GLOBAL DRUG POLICY

FUTURE DIRECTIONS

THE BECKLEY FOUNDATION

COVER: BURMESE GIRL TAPPING OPIUM

GLOBAL DRUG POLICY
FUTURE DIRECTIONS

HOUSE OF LORDS

LONDON

SOCIETY & DRUGS: A RATIONAL PERSPECTIVE

SEMINAR IV

GLOBAL DRUG POLICY : FUTURE DIRECTIONS

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PREFACE

This seminar, *Global Drug Policy - Future Directions*, is the fourth in a series of seminars entitled, *Society and Drugs: a Rational Perspective*. It is the first to focus on international drug policy.

We are living in a time when a large proportion of the population use controlled substances. Forty years of prohibition has done nothing to extinguish the use of psychoactive drugs. Indeed they are purer, cheaper and more readily available than ever before. Society may have to face the fact that many of its members wish to manipulate their consciousness, either by using legal substances such as alcohol, caffeine or tobacco, or by illegal means. The question faced by governments globally should maybe evolve from how to eliminate drug use, to how to minimise the damage done by it, both to the individual and to society at large.

The Beckley Foundation Drug Policy Programme was set up to cast light on the current dilemmas facing policymakers at national and international level, as they seek to improve the effectiveness of global drug policies. Its produces quarterly reports and briefing papers on subjects relevant to international drug policy, and disseminates them to academics, practitioners and policymakers around the world. It promotes a balanced and evidence-based debate on issues surrounding drug use and misuse.

At this seminar, high-level participation from around the world, including representatives from the EU, UN and WHO, as well as from many national governments, academic institutions and NGOs, created the forum for an innovative debate. The gathering of so many professionals who share a commitment to the evidence-based development and refinement of policy in this field was unprecedented. Following the usual procedure of Chatham House Rules, the discussions were encouragingly open and unconstrained, despite the politically sensitive nature of the subject.

The timing of the seminar was particularly relevant given the imminent release of the new EU Drug Strategy (2005-2012). Following the seminar, two new initiatives, the Beckley Foundation *International Network for Drug Policy Analysis* and the *International Drug Policy Consortium* (of non-governmental organisations and professional networks), were launched.

The Beckley Foundation is grateful to the Earl of Dundee for the invitation to hold the seminar in the House of Lords. The magnificent Moses Room provided a beautiful setting for the event, a rare opportunity to hold a rational debate in a field often dominated by ideological and moralistic arguments. Jan Wiarda, Chairman of the European Chiefs of Police and Michael Portillo, formerly Secretary of State for Defence, chaired the morning and afternoon meetings excellently.

The seminar Proceedings document summarises the presentations and the discussions that followed. We thank all those who gave talks, participated in the discussions and helped organise this event.

Amanda Neidpath

EXECUTIVE SUMMARY

Current drug policy prohibits the use of a wide variety of substances with the stated aim of eliminating their consumption. It is, however, demonstrably incapable of achieving that over-ambitious goal, indeed drug use throughout the world is wide-spread and increasing.

The anti-drug attitude that created prohibition is also inhibiting governments and international organisations from admitting this failure, or exploring other approaches. There has been little or no attempt to evaluate the current policy or to compare it with the likely effect of any alternative. Yet what evidence there is suggests that the side-effects of prohibition are more harmful than the drugs themselves. In simple economic terms, for example, the US government spends approximately $35-40 billion every year on the control of drugs, with little to show for it except staggeringly high (and costly) drug-related incarceration rates.

While it is difficult to dispute that the current policies are not achieving their goals, better control strategies have yet to be agreed on. Policies lacking rigorous evaluation methodologies persist and a lack of research in the area allows politicians to evade facing the fact that a change of approach is required in this difficult political arena. In such a climate, it becomes essential to provide a forum for those with expertise in the drug field to discuss ways of making progress, free from prejudice and political taboo.

The chairs for the day set the scene for the ensuing discussions. *Jan Wiarda*, Chairman of the European Chiefs of Police, stressed the importance of having a more reasonable and less emotionally and politically oriented debate. He greeted the seminar as an occasion for experts in the field to review the effectiveness of current policies at international level, and to consider how to move forward, especially focusing on science and evaluation, so as to reach the most rational conclusions possible. The chair of the afternoon session, *Michael Portillo*, used his insight into the British political system to suggest that, although the nature of politicians and policy has not changed very much over recent years, there has been quite a sea-change in the climate of discussion. People who question whether present policies are effective or correct have moved from being a fringe group to being, as seen at this seminar, a very large number of distinguished people whose qualifications to speak on the subject are universally recognised. He concluded that it was unlikely for such a change to occur in the field of ideas, without it eventually being reflected in a change of policy.

Peter Reuter first raised the point, which went on to become a theme of the day, that drugs are a moralistically defined problem in the Western world, a view that imposes constraints both on the policies allowed and the research that is done. If the underlying premise is that drugs are bad and should not be allowed, the agenda has already been set and research is redundant. Talking from an American perspective, he explained that science really plays no role in the formulation of a national drugs strategy, because a policy reliant on punishment is essentially exempt from research. There exists no evidence that tougher enforcement raises prices, reduces availability or prevalence, yet over two-thirds of all government drug budgets are spent on it. He further pointed out that, over a 20-year period, numbers imprisoned for violating

drug offences in the US have increased 1000%, while the price of heroin and cocaine has decreased by 90% in real terms, strongly suggesting that prohibitionist policies are failing. In contrast, there is a substantial body of work to suggest that treatment can and mostly does work, yet this remains a severely under-funded area, with most drug misusers only being offered treatment when they come into contact with the criminal justice system. Even then, access to treatment services is by no means guaranteed.

In today's climate, it is becoming increasingly necessary for those who defend an ever-escalating emphasis on policing and prohibition to clarify publicly what their reasons are for believing that this approach is ever likely to work. No single classification system can ever be perfect but, as *Colin Blakemore* pointed out, it is important to devise the most rational that we can. Because the literal eradication of drug use is not a practical goal of public policy, we should instead concentrate on ways of reducing the overall harmful impact of drugs on individuals and society. Although we must be wary of generalising, the Netherlands experiment seems to suggest that people can be trusted with more relaxed attitudes to less harmful substances. A scale of harm of all social drugs, in which the harmfulness of each drug is continuously reviewed in the light of scientific, sociological and economic evidence, is proposed as a more rational and evidence-based approach than the current classifications. It is recognised that harm is multi-dimensional, so a number of criteria are considered, and legal drugs like alcohol and tobacco need to be included for calibration purposes. Interestingly, these legal substances are at, or near, the top of every category of harm, comparing with, or exceeding, hard drugs such as heroin and crack cocaine on scales such as toxicity, mortality and dependency; costs to the NHS; relation to crime; and total economic impact.

Mark Kleiman agreed that the existing global drug policy, a one-size-fits-all policy aimed at a mythical drug-free society where caffeine, alcohol and tobacco are not counted as drugs, is fundamentally flawed. He argued that once a mature drug market is established, increasing law enforcement has little additive effect in deterring drug use. He drew attention to the fact that classifying a substance as a Schedule 1/Class A drug has the unproductive effect of blocking research into that substance. He also highlighted a disadvantage of an evidence-based, harm-minimising drug policy where controls placed on each drug are proportioned to the harmfulness of that drug, commenting that such a scale did not take into consideration the potential benefits of currently illegal substances. Many of these drugs are approved for medical use, but medical utility is not the only utility a psychoactive drug might have. Other potential benefits, such as facilitating collective worship, individual spiritual exploration, and the acquisition of self-knowledge are supported by a large evidence base which, although consisting mainly of self-reports, should not be dismissed. He pointed out that, just as it is impossible to form an optimal alcohol policy without acknowledging the fact that millions of people get harmless pleasure from its use, so the relatively low-risk benefits of other drugs should also be considered.

Two regional examples of some of the successes and failures of current national drug policies were presented, by *Margaret Hamilton* who considered the harm minimisation approach adopted by the Australian government, and by *Chairman Cherkesov*, who discussed the problems Russia encounters in trying to tackle international drug smuggling. The Beckley Foundation was honoured to have the head of the Federal Drug Control Service in Russia attend the seminar, and his talk

highlighted the international threat posed by the role of drugs in organised crime and the need for a united effort in order to deal with this threat. The trade in drugs empowers organised criminals, corrupts governments, erodes internal security, elicits violence and distorts economic markets and moral values, while creating the underbelly of an addicted population that is highly costly to society, both in terms of health and crime. He recognised that prohibition was not the only answer to the drugs trade and the problem of addiction, and that a vigorous prevention effort in conjunction with effective treatment and rehabilitation of addicts was also necessary.

Margaret Hamilton described the Australian drug market, and outlined the benefits of adopting a harm-minimisation approach informed by research. Due to their ability to change the way we think, feel and behave, drugs have attained symbolic status and meaning in our society. As a result of this powerful capacity, they may also have become easy targets and the scapegoat for the existence of unstable communities and disillusioned youth. The very illegal status of drugs may accrue some benefit for politicians whose hard-nosed reputations may be enhanced by a rhetorical fight in a 'war' against drugs. She highlighted the need for researchers to have done their homework for times when drugs become high profile in public and political arenas. At these times, researchers have to offer advice and predictions based on their previous experience and any available 'evidence'. Although the task proves difficult, they must most importantly try to remain independent. Drug policy is by its very nature irrational, but it is crucial for researchers and practitioners to become involved in the policy process, and to develop tools to help predict outcomes and evaluate policies, while being realistic about their limitations.

Having considered national interpretations of international policies and the effects of current policies on trends in drug use and supply, it was then interesting to hear how current legislation impacts on those meant to enforce it. *Jan Wiarda* spoke from a cop's point of view, highlighting the dilemma faced by police forces asked to fight a war that cannot be won. The ambiguity that this paradox creates for police officers in the field leads to personal dilemmas, and can cause corruption and lost integrity. Illegal drugs exacerbate the tension between the two roles of the police, to serve and protect the public versus to act as a power system of the state. The coping mechanisms used to combat these tensions are either to deny the problem (the attitude of management police), or to "do things your own way" (the attitude of the police on the street). The truth is suspended, hoping for better times, and open debate is blocked, because a code of silence is adopted at all levels. These problems will continue until international policy removes the elimination of drug use as its stated target.

Mike Trace, who introduced the morning debate, provided an overview of the role of the Beckley Foundation in formulating possible solutions, or at least improvements, to some of the current drug-related problems. He highlighted the difficulties faced when doing research with psychoactive substances, with particular concern for the invisible barriers blocking objective scientific research. Over a forty year period, one would expect there to be clear signposts as to the efficacy of the policies in place but the evidence base remains extremely sparse. Although it is unclear how successful policies have been, he asserted that evaluation should not be abandoned.

The afternoon session focused on how one could learn from previous experiences and build on the current evidence base to develop the new EU Drug Strategy (2005-2012). The process of the 'making of' the new strategy has once again shown that

rational debate is difficult to achieve at an international level in the drug policy arena. *Franz Trautmann* explained the difficulty of getting consensus on the various issues covered by the strategy at EU level, and the ultimate weakening of the strategy's content by necessary compromise. *Josef Radimecky* talked of the ambitious rather than realistic nature of the Strategy, and its inability to withstand critical reading. He described the need for such a document to stick to defined key principles, and the important role of experts in preparing a politically and scientifically correct document to present to politicians. Although both the current and future strategy came up against a barrage of criticism, both speakers were optimistic that at least some progress had been made.

Mike Trace, in summing up the afternoon session, highlighted the importance of evaluation as a means of providing evidence as to whether a particular policy was successful or not. The current EU Drug Strategy, drafted five years ago, although not without its faults, did attempt to set outcome objectives and an agenda of how those objectives could be measured. It is of particular concern that the commitment to evaluating progress in relation to objectives is much looser in the current draft of the future strategy than it was in the last. In effect, governments and international organisations are set to embark on an 8-year drug strategy without setting anything in place to measure whether it is achieving a reduction in drug-related problems or a reduction in drug-related harms.

The simple reason, ignored by most governments, for the widespread use of illegal drugs is that many people enjoy intoxication, experiencing a state that is in some way different to normal. Many consider moderate drug use to be fun and sociable, while others claim that it may also be therapeutic or mind-expanding. Humans have been using psychoactive substances since prehistoric times and most people today have experienced some form of chemically-induced altered state of mind. The majority are able to consume drugs in moderation without losing control and descending into the greatly feared abyss of abuse and addiction. *Mark Kleiman* raised the interesting comparison with alcohol, which like its illegal counterparts, is used sensibly by the vast majority, but misused by a small percentage of the population. The laws restricting alcohol are mediated by the government's recognition that millions get minimal-risk enjoyment from its consumption. It may be time for policymakers to acknowledge the existence of a human instinct towards occasional intoxication, by whatever means, and take the relatively 'safe' and enjoyable consumption of certain drugs by large numbers of people into account in future policy formation.

Forty years of international focus on criminalisation and punishment has had little success. The hard-line approach to drugs adopted to date has not been effective, and in those countries where drug policy is the most strongly prohibitionist, the problem is often the worst. This suggests it is time to look at alternative ways of dealing with these substances, based on knowledge of what they actually do to the body and the brain, and why people choose to take them. Drug taking is not restricted to any social category or class, and it is rapidly becoming a universal phenomenon, which cannot be ignored. The ultimate aim is to achieve a rational overview of the scientific, medical, social and economic issues surrounding the use and abuse of drugs, both legal and illegal. Most people would agree that more informed debate is needed as the basis of any further change in attitude and policy, and this seminar provided an arena in which to advance these discussions.

Amanda Neidpath
January 2005

Synopses of Presentations

Morning Session
Chaired by Jan Wiarda

INTRODUCTION & OVERVIEW

MIKE TRACE

CO-DIRECTOR, BECKLEY FOUNDATION DRUG POLICY PROGRAMME

This is the first Beckley seminar with an international focus, and it is rewarding to see such a gathering with an interest and hunger for debate in these complex issues. By way of an introduction to the Beckley Foundation, it was set up to look at the science, particularly the neuroscience, behind the modulation of consciousness and the use of psychoactive substances. A particular concern is the invisible barrier blocking objective scientific research in the area of controlled substances. Most would expect there to be a certain level of understanding of the brain chemistry of illegal drugs, but there have been numerous barriers to approval and funding of research and publication of results in this area. The Beckley Foundation provides an independent channel of funds, and supports and directs scientific research, in order to further our understanding of the effects of these substances on the human brain and behaviour. How important is this scientific base to policy formation? Understanding the science and properties of different drugs is certainly crucial to deciding their relative harms which has been, and will continue to be, instrumental in the discussion about how best to control and regulate them.

Research also helps us in terms of understanding new challenges. The policy world is slow to understand the fashion, culture and socio-economics behind drug use. One trend we have had to face recently was the increase in use of synthetic drugs over the last ten years. Policy makers are used to cultivated substances, which are grown, synthesised, transported and used somewhere else. They have had to rethink paradigms in view of these changes. The *Foresight Project* is trying to make judgements of what is going to happen in the next 10-20 years. It is likely that the pattern of drug use and type of stimulation in the future will be different to that which exists now. How does policy keep up with these major changes?

The *Beckley Foundation Drug Policy Programme* is an initiative that seeks to develop research in policy analysis and promote an evaluation of drug policy that is as scientific as possible. There have been debates over the years: legalisation *versus* prohibition; crackdown on *versus* support of addicts; zero tolerance *versus* harm reduction. When we get to the highest political levels where decisions are actually taken, diplomatic and ideological considerations take precedence over the evidence base of what actually works. Research has not developed as well as would have been expected in such a major area of social policy. Over the last 40 years, one would have hoped that there would be clearer signposts, but the evidence base remains extremely sparse. Development of that evidence base should help better decision-making in the future.

It proves difficult to acknowledge in public and political settings that the system now in operation to reduce the scale of illicit drug use, and the harms that flow from it, does not work. We have tried very hard to reduce the scale of the market. If we look at the statistics, it is incontrovertible that the market has increased dramatically over the last 40 years. We need to do something different if we aim to make improvements in the future.

The possibilities are to 1) C*arry on with current approaches.* There are some slight signs that current policy could succeed in certain areas, e.g. significant and sustained reduction of opium cultivation in the golden triangle (but accompanied by an alarming increase in methamphetamine production in the same area). 2) *Strengthen current approaches.* It is a plausible argument that we have tried to stifle local and international markets, but that the actions may just not be clear enough, or strong enough. 3) *Alter the focus in order to reduce harms rather than trying to eradicate the market.* 4) *Acknowledge that the current system is fundamentally flawed-* and needs a total overhaul, so that a regulated market of these substances is introduced.

There are good arguments for and against each possibility, but it is counterproductive to put all our energies into proving that the current approach works and trying to justify it. The evidence base is not as developed as one would like, but we have some signposts to what is effective. If any other area of policy had been so ineffective in terms of its primary objective for 40 years, it is inconceivable that government would not have drastically reviewed the process. In drug policy, we spend too much time trying to pretend we are on track towards our stated aims.

National governments, the EU and the UN are the right bodies to map out future directions in these areas. The non-governmental sector has a role to play as 'critical friend' to government. It should offer constructive help rather than a barrage of criticism. This is a very difficult tightrope to walk, and it is easy to fall off. The NGO sector is not part of government and therefore is not constrained by political process, but it does understand pressures on policy makers. One of the most frustrating things for those working in government is the tension between NGOs and policy makers: they currently have no way of communicating in a meaningful and positive way. The *Beckley Reports* offer suggestions to authorities on how a proper objective review and evaluation could be conducted.

I can understand why the drug policy issue brings out the risk-averse nature of politicians. Asking people with democratic accountability to show weakness, admit that things are not going well, is difficult, and the golden rule in modern democratic politics is *never admit things are going wrong*. In drug policy, we are asking people to admit that what we are doing is mistaken, and that we need to think again. We are also asking decision-makers to take positions that may appear 'soft' to the media and general public. This is ironic, as one could consider that doing nothing about the escalating increase in harms was the true 'soft' position.

We are trying to sell a very complex solution, and whatever is proposed will only ever be a partial solution. There is no structure of drug policy that fits every circumstance and there is unlikely to be one that fully solves the problem of drug-related deaths, drug addiction or drug-related crime. So all you can offer to a politician is a solution that it is very complicated which might allow some steps forward. That is not great rhetoric with which to enter an election. All of this is counterintuitive if you have a political mind. We cannot change the fact that we have sooner or later to admit to a lack of progress. It is also important to consider that the media deal with the drugs issue in a particular way, which in turn affects the public's attitudes. The response to all these difficulties should not be to give up, but to improve the evidence base and to give a better understanding of which policies can improve outcomes.

