Press conference for the release of the Report of INCB for 1998

23 February 1999

Ladies and Gentlemen,

Good morning and welcome to our press conference for the release of the Report of the International Narcotics Control Board for 1998.

I am pleased to see you all here. As you know, the Board firmly believes that the media have a very important role to play in support of drug control efforts world-wide. The media increase the awareness on the drug problem, point to dangerous developments and can thus, through courageous reporting, stimulate the communities' willingness to intervene. I trust that you, journalists representing the media here today, will use your responsibility to contribute to the prevention and combating of the problem of drug abuse and illicit trafficking world-wide.

Let me first briefly explain what the International Narcotics Control Board is. The Board is an independent and quasi-judicial body, consisting of 13 members elected by the Economic and Social Council, which monitors the implementation of the international drug control treaties. It has a secretariat which is part of the United Nations International Drug Control Programme located in Vienna, Austria. Under those treaties, the Board is required to prepare an annual report on its work and assesses the drug control situation and actions of Governments worldwide. This is the report which I will present to you today.

Each year, the first chapter of the Board's report has focused on one particular aspect of international and national drug control - for its 1998 Report, the Board chose to examine the past, present and future of international drug control. A summary of the main findings of this chapter can be found in press release No.3.

There were two main reasons for choosing this topic. The public debate on drugs tends to focus on the current situation and does often not see the issue in a historical context. Indeed, the public debate seems to centre on the here and now. It was felt necessary to add a historical perspective to the examination of the drug issue.

Drug control is older than everyone in this room. The first international conference on drugs was held in Shanghai in 1909, almost ninety years ago. Decisive action was needed against the addiction epidemics which had developed in some parts of the world when narcotic drugs were freely available and hardly any controls were in place.

The result of this unrestricted availability were unprecedented levels of drug use. Addiction was a mass phenomenon not only in Asia but also in some European countries. Opium dens were commonplace in Europe. The following figures may illustrate the magnitude of the addiction problem:

- 25 percent of the adult male population of China smoked opium. Consumption in China alone at the beginning of this century is estimated to have been more than 3,000 tonnes in morphine equivalent, compared to the worldwide medical use today of about 230 tonnes in morphine equivalent per year and illicit trade of opiates of about 380 tonnes.

- Only 3 to 8 per cent of cocaine sold in New York, Boston and other cities was used in medicine or dentistry. Altogether, more than 90 per cent of narcotic drugs in the United States were used for non-medical purposes.

- The total number of cocaine and heroin deaths in the United States exceeded 5,000 in 1912, according to a government report. This is about five times of today's figure.

The system of international drug control treaties brought about a very successful change to this disastrous situation. This system has, by and large, succeeded to limit the use of drugs to medical and scientific purposes. The international control system for narcotic drugs, in particular, has succeeded in limiting, for each country and territory and in the world as a whole, the licit cultivation of narcotic plants and licit production, manufacture and distribution of and trade in narcotic drugs to the quantities required for medical and scientific purposes. The diversion of narcotic drugs from licit sources into illicit channels has been kept to a minimum, despite the large volume of narcotic drugs manufactured and distributed each year for medical purposes. And while opiate addiction remains a serious problem, it is far less widespread than it was when narcotic drugs were freely available.

The treaties have been successful. This is not to say that everything is perfect. From its own experience, the Board knows all too well that drug regulations are not a panacea and drug control measures alone cannot eliminate illicit drug trafficking and abuse.

One challenge for the future is the availability and the appropriate use of drugs for medical purposes. At present, there are enormous differences in the medical utilization of morphine, codeine and other opioids which are used for the alleviation of human suffering. **The mean average daily consumption of pain relievers is 93 times higher in 20 countries with the highest consumption than in the 20 nations with the lowest consumption**. How to achieve freedom from pain for all people will be one of the most pressing issues for the coming years.

While there are not enough opioids available for all people who need them, certain psychotropic substances appear to be over-prescribed in many countries. The second half of this century has been characterized by a rapid increase in the number of pharmaceutical products utilized not to cure physical illness but to help people cope with the high demands of everyday life or to increase psychological well being. Nowadays there are pills for almost every ailment, including stress reducing drugs, that is, benzodiazepines, as well as performance enhancing drugs. The use of these drugs has mushroomed. **Some European countries, for example, report to the Board that**

medications containing benzodiazepines are consumed by as much as 10 percent of their total population, including babies and toddlers who will certainly not consume such drugs. While life is certainly stressful, the notion that the general stress of life requires a regular intake of benzodiazepines seems unlikely. The biggest use of benzodiazepines is reported for the aging population, that is, the population over 65 when professional stress has been replaced by other life stresses such as isolation and difficulties in coping with threatening changes in routine. Treatment of such symptoms with stress-reducing medication such as benzodiazepines may not be the most effective solution, particularly because these drugs have a high abuse and dependency potential.

