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DRUG POLICY REFORM PARLIAMENTARY SEMINAR

PLENARY SESSION V: DEMAND REGULATION POLICIES

ROGER HOWARD, PERNILLE SKIPPER, ALEX STEVENS and JINDŘICH VOBOŘIL

Demand Regulation Policies

[PAUL FLYNN MP *in the Chair*]

The Chair welcomed delegates and said that his reason for being there was that he was one of the oldest and longest-serving MPs, having seen 27 years of utter, abject failure on drugs policy. It was an area in which his Parliament, like many others, had acted on drugs policy out of prejudice, rather than evidence. There had been 41 years of evidence-free policy, which was a terrible failure for politicians. Many good things happened in Parliaments, but there had been all these years of legislation that was meant to appeal to the lowest common denominator of public prejudice, and not one of the policies had reduced drug harm or drug use. He said the session, on approaches to regulating demand for illicit drugs, would be most valuable. The panellists would present case studies and their views on what comprised best practice and was effective in reducing the detrimental effect and harmful health impact of drugs. He reminded the panellists, who would have a great deal to say, that they had 10 minutes only.

Regulatory Best Practice (Consumer Countries)

Speaker: **Professor Alex Stevens,** School of Social Policy, University of Kent.

Professor Stevens thanked Baroness Meacher and the group for inviting him speak. He said that, as an academic, he had to quibble with the question. He had been invited to talk about "consumer countries", but every country was a consumer country, so he would talk about the regulation of consumption.

He said he had been asked to talk about best practice as if there were one best practice. British men did not have a good record on telling the rest of the world how to act—they had tried that many times, not always with the best results for citizens of other countries. He would offer delegates a menu from which they could choose practices with evidence behind them for their countries.

He said that people normally talked about regulating drugs as though it was just a matter of legality, with the discussion focusing on prohibition versus legalisation versus decriminalisation. Every now and then, calls had been made for drugs to be treated as a public health problem—as though there were some necessary dichotomy between legal repression and public health, which always went together—but the social aspect was rarely heard about. He wanted to leave delegates with the clear impression that the social regulation of drugs and the drug market was too often neglected, but was extremely important—perhaps more so than legal and health policies.

He said he would not spend much time on the legal situation, because that had been much discussed. There were two extremes: prohibition—Sandeep and others had talked about some of its failures—and legalisation, meaning an "everything goes" situation in which anyone could sell anything to anyone for whatever price they liked. That was tried in the 19th century, but was not very successful. It had led to high rates of drug use and lots of deaths, and then to the original calls for some form of regulation. He said what was needed, as the Spanish delegate had said, was some form of middle way between the two ineffective extremes.

He said that at least three forms of middle way existed. One was depenalisation—drug offences staying within the criminal law, but the Government or prosecutor deciding not to punish people—of which the leading international model for that was the Netherlands.

Another was decriminalisation—drug possession being taken from criminal law to administrative law, with some sanctions, but no criminal record or imprisonment—of which the leading international example was Portugal. There were interesting moves towards what might be called legalisation, but which he preferred to call state control and regulation, in Uruguay, using a system of licensing marijuana. In Switzerland, there were proposals, which had not yet been implemented, to make cannabis available through legal, official clinics controlled by the state.

On the effects of decriminalisation and depenalisation, he said that the Uruguay model had not been in place long enough to generate any evidence, but evidence from the 21 countries with some form of decriminalisation suggested no necessary link between decriminalising possession and increasing use; however, commercialisation of drugs did lead to an increase in use. The Netherlands saw an increase in cannabis use between the 1980s and 1990s following depenalisation, but once it began to get tougher in imposing and enforcing regulations on coffee shops, that rise plateaued.