How Can Research Improve Drug Policy?

Peter Reuter
Professor, School of Public Policy and Department of Criminology
University of Maryland

This is the first instance I can think of in which a non-governmental organisation with a policy enthusiasm seems to think that analysis is actually central to the issue. As a researcher, I will try to suggest ways in which research can improve drug policy. I will focus primarily on the US, and to justify this parochialism I will explain that the US hangs over the rest of the world in terms of influence on policy and dominance of the research effort in this area.

The story is a depressing one for the US. Research is very little used in policy-making. At the macro- level, we rely predominantly on punishment, and in a sense that exempts policy from research because punishment is more of a moral than a management issue. There exists a drugs strategy, which year after year talks about the centrality of science rather than ideology, but only follows science if research produces attractive answers. In reality, science plays no role in the national drugs strategy.

This phenomenon does not simply happen at the gross level of the emphasis on punishment; research is also marginalized at a programmatic level. For a long time, Drug Abuse Resistance Education (DARE) has been the most widely-used programme, even though there is a compelling research base that suggests that it is at best ineffective, and possibly even counterproductive. Equally, within the medical profession, there exist regulations about methadone prescription, which push sub-optimal methadone dosing, and have done so for over 20 years now.

The drug problem is viewed essentially moralistically in the US and much of the Western world, which imposes constraints on the policies allowed, and also on what kind of research can be done.

Treatment

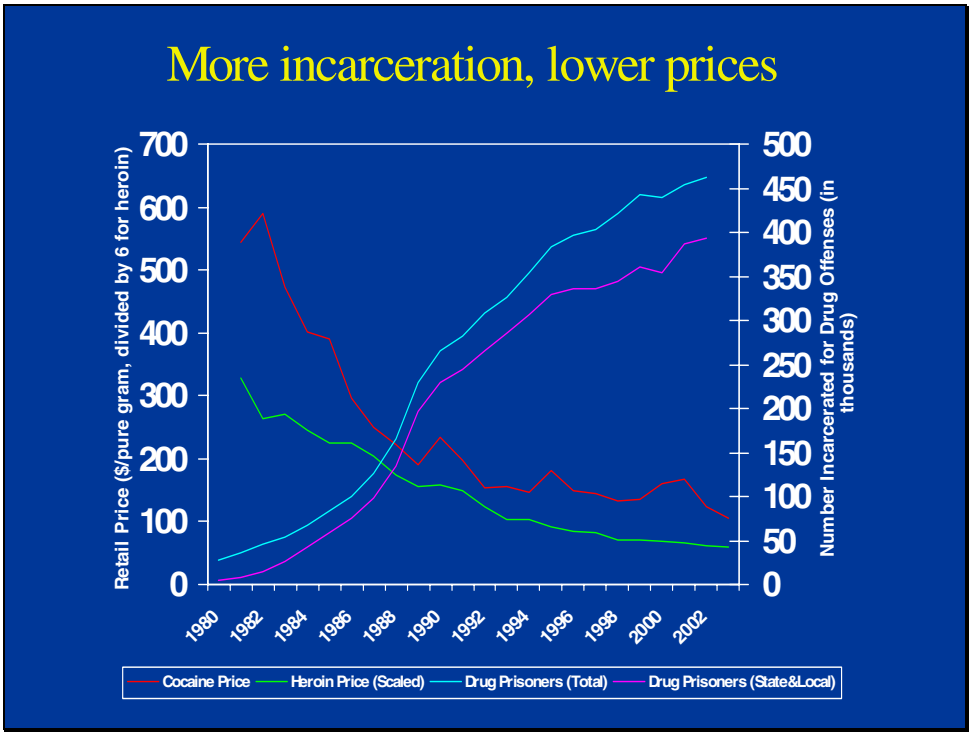
Treatment is clearly the best-researched of the policy areas in this field, if you take the standard classification of treatment, prevention and enforcement. There is a substantial body of work to suggest that treatment can and mostly does work. The evidence is adequate to make the broad case that treatment can result in the reduction of drug problems, and one can even make cost-benefit calculations. The research is no longer dominated by the US, *vide* the NTORS study in the UK, and similar efficacy and effectiveness studies elsewhere. Some treatment results are really quite dramatic, e.g. reductions in crime and HIV risk behaviours with methadone treatment are very substantial, often more than 70%. The problem is keeping patients in treatment. Even not very good treatment, which is what is mostly available, is good enough to generate quite high benefit/cost ratios.

PREVENTION

Prevention arguably remains a mystery. Everyone is in favour of prevention; there is no downside to it, but research here is dominated by the US. It is very hard to point to prevention-effectiveness studies outside the US. It is a very weak research field. There are considerable structural problems in doing these evaluations with a relatively rare behaviour like drug abuse. Many programmes have turned out to be ineffective. In the end, DARE itself was finally downed by such evaluation and is presently being redesigned by researchers. There are a few programmes which look promising, such as 'life skills' training by Gilbert Botvin. This approach performs very well in evaluations carried out by him and his colleagues, but it is troubling that the developers of the technique are carrying out the evaluation. There is a growing literature about implementing life skills training-type programmes. At the moment, prevention is more a slogan than a policy, but looking at some European budgets, it is not even a slogan that any country puts much money into. There may be effective prevention programmes, but we have yet to develop a base on which to measure them.

ENFORCEMENT

Enforcement is by no means a slogan, but it is even more of a mystery than prevention. There is very little money being invested in research here, so the resulting research base is extraordinarily small. There is no evidence that tougher enforcement raises prices, reduces availability or reduces prevalence. It may do so but there is no evidence that it does. The figures on the effect of tougher punishment on prices show the *prima facie* implausibility of enforcement policies. There has been a ten-fold increase in the number of prisoners for violation of drug offences in a 20-year period.



It is quite impressive that the US imprisons half a million people for violation of drug offences; it provides the rhetorically nice comparison that Europe does not lock up that many people for all criminal offences. In the last 20 years there has been a decrease of almost 90% in the price of heroin and cocaine. A causal link between these figures is not suggested, but there is no evidence that increased enforcement leads to an increase in drug prices.

EPIDEMICS

Some good work has been done by Jonathan Caulkins, with the help of researchers at Vienna University, to develop new models of epidemics that have real policy value. The work has the simple underlying notion that drug use is learnt behaviour, with current users 'infecting' non-users in a metaphorical sense. The extent and spread of drug use is a function of attitudes, and prices are a fairly minor part of the epidemic phenomenon. Epidemics burn out when the drug gets a bad reputation. Heavy users, especially of drugs like heroin, cocaine and methamphetamine are the ones that spread this bad reputation. The good news is that bad reputation seems to be a very long-lived phenomenon. There have recently been dramatic declines in cocaine and heroin prices but there has been no reignition of the epidemic, and the bad reputation is maintained. At some stage, in the beginning of an epidemic, there are a lot of new users, which suggests one set of policies may be particularly appropriate then. Later in the epidemic, when we are dealing with endemic use and we are no longer so worried about the spread of drug use, you may go to a lower level of drug enforcement and greater focus on treatment.

SUCCESS STORIES

Can research make a policy difference? It is useful to think about areas in which values and prejudices are comparably important and in which researchers have had some success, providing us with some source of comfort. Alcohol control provides a very large amount of policy relevant research and has had real policy consequences. Ten years ago, Griffith Edwards edited '*Alcohol Policy and the Public Good*'. He summarised what is known about the effectiveness of different interventions, and generated a rich base of analysis about the effects of constraints on availability, the effects of taxation and promotion. The simplest case in which we see policy having an effect on use is in regards to the legal drinking age. Repeated and well-designed research studies measured the effects of raising the drinking age from 18 to 21. Research indicated reduced numbers of road mortalities, particularly among 18 to 20 year olds. The findings had the signal effect of raising the legal drinking age as a matter of federal policy implemented through the states.

The recent UK government policy document on alcohol, which I take to be fairly scandalous scientifically, does not reflect this well. However, you can see throughout the world that taxation and availability controls are increasingly influenced by a growing body of good quality research. This research is much easier in the alcohol control area, as you have many policy levers, and the legality of research makes it much easier. This is not an argument for legalisation, but it is certainly a consequence of prohibition that research becomes very difficult.

In the drugs field there are also a limited number of success stories. For example, at a time when a large share of the federal drug budget in the US was going into interdiction, the Department of Defence commissioned RAND to see what would

happen if it became even more involved in drug interdiction. The research group did some simulation modelling which showed it would be very difficult, even with much more effective interdiction, in terms of increasing the probability of drugs being seized and of drug smugglers being captured, to increase the price of drugs by more than 5%. The results of this research came out when Congress was considering expanding the interdiction programme, and partly as a result federal expenditures on interdiction were cut from 28% down to about 10%.

Although the study was not particularly strong empirically, it looked scientific, was published by a highly respected analytical organisation and, at the time, the Defence Department was fairly neutral on the issue. Congress was being pushed into adopting a policy, which involved passing implausible legislation that would effectively require the Defence Department to seal borders to the smuggling of drugs within 90 days. This research had an impact because it was released at the right time, under the right auspices, it had the right look to it, and people wanted to hear the message, so they took it. About ten years later, another scientific-looking study with a similar number of equations (but the wrong equations and wrong data) was released at a time when the mood had changed, it was pro-interdiction, and policy moved in the other direction. Even though the mood eventually changed, RAND's initial research was the basis of a 10-year victory for rational policy-making, which seems something to celebrate in this area.

Some research has reconceptualised the nature of the drug problem. Early research in the *Drug Use Forecasting Programme* involved a lot of modelling work, and led to the monitoring of drug use among arrestees in the US, UK and Australia. It focused attention on the fact that the bulk of consumption of heroin and cocaine, was accounted for by a narrowly-defined population confined to those that came into contact with the criminal justice system. This gave drug policy an importantly different focus, and pushed policy makers to see the centrality of crime and the importance of treatment, which is increasingly a theme of UK policy. So there certainly are instances when specific research has influenced the way drug policy is conceptualised and, in some instances, it has even made changes in the characteristics of the drug policy itself.

HOW CAN THIS BASE BE BUILT ON?

We need to be realistic about the limitations of what research can do with a moralistically defined problem.

There is a huge research and policy mismatch between how money gets spent programmatically in the US and where the research money goes. It would be a fair estimate that the annual national drug control expenditure by federal, state and local governments is in the region of $35 – $40 billion. Considering just the federal budget, about two thirds goes on enforcement. This increases to three quarters if you include state and local budgets. In terms of research dollars, the National Institute of Justice have less than $50m, and the National Institute of Drug Abuse approximately $1bn dollars. In terms of policy-relevant research, NIDA only does treatment and prevention research. Almost nothing is spent on enforcement-focused federal research, and foundations do not like crime as it raises difficult values issues, and drug enforcement is caught up in that. Hence the mismatch between policy and evaluation.

Treatment programmes are required politically to show that they meet cost-benefit criteria but there is no such requirement with enforcement. Evaluation on the treatment side acts as a constraint, while enforcement has to meet no standards whatsoever. It is assumed that enforcement serves the public good and professionals should be left to do their jobs with no assessment: the government is acting as a moral agent. Lawyers, let alone the police, have no research tradition, and even the FBI has no analytical capacity.

INCREASING THE INFLUENCE OF RESEARCH ON POLICY

Research should start with relevant policy questions:
Who should be imprisoned for how long? There should be some evidence concerning what imprisoning drug users and dealers accomplishes.
Who should have access to treatment resources? Currently there are circumstances in which a dependent user has to commit a crime in order to get into a treatment programme. If we are always going to have grossly inadequate resources for treatment, we should have sound criteria to direct spending.
Are there effective interventions in producing countries?
Do we need to consider different policy options for substances which seem to be of little concern? There are whole lines of drugs, which are illegal but nobody thinks about, and which are just put in the prohibited category because they always have been, e.g. psychedelics.
Where might the results of research be accepted? A research agenda needs to identify areas which might be accepted, e.g. avoid 'legalisation', and exploit active debates.

IMPROVING POLICY WITH CURRENT RESEARCH

We must accept the frailty of the existing research base, but try to show the relative strength of the case for expanding treatment. We must also emphasise that harsh policies are without a good empirical base; are expensive and often inhumane; and are contradicted by such little evidence as is available.

CONCLUSIONS

Modest victories for research should be scored highly, and we must remember that drug policy research is still very young. Reframing drugs as a health problem helps research, and research can in turn help us to achieve that reframing.

ASSESSING THE HARM OF ALL SOCIAL DRUGS

COLIN BLAKEMORE

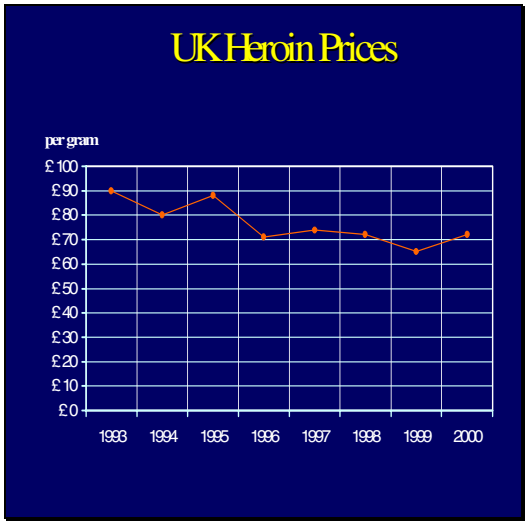
CHIEF EXECUTIVE, MEDICAL RESEARCH COUNCIL, LONDON
WAYNEFLETE PROFESSOR OF PHYSIOLOGY, UNIVERSITY OF OXFORD

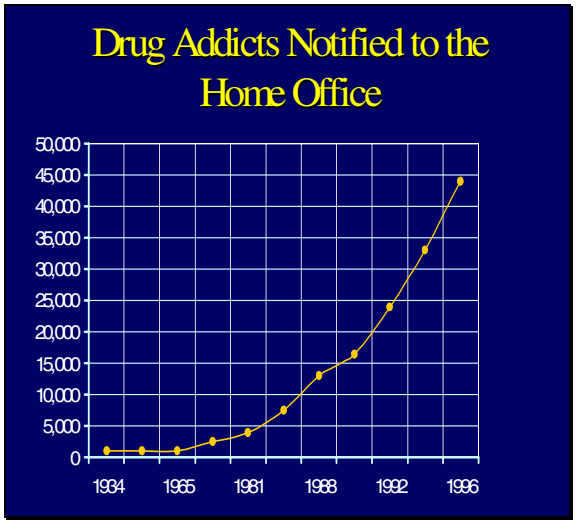
Although we recognise enormous problems in devising schemes for classifying drugs, yet classification is essential to guide sentencing in the law, to determine attitudes to education and social instruction, and to influence the emphasis put on the policing of different drugs. No single classification system can ever be perfect but it is important to devise the most rational one that we can. Are the systems of classification we presently have rationally based, and can they be improved?

In assessing the harm of drugs, science, research and evidence are crucially important. It would be nice to think that we could simply quantify the problems associated with a particular drug and assign a number indicating the harmfulness of that drug. But if we go too far along that track, we run the risk of reaching the same situation that risk assessment as a science did in the 1970s, when the entire system was dominated by numerical risk analysis and probabilities. This failed to take any account of people, and their idiosyncrasies, personal perceptions and prejudices, which we now know play an enormous part in risk assessment. So one has to take those aspects into account in thinking about classification schemes for drugs, as well as rational scientific information about real indicators of harm.

CURRENT SITUATION

The general approach which we have around the world, of tackling drug problems by draconian policing, has not worked. Street drugs have never been more freely available, more widely used, more potent, or lower in cost. If we judge the success of what we have been doing by its impact on the availability, price and use of drugs, it has clearly failed. It is incumbent on those who defend an ever-increasing emphasis on policing and prohibition to state what are their reasons for believing that this approach is ever likely to work.



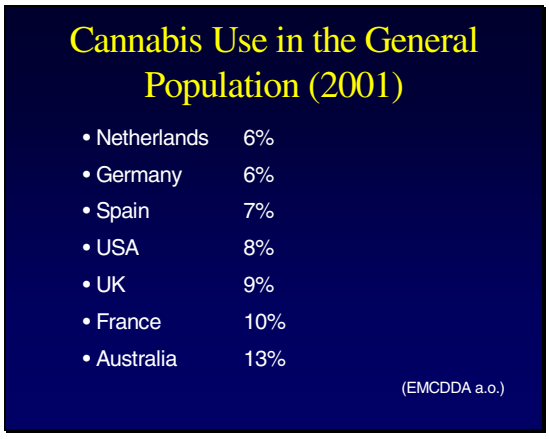


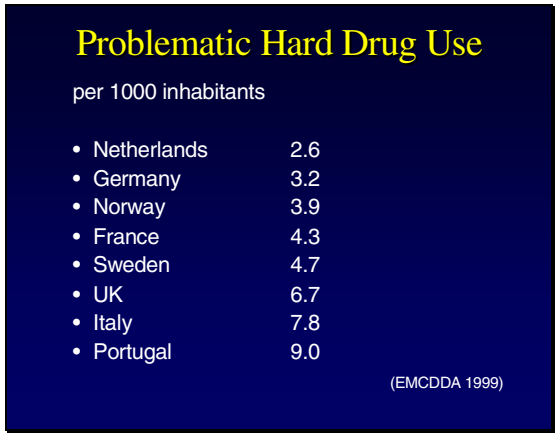
In real terms, UK heroin prices have been falling progressively from the early 1990s, and the number of notified drug addicts has increased. As availability has risen, prices have fallen.

