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Western European Civil Society Regional Consultation Event: United Nations General Assembly Special Session on Drug Policy (2016)

Tuesday 8th September 2015, 09:30 – 16:00

Thon Hotel Opera, Oslo

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Agenda

Better Global Drug Policies: Opportunities for health, human rights and development

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Background: The UN is holding the most important drug policy review in the last 20 years. It is called the UNGASS 2016 Process. This event is part of the Regional Consultations to ensure civil society engagement into that process.

09.30	**Registration and Coffee**
10.00	**Opening** Mina Gerhardson, Secretary General, Actis
10.15	**Introductory Remarks** Astrid Nøklebye-Heiberg, State Secretary, Norway Jean-Luc Lemahieu, Director of Policy, UNODC Fay Watson, Western European Representative, Civil Society Task Force (UNGASS 2016)
10.45	**Drugs and Health: How can we develop health based drug policies nationally and internationally?** Jean-Luc Lemahieu, Director of Policy, UNODC Thomas Clausen, Professor, University of Oslo
11.30	**Coffee Break**

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11.45	**Drugs and Crime: Is the way we tackle drugs related crime and new psychoactive substances appropriate both nationally and internationally?** Rune Solberg Swahn, Detective Chief Inspector, Oslo Police District Ola Røed Bilgrei, Researcher, SIRUS Lars Meling, Ministry of Justice, Norway
12.45	**Lunch**
13.45	**Alternative Development: Does it need a greater role in drug policy?** Dag Endal, Project Co-ordinator, FORUT Judith Ulirsch, Advisor Drug Policies, German International Co-operation Association (GIZ) *Facilitator: Anne Skjelmerud, NORAD*
14.45	**Human Rights and Drug Policy: How can drug policies best sustain the rights for all of society?** Elsa Maia, Policy Officer, Anti-Drug Unit, DG Home, European Commission Fay Watson, Secretary General, EURAD *Facilitator: Kenneth Arctander Johansen, RIO*
15:45	**Closing Remarks** Mina Gerhardsen, Secretary General, Actis

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List of Participants

First Name	Last Name	Current Employer / Organisation
Kenneth	Arctander	RIO Rusmisbrukernes interesseorganisasjon
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Øystein	Bakke	FORUT
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Heidi	Bjørklund	Romerike Politidistrikt
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Ester	Nafstad	NORMAL
Linda	Nilsson	World Federation Against Drugs
Astrid	Nøklebye-Heiberg	Secretary of State, Norway
Ståle	Nygård	uavhengig skribent
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Magne	Richardsen	DNT - Edru livsstil
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Judith	Ulirsch	GIZ (German Development Agency)
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Kjetil	Vesteraas	Juvente
Ragnhild	Vik	Nord-Trøndelag Politidistrikt
Eirik	Wangberg	Oslo Politidistrikt
Fay	Watson	EURAD
Hanne Cecilie	Widnes	IOGT i Norge

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Copies of Presentations

- Astrid Nøklebye-Heiberg, State Secretary, Norway (ENG)

Astrid Nøklebye Heiburg.pdf

- Thomas Clausen, Professor, University of Oslo (NOR)

Thomas Clausen PDF.pdf

- Rune Solberg Swahn, Detective Chief Inspector, Oslo Police District (NOR)

Rune Solberg Swhan.pdf

- Ola Røed Bilgrei, Researcher, SIRUS (NOR)

Ola Røed Bilgrei.pdf

- Dag Endal, Project Co-ordinator, FORUT (ENG)

Dag Endal.pdf

- Judith Ulirsch, Advisor Drug Policies, German International Co-operation Association (GIZ) (ENG)

Judith Ulirsch.pdf

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Report From The Event

Opening: Mina Gerhardsen, Secretary General, ACTIS

Mina Gerhardsen welcomed delegates to the seminar and gave a special welcome to international guests. She noted several pertinent issues related to current global drug policy – including advocacy for the abolishment of the death penalty, the need to provide alternative sources of income in drug producing countries and the surge of New Psychoactive Substances, which provide the background for the UNGASS 2016. She reiterated Actis' commitment to follow the UNGASS process.

Panel One: Introductory Remarks:

Astrid Nøklebye-Heiberg, Secretary of State, Health, Norway

Astrid Nøklebye-Heiberg thanked Actis and EURAD for arranging this seminar and noted the name of the seminar "Better global drug policy" and queried whether we had failed and what works in drug policy.

She noted that the UNGASS was a window of opportunity to address key issues such as the lack of available evidence-based treatment, drug policies which undermine civil rights by using inhumane punishment. She stated that "we must do better" and in this way, she agreed that the priorities of today's conference were perfect.

She stated that Norway is not in favour of legalisation as stated that it can create as many problems as it solves - however, we will keep a close eye on reviews in countries such as Portugal, were they are using some of the flexibilities contained within the UN Drug Control Conventions.

She stated that throughout the UNGASS process, Norway will strongly support a public health approach and that there will be clear "no" in regard to the use of the death penalty. She noted that we must consider alternatives to criminalization and increasingly focus on public health.