He said that the decriminalisation of drug possession seemed to help to achieve the main aim of the Portuguese drug policy, which was to incorporate drug users into the social body in order to provide support through the welfare and health systems. Decriminalisation of possession, however, did not solve what is known in the Netherlands as the back-door problem of how the drugs get into the country and to consumers. Such things, under the recriminalised system of possession in consumption countries, would not solve problems of violence in Latin America and Afghanistan.

He said that much more evidence existed for the benefits of health regulation than for repressive punitive or enforcement regulation. Health regulation was promising because chronic drug users made up a large proportion of the drug market. Millions of people used drugs occasionally, but they did not form a large proportion of the demand. The majority of the weight of drugs was used by those using lots every day, so reducing demand among those users would provide an opportunity to reduce the scale of the overall market, and the evidence suggested that treating, rather than punishing, helped to achieve that aim.

He said that treatment was much more cost-effective than punishment in reducing demand and improving health benefits. The best evidence related to opiate substitution treatment: putting people who had been injecting heroin on methadone maintenance programmes reduced the risk of death by one third and of catching HIV by a half compared with no treatment. Detoxification and abstinence services were also available, but good scientific evidence was scarce, partly because of high drop-out rates. However, observational studies suggested that outcomes of such services were roughly equivalent to opiate substitution treatment, but they were much more expensive—some 10 times more expensive in England, for example. The effectiveness of other kinds of drug treatment could be improved by offering drug users rewards, including cash rewards for making progress in treatment, known as contingency management.

The second form of health regulation was harm reduction, which has nine components according to the World Health Organisation. It is globally recognised as an effective approach, but some countries, such as Russia, still refuse to provide it. The principle could be applied to substances other than heroin and to other forms of intervention. He said that he had recently written a paper on applying harm reduction principles to the enforcement of laws in retail drug markets with the International Drug Policy Consortium. Risk behaviours and the transmission of HIV were reduced in the countries that had a comprehensive system of harm reduction, and the countries that did that early in the epidemic had much lower levels of HIV, the prime example of which is the UK. The USA's harm reduction came later. The UK has

small percentages of injecting drug users with HIV, but the USA has four or five times that number. Importantly, no evidence suggests that harm reduction increases drug use.

He said that social regulation is important but ignored. Drugs use is often thought of as a problem for poor people, but most studies show that drug use is more prevalent among wealthy people, who have the money and time to devote to using drugs. The poor, particularly ethnic minorities, suffer most from drug use and the repression of drug users. He showed a scatter graph taken from the "The Spirit Level: Why Equality is Better for Everyone" by Wilkinson and Pickett that shows the clear correlation between social inequality and drug use, with the rate of drug use rising with increases in social inequality. There is no international correlation between the level of repression of drug users and the level of drug use—a scatter graph portraying that relationship would have dots all over—so it might be more effective to reduce drug use through reducing inequality than through repressing drug users.

He said that there was evidence regarding welfare generosity. The decommodification index is a measure of the generosity of a welfare state, based on sickness pay, pensions and unemployment. The correlation between the estimated prevalence of injecting drug use and a country's welfare generosity is -0.62. The countries with more generous welfare states tend to have lower rates of injecting drug use, which is the most problematic. It is a correlation and cannot yet be claimed to be causal, but the correlation is much clearer than that between the legal regulation of drugs and drug use or between health regulation and drug use. Drug problems arise from the structure of society and people use drugs to solve social problems. That needs to be taken into account when designing drug policies.

He said that there was no one best practice, but a combination of the practices with evidence behind them should be used. What was done needed to be consistent with the culture and public opinion of the implementing country, and the human rights of drugs users and others needed to be respected. Harm reduction respected the rights of both, whereas law enforcement too often abused those rights, including those of the 80% of people who could not access opiate pain relief due to the restrictions imposed by prohibition. Inequalities needed to be reduced. Investment was needed in developing knowledge about effective regulation and the combinations of practices, so that all drug policies could be improved.

The Chair said that he was looking forward to what the next speaker had to say about the unique experience of the Czech Republic.