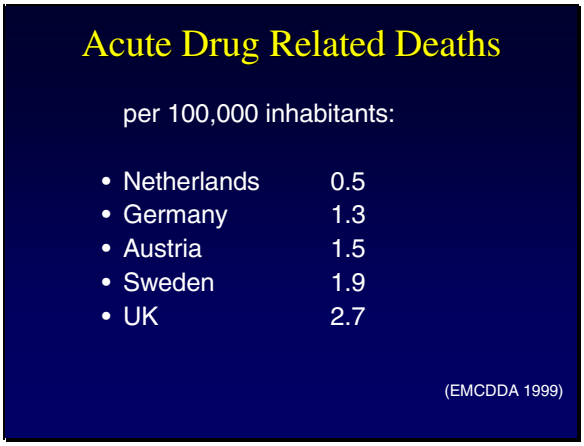
The Runciman Report recognised that one needs to stand back and ask what the objective of public, legal and political attitudes to drugs actually is? If it is the literal eradication of drug use, it is an enterprise bound to fail. "In the course of our enquiry it has become inescapably clear to us that the eradication of drug use is not achievable and is not therefore either a realistic or a sensible goal of public policy." (*Runciman Report 2000*.) If eradication is not the goal, a reasonable goal would be to limit the overall harmful impact of drug use on both society and individuals.

CHANGES IN POLICY

The question then to ask is whether relaxation of control, which will be a drawing back from the draconian policies that have been followed, particularly for less harmful drugs, inevitably leads to an increase in problematic drug use. The question becomes whether people can be trusted with more relaxed attitudes to less harmful substances. The Netherlands experience is widely cited, and there are many reasons to qualify what one says about the output and outcomes of what has happened, not least that the differences in cultural attitudes may mean that the findings are not generalisable. Nevertheless, there are lessons to be learnt from this experiment.







Even for cannabis, the drug for which the Netherlands' approach is most tolerant, there is no evidence that use has increased disproportionately. In fact, cannabis use

in the general population is lower in the Netherlands than in most other European countries, and substantially lower than in the US and the UK. Equally, problem hard drug use and acute drug-related deaths in the Netherlands are among the lowest in Europe, and very substantially lower than in the UK. Although the Netherlands is a single country with a particular culture that may not be representative of what would happen elsewhere, findings certainly do not support the conclusion that relaxing laws restricting less harmful drugs will inevitably lead to a huge abuse of the new freedoms, or to an escalation in the use of other more dangerous drugs.

How are Drugs Presently Classified?

- *Social drugs* – includes both legal and illegal drugs. Illegal drugs are further separated into hard and soft drugs, or Class A, B or C (according to the Misuse of Drugs Act). This system at least purports to be based on rational evidence of harm and impact on society.
- *Medical drugs* - therapeutic, preventive, and other drugs useful in medicine.
- *Enhancing drugs* – growing number of substances used, even if not completely socially sanctioned, for a variety of enhancing effects: cognitive enhancing, memory enhancing, physically enhancing, e.g. Viagra, a drug used to improve sexual function; Modafinil, an arousing drug which increases vigilance.

Difficulties with Classification

The distinctions between the different classes of drugs are becoming increasingly blurred:

- Social attitudes to names of drugs. For example, 'heroin' (illegal, universally condemned and target of most efforts of policing and control), and 'codeine' (painkilling drug of tremendous medical benefit, available over the counter in some forms), both work through a common pathway in the brain. These two drugs are at opposite ends of the scale of acceptability but both work chemically through the production of morphine in the brain, which then activates opiate receptors.
- There are many examples of drugs first introduced for medical purposes leaking into social markets, perhaps altered in their potency by methods of delivery, e.g. the injection of benzodiazepines.
- The acceptability of social drugs varies from culture to culture around the world. so no one scheme is likely to satisfy everybody.
- Some legal drugs are supplied illegally, so the boundaries between legal and illegal distribution methods are blurred: e.g. 30% of cigarettes are supplied illegally.
- Medical drugs spill over into social use, e.g. Modafinil is a drug used to treat narcolepsy, as it prevents sleepiness, but it is also used to maintain vigilance in troops and enhance performance in the workplace, and it elicits a minority interest in the illegal drug market.
- Legal drugs are used to treat drug abuse and addiction, e.g. Methadone is an opiate used to treat the problem of another opiate, heroin. A morally clear view is difficult with substitution therapies, which have similar pharmaceutical effects to illegal street drugs, so it proves difficult to maintain a clear distinction between them.

CRUCIAL QUESTIONS TO ASK ABOUT ANY DRUG

- Does the use of the drug harm individuals other than the user?
- Is its use costly to society in other ways, e.g. placing additional demands on health and social services?
- Is it so patently dangerous to the health or careers of users that society is obliged to protect them from their own wishes? There is a case for intervening and contradicting personal freedoms if the risk to the individual is so great.
- Do users perceive use as a problem? Most abusers of hard drugs recognise the negative impact their drug use has on their lives and do perceive it as a problem, whereas the use of hallucinogens is very rarely viewed that way.
- How regularly do users stop, and how difficult is it for them to abstain?
- How do the risks of any particular drug compare to socially acceptable drugs like alcohol and tobacco? When considering social attitudes to drugs, it is very hard to condemn a street drug that is, by any standards, less dangerous than those drugs we already live with in society.

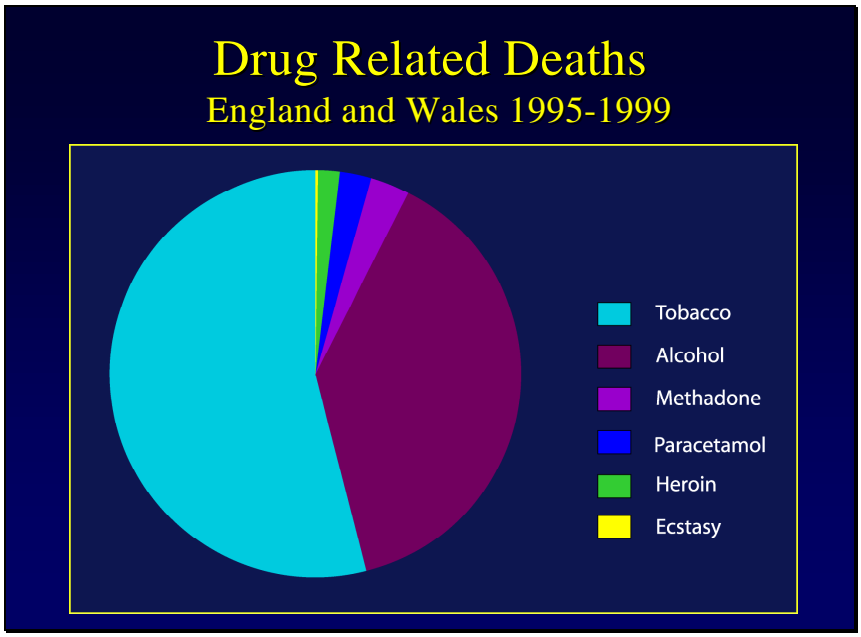
Another conclusion of the *Runciman Report 2000:* "We believe that the present classification of drugs in the MDA should be reviewed to take account of modern developments in medical, scientific and sociological knowledge." This has happened and continues to happen.

HOW ONE MIGHT BASE A SCALE OF HARM

This would involve a continuous review of scientific, sociological and economic evidence by a panel of experts, with representation from academia, the police, relevant NGOs and the general public, in order to assess the potential harm of each individual substance. Drugs would be ranked ordinally according to the currently available evidence of harm by a number of criteria. Alcohol and tobacco should be included in this process, even if only to provide calibration for the absolute assessment of harm in other drugs. Finally, sharp classification within the scale contradicts its continuous and shifting nature, so there should not be sharp demarcation such as A, B, C or soft and hard, or other subdivisions one might like to impose.

WHAT SHOULD THE CRITERIA OF ASSESSMENT BE?

Toxicity, mortality and dependency
On this basis, tobacco is at the top of the list because tobacco claims the lives of more than half of its users and every cigarette reduces life by 11 minutes on average. Alcohol follows closely, and then illegal drugs - injected opiates, smoked cocaine, injected amphetamines, barbiturates and paracetamol - coming lower down in the list. On the graph below, the number of deaths related to the use of ecstasy has been exaggerated, as it is not even one pixel wide in reality.



Relation to violent behaviour
Most crimes of violence, particularly domestic violence, are alcohol-related. Crack cocaine also has a strong connection to violent behaviour.

Relation to crime
Crime often occurs to support a habit. One third of the proceeds of acquisitive crime are used to purchase heroin or crack cocaine. 80% of drug addicts have convictions for theft. Alcohol is associated with criminal actions, such as personal injury and violence to others. Smuggling is significant for both illegal and legal drugs, such as cocaine and tobacco.

Cost to the NHS
Tobacco and alcohol are very high in terms of medical costs. Injected opiates have the highest costs of the illegal drugs.

Negative impact on others
Violence, disruption to family life, problems created for helpers and carers are common effects of addictions to all substances, both legal and illegal.

Total economic impact
Costs of the loss of productive working life and costs incurred by the health service.

Problems with the Scale of Harm

We all recognise that the assessment would have to be multi-factorial; there are many components to it, so how should the individual criteria be weighted? Should the main emphasis be on crime, or on the costs to society or the individual? There are significant individual differences in the extent of harm. Some people are able to live productive lives while using drugs, even when addicted. They experience few physiological effects as long as they can maintain a clean supply of the drug. So there are going to be huge differences in the individual extent of harm. Some people with

addictive personalities may succumb completely to substances and to certain behaviours, which other people deal with very readily.

Public perception is also a factor. However rationally one might devise the system, it needs to be acceptable to the public, media and politicians. It is important then to consider how one approaches providing education and information to the general public, not just how one numerically ranks the dangers of drugs. The personal benefits to some people of the drugs that they use should certainly be part of the process of assessment, although that would be difficult to rank because it is always an individual judgement. In particular, personal medicinal use must be respected as well as cultural and religious use.

Although a classification system of this kind might be considered over-simplistic, there are so many faults with the system we have currently that it is important at least to consider alternatives.

DRUG POLICIES TO MINIMIZE AGGREGATE HARM

MARK KLEIMAN
PROFESSOR OF PUBLIC POLICY
DIRECTOR OF THE DRUG POLICY ANALYSIS PROGRAM
SCHOOL OF PUBLIC AFFAIRS, UCLA

The central proposition that underlies today's meeting is that we ought to have evidence-based, harm-minimising drug policies, where the controls placed on each drug are proportioned to the harmfulness of that drug. Since that is a relatively well-agreed doctrine among the participants today, I wish to challenge it.

An evidence-based harm-minimising policy is obviously better than a policy made at random or the one-size-fits-all 'war-on-drugs' policies aimed at a mythical 'drug-free society' (where alcohol and tobacco are not counted as drugs). However, the notion that we can nicely proportion controls to harmfulness may be one degree too simple to constitute useful policy advice. Harm is multi-dimensional. Therefore, it is not possible to arrange all the possible psychoactives on a spectrum from less harmful to more harmful without comparing incomparables.

Not all drugs yield to the same policies. By any reasonable set of standards, heroin is a more harmful and dangerous drug than cannabis. That suggests that heroin should have stiffer, stricter policies applied to it than cannabis does. Yet cannabis maintenance seems like a silly idea, while heroin maintenance might actually work. Thus what seems like a looser policy would apply more appropriately to what is clearly a more harmful drug.

By the same token, the intensity of enforcement should be less related to the harmfulness of the drug than to its stage in the epidemic cycle. Early in the spread of a drug, enforcement can be quite useful. Later on, when use has stopped soaring and market connections have thoroughly exfoliated, even the highest levels of enforcement severity do roughly no good. That observation suggests that the level of enforcement should not simply be a function of how harmful a drug is.

The discouraging historical data on enforcement levels and prices presented by Peter Reuter cast serious doubt on the assumption that the primary utility of drug law enforcement is reducing the extent of drug abuse. The laws introduced to prevent abuse do, in fact, do so to some extent: cocaine, for example, would be more widely used if it were available at your local chemist or on the same terms on which alcohol is available. However, there is reason to doubt that, once a mature market is established, drug law enforcement can further reduce the extent of abuse. Thus most of the drug abuse control benefit of drug prohibition is a property of the laws themselves, along with enough enforcement to prevent their becoming dead letters, and additional enforcement (after the epidemic phase) has little additive effect.

If that is the case, then the job of drug law enforcement ought primarily to be to manage the side effects of prohibition. The cost of the reduction in drug abuse we get with prohibition is an increase in crime and disorder. Those unwanted effects might yield well to highly focused and targeted enforcement strategies, as long as

enforcers are not under the illusion that it is their mission to reduce drug use. Particularly in the US, where there exist extremely violent drug markets, there is considerable evidence that focused enforcement can make the use of violence, and open, indiscreet dealing, sources of competitive disadvantage (rather than of competitive advantage) to dealing organisations, and can thus change the conduct of the markets without markedly changing their volume.

There is another reason to doubt that we should scientifically judge the relative harms of various drugs and devise interventions solely on that basis: *the harm minimisation principle ignores benefits*. But, in a proper analysis, benefits count. There is no particular reason to believe that just because a substance is currently illicit it has no benefits. Many otherwise illicit drugs are approved for medical use and their use restricted by a differentiated control regime. Nor is medical utility the only utility a psychoactive drug might have. Any attempt to design an optimal alcohol policy that failed to acknowledge the fact that tens of millions of people get harmless pleasure from alcohol would be, to that extent, deficient, and the resulting policy sub-optimal. More generally, therefore, policies to reduce harm ought to be tempered by the opportunity-cost of the benefits forgone by the drugs being controlled.

There is some scientific evidence that hallucinogens can be useful in various medical situations, and intense anecdotal evidence, not yet backed by controlled studies, that hallucinogens can generate important non-medical benefits such as facilitating collective worship, individual spiritual exploration, and the acquisition of self-knowledge. The potential benefits of doing research in this area are great, and anything that interferes with such research ought to be a matter of concern.

One unnecessary consequence of making something a Schedule 1 or Class A drug is that research is burdened. The considerations about how tightly to attempt to enforce the controls against casual use of a given drug are not the same considerations that ought to determine whether research with it ought to be allowed to proceed. Some drugs, such as LSD, are potentially quite dangerous if used unwisely, but quite safe under controlled conditions.

Research with scheduled drugs can be blocked both by official research approval bodies such as the Food and Drug Administration in the United States and the human subjects protection panels (called Institutional Review Boards in the United States) that are required by the institutions that fund research and managed by the institutions that carry it out. Both sets of bodies, but especially the human subjects panels, have displayed what seems to me excessive caution in approving research with currently illicit substances. There is no earthly reason that it should be harder to do research on cannabis than on cocaine, or for that matter on heroin as opposed to fentanyl. In the United States, research on the medical uses of smoked cannabis to increase appetites in AIDS patients has been substantially blocked for no good scientific or ethical reason. We should be vigilant against the danger that human subjects protection will become a cover for scientific censorship.

Even setting benefits aside, to create an appropriately differentiated policy of harm-minimisation based on relative risk, we would need to consider not just some imagined total risk but the varieties of harm done by different drugs.

Drug-taking creates three kinds of risk:

1. *Toxicity*- acute or chronic, physical or psychological;
2. *Intoxicated behaviour* - especially behaviour that constitutes crime or leads to accident;
3. *Addiction.*

While we would not bother to restrict substances, even dependency-inducing ones, if they did not have toxic effects on the body, mind or behaviour, it is also true that toxicity and intoxication alone, without addiction, would justify only rather minimal controls. In the absence of the loss of control over drug-taking that characterises addiction, we would expect healthy adults to adjust their drug-taking in the light of their experiences, as we expect people to do in dealing with other potentially unsafe consumer products or activities. Warning labels, not criminal penalties, would be the primary policy tool.

The primary evidence for the loss of control over drug-taking – a phenomenon which has been denied on theoretical grounds by some philosophers, psychologists, and economists – is self-report. Many people complain about their own use of cigarettes or alcohol, heroin or cocaine, methamphetamine or (much less frequently) cannabis. That is simply a lot less true of blue jeans or compact disks or automobiles, or of skiing or scuba-diving or mountain climbing. Certain drugs keep their dependent users from appropriately adjusting their behaviour despite the harms they observe. In fact, a defining characteristic of abuse is continued use despite knowledge of damaging effects.

Five factors influence the harm level associated with a given drug:

1. *Prevalence*
2. *Harmfulness in ordinary non-addictive states* - 25% of the damage done by alcohol is done by people who do not have a diagnosable alcohol problem. It is not diseased behaviour to get drunk once in a while, yet because being drunk is risky and alcohol use is common, a great deal of damage gets done to and by people who are not identifiably "problem drinkers." Cannabis produces quite intense intoxication, but there is little evidence that cannabis intoxication is importantly linked to accident or crime. Alcohol, by contrast, can cause even its casual, non-dependent users to behave very badly.
3. *Capture rate to abuse* – Drugs vary in the proportion of the population that starts to use them winding up losing control. Half or more of those who try more than a few cigarettes will become dependent smokers for at least a period of months. Heroin has a "capture rate" somewhere below that, smoked cocaine about 30%, snorted cocaine 20%, alcohol somewhere in the high teens, cannabis 11%, hallucinogens a percent or two at most.
4. *Harm from heavy use* - Abuse matters mainly if there is a lot of damage associated with heavy use. The damage done by a month of heavy nicotine use is tiny compared to the damage done by a month of heavy alcohol use. Thus, although cigarettes are more addictive, alcohol does more aggregate harm.
5. *Chronicity* - Nicotine and opiates are typically very long-lasting addictions. It used to be thought that addiction to the stimulants was not as long-lasting because the physical side-effects become so unpleasant, but recent statistics are not reassuring: e.g. crack addiction seems to be nearly as durable as heroin addiction. Methamphetamine addiction tends not to last as long, merely because the body will not stand for it. Alcohol is a complicated case,

> with a moderately high capture rate but low average chronicity. Chronic alcoholism is atypical, even among those who become alcohol abusers. Most people who have a drinking problem have a problem once and then get over it.
>
> That pattern is more typical than ordinarily believed for other drugs as well. Treatment is not the primary cause of desistance from heavy drugs use; substance dependence primarily comes to an end through unassisted quitting. Yet there is little public appeal for hard-drug users to stop. The treatment world has convinced us that drug addicts cannot recover without professional help. By contrast, public appeals are the primary focus of intervention into smoking, even though there is nothing very useful to tell smokers about quitting, except that they should quit. Although the success rate for any given quit attempt is low, over time in the United States, half the adult dependent smokers who have not died, have quit. People who go into nicotine addiction treatment are actually less likely to succeed than those who do not seek help, due to self-selection.

Substances that combine high capture, high damage, and high chronicity are thought of as "hard" drugs: e.g. cocaine, heroin, methamphetamine and alcohol.

