like to thank you all for supporting the Board as the guardians of the International Drug Conventions, trying to protect what the governments decided according to the rule of the law. We appreciate the difficulties that some countries have – we are going to Bolivia and seeing certain aspects of drugs in South America. Europe, well drugs are not only produced in Afghanistan or Columbia or in Peru – there is plenty of illicit drug production in Europe - ecstasy is mostly produced in Europe. Therefore, we are in this problem together and we must try to help it together also.



RESOLUTION CONCERNING DRUG ABUSE AND HUMAN RIGHTS

Whereas, drug abuse is a fundamental humanitarian and social issue that transcends political ideas, parties, and national boundaries; and,

Whereas, drug abuse, as defined by United Nations Drug Control Conventions, destroys the unique dignity of individuals, their freedom to think, and ability to evaluate the difference between right and wrong; and,

Whereas, individual freedoms, as defined in Article 3 of the United Nations Universal Declaration of Human Rights, should not be compromised; and,

Whereas, drug addiction means chemical enslavement and perpetuating drug abuse leads to poverty, loss of dignity, and health, actions that are rejected by the Universal Declaration of Human Rights specifically addressing the freedom from any forms of slavery, torture, cruel, and inhumane treatment; and

Whereas, all individuals have the right to live in a world with dignity, work, and a decent standard of living, as defined in Articles 22, 23, and 25, respectively of the Universal Declaration of Human Rights; and,

Whereas, these rights are seriously compromised in a world which would condone drug abuse; and,

Whereas, non-drug users, especially children, as defined by Article 33 of the United Nations Convention on the Rights of the Child, are entitled to live in a safe, secure, drug-free environment, and to have their human rights protected by society; and,

Whereas, drug abuse limits human potential, threatens the safety and well being of children and unborn children, diminishes freedom to choose, leads to addiction and chemical slavery, and creates an inequity in society for those who choose not to use drugs; and,

Whereas, programs which facilitate drug abuse and drug trafficking perpetuate the violation of human rights among the most vulnerable individuals, those whose free will has been denied by addiction;

Therefore, let it be resolved that all people have the right to expect governments to protect them from drug abuse and have a life free of drugs; and, in particular, parents have the right



to expect governments to assist them in their efforts to help their children to remain free of drugs; and,

Therefore, let it be resolved that communities have the right to be protected from consequences resulting from drug abuse; and;

Therefore, let it be resolved that those abusing drugs should have timely treatment available to them and the equal protection under the law to ensure their individual rights; and, finally

Let it be resolved that we reaffirm the spirit and letter of the United Nations drug conventions and the political declaration of United Nations General Assembly Special Session 1998 which expressly call upon governments to prevent drug abuse and to promote full recovery for those suffering from abuse and dependence.

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