Decriminalisation *v.* Legalisation (Czech Republic)

Speaker: **Jindřich Vobořil,** National Anti-drug Co-ordinator, Czech Republic.

Jindřich Vobořil said that he was born in the Czech Republic under heavy totalitarian Stalinist communism, 21 years after the Nazi occupation during the second world war and two years before the Russian army occupation. That history determined how Czechs see the world and their very sceptical nature. When the revolution came and communism collapsed in 1989, Czechs did not want to impose any big ideas, such as a war on drugs. He said that he was a conservative politician, but in the Czech Republic no such politician could stand against journalists to call for a "war on drugs".

He said that it was not that people in the Czech Republic were very progressive; it was more that they were sceptical about big ideas. Right after the revolution in 1989, the country was not in a good state economically—the situation was probably similar to that in Portugal, especially with regard to tax legislation—and a cheap, effective solution needed to be found.

Soon after the totalitarian system collapsed, they learnt from other countries what to do. The main aim was to put not only harm reduction services but harm reduction policies in place. First they introduced harm reduction services across the whole country, so that there was access to low-threshold programmes and outreach programmes. It was much more successful to detect users early than to put a lot of money into law enforcement and high-care treatments.

He said that he had a PowerPoint presentation containing the relevant figures, which he had not shown because he did not want to bore people, but that he was happy to share with delegates. After the revolution, drugs-related problems had risen. When the Czech Republic had been behind the iron curtain very few so-called traditional drugs had been brought in, so people learnt how to produce methamphetamine, and for two decades that drug was produced and used by people who were not interested in producing it for money. It was produced in small kitchen labs, with people bringing materials such as ephedrine and recipes for different drugs, which were then made and distributed, but that was it. Demand therefore probably came before supply.

He said that very soon after some money was invested in supporting harm reduction services, the problems associated with drugs decreased. The present rate of HIV among injecting drug users was 0% and rates of hepatitis C had dropped by half to about 27% of injecting drug users now. It was thought that the system was working, so people should go further, and harm reduction became the main philosophy behind drugs policy and legislation. In the Czech Republic, harm reduction was not a type of service but a central idea—if people looked at the website of the Czech Government, they would find material on it in English. Harm reduction was the overall philosophy behind the policy, and it was important that it was placed in legislation.

He said that it was too expensive and ineffective to imprison people for possessing drugs, especially if those drugs were only for their own use. In 2010, the Czech Republic passed a new Bill allowing the Government to decide the permitted threshold for possession of different types of drugs: for example, for possession of up to 15 grams marijuana did not come under the penal code but was an administrative offence. Last year, a Bill had been passed on medical marijuana, and as there was a lot of scepticism in the Czech Republic about the war on drugs, there was virtually no opposition to that Bill. One of Mr Vobořil's colleagues, who in the Czech elections during the weekend just past had run as the conservative party candidate for Prime Minister, had been the person pushing that law through Parliament. Even the media were behind the idea. There were a very small number of people in prison for drug offences—the figure was about 1%.

Maria Angelica Cristi *(Chile)* asked whether Mr Vobořil's party candidate won.

Jindřich Vobořil said that unfortunately the conservatives had been in power for two terms and now the Social Democrats had come into Government, but despite the fact that in the Czech Republic the Social Democrats were more conservative than the conservatives on drugs policy, he thought that they were unlikely to change anything, because public opinion was so strong on the matter, especially as it was so expensive. When the United States had been doubling its amount of prison cells, the Czech Republic had been trying to cut the number of its prison cells in half. That was the only way that drugs policy would work.

He said that the number of problem drug users in the Czech Republic was below the European Union average and the world average. That proved that the policy and the practice had worked. Although we could look scientifically at the reasons why it worked, the main point was that nothing had gone wrong. The model was similar to the Portuguese model.

There was no HIV, there was low hepatitis and there was no group of problem drug users. The policy had been in place for two decades, so there was no need for fear.