As noted above, the toughness of alcohol policy is appropriately limited by the number of satisfied customers. The same ought, in concept, to apply to the currently illicit drugs. That implies that we should pay some attention to consumer reports. Relatively few people who are long-term hard drug users would recommend the activity to a friend or think they benefit from their drug use. The picture is entirely different for MDMA or hallucinogen users. We would be rash to take their positive self-reports at face value, but equally rash to ignore them. If somebody who used MDMA four times in his life twenty years ago is now writing articles describing how much his life has been improved by it, those reports should not be dismissed out of hand. He might easily be self-deceived, but he might equally well be right. It is worth finding out, by doing the research.

And the notion that the research would be unethical because the benefits to the user are unproven, and the risks unknown, seems to me to turn the notion of "informed consent" on its head. It is not impossible to give potential subjects a clear understanding of what is now known, and not known, about what MDMA is likely to do to them, subjectively and neurologically. If, once having that understanding, some of them decide to try it under laboratory conditions, it's hard to see how allowing them to do so would amount to maltreatment. It is not, after all, as if those same individuals couldn't easily obtain the chemical illicitly, as tens of millions of people have already done.

Another conceptually important (but not, at the present, quantitatively important) issue is ritual use, e.g., ayahuasca use in Amazonia, which has now spread in the form of syncretic, part-Christian ayahuasca-using churches; the peyote cult in Central and North America; psilocybin mushrooms still in use among smaller indigenous groups, and some unknown amount of ritual use among the cosmopolitan population in connection with various New Age, Wiccan, or neo-pagan cults. Note that there is not a good fit between international conventions on psychedelic drugs and international conventions on human rights. Freedom of religion cannot be properly understood without the right to proselytise, and yet most

current laws, where they protect the rights of indigenous peoples to use traditional substances at all, do so as long as *only* members of narrowly defined ethnic groups participate in those rituals. Nor is it obvious why someone who is not a member of an indigenous group but whose rituals involve hallucinogens should be denied the opportunity to undertake a spiritual quest involving the use of hallucinogens, under conditions safer than, say, mountain-climbing or scuba-diving. (Whether the existence of a congregation or some congregation-analogue ought to be among the required conditions is a harder question.) American courts are now wrestling with these problems, with one hallucinogen-using church having won a preliminary injunction to prevent the government interfering with their use of Schedule 1 substances in religious rituals. These decisions arguably would benefit from more scientific knowledge than is now available.

Thus, I would argue, benefits research should not be limited to medical benefits and treatment of disease. For example, there is good evidence that the class of profound psychological phenomena variously called awe-inspiring experiences, primary religious experiences, or unitary or mystical experiences can have benefits both for those that experience them and for others. There is also some evidence, including evidence from ritual use, that such states can be relatively reliably produced with the use of hallucinogens in the appropriate settings. It would be a shame to let concern about crack-smoking interfere with research on materials that do not have the addictive, toxic or behavioural risks of smoked cocaine and which might, if properly used, produce extensive benefits.

To sum up, it would be massive progress to scale policies to harms, as estimated from rational evidence. But the phenomena are too complicated to make that simple idea quite right conceptually. Properly, we should have more differentiated measures than a single unidimensional "harmfulness", and include a scale of "benefits" too.

QUESTIONS & ANSWERS

John Strang
Many in this room are comfortable with the objective of reducing individual and societal aggregate harm. Harm reduction does not necessarily mean reduction of drug use, but at the same time, we must be careful not to throw this objective out, as it is one possible effective way of reducing aggregate harm.

Mark Kleiman
Aggregate damage is determined by the product of the harmfulness of a drug (i.e. its rate of damage per unit consumed), and the quantity consumed. Reducing either harmfulness or quantity, without increasing the other, will reduce aggregate damage. Minimising harmfulness, which often goes under the label "harm reduction," is not in fact a complete strategy for minimising aggregate harm.

John Strang
With regard to having maintenance for cannabis use, there is a need to look at where we have effective levers and want to apply them. It may seem unfair that we have treatments for some diseases and not for others, but this should not stop us using what we have, e.g. hepatitis B vaccination should be applied even though we do not have one for hepatitis C.

Mark Kleiman
Again, I agree entirely. There are some things we can do something about, and other things we care about, but cannot do anything about. On balance, one would rather cure crack addiction than heroin addiction, but we have no treatment for crack addiction a tenth as useful as methadone or any other maintenance therapy for heroin addiction.

John Strang
We need to factor in different sub-populations within substance misuse, to have a different approach to an addict versus a recreational drug user, to an injector versus a non-injecting drug user. Planning would be different, and ways in which it may backfire could be different for these different sub-populations.

Mark Kleiman
Yes, differentiating by user is crucial. The widely-accepted statement that drug misuse is a chronic recurring disease is simply not evidence-based. Most people are able to stop using without seeking treatment, and those seen by treatment services are the minority who could not quit on their own. So the treatment services are busy with the small minority of chronic, relapsing, drug-dependent users, and that small minority is therefore taken as typical of all drug-abusing individuals, or even of all drug users generally. That is simply a mistake. It is unfortunate to have established a very negative set of beliefs based on this filtering system.

David Nutt
Why do the media always seem to side with demonstrably unsuccessful repressive policies?

Mark Kleiman
Drug warriors engaged the mass media in the late 1980s and early 1990s and instigated media self-censorship and fairly deliberate propaganda. As citizens and parents, media leaders were easily led to believe that it was their job to make sure everyone knew that "all drugs are bad." The audience for drug policy discourse is the same as the consumer base, so anything positive you say about any drug in a mass-media context may influence somebody to go out and try that drug. Nobody wants the responsibility of promoting use, so the media become very wary of saying anything positive about any illicit drug, or anything against prohibition or its enforcement.

RESPONDING TO DRUGS – HOW? EXPERIENCE FROM AUSTRALIA

MARGARET HAMILTON
UNIVERSITY OF MELBOURNE
MULTIPLE AND COMPLEX NEEDS PANEL, AUSTRALIA

Australian patterns of drug use are similar to other western industrialised democracies but there are some differences and some interesting recent changes for drug policy analysts.

Of the illicit drugs, cannabis remains the most commonly used. Although there has been a reduction in the total proportion of Australians using cannabis in their lifetimes, there is evidence of changing patterns of use that could lead to an increase in the level of harm associated with this substance (that is, more intensive use by individuals, especially those with a mental health disorder). Amphetamines are the second most commonly used illicit drug. This reflects a general trend away from the use of the traditional plant-based illicit substances towards manufactured chemical substances. Heroin, cocaine and other substances, although used by smaller proportions of the population, remain significant contributors to the overall pattern of drug-related harm, such as injecting drug use and acquisitive crime.

PATTERNS OF USE AND PATTERNS OF HARM

The pattern and incidence of drug-related harm varies with the type of substance. For example, tobacco use is the cause of chronic and debilitating disease, and for most smokers its effects are not realised until later life. For this reason, it contributes more than any other drug to mortality and hospitalisations. However, alcohol and illicit drugs contribute to a wide range of acute harms such as overdoses and acts of violence. As such they contribute more to the total years of life lost, despite their lesser impact on health care costs.

Despite the decline in daily smoking rates, smoking continues to be the single largest preventable cause of death in Australia. Tobacco accounted for approximately $21 billion of the total social cost of drug abuse in 1998-9 ($34 billion). Of note, the value of excise collected by the Government on tobacco products is estimated to be approximately $4.6 billion a year. Alcohol continues to be the most widely used drug in Australia, with 82.4 per cent of the population aged 14 years and over having recently consumed alcohol. There is particular concern about youth drinking, with 28.3% teenagers consuming alcohol weekly. The proportion of 16-17 year olds that drink, putting themselves at risk of short-term harm, increased from 15% in 1990 to 22% in 1999. After tobacco, alcohol causes the greatest number of deaths attributable to drug use in Australia. In 1998-9 the total tangible (e.g. loss of labour in the workforce and road accidents) and intangible (e.g. loss of life and pain and suffering) costs of alcohol misuse to the Australian community was approximately $7.5 billion. In the same period, the combined costs of all illicit drug use to the Australian community was estimated to be approximately $6.1 billion.

AUSTRALIAN NATIONAL DRUG STRATEGY (NDS) – FEATURES

A National Campaign Against Drug Abuse was introduced in Australia in 1985; our first explicit national drug policy in response to recognition of the increasing use of a range of drugs, principally cannabis, and an emerging picture of injecting drugs, predominantly heroin. At that time, the global alarm regarding HIV/AIDS was a strong driver in shaping the harm reduction tone of this policy. Harm reduction or harm minimisation has been the main philosophy underpinning Australia's approach to date, with the existing framework identifying three areas for attention: supply, demand and harm reduction.

Our drug policy incorporates licit as well as illicit drugs, and so tobacco and alcohol are considered together with illegal drugs and the inappropriate use of pharmaceutical drugs. Some ambiguity remains regarding performance - and image - enhancing drugs but our drug policy does include inhalants and some more 'exotic' drugs. Our experience suggests that this combining of different classes of drugs in thinking about drug policy is functional and rational. Australia has conducted periodic government reviews and evaluations, and drug-related enquiries are common.

AUSTRALIAN NATIONAL DRUG STRATEGY - COMPONENTS

Information/data. Surveys and other epidemiological data on mortality/morbidity and other health data (e.g. ambulance and drug treatment attendances), some crime data and coroners court records.

Education and prevention efforts. Like most other countries, this is a 'given' even when there is some challenge about its effectiveness. We have devoted significant effort to drug education in schools and mass media campaigns, with more recent attention paid to the shared aetiology with other social and behavioural problems (e.g. juvenile crime, mental illness, youth suicide and homelessness). Therefore, the current focus is on the identification of risk and resilience factors.

Treatment and rehabilitation. Treatment has been well funded so the menu of options is relatively broad, e.g. self-help groups and substitute pharmacotherapy treatment.

International treaties and legal status of drugs. Australia is a signatory to the main UN treaties regarding drugs, and an active participant in international drug policy discussions. There is considerable ongoing debate about the legal status of cannabis.

Interdiction and law-enforcement. There is a history of local community policing; state-level drug squads; national police drug-law enforcement and interdiction through customs and other services. As in many other countries over the past four years, heightened concern about illegal migration, terrorism and purported links to the drug trade has heightened the profile and resources going to law enforcement.

Capacity building. Much of the drug-related research of the past decade has been government funded. There is now a significant body of research literature, a mix of investigator-initiated and specifically-commissioned research, available to help inform drug policy decision-making. The extent to which it is used in this context is now itself a matter of some research. One of the consequences of this investment that warrants comment is the advantage of a 'critical mass' of researchers, who can and

do engage in public policy debate in Australia. While the roles and relationships can sometimes be difficult to manage, and while the research and researchers are only of real value when independent, this community is an important part of the drug policy domain. This resource is potentially threatened by the move away from investigator - initiated and independent research towards government-commissioned research.

WHY IS DRUG POLICY SO COMPLEX AND APPARENTLY IRRATIONAL?

Drugs have symbolic status and meaning in our society, and psychoactive substances have always attracted attention due, in part, to their powerful capacity to change the way we think, feel and behave. Drug use and its consequences is inherently a complex phenomenon. The community however seeks clarity. Simple messages are more likely to sound convincing than erudite explanations of complexity. Thus the drug arena attracts attention and commentary from those in power. Holding some drugs illegal, or outside the mainstream of commerce and use, allows leaders opportunities for 'tough' talk, including declarations of 'war'. This provides an additional apparent show of leadership in an era increasingly preoccupied with risk and enemies.

It is in this environment that drug policy emerges, peppered by politically expedient, knee-jerk reactions that can appear to provide a 'quick fix'; although we must recognise that in this field, common sense is often common but not sense, if effectiveness in reducing drug-related harm is our measure. However, this goal is sometimes not the motive for strong actions in relation to drugs. Drug-related matters are often not especially drug-specific, given that much of the community concern is about public amenity, about perceptions of risk and reduced safety, about the alienation or hopelessness of some sub-groups of young people. Drugs may just come to represent an easier 'target' than the multiple aetiologies of these woes.

Drug policy straddles a number of ministries in government, providing opportunities for responsibility to be both dissipated and confused. At both local and international levels of governance, policy positions about other goods or services and alliances are often traded in exchange or recognition of positions taken on drug matters. Drug policy is thus a pawn in policy-trading. Drug policy requires a mix of responses and choices, thus is very political.

The role of the media is crucial in moulding public perceptions and so in directing politicians' preoccupations. In this environment it is easier for policy-makers to follow than to lead. Policy-makers are nervous about change, and understand that making policy that is 'ahead' of the community is risky. This suggests that in order to achieve better-informed outcomes and to prevent a community backlash, we need to take the community with us on the drug policy journey and not leave it to apparent 'experts' alone. In this sense, perhaps, drug policy is actually more rational than we think: it is just that we have not fully examined the ingredients that inform drug policy.

RESEARCH – POLICY INTERFACE

Drug policy is an arena increasingly reflecting the attention of a mix of disciplines, including programme-evaluators, public health and crime professionals, policy-analysts, and education and training professionals involved in dissemination, uptake and utilisation studies. From my own experience in research, education, treatment, community-level advocacy and national policy process, this mix of orientations brings a strength that any one alone lacks in responding to the complexity of drug policy.

Over the life of the National Drug Strategy (with changes in both state and national governments, ministers and public officials), a system of advisory bodies has emerged in Australia as a means of tapping expertise, 'evidence' and advice. This advice structure is now undergoing change and is in a state of flux. Certainly there is concern that the recent dissolution of the National Expert Advisory and Reference bodies will result in a reduction in consultation, furthering the distance from science, experience, and mix of views. Instead, it is likely to herald an increasing reliance on public officials and on specifically-commissioned research.

REVIEWS, EVALUATIONS, ENQUIRIES – SIGNIFICANT SOURCES OF CHANGE

Government-driven enquiries represent significant opportunities for evolutionary development, and have become drivers for overall collation, analysis and review of evidence from overseas as well as within Australia. They have also, to varying degrees, been an opportunity for public education as well as vehicles for hyperbole and controversy. It is important to garner the progress involved in these, and not to be too distracted by the recommendations that were not adopted or attracted high media profile. In fact, there is great value in being ready with research evidence to help frame the debate at times when drugs take on a high community profile. In these environments, having 'homework' done helps.

Researcher-developed 'new knowledge' is not as readily disseminated to the general public and tends to be a less powerful driver of change. However, it can be a constant informant and provocateur at times of 'usual business' and lower profile development, as well as vital and called for at times of crisis (especially if a relationship respectful of independence has already been built).

There are a number of examples of research and 'homework' informing policy in Australia. These have occurred at many levels, including those driven by National and State governments, e.g. planned and regular evaluations of the National Drug Strategy since 1985, although the most recent commissioned report has not been released publicly. Others have been reactive, and usually represent a strategy for managing community disquiet or challenge expressed or provoked by media attention, e.g. State Summits. These actions produce a phenomenon of competition or 'me-too-ism', with other States then holding similar summits. Local government, especially State capitals, have attracted policy attention often with a particular focus on the impact of drug markets on public amenity. Professional groups or service-providers working with researchers in pursuit of 'best practice' can also provoke change.

OBSERVATIONS REGARDING POLICY, PROGRAMME AND PRACTICE EVALUATION

In the early days of the new era of Australian drug policy there was an inclination towards independent review and evaluation. In the mid- to late 1990s, governments started to set 'hard targets' on the advice of evaluators. Results under these circumstances are hard to read and can be politically embarrassing. International comparisons are difficult, given the varying state of data collection and analysis, yet these are valuable in considering what the situation might have been had the policies and programmes not been in place. More recently, governments and public officials are opting for softer process targets with some avoidance of explicit goals for overall drug policy evaluation, while still urging harder targets for specific programmes, such as treatment services.

Politicians are prone to set unrealistic goals regarding drugs when caught up in community rhetoric. They are quick to claim 'success' or 'wins', but mute on a lack of positive change. Governments are increasingly risk-averse, with bold leadership rare. Public officials are important in the policy-development, sustenance and progress process. They often represent the relatively anonymous continuity underpinning drug policy, while others engage in peripheral debate. It is important that we as researchers remain willing to respond to their needs for information, if or while we can do this and still remain independent. I do recognise that this is a risky position to take, and not easy to achieve.

Researchers and evidence-led drug policy advisors are loath to engage in prediction, which is frustrating and unhelpful to politicians and the community. Perhaps we must ask questions of ourselves. Is our science underdone? Are we missing vital data? Do we lack appropriate methods and measures, or is the task inherently too difficult? It does seem to me that we must ask ourselves these questions and try to overcome our reticence if we want our experience and evidence to be noted.

It is necessary to identify and sustain a critical mass of committed people to journey the 'highway' and support forward motion (avoiding the by-ways where much of the political rhetoric and dispute is conducted). Much of the political debate is on the fringes. The core of drug policy, and ongoing improvement and increases in evidence, can continue even in these sometimes volatile environments. It is pleasing to see the emergence of an increasing commitment to evaluation of law-enforcement initiatives in Australia in recent times, e.g. the Australian Federal Police have employed a full-time evaluator, and are starting to publish findings in International journals. This is all the more significant given that law enforcement has in the past rarely been expected to provide evidence of effectiveness.

It is likely that change will occur more through small increments than through bold new policy shifts. 'Shaping' not 'changing' might be the credo. Options and a mix of possible responses are needed. In this context, I have developed the *Drug Policy Modelling Project (DPMP)* to respond to some of the big questions that are posed in our drug policy debates. That project, and forums such as this one offered by the Beckley Foundation, provide an opportunity to meet with colleagues around the world involved in drug policy study, analysis and advice. Even if 'answers' are not achieved, perhaps trying to answer the questions will help inform future policy and provide impetus for engagement in drug policy debate.