While Europeans are the worldwide leading consumers of drugs taken to reduce stress, Americans are known as record users of performance enhancing substances. The Americas, particularly the USA, are the biggest users of performance enhancing drugs, which are also given to children to improve their school performance and to help them comply with the norms and demands of school life. Performance-enhancing drugs are taken to achieve conformity with the generally desired body image; to boost athletic performance or to improve social skills. **The difference in the rate of consumption of these performance enhancing drugs in the United States and in the rest of the world is extremely large, particularly with regard to stimulants either used as anorectics or in the treatment of attention deficit/hyperactivity disorder (ADHD) in children**. While there is no doubt that such performance enhancing drugs have their place in the medical treatment of a limited number of conditions and patients, they have become so widely available that they have become a household item consumed mainly to respond to normative performance demands set by society and further enhanced by the influence of advertising.

[*Speakers may wish to elaborate on this aspect of the subject by adding the following:* The high use of amphetamine-type stimulants as anorectics and the equally high use of methylphenidate, particularly in the form of the preparation Ritalin©, in the treatment of ADHD, suggests that the requirements for individuals to comply with society's norms carry a too high price. For example, treatment rates for ADHD in some schools in the United States are as high as 30 to 40 percent of a class population. **Children as young as one year are treated with methylphenidate**. It is worrisome that the abuse and dependency potential of these drugs does not appear to be always taken into account in prescription practice. Even more ominous is the fact that this type of drug-taking behaviour is spreading to other parts of the world. Australia, Canada and a number of countries in Europe show rapid increase rates in the use of methylphenidate for children, with the fastest increase rates encountered in countries where specialist involvement in the diagnosis of ADHD is not required [(1)] and where few mechanisms exist to monitor consumption. The use of amphetamine-type stimulants as anorectics is reported to be increasing in a number of countries in Asia.]

The over-prescription of drugs goes hand in hand with societal attitudes encouraging pharmaceutical solutions for all social and behavioural problems, however minor. If young people are told to take prescription drugs to respond to emotional stress, to improve their school performance and to achieve conformity with the generally desired

body image, how can they be expected to refrain from abusing drugs? The pressure of the generally accepted norm may become an extreme burden on individuals who may resort to extreme means, including the use of anorectics, to comply.

The aggressive marketing strategies of some pharmaceutical companies exert a strong influence on doctors and patients and their drug prescribing and drug consuming behaviour and due to rapidly developing communication and information technology, including the increasing use of the Internet, drug consumption trends in one part of the world are rapidly imitated in other regions without full investigation of their appropriateness and their long term effects.

To avoid undesirable developments which are difficult to reverse, the medical community, health officials and consumer protection groups may wish to play a more active role in determining the sound medical level of consumption of psychotropic substances within their countries. In a number of cases, treatment with drugs may just be the easiest way out, dealing, however, only with symptoms and not with the cause of the problem. More information on this subject can be found in press release No. 4.

The Board's Report for 1998 also reviews major drug control developments. One such development is the continued increase in the number of States which become party to the international drug control treaties and implement their provisions. Currently, around three-quarters of all countries in the world are party to one or more of the international drug control treaties. The Board hopes that universal adherence to these treaties can be achieved by the beginning of the next century. (*Speakers in some regions may wish to give more details about developments in treaty adherence during 1998 which is summarized by region on page 6*)

The universal acceptance that the treaties enjoy has made significant successes possible. This is particularly evident in the control of chemicals which are used to manufacture illicit drugs. Ten years after the adoption of the 1988 Convention, most of the major manufacturing, exporting and importing countries are parties to the 1988 treaty or apply the treated-mandated controls over chemicals. Many Governments apply tight controls to most of the important precursors and chemicals needed to manufacture drugs illicitly -- even to commonly used industrial chemicals such as potassium permanganate and acetic anhydride which are needed for the illicit manufacture of cocaine and heroin, respectively. Ten years ago nobody thought it was possible to control these chemicals as effectively as they are controlled now. Now diversions of common chemicals with many legitimate uses and traded in large quantities are prevented -- several thousands of tonnes worldwide.

The result of dedicated work of Government authorities has been a staggering increase in the number of chemical shipments that have been stopped before they could reach drug traffickers. Shipments of precursors prevented from being diverted into traffickers' hands by authorities grew from a mere three cases reported to the Board in 1994 to about 60 major shipments in 1997, as *governments joined forces* and discovered an increasing number of methods and routes traffickers use to obtain these substances.

For example, a total of over 4,000 tonnes of methyl ethyl ketone, acetone and toluene, solvents which would have been used for about 250 tonnes of cocaine, have been prevented from reaching illicit routes since 1994. Some 84 tonnes of P2P (1-phenyl-2-propanone), enough for about 40 tonnes of amphetamines and *about 48 tonnes of a precursor which would make* 25 tonnes of MDMA or "ecstasy", were also stopped en route to traffickers during this time.

These successes were made possible by scrupulous, systematic checking of precursor transactions before shipment by Government authorities -- the Board assists Governments in this task. Governments of exporting countries regularly send pre-export notices for treaty substances to governments of importing countries or to the Board. The chemical industry has also alerted the authorities to several suspicious chemical orders. Communication and exchanging information on suspicious cases is crucial to make precursor control a success.