He said that the Czech Republic had a very high number of cannabis users—the highest in Europe—but that did not correlate to problematic drug use. The number was the highest even though the regulations were not as lenient as in the Netherlands or Uruguay, because police practice had been very much to tolerate the possession of small amounts of cannabis. That was now no longer a criminal offence, and people in possession of a small amount of cannabis—up to 15 grams—were not hassled by the police.

He said that his final thought was one inspired by seeing so many people from different countries, and one that he had been talking about for several years. The war on drugs arose from the 1961 convention. It was not the fault of the convention, but that had been when it had all started, and it had later been followed by Nixon's declaration of a war on drugs. However, the war on drugs was not working, and the Czech policy was based on that belief; it was a very cheap policy, and had been shown to work.

He said that now was the time to look at such a policy not only in the Czech Republic, Portugal, Uruguay or Guatemala, but globally. Nations should get together. The meeting of the Commission on Narcotic Drugs in March 2014 was important, and should be used to start a discussion that should go on until the UN General Assembly Special Session in 2016. Together, people should look at the possibility of looking at amending the single convention. Perhaps they should not yet change the text of the convention, but they should try to allow a drugs policy for the 21st century. The past 50 years had been an experiment that had cost many lives. There were countries that showed that the experiment was no longer necessary, because they proved that policy could move in a different direction. He said he would advocate for harm reduction in any policy.

The Chair said that the presentation was encouraging and powerful. He thanked Jindřich Vobořil and said that the next speaker was a long-term campaigner of at least 25 years and a voice of sanity and sense.

Drug Policy Governance

Speaker: **Roger Howard**, former CEO, UK Drug Policy Commission.

Roger Howard said that they had heard on Monday from Sandeep from the UNODC how political and policy interest had been dominated by enforcement, to the detriment of public health policies. He said that he wanted to make the case to the parliamentarians and policy influencers present that one important reason for that was that national governance systems had not been fully used to address that imbalance. Governance of drug policy was important for demand regulation and drug policy as a whole. He hoped to persuade the delegates that there were financial and practical benefits in scrutinising how policy is made just as much as in choosing which drug policies to pursue. That distinction was often overlooked in bigger, public debates on drug policy, where feelings run high.

He addressed the Swiss representative's question to George Soros on why, after 40 years, we were still in the same situation by saying that governance systems had systemically failed to address adequately the emerging evidence of which policies work and which policies do not. The UK Drug Policy Commission carried out an 18-month study looking at how drug policy was made in the UK. It was not about dictating to countries how to make drug policy,

but explaining the principles and lessons of the commission's work that can be applied more generally.

He said that he wanted to clarify two definitions. Drug policy governance is the processes and mechanisms by which policy is directed, controlled and held to account; it includes activities such as performance management, research, evaluation, auditing, scrutiny and mechanisms for politicians and others to engage with evidence and knowledge. Drug policy is the pattern and legislation of Government actions that aim to affect the use of drugs and related problems. There is a connectivity between the two. He said that while drug policy can be direct, through the law, policing activity, health care and things like that, the indirect policies, such as social and economic development and public health policies, were much more important to improvement in the long run, as Alex illustrated. He said that the area was worth examining, rather than getting locked into debating the strength of policies such as methadone maintenance or decriminalisation, because it is absolutely clear that there are considerable health and socio-economic problems.

He said that drug policies and their governance are a public spending issue. The UK spends some £5 billion of taxpayers' money every year on drug policy. A couple of years ago, the National Audit Office, the UK's supreme auditing body, carried out a review of drug policy. One of its conclusions—the UK is obsessed with drug policy—was: "Neither the current Strategy, nor the supporting action plan for 2008-2011, set out an overall framework for evaluating and reporting on the degree to which the Strategy is achieving the intended outcomes or the value for money provided." Most countries would not see that as unusual. Criticism of the system for making drug policy had mounted over recent years, both in the UK and elsewhere. The public policy debate had become immensely polarised, with politicians and the public often drawn to simple solutions, because they were attractive, but people were becoming increasingly aware of the unintended consequences of policy.