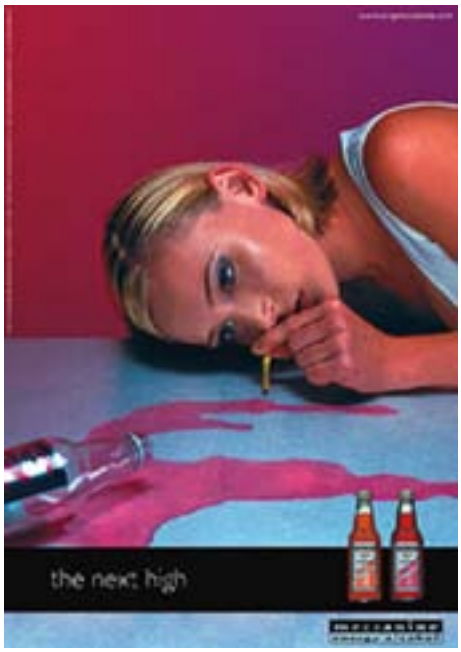
Fundamentally, both enterprises are trying to enhance the chance that research evidence will be used more consistently and frequently in drug policy planning. There are two aspects to the DPMP: research, evidence and apparent rationality on one hand; and the *realpolitik* and/or a study of the policy process on the other. The project is grounded in consideration of the necessary mix of responses to drugs, and uses different ways of asking questions about the 'best mix'. It is inherently interactive, multi-disciplinary and complex.

CONCLUSION

Overall, I think that if we are to see better drug policy we must recognise that drug policy is complex and that we have to use complex approaches to our understanding of it, including engagement in complexity science.

Determining appropriate expectations and objectives can be based on a consideration of research evidence and on an understanding of the policy drivers. We need to develop tools to help tell us which are the most harmful drugs and drug policies, and to whom these harms accrue – both individuals and communities. We need to differentiate reasonable short- and medium-term goals (long-term goals are likely to be beyond us), identify which are realistic, achievable, or at least promising, and frame them in a manner so that they can be readily conveyed to others.

Drug policy might appear to be irrational. This however does not reduce the value of studying it. It is important to continue to build a better scientific base and to prepare our 'homework'. All this will be of limited value if we are not willing to engage in the messy business of the policy process. This involvement will ask us not merely to describe the past but also to predict the future. We therefore need tools that can approach this, while remaining humble about their limitations.



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PROSPECTIVE DRUG POLICIES

CHAIRMAN VIKTOR CHERKESOV

CHAIRMAN, FEDERAL CONTROL OF NARCOTICS OF THE RUSSIAN FEDERATION

Dramatic growth of drug prevalence is posing a serious threat to many states. This context makes fighting drug trafficking not a local but a comprehensive problem of social development. The drugs business has long since acquired trans-national characteristics, featuring high organisation, a stable protection of trafficking routes and an established mechanism of laundering proceeds. There is an ever more sustainable tendency among the criminal agents of the process, i.e. manufacturers, couriers and vendors, to unite into a single global network.

It is becoming clear that because of the internationalisation and globalisation of drug distribution, the epidemic of drug addiction has grown to an unacceptable and very dangerous scale. No one can fail to notice that the problem of addiction has become a deeply personal pain for many people today. Drug-related crime is seeking to penetrate economic, political and social structures of society. It harms legal economies, lowers the efficiency of social protection systems, stimulates the growth of drug trafficking and abuse, and threatens democratic values and the international community as a whole.

No single state can tackle this disaster on its own – there is a need for international solidarity and balanced, collective and simultaneous actions of the international community. It is time to somehow summarise the international understanding of the problem. Thus Russia welcomes the efforts of international organisations, including an organisation of such authority as the Beckley Foundation, as well as the efforts of individuals, to fight drug abuse.

The Russian Federation is deeply concerned with the linkage of illicit drug trafficking, finances of terrorist groups and transnational organised crime. Because of so-called transparent borders, the international drugs business establishes itself on our territory, harvesting enormous profits and leaving us thousands of sick people and problems – family, medical, social and economic.

Organised criminal groups from foreign countries engaged both in drug business and financial fraud, treat Russia as a growing market and an important transit point, as well as a reasonably safe region to launder the money. These are the reasons why the foreign drug business is expanding in Russia. Official medical statistics point out a strong growth in the involvement of a sizeable part of the Russian population, mainly the youth, in illicit consumption of drugs. Between 1991 and 2004, registered prevalence increased eleven fold. Assessments indicate even more dramatic dynamics.

Fighting drug addiction and drug business includes a sizeable complex of diverse measures, which are carried out by various state bodies and public entities. Generally we would like to see a well-adjusted, well co-ordinated system of counter-narcotic legislative, social, enforcement, economic, medical, psychotherapeutic and other measures.

It is understood in Russia that an increasingly important condition of more effective counter-narcotic operations is the deployment of a multi-level system of international cooperation as a mechanism of coordinating the efforts of everyone involved in fighting drug business and addiction. It is impossible to achieve any tangible results in this fight solely by initiatives of one or several nations. We have had fruitful developments in relationships with many international organisations, including the United Nations. Russia has become involved in the international system of countering drugs, and is prepared to oppose this threat together with the international community.

In setting up international co-operation, particular attention should be paid to measures of preventing drug aggression from the territory of Afghanistan. After the overthrow of the Taliban, the expectations and hopes of the international community for the liquidation of a hotbed of opiate and heroin production and general drug threat proved to be premature. Incidentally, intelligence analysis puts the Afghan-sourced opiates on the UK market at nearly 80%. Countering the Afghan drug threat is a priority for the Russian Federation, as Russia lies along the supply route of Afghan narcotic drugs into European countries.

The initiative of our country contributed to the framing of new international approaches to the containment of Afghan drug trafficking, and was reflected in the political declaration of the Berlin *International Counter-Narcotics Conference on Reconstruction of Afghanistan*. It confirms support for the Russian conception of creating security belts around Afghanistan to form an effective system to disrupt the production and contraband of opiates. Russia has been undertaking practical steps to implement the idea of security belts. Together with the *Collective Security Treaty Organisation,* it has been conducting international, inter-agency operations to disrupt the activity of transnational criminal drug communities on the territories of adjacent states.

It is apparent that prohibition cannot be the only method of fighting drug business and addiction. This most complicated social issue cannot be resolved without a vigorous prevention effort in conjunction with effective treatment and rehabilitation of addicts. Eradication of illicit drug trafficking is a collective task for the entire international community that should be translated into moral, legal and enforcement influences at regional, national and international levels. Illicit drugs have imposed hard tribulations upon humanity that it cannot be easily relieved from. Together we will be able to accomplish a lot more than we are able to carry out today.

MORNING DISCUSSION SESSION

Mike Trace
Is it realistic to expect policy makers to base policies on evidence in the future?

Jan Wiarda
There are several important categories of policy makers so, in addressing this question, we need to define what is meant by the term. At the higher level, there are politicians, civil servants, NGOs and scientists thinking critically about the problem. At street level, there are workers in medicine, social welfare and prisons. They are all policy makers, but the politicians and those that advise them directly are the most important category to target. We must also question to what extent the media themselves act as policymakers or agenda setters. The present EU Commissioner, when he was the leader of the Liberal Conservative party in the Netherlands, agreed that irrational approaches should be avoided, and substances regulated sensibly, but he questioned how to explain these views to his voters. Politics is not usually based on evidence, rather the illusion of rationality. We should consider that policymakers have to be convinced and politicians have to be seduced to base policies on real evidence.

Brian Paddick
Politicians will only base policy on evidence if the evidence is clear and is accepted by the public. The present evidence is uncertain, as nobody knows exactly what will happen if you do liberalise. It also needs to be accepted by the media, as there seems to be a decline in conviction politicians and a rise in politicians who will make whatever decision is necessary to increase the number of votes attracted by their political party. So if the evidence is clear and convincing, and you can convince the public and the media that it is the right direction to go in, then politicians will follow because they will see that as a way of securing more votes. Although a circuitous route, that is one way of basing policy on evidence, rather than just presenting the evidence to the politicians and asking them to change their minds.

David Nutt
Talking as a scientist from within the Foresight Project, I would be surprised if the drugs used in 20 years' time will be different to those used now. We have got enough problems today, so we would not want to be sidetracked into thinking there would be a completely different set of emergent problems. We need to focus on the present problems in order to set conditions and paradigms for dealing with any future drugs.

Mike Trace
One view talks of constant new challenges with continuously reinvented drugs, while the other says you can only get high and come down, and there are different ways of achieving that. The future is likely to bring differently-named drugs, produced in different ways. The point relevant to policy is that we still have a mindset around the cultivation and transportation of natural products, and intercepting these. I concede that the way drugs are used will probably be the same, but the production is likely to be different.

Lord Layard
In principle one should weigh out all the different effects of drugs and compare them, but many consider the most important thing in public policy to be the

alleviation of extreme misery. Therefore, in the scale of harm, the elimination of addiction would have a different standing from almost everything else.

Colin Blakemore
You are quite right to suggest that reducing misery or increasing pleasure in the joy of life should be what we are aiming at. However, the misery associated with drugs is often the product of the way in which drugs are supplied or maintained rather than the action of the drug on the body. An interesting example is the wife of William Osler, possibly the greatest physician of the first half of the last century, who became addicted to narcotic painkillers when her husband treated her for some condition. She was a doyenne of North Oxford, did great charitable works, was very active in society and was maintained as an addict, injected by her husband twice a day, all her life. It is not so much the drugs that make life miserable, it is the way in which they are supplied, the crime that is necessary to support this supply, the problem of drug contamination, the routes of administration and so on. So one has to stand back a bit on the issue of whether it is the drugs that actually cause the misery.

Lord Layard
Would you say the same then about alcohol? Alcohol addiction is pretty awful, even if you are able to afford it. If alcohol addiction cannot be controlled very well, does this support making it easier for people to get addicted to other substances?

Colin Blakemore
It is clearly not a simple judgement. However, alcohol in excess does actually kill you whereas, if you are protected from the acute effect of respiratory failure associated with heroin overdose, heroin does not. You can live a perfectly normal life sustained on heroin. So it is not addiction alone that kills; it is the associated toxic qualities of what you are taking. Alcohol and tobacco rate highly in that respect, as both are highly addictive, at least to some personalities, and also extremely toxic.

Mark Kleiman
It is not so straightforward as to weigh a lot of distributed benefit against a little bit of concentrated misery. It does seem that the alcohol case is a very strong one, that the misery of addiction is not merely a function of supply difficulty or even of toxicity. Certainly some people can be heroin-dependent for a lifetime without having their lives dominated by heroin-seeking, but that is somewhat short of a normal life. The life of a full-blown heroin addict, even with a lot of heroin around, is a pretty awful one. The claim that we should not regulate any drug less dangerous than alcohol any more rigorously than we regulate alcohol, would be logically sound only if we knew our current alcohol policies were adequately tight. This may be the case, given the difficulty and expense of trying to regulate a drug that is so widely used.

Lord Layard
The interest for many of us, and something there seems to be much confusion about, is what is likely to happen if there was some liberalisation?

Peter Reuter
In terms of making projections about the effect of liberalisation, I have made many detailed tables of predictions, and the most important thing to take away is the huge uncertainty that governs this type of research. Mistrust researchers bearing certainty on this matter.

Sean Cassin
I think we have won the evidence base for harm reduction around individual use, and how things like needle exchange, methadone maintenance, heroin prescribing and safer consumption rooms can be of benefit. The evidence is that these help the people that use drugs and help society. Should the next phase in relation to harm reduction be a shift to looking at the harms within the system, i.e. the harm outcomes of the supply control systems, the criminal justice systems and the health systems?

Peter Reuter
Clearly, if you take the harm reduction framework and ask what it means for a policy research agenda, it is asking what are the harms, as well as the benefits, that come from enforcement. This should definitely be the approach, but there is a research problem finding effect in something as diffuse as enforcement.

Margaret Hamilton
The scientists committed to getting more rational policy still have more homework to do. We have got bits of the jigsaw but certainly not the whole picture. If we cannot convince our colleagues, including civil servants, and cannot take the community with us on this journey of discovery, reflection and thoughtfulness, then we will not get politicians to be bold. I do not think we are sufficiently prepared for opportunities that arise (at local, state, national and, occasionally, international level), to hand over the necessary research evidence to back up changes in policy.

John Strang
An important, if optimistic, conclusion would be the need for a new research warrior that does a lot of preparation beforehand and is ready to act given a very narrow window of opportunity. It would be pretty difficult to do, as funding is hard to secure for an area of work that is not currently topical, and there may even be active governmental and organisational resistance to study in such an area. Instead of experimenting with completely new models, we should look at instances of small incremental change and see whether that has led to an improvement or worsening, as a way of guessing what would happen if change occurred on a larger scale. Changes occur all the time, but go undocumented and certainly unstudied, e.g. downgrading of cannabis, temazepam laws, police activity in response to possession of drugs, etc. These would give us at least a glimpse of what would happen if you moved further forward. The agencies that could help researchers do that, actively block efforts to secure funding or access.

David Nutt
Do you believe that having national institutes that look at addiction is of benefit? Is there evidence that this kind of coming together of expertise has actually been useful?

Margaret Hamilton
Certainly in Australia, it has been crucial. It has been an absolutely vital ingredient to having a much more research-grounded development of services and policies. That is part of the resource of building a critical mass of researchers that can ask and answer some of the questions politicians may ask.

Roger Graef
None of the three sides of the debate really listen to each other, especially the enforcers, but the good news is that quietly, over the last ten years, there has been a behind-the-scenes change both in police and prison policy. Seven or eight years ago there was only one drug-free wing in one prison. Now there are about 30 and they are on the increase. Drug services are available in nearly all prisons. Slowly, below the surface, a kind of common sense argument is being won, while the rhetoric that our colleagues have been describing stays the same.

Another major problem is that the medical profession remains resistant to getting involved in these changes. When the police changed their approach, as they did in Manchester, and were willing to make drug referrals, the local doctors involved would not accept them. They did not recognise drug addiction as an illness, or want violent, unreliable people in their surgeries. There is already a tacit understanding that rehabilitation is better than enforcement. The way out of this is not to expect a big sea change at the top but to enlist other allies. Rather unhelpfully, key players like the medical profession and social services are keeping their distance.

Charlie Lloyd
We are not very good at doing what we can with the best that we have, and we need to get better at this to take advantage of the opportunities that do arise. Researchers need to be a little more fleet of foot, and to comment on issues on the basis of the best evidence they have, rather than remaining silent waiting for stronger evidence.

Peter Reuter
I agree that we need to make sure that real scientists, those that are purists, stay out of this. Many of the studies involved in drug policy have fairly weak research designs, and cannot be published in peer-reviewed literature, but they can still tell us things that can be substantially useful. This is a field in which not very good research can be influential, as it is so much better than any other kind of evidence that is around.

Mark Kleiman
The war on drugs leading to a drug-free society is indeed a faith, and an unreasonable faith. An equally unreasonable faith is the idea of the end of prohibition and a drug-law-free society leading to utopia. The right response to ignorant faith is not more ignorant faith in the opposite direction. The reification of drug laws into prohibition is a big mistake electorally and a catastrophic mistake politically. The drug warriors in the US have convinced the public that the alternative is either the drug war as currently being fought or legalisation, so if you criticise any aspect of the current policy then you are dismissed as a legaliser.

Colin Blakemore
A lot of the fears and concerns about liberalisation seem to be predicated on the assumption that the problem is not there at the moment and that we might create one. In the UK, about half of all school leavers have tried drugs while at school. We are not talking about how experiments of liberalisation would work on a drug-free society. We are asking how changes in attitude might actually help us out of a mess that, if not actually caused by past strict approaches, is at least correlated with them.

Afternoon Session
Chaired by Michael Portillo

THE TRUTH HAS SOMETIMES TO BE SUSPENDED

JAN WIARDA
CHAIRMAN, EUROPEAN CHIEFS OF POLICE

I was asked to speak on the subject of what should be expected of the enforcement agencies in the next years of the EU drug strategy:

- Can they stop the flow of heroin and cocaine into the EU? Answer: No.
- Can they gain control of the markets within the EU so as to avoid the worst effects on the quality of life in communities? Answer: No.
- Can they help drug users to get treatment? Answer: Yes.
- What resources and institutional arrangements are needed to achieve these aims? Well, a lot.
- Finally, and most importantly, how should progress against these aims be evaluated?

Some difficult questions, so I decided to comment only on what being a part of a global and EU drug strategy means for the police and the damage it can cause the police.

The more I hear about evaluation, the more I have my doubts whether politicians really love transparency. Maybe, we are better off putting these issues in the context of managing public confidence and the credibility of government, rather than asking all those nasty quantitative questions, which are only likely to result in evidence that we failed to reach any of the set targets, so damaging public confidence and undermining the credibility of government. We cannot eradicate drugs out of society. We can only mitigate community problems, human problems, and the damage to the credibility of governments caused by drugs. Gradually, the situation of the drugs phenomenon in society may be getting better. Asking for very precise kinds of evaluation may make things more complicated, and scare politicians, chasing them into safe houses of tough political statements.

EVALUATION

Barleus, a director of the Latin school of Amsterdam in the beginning of the 16th century said, "the truth has to be suspended." Sometimes we cannot live by the truth, because it will cause us great difficulty, so we have to suspend it. In this context, that statement could be replaced by "we cannot live with total transparency".

I focus on a simple set of recommendations on the evaluation aspects of the EU drugs strategy from a cop's point of view, and I assume that that point of view is to a certain extent relevant for all field workers. Reducing availability and reducing harm are two tasks that the police are engaged in that are rather different in scope. When making a drug strategy for the EU, the authorities should consider the impact that drug policy has on policing, police systems and police officers, as well as prison workers and other field workers.

Present policy faces legitimacy considerations in terms of ambiguity for police officers in the field, leading to personal dilemmas and risking corruption and loss of integrity. The role of the police contains two dimensions: one is to serve and protect (the horizontal perspective); the other is to act as a power system of state (the vertical perspective). Police as a system and police as human beings have to unify, continuously and incidentally, to balance out these two within themselves and within the structure. They are almost always out of balance. Either too much serve-and-protect and too little power-of-state, or vice versa. My British colleagues always try to deny the power-of-state, and teach me that it is always serve-and-protect. However, it is only semantics when you consider bringing 10,000 officers together to serve and protect in a strike or demonstration. There is always tension between the two dimensions. When officers encounter problems, organisational tensions arise and the system will be affected by it. The coping mechanisms that exist when this tension arises are as follows:

1. Resign: hardly anybody does.
2. Raise your voice: hardly anybody does.
3. Deny the problem ('Suspend the truth'): this is mainly the response of management cops.
4. Do it your own way: this is mainly the response of street cops.

The last two mechanisms involve a kind of code of silence. Given these situations, you cannot enter into real debate about the problem. The truth is suspended, hoping for better times.