More of the examples of chemicals seized and other information on this issue can be found in press release no. 5 of your press kit.

Before closing, I would like to make a brief remark on cannabis. We all have witnessed an increasingly politicized battle over the cannabis plant. This must end. Exaggerated rhetoric has had a negative effect on attitudes, particularly those of young people towards drugs. The Board has noted with regret how possible medical uses of cannabis in treating glaucoma, AIDS wasting syndrome and in alleviating side effects of cancer chemotherapy have been abused to justify the legalization of all cannabis use or the "prescription" of cannabis under the guise of medical dispensation. **I would like to emphasize strongly that the Board welcomes and encourages *serious, scientific research* on the medical properties of cannabis and wide dissemination of such research but warns that such research efforts could be misused for legalization purposes**. **Should the medical usefulness of cannabis be established, it will be a drug no different from most narcotic drugs and psychotropic substances. This means that cannabis used for medical purposes would be subject to licensing and other control measures foreseen under the international drug control treaties.**

Ladies and Gentlemen,

I think I have given you an idea of some of the main features of the Board's report for 1998. Thank you for your attention.

Regional information on adherence to the international drug control treaties

Africa

The Board welcomes the accession of Mozambique to all of the three international drug control treaties and the fact that Namibia has become party to the 1961 and 1971 Conventions. The Board urges the Governments of Angola, the Central African Republic, the Comoros, the Congo, Djibouti, Equatorial Guinea and Eritrea, which are not parties to

any of the three main international drug control treaties to accede to them. Several countries in Africa still lack adequate legislation to implement the provisions of the treaties as well as the administrative capacity to give full effect to their national laws and regulations.

Central America and the Caribbean

All States in Central America and the Caribbean are parties to the 1988 Convention. However, Belize, Haiti, Honduras, Saint Lucia and Saint Vincent and the Grenadines are not yet parties to either the 1961 Convention, the 1971 Convention or both. This is unfortunate since both treaties provide for the establishment of a functional control system which ensures that narcotic drugs and psychotropic substances are not diverted into illicit channels. Unless these two conventions are fully implemented, the objectives of the 1988 Convention cannot be achieved. The Board therefore strongly urges those States to accede to those conventions as soon as possible, since implementation of the 1988 Convention cannot be dissociated from the implementation of the earlier conventions.

North America (no special news, all three States are parties to all conventions)

South America

With the exception of Guyana, all States in the region are parties to all three international drug control treaties. The Board, therefore, calls on the Government of Guyana to accede to the 1961 Convention as a matter of priority.

East and south-east Asia

Cambodia and the Democratic People's Republic of Korea remain the only two countries in the region that have yet to become party to any of the international drug control treaties. The Board urges them to accede to these treaties as a matter of priority.

The Board encourages the Government of Thailand to enact legislation on money-laundering without delay as a further step to enable it to meet the requirements of and become a party to the 1988 Convention.

While encouraged by the accession of the Government of Viet Nam to all of the international drug control treaties, the Board notes with concern the reservations formulated on the extradition provisions of the three treaties. As extradition is an essential mechanism in the provision of international cooperation under the international drug control treaties, the Board urges Viet Nam to review its position in that regard and to withdraw its reservations.

South Asia

The Board urges the Government of Bhutan and Nepal to accede to the 1961 and 1971 Conventions. The Board welcomes the announcement of the Government of Maldives, which is not a party to any of the international drug control treaties, that the necessary steps for accession to those treaties will be taken shortly.

West Asia

Except for Israel and Kuwait, all States in West Asia are party to the 1988 Convention. However, the Government of Lebanon has not yet withdrawn its reservations on the provisions in the 1988 Convention against money-laundering. While the Board welcomes the law that has been adopted in Lebanon, which allows for bank secrecy to be lifted in certain cases, it also calls on the Government of Lebanon to withdraw its reservation on that provision.

Azerbaijan, Georgia and the Islamic Republic of Iran, which have adhered to the 1988 Convention, have not yet become parties to either the 1961 Convention, the 1971 Convention or both. This is unfortunate since both treaties provide for the establishment of a functional control system which ensures that narcotic drugs and psychotropic substances are not diverted into illicit channels. Unless these two conventions are fully implemented, the objectives of the 1988 Convention cannot be achieved.

The 1972 Protocol amending the 1961 Convention is another important international treaty because it stresses the need not only to tackle the problem of drug trafficking but also to assess the extent of drug abuse and to take measures to treat and rehabilitate drug abusers. Nevertheless, Afghanistan, Islamic Republic of Iran, Pakistan and Turkey continue to be parties to the 1961 Convention in its unamended form only. The Board therefore urges those countries to accede to this Protocol as soon as possible, following the example of Saudi Arabia which did so in 1998.

Europe

The Board welcomes the anti money-laundering legislation that entered into force in Switzerland in April 1998 and hopes that this removes all obstacles for the Swiss Government to become party to the 1988 Convention as a matter of priority.

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1. Those countries are, *inter alia*, Austria, Belgium, Germany, Iceland, Netherlands, Spain, Switzerland, USA and Canada.