He said that a growing number of leading public figures, including Ministers, ex-Ministers and senior public officials, had called for policy change after leaving public office. It is often claimed that drug policy is a toxic issue for those in government. Those that question drug policy are subject to intense scrutiny and often vilification, so the UK Drug Policy Commission thought it was important to look at how UK drug policy is made. The study was simple and first looked at what a good governance framework was by examining how drug policy is developed, implemented and scrutinised. The second task was to check how policy making lived up to the ideals and good characteristics. Finally, suggestions were made on how to improve the governance system. The study was published in December.

He said that it was a fairly unique study and that he did not think any similar studies existed. Four broad groups of actors were included. The Home Secretary is responsible for the leadership and co-ordination of drugs policy across Government. Until a few years ago, the Home Secretary ran an organisation that combined a ministry of the interior and a ministry of justice, but those roles had now been separated. For the study, ex-Home Secretaries and Ministers, a number of parliamentarians from both Houses of Parliament and from different political persuasions, public officials and others were interviewed. Nearly 110 people were involved in developing the good characteristics.

He said that the first characteristic was that drug policy needed clear, realistic, but aspirational overarching goals. The study found huge confusion on the goals of drug policy. The second characteristic was effective political and administrative leadership. The third characteristic was ensuring good co-ordination between foreign services, security services, health and justice. There needed to be effective co-ordination of policy effort to ensure commitment and resources. The fourth good characteristic was a policy design based on scientific and other evidence. The fifth characteristic was a governance system that developed

and used evidence. For some countries present, that was not possible, but there was much evidence from other countries that could be used.

The sixth characteristic was that the governance system needed to ensure that implementation was flexible enough to take account of local needs. It also needed sufficient resources. Those present had heard about the public health benefits, but for a lot of countries, resources for public health and for health interventions and treatment were probably minimal. The seventh important good characteristic—this was particularly for parliamentarians—was ensuring there were good accountability and scrutiny mechanisms to hold policy makers to account. Supreme audit institutions and parliamentary scrutiny committees were important. Finally, any good governance system needed good stakeholder engagement, especially in the drug policy field. In the morning, he had listened to Judge Maria Lucia Karam talking about marginalised groups. There was a question about the extent to which they were involved in making and influencing policy.

He said that those present were probably thinking those characteristics could apply to health or economic policy, and they would be right. However, one thing that made drug policy different was the reason why it had failed globally and nationally to embody the characteristics—he was careful about calling them standards—he had described. Why did global and national systems fail to do that? In many ways, it was due to polarisation, the challenge regarding the interpretation of evidence and the need for an open public debate.

He said that there had not been sufficient, informed challenge and analysis of supply-side interventions. They all knew they needed some form of regulation in supply, although he was not arguing for a particular form. However, there had been no rigorous analysis of the effectiveness and cost-effectiveness of supply-side interventions, whereas, on the public health side—the treatment side—there was a wealth of international evidence about effectiveness. That was one reason why there had been 40 years of the status quo and being stuck on particular policies. One outcome was that some in the UK felt they needed a much more vigorous public dialogue, particularly where that could achieve a degree of cross-party consensus about the goals of drug policy.

He talked about why paying attention to the themes of good governance delivered better demand-regulation outcomes. The Portuguese decriminalisation and treatment expansion came about through strong political national leadership and a degree of political consensus. Colleagues from Uruguay had said previously that there was not necessarily a political consensus on the issue, but strong political leadership had led to one in this case.

He said that referendums had taken place in Switzerland and in the US, in Oregon and Washington, under particular constitutional arrangements, which could be used to leverage change. New Zealand had used a constitutional device to ask its independent law commission to look at the efficacy of the country's drug legislation. That eventually led to new proposals, new plans and new legislation, which wa operating now, for the control of new drugs. Accountability and scrutiny mechanisms were important.