Police authorities are inclined to give more directives and to provide more regulation in order to keep control of the police, thus reducing the room for discretion that officers in the field need. Officers tend to escape after their required years in street duty, finding their way to investigation where they can catch really bad guys, or as beat officers where they have more freedom to engage in social problems within communities. Therefore the real problems caused by drugs (where there are no solutions) are left to their younger colleagues.

The former EU drug strategy was unsuccessful, as the laws did not permit adequate intervention within the framework of law. Administrators, governors and politicians do not like the legitimacy concept because it allows some discretion to the workers in the field. If the worker in the field makes choices which management then criticises, the gap between the leadership and the workers is broadened. Political and management cops on the one hand and street cops on the other hand protect themselves by adopting a code of silence. Only strong leaders have good understanding, communication and relations based on mutual respect.

The ambiguity of official policies, rules and regulation, and the ties of the code of silence seen from the perspective of the street cops, increase the gap between those on the top and those doing the work. They hear the official statements 'we will eradicate all drugs' or 'we will make a drug free society', and compare it with the reality of the marginal people on the street. These police find themselves with no solutions for a lot of problems, going over the line of what is legitimate and having to keep it secret. Hearing about policing incidents elsewhere, and not really seeing any reduction in drug-related problems in society, must cause dilemmas and sometimes stress. The street cops turn their backs on the official systems (authorities, leaders,

press and society) and close ranks, doing work as they think it has to be done according to the unwritten code of the group.

Again, everything depends on leadership, but the situation is sometimes too complicated even for leadership. These situations act as breeding grounds for a lack of integrity and corruption, which is why a drug strategy must pay attention to its effect on the system meant to enforce it.

The European Chiefs of Police have come together and decided on joint planning operations regarding serious and organised crime, based on their common interests. This differs from the former approach, which promoted a national point of view and negotiation with other countries, a 'you help me; I help you' approach. Although difficult to bring into practice, this change will be a very big step forward. One of the target fields chosen was synthetic drugs, including ecstasy. The French suggested this target area and a group of four other countries are developing the project, on behalf of all 25 Member States, in close cooperation with EUROPOL and EUROGERT. In due course, other fields of drugs, like cocaine from South America or cannabis from Turkey, will be added to it. This is interesting for politicians, not because it is about drugs, but because of the massive profits gained form drug trafficking that can be used to fund organised crime and cause societal problems. The crucial point in the evaluation of such a project is a balanced approach between prevention and harm reduction.

QUESTIONS & ANSWERS

Mark Kleiman
If I understood you correctly, you were quite discouraging that it is possible for the police to shrink the community impacts of drug dealing, and change policing tactics to minimise the damage to communities and reduce the side effects of drug dealing. I am curious about the source of that discouragement because there is a lot of evidence in the US that this can be done and is being done.

Jan Wiarda
To the contrary, the police are in a good position to interact with the community and deal with problem situations in cities and suburbs, and thereby reduce the problems and bring drug misusers in the direction of treatment. The police also have more to do sometimes because they have the possibility to stimulate people and get them to agree on some kind of change of attitude or treatment.

Michael Portillo
I understood you to say that you could not prevent the flow of drugs, but that you could mitigate the problems. That is what the police are doing.

Jan Wiarda
As police, we cannot control the market, but we are still in favour of mitigating the effects of that situation so as to avoid the worst consequences on quality of life in communities.

Mark Kleiman
We are trying to distinguish between controlling the market and controlling the volume or conduct of the market. We are talking about inducing users into treatment; that is certainly something the police can do. Also, the police can and

should learn to induce dealers to avoid those dealing practices that are most devastating to local communities.

Jan Wiarda
I agree to an extent, but controlling the market is controlling the total market, and if you suppress it in one area, it may be difficult to prevent it from coming up elsewhere. The police can influence the situation, but the problem will always come up in another place. The smaller you make your target and the location of that target, the more easily you can have an effect but it is not what I would call control.

Peter Reuter
It sounds like you have a bottom-up rather than top-down approach. In other words, going after small dealers not top dealers.

Jan Wiarda
That is not the idea, although I can imagine it sounds like it. The European project is going for the top producers and dealers, those people that are getting the most profit from crime, and often reinvesting it in alternative markets. Targeting the smaller dealers is a national, regional and local law enforcement issue, rather than an EU concern.

Andrej Kastelic
Chairman Cherkesov and Jan Wiarda presented two very different views on law enforcement. It is very important to realise the big differences we have between, not only Central and Western Europe, but also between Central Asia and the rest of the world. It is important to say something to the United Nations, not just the EU. This should be set out in very achievable recommendations, as only very pragmatic suggestions are effective. It is important to reach collaboration between different practices around the world, and not just to focus on Western Europe and the US.

Jan Wiarda
At EU level, there are two different projects on Eastern and Western European organised crime, both of which involve drugs. Synthetic drugs have had to be added because it is a European-originated crime field. With cooperation from the US and South America on the one side, and from Asia and Eastern Europe on the other, the problem is bringing information together. The question is always: Is the information we get from far away as reliable as more local information? Is it gained in an acceptable way from our point of view? The main concern is that no intimidation, torture, or transgression of police duties has been used to gain that information. The illusion about a drug policy that is meant to eradicate all drugs causes problems for police officers in their work, and for the credibility of the system. This is exactly the same in Russia, the US or Columbia. It is no different in any country. It is only denied. The truth is suspended. If you deny it, you only create breeding grounds for corruption.

THE NEW EU DRUG STRATEGY – HOW TO CREATE A MEANINGFUL EUROPEAN POLICY FRAMEWORK

FRANZ TRAUTMANN
HEAD OF INTERNATIONAL AFFAIRS UNIT, TRIMBOS INSTITUTE

The main focus of this presentation will be on the lessons that can be learned from the evaluation of the existing *EU Drug Strategy and Action Plan on Drugs (2000-2004)* for formulating the new EU Drug Strategy (2005 – 2012).

REMARKS FOR CLARIFICATION

There are two major 'policy' papers of the European Union in the drugs field which should be clearly distinguished as they are of a different nature. The EU Drug Strategy defines the general direction and framework for dealing with the drug problem at the EU level. It states general aims and objectives. The EU Action Plan on Drugs, as stated in the Action Plan 2000-2004, is 'a guide to the activities of the European Union in order to follow the EU Drugs Strategy'. It describes, in more detail, the actions to be taken by each of the EU Agencies and Member States, with the aim of reducing drug problems in Europe.

In a way, it does not make sense to focus on just one of these two. They form a package deal. They only make sense together. There is no such a thing as an EU drug policy. It might be most appropriate to see the EU Drug Strategy and the Action Plan as a policy framework, in which starting points and drug policy priorities for drug policy in the Member States are formulated. Whereas there are some (legally) binding EU regulations in the field of supply reduction (e.g. dealing with precursors of synthetic drugs), the EU has, bluntly speaking, no say in how demand reduction should be dealt with. Demand reduction policy and programmes are the sole responsibility of the Member States.

This does not mean that there is no line, no shared view in demand reduction. When one looks back on the last ten or fifteen years, one can see that demand reduction policy and programmes in the different Member States have developed towards each other. Member States do not differ so much any more in their prevention, treatment and care programmes. Importantly, this is partly due to a growing exchange and cooperation between Member States. In a way, supply reduction harmonisation between Member States is a top-down process, whereas demand reduction policies in the different Member States have been brought in line bottom-up.

THE EVALUATION OF THE EXISTING EU DRUG STRATEGY

When drafting a new EU Drug Strategy, one is of course looking back to the experiences with the preceding one.

1. One major problem is that it has proved difficult, if not impossible, to evaluate the degree to which the objectives - targets formulated in the strategy and translated in the Action Plan - have been realised, despite the explicit postulate of the EU Action Plan to 'provide a solid base for the evaluation of the EU Drugs Strategy (2000-2004) promised by the Commission'. Policy evaluation in general is not an easy job. There are a lot of

issues of interest when one wants to know whether a certain policy has been successful. Has it been consistent? Has it been effective? Has it been efficient? Has it been relevant? Has it been useful? Are its results sustainable? One can limit the scope, and in general this is done. However, even if we reduce the scope to the results achieved by a policy, things are still far from easy. The main drug policy fields, demand reduction and supply reduction, include a wide range of objectives or results to be achieved. Evaluating the impact of drug policy on a national level has taught us that collecting the necessary relevant and valid data is an extensive effort, both time consuming and expensive. At EU level, the bigger scale and the need to ensure the comparability of the collected data add to the problem. Researchers are unsure of which indicators to use to measure success or failure, and cannot be sure that certain changes are the results of the policy evaluated. In general, the best we can get here are some indications but no real proof.

2. Policy evaluation in general is a complex undertaking, and both the Strategy and Action Plan as policy papers are particularly difficult to evaluate. One major criticism of the existing Drug Strategy has been that a meaningful evaluation of its targets is impossible. Besides an extensive list of general aims, the existing Drug Strategy presents the following main targets:

   - to reduce significantly over five years the prevalence of illicit drug use, as well as new recruitment to it, particularly among young people under 18 years of age;
   - to reduce substantially over five years the incidence of drug-related health damage (HIV, hepatitis B and C, etc.) and the number of drug-related deaths;
   - to increase substantially the number of successfully-treated addicts;
   - to reduce substantially over five years the availability of illicit drugs;
   - to reduce substantially over five years the number of drug-related crime;
   - to reduce substantially over five years money-laundering and illicit trafficking of precursors.

   On closer inspection, these targets are much less specific than they sound, e.g. the stipulated '*substantial increase of successfully-treated addicts*.' Besides questioning what is meant by 'substantial' in this context, the problem is that there is no EU-wide shared definition of what we call success, and there are no clear indicators for measuring success or failure. Does success only mean abstinence, or are improvement of health and psycho-social functioning also counted? If so, how do we measure this type of success? How do we define criteria for the time interval after treatment? There is agreement on the objectives themselves, but no agreement on how to realise these objectives.

3. EU policy making in general, the decision-making itself, is a very complex and time-consuming process. Finding consensus in the Third Pillar - to which drug policy as a chapter of Justice and Home Affairs belongs – is very difficult. The fact that the drug issue is a highly politicised and 'ideologised' matter does not help. This means that policy papers like the *EU Drug Strategy and Action Plan* are not particularly strong, in terms of giving explicit direction for action. They are clearly the result of compromises between the diverging views and interests of the different Member States. When it comes to actions, the existing Strategy and Plan give the impression of a fruit basket, offering a wide range of nice things to cater for all different tastes, but lacking a consistent view on how to tackle the drug issue. The agreement on the clear targets formulated in the Drug Strategy can be seen as a type of victory, concealing the disagreement on the means to reach these ends. Everybody can agree on the objective

that over five years the prevalence of illicit drug use should be reduced significantly, but this does not mean that there is agreement on how this objective can and should be realised with a consistent package of actions.

THE MAKING OF THE NEW STRATEGY

The weak points of the existing EU Drug Strategy and the problems encountered in its evaluation have been reflected in the preparation of the forthcoming Strategy. The key concern in this process has been to formulate a comprehensive and consistent strategy, leaving the general aims and the targets of the existing Strategy unaffected.

STRONG POINTS

- A key concept is **subsidiarity**, meaning that actions at EU level are only taken when the Member States cannot take them. This recognises that most activities are the responsibility of Member States.
- The Strategy is aiming at a **balanced approach**, meaning that for an optimal result one needs a coherent combination of demand and supply reduction, in which both parts of the strategy are well-adapted to each other.
- The Drug Strategy emphasises the importance of **evaluation** and **review** for an effective policy in the drugs field.

Other elements could contribute to strengthening the Strategy:
- emphasis on making use of existing instruments instead of introducing new ones;
- a thematic, regional approach in certain fields, facilitating cooperation between Member States facing common problems. It does not make sense and is inefficient to have all Member States involved in all issues covered by the strategy.
- in comparison to the existing Strategy, the new paper makes a clear distinction between the Strategy and the Action Plan. It confines itself to a description of the framework and directions for the two envisaged Action Plans, making it relatively short and clear.

The existing draft gives direction to the Action Plans by defining 'concrete, identifiable results and priorities', and by including the following criteria for actions to be taken:
- actions at EU level must offer clear added value, and their results must be measurable and realistic. The intended results should be stated in advance.
- the Action Plans must expressly state the time-frame in which the actions should be implemented, and those bodies responsible for executing them and for reporting on their progress.
- activities must contribute directly to the achievement of at least one of the goals or priorities set out in the Strategy.
- interventions must be reasonably cost-effective.
- there must be a limited number of interventions or activities in each field.

The current draft of the new Drug Strategy is a more consistent policy paper than the previous one. It has a clear and logical structure, and divides drug policy into two main policy fields, i.e. demand reduction and supply reduction. International cooperation, and information and monitoring, are presented as two cross-cutting themes. Adequate coordination is highlighted as a pre-requisite for all work done in drug policy. The draft Strategy shows that progress has been made when it comes to presenting a consistent framework for actions to be undertaken.
To take one example: *"Reducing the demand for drugs implies the following measures:*

- *preventing people from starting to use drugs;*
- *preventing experimental use becoming regular use;*
- *treatment programmes;*
- *rehabilitation and social re-integration programmes;*
- *reduction of drug-related health damage.*

All these measures are of equal importance, they should be offered in an integrated manner and ultimately contribute to the reduction of the demand for drugs."

The above describes measures in a clear structure of what comes first and what comes later, simultaneously emphasising that all measures should be understood as equally important parts of an integrated approach. This is not news for many Member States, especially not for those working in the demand reduction field, but it is the consensus reached that is significant.

WEAK POINTS

The absence of any clear intention to review the policy over the next eight years against indicators of outcome is particularly concerning. The draft is emphasising the importance of evaluation, and states for instance the need "to learn more about the effectiveness, impact and full potential (of supply reduction instruments) before introducing new EU-wide measures and regulations". The Strategy should include a clear framework and guidelines for the evaluation of the actions to be defined in the two envisaged Action Plans. Another weak point is that the draft of the new Strategy is, like the existing strategy, a result of compromises between the diverging views and interests of the different Member States. The impact of this can be seen in the development of the paper, from the relatively short and clear initial drafts to more lengthy and ambiguous later drafts. Finally, despite original plans, the consultation with NGOs has been very limited.

An additional problem concerns the consistency of the so-called 'balanced' approach. The economic law that suggests demand and supply are two sides of one coin, does not imply that supply and demand reduction go together easily. This would only be the case if demand reduction was abstinence-oriented, which we know is not a realistic objective for all drug users, at least not in the short term. The implausibility of abstinence is the raison d'etre of harm reduction. The relation between harm reduction and supply reduction is problematic because there are contradictory elements, e.g. aligning the illegality of substances like heroin with harm reduction measures like syringe distribution, injecting rooms and heroin prescription. Also, prohibition as a means of supply reduction can contribute to adverse effects on the health of users of illegal substances, e.g. the prohibition of MDMA has contributed to a diversification and adulteration of the supply. The availability of adulterated drugs can, at least partly, be explained by the existence of an illegal market.

CONCLUSIONS

In the draft of the new EU Drug Strategy emphasis is on finding – as far as possible – a coherent combination of demand and supply reduction, and on formulating objectives that give direction and contribute to the consistency of the envisaged two Action Plans (2005 – 2008, 2009 –2012). The process of the 'making of' the new strategy underlines once more that having a rational debate of the drug issue is far from easy. This is even more true for finding a shared view at EU level on the various issues covered by the strategy. Again, the final result will be weakened by compromise but looking back to the existing strategy, we can say that we are at least some steps further forward.

NO REASON TO MAKE THE SAME MISTAKE TWICE

JOSEF RADIMECKY
NATIONAL DRUG POLICY COORDINATOR, CZECH REPUBLIC

The preparation of a new EU Drug Strategy (2005-2012) provides a unique opportunity to use acquired experience and to avoid mistakes made in the past. A growing body of evidence and expertise is available to help draw up a drug strategy that will contribute to the implementation of a set of measures effective in reducing the adverse consequences of substance use at both national and EU level. I will look at the discrepancy between the key principles stated in, and the content of, the text of the EU Drug Strategy draft (version made accessible on 26 October 2004) from the point of view of a National Drug Coordinator.

FUNCTIONS OF STRATEGY FOR NATIONAL DRUG COORDINATORS

The EU Drug Strategy has several functions for the work of National Drug Coordinators. It provides:

- Guidelines or framework for national drug policy formulation and implementation.
- Support and source of arguments for national drug policy construction (especially in the case of new Member States with 'less developed' policies).
- Tools for harmonisation (not unification) of EU Member States national policies.
- "Vocabulary" of terms used to increase mutual understanding between experts representing different Member States.

My main intention then is to use the strategy as a basic framework within which I can construct a national drug policy, while taking into account Czech-specific historical, cultural, social, economic and political circumstances, as well as identified needs influencing development in drug issues. I have prepared and submitted proposals of national drug policy based on my own six years of experience working as the National Drug Coordinator, and on the key principles of the EU Drug Strategy (2005-2012), as they are referred to in the most recent draft. These are continuity and learning from experience; evaluation of measures implemented; evidence-based policy; setting realistic and measurable aims; added value to national drug policies of the EU Member States; and improvement of coordination at EU level.

LEARNING FROM EXPERIENCE VS. EVALUATION

If rats can learn from experience, then why cannot people? After carefully reading the document, '*Communication from the European Commission to the Council and the European Parliament on the results of the final evaluation of the EU Drugs Strategy and Action Plan on Drugs (2000-2004)*,' you could ask the same question. Two main conclusions can be drawn: 1) process evaluation suggests that implementation of activities has been successfully achieved; 2) it was impossible to make an impact evaluation, because the timing of the final evaluation was inappropriate (data was only available from 2003), and it was difficult to assess the impact of the Strategy,

because it defined vague aims without setting precise indicators for verification of their achievement, and causality between actions and their impact on the situation in drug field could not be proved.