He said that in 2006, the supreme audit body in the US, the Government Accountability Office, carried out an effectiveness review into a $2 billion youth prevention mass media campaign. It found that the campaign actually increased drug use, so it called for it to be abandoned. To those who said prevention and education were the answer, he said that some prevention and education could be effective, and some kinds were more effective than others, but some prevention and education interventions proved more harmful than people thought. The important principle was using a supreme audit body to ask the right questions. The Czech Republic had been good at using evidence and research to support its decriminalisation campaign.

His argument to the parliamentarians present was that they should use bodies such as supreme audit institutions and other mechanisms to try to redress some of the imbalance Sandeep spoke about on Monday and to focus on demand regulation.

The Chair said that he was grateful to the speakers, who normally spoke for an hour but had had to compress their comments into 10 minutes.

Case Study (Denmark)

Speaker: **Pernille Skipper,** Member of the Danish Parliament and spokesperson on Legal and Social Affairs.

Pernille Skipper said she was asked to comment on what Denmark had been doing recently on demand regulation. Having spoken to some of those present on Monday, she had decided to change everything she was going to say, because everyone had asked about Christiania. That special area in Denmark was more famous than need be, but it was a good example to share.

She said that Christiania could be an example of a regulated cannabis market that had now been deregulated, and that had had some consequences. Christiania had a street popularly called "Pusher street" where, since 1971, there had been opening dealing in cannabis—marijuana or hashish—but only in cannabis. Cannabis was sold openly in the street from little stands, with prices and THC levels. Regulations among the people who sold it meant there was an age limit: no children below the age of 15 were allowed to buy. In some cases, dealers asked young people for identification before allowing them to buy. In Christiania the use, processing or sale of hard drugs were not allowed—nothing other than cannabis and marijuana. The market was fairly regulated. It was not legal, but the police and the Government accepted that it existed. It was controlled because everyone in her small country who used those drugs bought them there. Denmark has 5.5 million people and it is not far from one end to the other, so the majority of sales in Denmark at that time were in Christiania.

She said that in 2003, the Government decided to have a political debate on the fairness of Christiania's existence and wanted to stop the sale of cannabis there. The police director warned it that if the so-called "Pusher street" was cleared, the sale of cannabis would spread throughout Copenhagen, it would be harder to control and users would meet dealers of harder drugs. The police director was right: when the street was cleared, the pushers were jailed and sales were no longer accepted, they spread throughout Copenhagen.

Then the really bad part began—the conflict between hell's angels and other gangs who wanted to dominate the cannabis market in some areas of Copenhagen. That led to the "gang war" in 2008 and shootings in the streets, which even her grandparents could not remember before that. The crime rate in Denmark is low and organised crime did not previously result in street shootings, but that happened now and there was an ongoing conflict between criminal groups selling cannabis and marijuana over who should dominate which areas of Copenhagen. She said that there is no longer an age limit, that sales take place in schools and that it is not easy to know the contents of the drugs. The market in Denmark used to be fairly controlled. that was not the intention of politicians, but it existed. Now, there was an unregulated market that had led to gang violence in less than five years. The question was not whether cannabis should be liberalised, but whether it should be regulated, as someone said yesterday.

She talked briefly about harm reduction initiatives that have been introduced in Denmark in the past few years. Drug use has come to be seen as more of a health problem,

and that is widely accepted throughout the political spectrum in Denmark, which has implemented two initiatives: the heroin treatment programme and consumption rooms. In 2010, it initiated the treatment programme and today there are 200 people in that programme. They are allowed to attend daily and to inject their drug with the help of health personnel. It has been quite successful. There has been general normalisation of everyday life and a reduction in crime by those on the programme because it is no longer necessary to finance their drug use. There are even examples of fathers who are again in contract with their children. Some regular drug users have ordinary jobs and live quite normally. That is a big success. She said that this year the programme was expanded to include consumption in the form of pills. Formerly, it covered only heroin that was injected, but the discussion now is whether it should be expanded to other drugs, such as cocaine, which unfortunately is being used increasingly.

She said that a little over a year ago, consumption rooms were established and that they now exist in Denmark's three major cities. Drug users come into the room and under the supervision of health care personnel they are provided with clean injection tools, they are helped and guided, and they leave when they have done what they need to do. In addition to health care personnel, general health care is provided, so drug users, who often belong to social minorities, have access to other forms of health care. They often have problems with their feet, and they can be treated for other diseases.

She said that Denmark has little knowledge so far of how consumption rooms are working, but gave two examples. First, in the first 99 days in Odense, which has one of the newest rooms, 11 potentially fatal overdoses were averted by the presence of health care personnel. Secondly, before the rooms were opened, the daily weight of drug-related trash in Copenhagen was 3.7 kilos, and it is now 1.6 kilos. She said that less trash in the streets means fewer needles near children and everyone else. That shows how Denmark is providing better health and security not only for users, but for people living in the area.

The Chair said that that was an encouraging picture of wonderful, wonderful Copenhagen.

Questions from Delegates

Papa Owusu-Ankomah *(Ghana)* said that Ghana was a transit country for illicit drugs, particularly cocaine, but that drug use was not as widespread as in other countries and was not seen as a major health problem. Cannabis—weed—was used when he was in secondary school in the 1960s and 1970s. Students smoked it clandestinely. It was produced in villages and farms. It had not proved a major health risk, even though mental cases were involved.

He said there was not a one-size-fits-all solution to all those things. The problem depended on the culture and history. If a politician in his country said that they had even sampled cannabis, the backlash would be so great it was doubtful they would be elected. It had to do with the dynamics of every society.

He asked, having heard all the examples, about the supply side. Did they mean that it was legal in Denmark to import cocaine? Did they mean that in the Czech Republic it was legal to import less than two kilos of cannabis? All the solutions were good, but that did not mean opening the gates. As he had said earlier, that did not mean cocaine plants could be set up and that people could be taxed on cocaine they brought in, as if they were producing alcohol.

He said the debate was important. He had been extremely educated by the presentations. In his country, there were pockets of people who would become a problem if they could not work, but a solution could be applied. He again asked about the supply side—the dealers.

Ignazio Cassis *(Switzerland)* said it was a shame that their friends from the Turkish Parliament had left, because they would have heard the answers they wanted about the scientific evidence and knowledge. The lesson from such excellent presentations was that they should be given at the beginning of the session.

He said his main point was that, as in Switzerland when MPs from several countries talked together, they never agreed on a common language beforehand. They used the same words, but applied their own definitions. A wide vocabulary was used—legalisation, decriminalisation and so on—but it was not defined beforehand, so they had not necessarily understood each other. That applied not just to drugs, but politics in general. It could have been done today.

He thanked Mr Howard for responding in depth to his earlier question about why we had not done what we should in the past 40 years. Politics was not always rational—a lot of emotion was involved—but more evidence-based policy would be useful.

He said he often felt that there was either repression, looking at crime and supply, or humanitarian aid, looking at demand and health, but it did not have to be so black and white. Both sides were necessary, with a joined-up approach that depended on each country's circumstances.

Manuel Plana Farran *(Spain)* thanked the panellists for their presentations. He wanted to ask Professor Stevens how social inequality led to increased drug use. He said he would give his opinion from a European point of view, as had representatives of different Governments. Members of the Dutch royal family had said that the welfare state would not survive much longer. The increase in drug use should be taken into account when the dismantling of the welfare state was considered. He asked Professor Stevens whether he had considered whether drug use might increase as a consequence of the social situation, and whether he had related that to his theory.