Despite these conclusions you can find an array of 'old mistakes' in the text of the new Strategy:

1. There is a lack of shared definitions of terms, such as 'drug problem', 'drug-related harms', and 'drug-related crime'. A 'vocabulary' of terms would add real value to the EU drug policy, because the responses are constructed on the basis of how the problems are defined. Clarity and consistency in the terminology used may contribute to the implementation of effective measures to reduce drug-related harms across Europe.
2. Vague, unrealistic and immeasurable aims of the recent strategy should be re-thought and replaced by achievable, realistic and measurable ones. Setting a baseline - a comprehensive analysis of the recent situation - will allow evaluation of policy implementation and its impact against set objectives. Therefore, it will contribute to greater credibility and support of the EU drug policy from the public, politicians and professionals.
3. A clear relation between Strategy and Action Plan should be made in line with recommendations of the EMCDDA, and both documents should be drafted in a structure which allows the objective evaluation of policy achievements. The overarching aim of the policy, objectives, targets, resources, responsibilities and activities should be detailed in the Action Plan within a set time-frame, in order to establish an 'evaluable structure.'
4. There appear to be other important 'supporting' topics that may remove obstacles to creating an effective EU drug policy. These include the coordination of activities and definition of competencies and responsibilities of key players, within as well as outside the EU, the coordination of research in Europe, and the use of EU information policy and financial sources

EVIDENCE-BASED APPROACH VS. RISK MINIMISATION

Even the rhetoric used about the evidence-based construction of the future EU drug policy is doubtful. This is illustrated by the absence of harm reduction or risk minimisation as a meaningful and separate concept in the Strategy, which relies instead on a balanced approach combining drug supply, and demand-reduction interventions. Harm reduction is included only as one aspect of demand reduction, but evidence suggests that this approach does not necessarily aim to reduce drug use, and demand and supply reduction does not necessarily lead to the minimisation of harms caused by drug use. This is of particular concern given that risk minimisation is, compared to prevention and drug supply reduction, the most scientifically-proven approach. In our daily lives, we are surrounded by a variety of risk minimisation measures that we, in contrast to such measures in a drug field, do not doubt, e.g. car-belts, airbags, sun-screens, work-safety protection, etc. Thus it seems to be just the morality of recent policy-makers that does not allow them to recognise harm reduction as an important and legitimate part of future EU policy.

COORDINATION

First we should try to define the term coordination. In my view, cöordination should ensure that all relevant key players involved in drug policy-making at the EU level share common goals, respect each other and thus follow a joint approach. For this they need to understand each other; use 'common language' which could be based on shared definitions of specific terms; know their and each others' respective responsibilities and competences; and have clear information about accessible human as well as financial resources for drug policy implementation, as well as previous research and evaluation findings. All this information should be an integral part of the EU Drug Strategy, and while some if it may already be present in the new Strategy, it is fragmented and not concentrated in one dedicated paragraph.

A more 'user-friendly' structure may help to develop a more practical EU Strategy for the EU Member States to use. Drug policy cannot be formulated and implemented in a vacuum. Thus, it seems obvious that policy would not only define approaches and measures related to drug-trafficking and use, but also clarify its technical and organisational environment. Another weak point of the new Strategy is the absence of information about existing or planned supporting (technical and organizational) components of the future drug policy. Drug policy can be portrayed as a house, in that it is built from a complex of various seemingly incompatible components (measures and interventions) to create a whole, which needs to satisfy certain standards. If you forget any one of these components (e.g. basement or roof), you can hardly build a functional house.

DRUG POLICY AS A HOUSE:

FUNDING			
INTERNATIONAL COOPERATION			
Primary prevention	**Treatment & rehabilitation**	**Risk minimization**	**Accessibility decrease**
ACTIVITIES TO PREVENT ANY DRUG USE OR TO POSTPONE FIRST EXPERIENCE WITH DRUG TO THE POSSIBLE HIGHEST AGE.	A VARIETY OF DRUG-FREE TREATMENT SERVICES ACCESSIBLE FOR DRUG USERS WHO FREELY DECIDED TO CEASE DRUG USE.	SERVICES FOR REDUCTION OF POTENTIAL HEALTH & SOCIAL RISKS AND ADVERSE CONSEQUENCES OF DRUG USE ON INDIVIDUALS (I.E. USERS AT THE TIME-BEING NOT DECIDED TO LIVE WITHOUT DRUG USE) AND ON SOCIETY.	CONTROL, REGULATORY AND LAW-ENFORCEMENT ACTIVITIES TO DECREASE AVAILIBILITY OF BOTH LICIT AS WELL AS ILLICIT DRUGS.
DRUG DEMAND REDUCTION		RISKS & HARM REDUCTION	DRUG SUPPLY REDUCTION
AIMS TO REDUCE DRUG USE THROUGH REDUCTION OF DRUG DEMAND		AIMS TO REDUCE POTENTIAL RISKS & ADVERSE CONSEQUENCES OF DRUG USE (NOT DRUG USE *PER SE*)	AIMS TO REDUCE DRUG USE THROUGH REDUCTION OF DRUG SUPPLY
RESEARCH, INFORMATION & EVALUATION			

'EVALUABLE' STRUCTURE OF THE ACTION PLAN

In order to assure a clear relationship between Strategy and Action Plans and to allow easier evaluation of the achievements of the EU drug policy, it would also be useful to define the basic structure of an Action Plan. There is a lot of scientific literature that might be used for this purpose. One example of such an 'evaluable' structure of the future Action Plans is as follows:

- Analysis: of the situation in the drug field, identifying main problems as a base-line for future strategy development & implementation.
- Objective: a general statement of the desired condition or state to which drug policy is directed.
- Aims/goals: more specific statements that describe what the implemented drug policy should accomplish.
- Targets/ indicators: each objective should have a specific target - an indicator that the target has been achieved, and a method of verification.
- Strategies: the complex of activities/measures used to achieve the aims and objectives.
- Activities: each strategy is made up of number of activities, i.e., defined interventions.
- Outputs: the end-products of particular interventions.
- Milestones: often need to be achieved by a certain date or in a certain Sequence. They assess whether the policy is developing in the right way.
- Outcomes: changes that occur in the target population.

CONCLUSIONS

Some may argue that the EU Drug Strategy is 'only' a political document, that it is ambitious rather than realistic, and that it does not fulfil the strict criteria which are normally used for the critical reading of any scientific paper. In this respect I would refer to §1.7. of the Strategy draft which calls for '*coherent and consistent propositions*'. This statement provokes these questions: Should the EU Drug Strategy stick to the key principles it refers to or not? Is the role of experts to prepare a politically - and at the same time scientifically - correct document for discussion of politicians or not? Do we, as drug policy-makers responsible for the preparation of the EU Drug Strategy 2005-2012, want to achieve credibility for our work in front of the wider as well as the scientific public, or not? My answer to all of these three questions is definitely YES.

SUMMING UP

MIKE TRACE

The debate on the principals of evaluation in the morning session was very rounded and sophisticated, and the afternoon session concentrated on the European Union Drugs Strategy. Although drafted five years ago, and not without its faults, it did attempt to set outcome objectives and an agenda of how those would be measured. The meeting today falls right in the middle of the reconsideration of the future strategy. The last European Union Drug Strategy (2000–2004) runs out in December. It introduced a lot of good concepts for European drug policy, such as subsidiarity (member states having the primary responsibility for all the actions under the strategy); the integration of activities; a balance between activities targeted at supply, demand and harm reduction; and a commitment to evaluation.

The fashion when the current strategy was being drafted in the late 1990s was to actually set objective targets for a drug policy and measure against them. The position we are in at the moment is that the review of progress against the last strategy has been in the process of compilation but no clear measure of success or failure has been established. The next strategy is in the process of being drafted, and it is of concern that the commitment to evaluating progress in relation to outcome objectives seems much looser than it is in the current strategy. At its simplest and most basic, if governments and international organisations embark on a drug policy without actually asking whether it is achieving a reduction in problems or a reduction in drug use, then what hope is there for measuring the success or failure of the implemented policy?

The summary of the contributions so far has suggested that evaluation is methodologically too difficult; the results of the evaluation will never lead to clear policy advice; you cannot link the results of the evaluations to the actions and programmes that you have invested in; even when you can, politicians ignore your results. In addition to that, I am conscious that asking awkward questions (as Jan Wiarda pointed out) is not good for your career. Putting that together, it is easy to see why people react to that reality by saying it is all too hard and there is no point doing anything. However, I think we should be making exactly the opposite decision at this point in history on drug policy. Evaluation is hard; getting the methodology right is hard; getting the results right is hard; so it relies on those of us with some expertise to work harder and get it right. The other option is to carry on giving no advice to policy makers and allow them to carry on making decisions on the basis of the Daily Mail or its equivalent in different countries, and try and negotiate some very difficult social policy decisions without any signposts. That is not the right reaction to things being hard.

The Beckley Foundation Drug Policy Programme commenced on the basis that there were a lot of people in a lot of sectors related to drug policy, whether it be NGOs, academics, officials or politicians and policy makers themselves, who were interested in promoting and enabling some more textured debate than we have seen in public on this subject. It is impressive that so many people of such seniority have been able to attend, and the detail and texture of the debate can only be positive. We know there are no simple solutions but we are willing to talk about it and here we are in an environment where we are not going to get castigated for that.

AFTERNOON DISCUSSION SESSION

Sandeep Chawla
If it is so difficult for researchers to put a consensus agenda forward for 15 or 25 countries at EU level, you can imagine the nightmare of trying to do it for 185 countries at UN level. That is the principle reason why debates in this field end up being so ideologically fixated between prohibition and legalisation. The only way to take this discussion forward is to put together the little empirical evidence we do have in the context of individual countries or international comparability, and offer it up for any pragmatic purpose it can be used for, rather than making general remarks about policies and strategies.

There is a lot of need for development when it comes to cross-national evidence, beyond individual research studies in different countries. For example, a figure frequently cited (for instance in the background paper for this seminar) is that 85% of countries feel that their drug problem is getting worse. This figure is constructed on the basis of findings from an annual reports questionnaire sent every year to every government of every member state of the United Nations. The relevant question asks governments if they think their drug problem is getting worse, better or is stable. An official in the government ticks a box, often purely on the basis of a hunch. These answers are then put together in quantitative terms to give us an overall figure on the status of the global drug problem. When speaking about drug policy at international level then, we need to come down to earth and focus on what is pragmatically possible given the circumstances.

Mark Kleiman
Coordination is only desirable if there is interdependency, when the right action for someone to take depends on the action someone else is taking. It is a good question to ask how many of the things put forward in these multi-national drug strategies are issues of interdependency, where it is valuable for each country to be pursuing comparable activities to others. We may be better off with many states serving as laboratories to determine which set of policies works best. Is it conceivable this rush towards coordination should or could be slowed? The principle of subsidiarity seems to suggest that things should only considered at high levels if they cannot be dealt with at lower levels. Lip service is paid to this principle, but none of these international strategy documents seems to be dealing with it. We may want to ask whether these international conventions are actually of use.

Chung Yol Lee
It is important to differentiate strictly between two terms often used interchangeably: harmonisation aims to make things similar to each other, whereas coordination is needed exactly when there are differences, so providing a structure to learn from one another. What is the influence of the international conventions, given that they do not help with experimentation at local level?

Franz Trautman
It is crucial to have some sort of international framework, but such conventions do restrict flexibility. When we started prescribing methadone and giving out clean needles in the Netherlands, we had a massive influx of drug users from neighbouring countries because they were denied this sort of treatment. We chose to serve a humanitarian interest, but got widely criticised by our neighbours who

accused us of being a narcotic state. Coordination is key, but to allow people in different countries comparable treatment, there has to be an agreed-on standard. This would not have to go into detail, e.g. an internationally agreed-on specific methadone dose, but should give some guidelines as to effective services. It may be good to define different frameworks for countries at a comparable stage in their drug problem, e.g. Portugal, the Czech Republic and Iceland.

Peter Reuter
Coordination is the best policy. There are many problems with harmonisation. We do not know what good drug policy looks like. It is very hard to say that there is one model that would be appropriately adopted, putting aside the inherent heterogeneity of countries. It is harder to evaluate strategies that are carried out by more heterogeneous groups. Evaluation is best done on the most narrowly defined intervention and population. The whole notion of an EU strategy that goes beyond the principles of coordination should be examined fairly critically, as it is implausible to evaluate the success of an international strategy of this type.

Chip Steinmetz
Right now one can order almost any drug one wants over the Internet from any country and it is impossible for customs to regulate it. It would just be way too much work. Bearing this in mind, what is the feasibility of actually being able to cöordinate and harmonise the control of drugs worldwide (not just between European countries)?

Dave Liddell
In terms of cooperation, we could do far more in terms of using a transfer of knowledge and understanding between member states. A lot of change is influenced by things like visits to services in Holland, or by guest speakers from other member states talking about their practices. It is possible that we should be looking at other models, not just evaluation, as vehicles to influence policy. These informal interchanges, coming more from the bottom-up, are crucial to developing a consensus. They may be more effective than more quasi-scientific methods adopting a top-down approach.

Michael Portillo
If you just have these very informal contacts and people come and have very bright ideas, how do you know whether you are adopting a good bright idea or a bad bright idea, if it is not being evaluated?

Dave Liddell
An example can be found in Swiss heroin-assisted treatment programmes, which are supported by ten years worth of rock solid evidence of their effectiveness. The problem in the Scottish context is convincing politicians that this is a good idea. What makes an impact with politicians and policymakers is actually seeing examples in practice; visiting a consumption room rather than having a moral view that it is somehow disgusting and encouraging drug use. Taking politicians there so they see it first hand can start to incrementally change their perspective towards understanding the pragmatic benefits of such services.

Alexander Dundee
I can think of two obvious, simple things that could have a positive effect on drug use. Young people should not be put in prison for minor drugs. Those who are put in prison for a long time should be helped with their addiction while they are there. Would you agree?

Mike Trace
Unfortunately, prisons are not free of drugs. Those that stay long-term in prisons may follow a full path of recovery, and remain drug-free, in those countries and prisons where there are services available. But research has shown, depending on the countries and depending on the prisons, that there is a large proportion of people who actually take up drug use while in prison. Prisons are far more likely to worsen the problem than solve it.

Mark Kleiman
The belief that prison is a good place for drug treatment is widespread; it seems obvious, but there is no research support for it. The best explanation for the failures in prison drug treatment is that not using drugs is not a skill; it is a set of social habits. Even if you could teach somebody not to use drugs in prison, the knock-on effect for his or her behaviour on the street would be quite limited. If we have limited resources to spend on improving drug-related behaviour of the offending population, most of it should be spent on community initiatives rather than those in institutions.

Peter Reuter
Another thing to worry about, in addition to prison increasing the use of drugs, is the increased risk that drug-abusing prisoners face on release. There are estimates of the excess mortality associated with the first two weeks of release from prison that are quite stunning. Reduced tolerance and lack of awareness of that leads to dramatically higher overdose rates.

Franz Trautmann
Everything that prisons can do to reduce the harm associated with drugs should be supported. Drug-free units in prisons in some countries have been quite effective. In Switzerland, prisoners were given pre-release training highlighting some of the risks, and a package containing clean syringes. In the Netherlands, prisoners were given training on how best to deal with substance use. Counselling can be very effective in preparation for treatment after prison. Although prisons are not the solution for substance users, as long as they are involved in the field, they should be working to reduce harms and promote safe use.

Rock Feilding Mellen
From your political experience, what do you think will have a greater impact on our policymakers? Evidence from prominent scientists, or articles written in the *Daily Mail*?

Michael Portillo
I once thought my role in politics was to try to emancipate politicians from the *Daily Mail*. The tendency, when people do not know what else to do, to chase after tomorrow's headline is really deeply depressing. Having listened with rapt attention to the talk by Colin Blakemore this morning, I unfortunately know that scientific evidence is not worth a damn compared with tomorrow morning's *Daily Mail*.

Cindy Fazey
We can repatriate domestic drug policy and leave all the cooperation at the international level for examples like precursors. Why then, when we are dealing with our own drug policy, do we have to compromise with those that are particularly anti-prescribing and anti-anything maintenance at all?

In 2000, the House of Commons select report made a lot of recommendations on whether drug policy was working, which influenced the 2002 policy paper. It said there are 250,000 problem drug users in the UK; some were crack addicts, but most were intravenous heroin users. A very important part of this document said that diamorphine heroin should be prescribed to those that need it. This has not been implemented and not because it is not in the policy papers but because it has been sabotaged by sections of the medical establishment.

Mike Trace
We have to remember that just because coordination is difficult to implement, we should not give up on it. Administrations coming together (whether through the UN, the Organisation of American States or the EU) to acknowledge the scale of drug problems, to try to set out a framework of what can be done about them and to agree some principles around those actions, has to be a good thing. Those administrations trying to constrain the actions of one another, even within the minor details of those principles, is not a good thing and explains why many people are against the ideas of harmonisation (i.e. an attempt to have the same laws implemented in the same way). There is a worrying movement towards harmonisation in European Union drug policy at the moment.

Appendices

I. Biographies of Speakers

II. Participants attending Seminar iv

III. The Beckley Foundation

BIOGRAPHIES OF SPEAKERS

COLIN BLAKEMORE
CHIEF EXECUTIVE, MEDICAL RESEARCH COUNCIL

Colin Blakemore, FMed Sci, Hon FRCP, FRS, is Waynflete Professor of Physiology at the University of Oxford (presently on secondment from University of Oxford), and he became Chief Executive of the Medical Research Council in October 2003. From 1996-2003 he was Director of the Centre for Cognitive Neuroscience at Oxford. Colin Blakemore studied Medical Sciences and Experimental Psychology at Cambridge and completed a PhD at the University of California, Berkeley.

His research has been concerned with many aspects of vision, early development of the brain and plasticity of the cerebral cortex. His prizes and medals from medical and scientific academies and societies include the Robert Bing Prize from the Swiss Academy of Medical Sciences, the Prix Netter from the French Académie Nationale de Médecine, the Gregg Medal of the Royal Australian College of Ophthalmologists, the John P. McGovern Science and Society Medal from Sigma Xi, the international Alcon Prize for vision research and the Royal Society Michael Faraday Prize for furtherance of the public understanding of science. He has been President and Chairman of the British Association for the Advancement of Science, President of the British Neuroscience Association, the Physiological Society and the Biosciences Federation.

Colin Blakemore is a frequent broadcaster on radio (including the 1976 BBC Reith Lectures, *Mechanics of the Mind*) and television (including the 1982 Royal Institution Christmas lectures on the senses, and *The Mind Machine*, a 13-part series on brain and mind, broadcast on BBC2 in 1988). His books for the general public include *Mechanics of the Mind* (for which he won the Phi Beta Kappa Award in Science), *Images and Understanding*, *Mindwaves*, *The Mind Machine*, *Gender and Society* and *The Oxford Companion to the Body*.