Janja Napast *(Slovenia)* said she would talk about her experiences and the social factor. She lived with a youth and had seen this kind of problem. She had lost a school friend not to the fact that he was a heroin user, but when he came back from Spain cured, he had died of alcohol-related kidney damage.

She said the focus should be on the word "war". It should genuinely be accepted that the war was lost 15 years ago, and that the normal point of view should be that criminals had to be fought against. The scapegoats—drug users—should not be treated as victims, as alcohol users were, but taken very seriously. The young were angry because of such demonisation.

She said there should be a more positive discussion of medical cannabis or marijuana. The young knew about the negative effects, but were trying to say that medical cannabis could provide benefits, without being knowledgeable about it. An alternative way to focus on marijuana was to be clear about the health issue and brain damage causing short-term memory loss. She said that this was more effective than concentrating on misusing words like "war" or the definition of reality.

Alex Stevens responded to the question about the causal mechanisms that link inequality to drug use and drug-related problems. One of them was sociocultural. Countries with higher levels of inequality tended to have a greater focus on consumerism and drugs were the ultimate consumer product. They were small, glamorous and made you feel great if you were taking them the right way. There was a strong link between a consumerist society and buying pleasure through drugs.

He said that the second mechanism was sociobiological and quoted Richard Wilkinson and Kate Pickett, who had written about the effects of inequality. They argued that stress turned into higher levels of cortisone in the body and was something that people could self-medicate for, using certain types of drugs.

He said that the third mechanism was purely sociological. If millions of people were thrown out of work and given no other legitimate means of earning money and respect, they would find an alternative, and for many in Europe and Latin America, the drug market had been the only way. Professor Stevens believed there was a huge risk of drug problems increasing through the factors of consumerism, inequality and unemployment, although he had not yet seen the evidence for that. However, in Romania and Greece, harm reduction services, such as needle exchanges that suppressed HIV levels, had been taken away, leading to spikes in HIV rates among injecting drug users. These were dangerous times.

Jindřich Vobořil spoke of the need for a common language when talking about drugs so that everyone knew what they were talking about. There were many myths about drugs, such as the division between producer and consumer countries. He worked for about a year in Afghanistan, which was called a producer, yet it was primarily a consumer country. Along with Pakistan and Iran, it had the highest rate of opiate drug use in the world. Another myth was about supply and demand reduction, because people still thought that if supply was reduced, demand would be reduced.

He said that, in the field of mental health, about 2% to 3% of the population had some form of addictive behaviour. It differed between countries, cultures and social situations, and might involve alcohol, pharmaceutical products or illicit drugs, but it was mixed-up thinking not to look at all these substances in the same way, as Ms Napast had said. He said that Papa Owusu-Ankomah had asked whether cannabis could be imported and produced—they were, but only for medical use.

He said that the UN conventions divided the world between illicit drugs and legal ones, which was confusing. An integrated policy was needed, with all drugs, including alcohol and tobacco, put together into one policy.

Roger Howard said that Papa Owusu-Ankomah had raised demand regulation. His commission had spent six years looking at the supply side. Although Ghana was a transit country and had low levels of drug use, Afghanistan, Pakistan and the Caribbean were also transit countries and now had full-blown demand. One lesson was that things did not remain static. He said that the question of whether drugs should be legalised was the wrong one; it should instead be about how to inhibit the commercialisation seen with alcohol and tobacco. He said that criminalising drugs for personal use was not a proportionate response from the state regarding what was essentially a health condition.

Pernille Skipper agreed that it was not the state's responsibility to outlaw a crime that only happened to oneself. She said she wanted to look at marijuana and cannabis separately from harder drugs, as in Denmark. Cannabis and marijuana were accepted as normal by

middle-class people and were different from harder drugs. People were dying in the streets from injecting heroin and that was at the core of harm-reduction initiatives. She said that one could not look on passively as people died in the streets.

The Chair said it had been a fascinating afternoon and thanked the panel.