VIKTOR CHERKESOV
CHAIRMAN, FEDERAL CONTROL OF NARCOTICS OF THE RUSSIAN FEDERATION

Born in 1950 in the city of Leningrad. After graduating in 1973 from the law faculty of the Leningrad State University, worked for prosecution bodies. Since 1975, he has worked in state security organisations. He was the First Deputy Director of the Federal Security Service of Russia. Since 2000, he has been the Plenipotentiary Representative of the President of the Russian Federation in the Northwest federal region. At present, he heads the Federal Drug Control Service of the Russian Federation. General of the Police. Jurist emeritus. Married with two children.

MARGARET HAMILTON

SCHOOL OF POPULATION HEALTH, UNIVERSITY OF MELBOURNE
CHAIR, MULTIPLE AND COMPLEX NEEDS PANEL, VICTORIA

Margaret Hamilton has over thirty years experience in the alcohol and drug field including clinical work, education, research and policy development. She has a background in public health and social work. She has carried out drug research in epidemiology, evaluation (prevention and treatment), young people and drugs, women and alcohol, drug problems in remote Australia and policy.

She has been a policy advisor to various bodies including many Australian national committees, such as the current appointment to the National Council on Drugs; delegate to the UN Commission on Narcotic Drugs; and Premiers Drug Prevention Council in her home state of Victoria. She has been involved in legislative reviews, summits, and academic and community-based drug policy forums.

She has also been Chair of the Capital City Lord Mayors Drug Advisory Group; Deputy Chair of the National Expert Advisory Committees on Alcohol; Part of the NH and MRC National Illicit Drug Strategy Working Committee; Foundation Board member for the Youth Substance Abuse Service; Member of the National Expert Advisory Committee on Illicit Drugs; Chair of the National Illicit Drug Campaign Reference Group, Chair of the Editorial Reference Group for 'Of Substance', and Deputy Chair of the Cancer Council, Victoria. Her publications include articles (Hamilton, M., King, T & Ritter, A. (Ed's) "Drug Use in Australia – Preventing Harm", Oxford University Press, 2003), research monographs, and reports.

MARK KLEIMAN

PROFESSOR OF PUBLIC POLICY AND DIRECTOR OF THE DRUG POLICY ANALYSIS PROGRAM, SCHOOL OF PUBLIC AFFAIRS, UCLA

Mark A.R. Kleiman is Professor of Public Policy and Director of the Drug Policy Analysis Program in UCLA's School of Public Affairs. His teaching and research cover drug policy, crime control policy, theories of imperfect rationality, and methods of policy analysis.

In addition to his scholarly work, Prof. Kleiman regularly advises governments at all levels on policies for controlling crime and drug abuse. He is currently at work, under United Nations auspices, on a plan for managing the problem of drug-related violence in El Salvador. Before entering academic life, he worked on Capitol Hill as Special Assistant to Edwin Land at Polaroid, as Deputy Director of Management and Budget for the City of Boston, and as Director of Policy and Management Analysis for the Criminal Division of the U.S. Department of Justice.

Professor Kleiman is the editor of the *Drug Policy Analysis Bulletin* and the Chairman of BOTEC Analysis Corporation, which provides policy advice to governments at all levels on drugs, crime, and health. His books include *Marijuana: Costs of Abuse, Costs of Control* and *Against Excess: Drug Policy for Results*. He is currently at work on *When Brute Force Fails: Getting Deterrence Right*. Before moving to UCLA, he taught at Harvard's John F. Kennedy School of Government, where he received his Masters and Ph.D. degrees in public policy.

JOSEF RADIMECKY

NATIONAL DRUG POLICY COORDINATOR, CZECH REPUBLIC

Josef Radimecky established the third therapeutic community for addicts in the Czech Republic in 1993, which was the first to introduce a complex model of involving relatives into the therapy of drug users. Since 1999, he has worked as a National Drug Coordinator in the Czech Republic. In 2003, he finished a postgraduate MSc course in *Drug Use: Evidence-based Intervention and Policy* at Imperial College in London. He publishes mainly within the governmental National Drug Commission monographies and periodicals and in Czech professional journals.

PETER REUTER

PROFESSOR, SCHOOL OF PUBLIC POLICY AND DEPARTMENT OF CRIMINOLOGY, UNIVERSITY OF MARYLAND

Peter Reuter is Professor in the School of Public Policy and in the Department of Criminology at the University of Maryland. He has just completed five years as editor of the *Journal of Policy Analysis and Management.*

From 1981 to 1993 he was a Senior Economist in the Washington office of the RAND Corporation. He founded and directed RAND's Drug Policy Research Center from 1989-1993; the Center is a multi-disciplinary research program begun in 1989 with funding from a number of foundations. His early research focused on the organization of illegal markets and resulted in the publication of *Disorganized Crime: The Economics of the Visible Hand* (MIT Press, 1983), which won the Leslie Wilkins award as most outstanding book of the year in criminology and criminal justice. Since 1985 most of his research has dealt with alternative approaches to controlling drug problems, both in the United States and Western Europe. His book (with Robert MacCoun) entitled *Drug War Heresies: Learning from Other Places, Times and Vices* (Cambridge University Press) appeared in August 2001. Recent papers have appeared in *Addiction, Journal of Quantitative Criminology, American Journal of Public Health, Journal of Policy Analysis and Management,* and *Science.*

Dr. Reuter was a member of the National Research Council Committee on Law and Justice from 1997-2002. He served on the Institute of Medicine Committee on the Federal Regulation of Methadone (1992-1994) and the IOM panel on Assessing the Scientific Base for Reducing Tobacco-Related Harm (2000). He was a member of the Office of National Drug Control Policy's Committee on Data, Research and Evaluation from 1996-2002. The Attorney General appointed him as one of five non-governmental members of the Interagency Task Force on Methamphetamine in 1997. He testifies frequently before Congress and has addressed senior policy audiences in many countries, including Australia, Chile, Colombia and Great Britain. He has served as a consultant to numerous government agencies (including GAO, ONDCP, NIJ, SAMHSA) and to foreign organizations including the European Monitoring Centre on Drugs and Drug Abuse, United Nations Drug Control Program and the British Department of Health. Dr. Reuter received his PhD in Economics from Yale.

MIKE TRACE

CO-DIRECTOR, BECKLEY FOUNDATION DRUG POLICY PROGRAMME

Mike Trace is currently Co-Director of the Beckley Foundation Drug Policy Programme and Chief Executive at RAPT (Rehabilitation of Addicted Prisoners Trust), one of the UK's foremost providers of drug addiction treatment.

After leaving a secondment to the United Nations Office on Drugs and Crime in January 2003, Mike Trace worked as the Chief Executive at The Blenheim, an independent drug treatment service provider in West London. From June 2001 to November 2002, he was the Director of Performance at the National Treatment Agency for Substance Misuse, a special health authority charged with overseeing the expansion and improvement of the substance abuse treatment sector in England. From November 1997 to June 2001, he was the Deputy UK Anti-Drug Co-ordinator. This role involved giving advice to UK government ministers on all aspects of drug policy, the creation of the 10-year strategy, *Tackling Drugs To Build A Better Britain*, and overseeing its implementation.

Previous to this, Mike worked in and managed projects tackling drug-related offending for many years. From 1987 to 1995 he was Head of the Criminal Justice Service at The Cranstoun Projects, one of the largest independent sector providers of drug services. In 1986 he worked for the California Youth Authority on rehabilitation for drug-using offenders in the USA. Mike was a member of the Criminal Justice Working Group of the Advisory Council on the Misuse of Drugs (ACMD) from 1992 to 1995 and was a full member of ACMD until 1997. From 1995 to 1997, he was Chief Executive of the Rehabilitation of Addicted Prisoners Trust (RAPT) and Chair of the Criminal Justice Forum of the Standing Conference on Drug Abuse.

Mike has chaired United Nations technical committees on the drugs issue and was for 2 years Chairman of the Lisbon-based, European Monitoring Centre for Drugs and Drug Addiction where he was responsible for overseeing the collection and analysis of objective, reliable information concerning drugs and drug addiction at a European level.

FRANZ TRAUTMANN

HEAD OF INTERNATIONAL AFFAIRS UNIT,
TRIMBOS INSTITUTE OF MENTAL HEALTH AND ADDICTIONS

Franz Trautmann (educational scientist) is head of the Unit International Affairs of the Trimbos Institute - Netherlands Institute of Mental Health and Addiction (Utrecht, the Netherlands).

After having worked for several years in different drug services in the Amsterdam region he joined the Netherlands Institute of Alcohol and Drugs and later the Trimbos Institute. Main themes in his work have been the development of harm reduction low-threshold treatment services, Rapid Assessment and Response as project development tool, project management and drug policy in the EU framework. He has been responsible for various projects in the field of drug policy and drug prevention, treatment and care in Central and Eastern European countries.

JAN WIARDA
CHAIRMAN, EUROPEAN CHIEFS OF POLICE

Jan Wiarda was born in 1940 into a farmer's family of the Frisian minority.

1959	Police Academy
1962	Municipal Police- Utrecht
1968	District commander
1975	Innovation team- Policing in change
1979	Security Director- Private bank
1983	Chief Constable- Municipal Police Utrecht
1989	Change manager- Police Region Utrecht
1994	Chief Constable- Regional Police Utrecht
1997	Chief Constable- Haaglanden (The Hague)
From 1989	International Affairs of the Dutch police
From 2000	Head of Dutch delegation- European Police Chiefs Task Force

Morning Session Chaired by Jan Wiarda

Afternoon Session Chaired by Michael Portillo

PARTICIPANTS ATTENDING SEMINAR IV:

SPEAKERS

Prof. Colin Blakemore	*Chief Executive, Medical Research Council, UK*
Prof. Margaret Hamilton	*Chairperson, Multiple and Complex Needs Panel, Australia*
Prof. Mark Kleiman	*Professor of Public Policy, University of California Los Angeles, USA*
Josef Radimecky	*National Drug Policy Coordinator, Czech Republic*
Prof. Peter Reuter	*Professor, School of Public Policy and Department of Criminology, University of Maryland, USA*
Mike Trace	*Director, The Beckley Foundation Drug Policy Programme, UK*
Franz Trautmann	*Head of the International Affairs Unit, Trimbos Institute of Mental Health and Addiction, The Netherlands*
Jan Wiarda	*Chief Commissioner of Police, The Netherlands and Chairman of the European Chiefs of Police*

CHAIRMEN

The Rt. Hon. Michael Portillo, M.P.	*Conservative Member of Parliament for Kensington and Chelsea, formerly Secretary of State for Defence*
Jan Wiarda	*Chief Commissioner of Police, The Netherlands and Chairman of the European Chiefs of Police*

PARTICIPANTS

Dr. Pavel Abraham	*President, National Anti-Drug Agency, Romania*
Athanasios Apostoulou	*Special Adviser to the Leader of The Greek Opposition Party*
Emma Basker	*Deputy Director, International Harm Reduction Development Centre (IHRD), Open Society Institute (OSI), USA*
Patricia Begin	*Director, Policy and Research, Canadian Centre on Substance Abuse, Canada*

Christoph Berg	*Head of Programme, Development-oriented Drug Control Programme (DDC), GTZ, Germany*
Henri Bergeron	*Head of Policy, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Portugal*
Dr. David Bewley-Taylor	*Department of American Studies, University of Wales, UK*
Prof. Gustav Born	*Professor, William Harvey Research Institute, UK*
Prof. William Butler	*Chair of Comparative Law, University of London, Founder and Director of The Vinogradoff Institute, Preeminent authority on the legal systems of Russia and other members of the CIS, UK*
David Cameron, M.P.	*Head of Policy Co-ordination, Conservative Party, and Member of Parliament for West Oxfordshire, UK*
Fr. Sean Cassin	*National Drugs Strategy Team, Ireland*
Prof. David Clark	*Department of Psychology, University of Wales, UK*
Sandeep Chawla	*Head of Policy Analysis and Research Branch, UNODC, United Nations*
Chairman Viktor Vasilievich Cherkesov	*Chairman, The Federal Service of Control of Narcotics of the Russian Federation, Russia*
Dr. Anna Chisman	*Senior Advisor and Chief of Public Communications, Inter-American Drug Abuse Control Commission (CICAD), USA*
Daniela Dombrowski	*Coordinator, NAS / CPD, Switzerland*
The Earl of Dundee	*Host, Member of the House of Lords, UK*
Alex Eavis	*Raconteur and researcher, The Beckley Foundation, UK*
Victor Everhardt	*Senior Policy Advisor, Addiction Policy Division, Directorate of Mental Health and Addiction Policy, Ministry of Health, Netherlands*
Prof. Cindy Fazey	*Professor of International Drug Policy, Liverpool University, UK*
Aleksander Fedulov	*Head of Section, Directorate of International Cooperation, Russian Federation Narcotics Control Service, Russia*
Rudi Fortson	*Barrister of Law and author of 'Misuse of Drugs and Drug Trafficking Offences', UK*
Nuno Freitas	*Chairman of the Institute on Drugs and Drug Addiction and National Drug Policy Coordinator, Portugal*

Edina Gabor	*Deputy State Secretary for the Co-ordination of Drug Affairs, National Drug Co-ordination Office, Hungary*
Prof. Roger Graef	*Visiting Fellow at the Mannheim Centre for Criminology, UK*
Paul Griffiths	*Head of Epidemiology, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Portugal*
Robin Hart	*Associate Director, Wilton Park, UK*
Andrew Jackson	*Deputy Director, Foresight Directorate, Office of Science and Technology, Department of Trade and Industry, UK*
Alison Jamieson	*Independent Consultant and Author on issues of political violence, organised crime and drugs, Italy*
Martin Jelsma	*Drug and Democracy Programme Coordinator, Trans-National Institute, The Netherlands*
Lorie Karnath	*Chair, Dahlem Conferences, Managing Director and Chair Scientific Board, Rescentris, Germany*
Dr. Andrej Kastelic	*Director, Centre for Treatment of Drug Addiction, Health Ministry, Slovenia*
Christine Kluge Haberkorn	*AKZEPT eV (Federal Association for Drug work and Politics), Germany*
Danny Kushlick	*Director, Transform Drug Policy Foundation, UK*
Prof. Lord Layard	*Director, Wellbeing Programme, Centre of Economic Performance, UK*
Dr. Chung-Yol Lee	*Vice-Director, Substance Abuse & Aids, Swiss Federal Office of Public Health, Switzerland*
Jeff Lee	*Executive Director for Scientific Affairs and International Policy Lead, The Mentor Foundation, UK*
Dave Liddell	*Director, Scottish Drugs Forum, Scotland*
Charlie Lloyd	*Principal Research Manager, Joseph Rowntree Foundation, UK*
The Lord Mancroft	*Chairman of the Drug and Alcohol Foundation, UK*
Dr. Peter Miller	*National Addiction Centre, Institute of Psychiatry, UK*

Amanda, Lady Neidpath	*Hostess and Director, The Beckley Foundation, UK*
Prof. David Nutt	*Chairman of the Technical Committee, Advisory Council on the Misuse of Drugs, UK. Professor of Psychopharmacology and Head of Department of Clinical Medicine, University of Bristol.*
Commander Brian Paddick	*Deputy Assistant Commissioner, Metropolitan Police, UK*
Dr. Vladimir Poznyak	*Coordinator, Management of Substance Dependence Team, Department of Mental Health and Substance Misuse, World Health Organisation, Switzerland*
The Viscountess Runciman, D.B.E.	*Chair of the Police Foundation Report "Drugs and the Law" (2000), UK*
Justin Russell	*Home and Legal Affairs Advisor, No. 10 Policy Directorate, UK*
Jeremy Sare	*Head of the Drug Legislation Section, Drugs Strategy Directorate, Home Office, UK*
Eberhard Schatz	*Project Coordinator, AC Company, AMOC/DHV, AKZEPT eV, Germany*
Dr. Blazej Slaby	*Director, General Secretariat of the Board of Ministers for Drug Dependencies and Drug Control, Office of the Slovak Government, Slovak Republic*
Eduardo Spacca	*European Network of Drug and HIV/AIDS Services in Prisons, UK*
The Baroness Stern	*Senior Research Fellow, International Centre for Prison Studies, UK*
Prof. John Strang	*Professor of the Addictions, Institute of Psychiatry, UK*
Bill Stronach	*Chief Executive Officer, Australian Drug Foundation, Australia*
Tatiana Tikhonravova	*Expert on Economics of Drug Use, The NAN Foundation, Russia*
Annette Verster	*European Association of Professionals Working in the Drug Field (ITACA), Europe*
John Walsh	*Washington Office on Latin America, USA*
Dr. Tomas Zabransky	*National Focal Point for Drugs and Drug Addiction, Government Office, Czech Republic*

PRINCIPLES UNDERPINNING

THE BECKLEY FOUNDATION DRUG POLICY PROGRAMME

- That the current global drug control mechanism, (as enshrined in the three United Nations Conventions of 1961, 1971 and 1988), is not achieving the core objective of significantly reducing the scale of the market for controlled substances, such as heroin, cocaine, methamphetamine and cannabis.

- That the negative side-effects of the implementation of this system may themselves be creating significant social problems.

- That reducing the harm faced by the many individuals who use drugs, including the risk of infections, such as Hepatitis C and HIV/AIDS, is not a sufficiently high priority in international policies and programmes.

- That there is a growing body of evidence regarding which policies and activities are (and are not) effective in reducing drug use and associated health and social problems, and that this evidence is not sufficiently taken into account in current policy discussions, which continue to be dominated by ideological considerations.

- That the current dilemmas in international drug policy can only be resolved through an honest review of progress so far, a better understanding of the complex factors that create widespread drug use, and a commitment to pursue policies that are effective.

- That analysis of future policy options is unlikely to produce a clear 'correct' policy - what may be appropriate in one setting or culture may be less so in another. In addition, there are likely to be trade-offs between policy objectives (i.e. to reduce overall drug use or to reduce drug-related crime) that may be viewed differently in different countries.

- That future policy should be grounded on a scientifically based scale of harm for all social drugs. This should involve a continuous review of scientific and sociological evidence of the biological harm, toxicity, mortality and dependency; the relation to violent behaviour; the relation to crime; the costs to the health services; the general impact on others; and the total economic impact of the use of each individual drug on society.

The aim of this programme is to assemble and disseminate information and analysis that supports the rational consideration of these sensitive issues, and leads to the more effective management of the widespread use of psychoactive substances.

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