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Jean-Luc Lemahieu, Director of Policy, UNODC

Jean-Luc Lemahieu thanked Norway for their help in supporting civil society input into the UNGASS process. He described how the UNGASS 2016 had been formulated and said that Mexico had become increasingly frustrated at international global drug policy discussions and had called the UNGASS to review the successes and challenges for the future.

He noted the importance for NGOs to upload their contributions to the UNGASS website as soon as possible and to quickly draw attention to any documents you think should be highlighted.

Fay Watson, Western European Representative, Civil Society Task Force for UNGASS 2016 and Secretary General, EURAD

Fay Watson thanked Actis and the Norwegian Government for supporting Civil Society engagement in the UNGASS process so far and highlighted how today's participants could become more involved in the regional consultations and that they were free to send recommendations and papers to her for inclusion in the regional reports.

Fay also highlighted the work of EURAD and Actis on some of today's themes, such as the new publication on Alternative Development, which was provided to today's delegates.

Fay encouraged the audience to make their voice heard through today's event.

Audience Participation:

- Should there be a prioritisation of the most important aspects of tackling the drugs problem? For example, is heroin assisted treatment the priority? How best can we protect young people from drug use in the first place?
- There was then a discussion about the need for a fully comprehensive approach to drugs, not just a series of single interventions
- What are the intentions of lobby groups involved in the UNGASS process? Does everyone really have good intentions to help reduce drug use and harm? If laws and regulations are loosened on cannabis, is the intention then to move on and loosen the regulations on other substances too to create commercial markets? Is this really a good intention for health?

Panel Two: Drugs and Health: How can we develop health based drug policies nationally and internationally?

Jean-Luc Lemahieu (UNODC) noted that demand reduction alone is not working and said that in his experience, supply creates demand. Neighbouring countries of Afghanistan suffer from the highest drug dependency rates in the world, as a result of the supply. He also noted that it was important to note that not all poor farmers cultivate opium and not all opium farmers are poor – so whilst poverty is a vulnerability but opportunity linked to vulnerable corrupt governments is also a risk.

He noted the need to invest in HIV treatment to enable people to lead productive and healthy lives and the need to invest in women specific services because whilst 1 out of 3 drug users are women, only 1 in 5 people in drug treatment are women. The question is how come it has taken so much time for the international community to see demand reduction as equally important as supply reduction and why drug demand reduction has been for so long seen as a national issue. He noted the need to maintain pressure to keep the bar high to attain high international standards in terms of drug demand reduction.

Thomas Clausen (Professor of Medicine at University of Oslo) noted the difficulties in properly calculating the harm caused by drugs to individuals, societies and others and stated that it was not as simple as calculating various health impacts of drug use. He noted the problems of treating drug problems from a purely medical angle and described how often people with drug problems not only deal with health problems but also have housing issues and require a supportive social environment of family and friends who support them, rather than groups of friends who use drugs around them when they are trying to make changes.

He highlighted the need for evidence based treatment and long-term evaluation and follow-up of people who had been in all of the various types of treatment approaches in Norway to see what happened to the people in the long term, not the short term. He stated that "we need evidence –based treatment, not just a pill".

Audience Participation:

- There is tendency to treat drug use as a health problem or a crime but why cannot it be both? For example, with alcohol, if someone is drunk and drives and kills someone we still hold them accountable for their actions but in drug policy, there is the tendency to not hold someone accountable for their actions if they use drugs. The delegate believed it can be a health issue, a choice and also have criminal repercussions.
- One delegate asked if the World Health Organisation (WHO) have more of a role

- One delegate raised the need for housing and wider social support required to address drug use problems
- One delegate explained the problems of services not talking to each other and people having to move far away from their homes to access services
- One delegate asked whether legalisation would improve health. Thomas Clausen replied that there would be pros as well as cons of such a system.

Panel Three: Drugs and Crime: Is the way we tackle drugs related crime and new psychoactive substances appropriate both nationally and internationally?

Lars Melling (Ministry of Justice, Norway) noted that historically there has been a supply side debate and that there was a need to refocus more on the health issues related to drugs. He was happy for Actis to bring forward this conference and thought it was a good opportunity to reflect also on the Norwegian approach, which he thought was good in terms of few users but negative in terms of high overdose deaths.

He noted that the approach of the Norwegian government was that legalisation would not solve the existing problems.

Rune Solberg (Oslo police district) noted the need to prevent drug use through close collaboration between parents, school, the welfare state, work and youth. In terms of criminal approach, the priority should be on the large criminal networks and to reduce as much as possible their overall power and influence on communities.

Ola Røed Bilgrei (SIRUS) noted the rise of NPS on the market and how this poses a problem in tackling a rapidly growing market. He described how Norway had used medicines regulations to tackle NPS and they are now operating a generic system and highlighted some of the problems in New Zealand, where the law makers have not managed to follow up the law with operating procedures.

Audience Participation:

- One delegate asked about cost of legalisation, treatment and prevention. Lars Melling responded that it would be much more cost effective to put resources into prevention efforts.

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Panel Four: Alternative Development: Does it need a greater role in drug policy?

Anne Skjelmerud (NORAD) introduced this panel by referring to the German government in terms of proving concrete results in the field of development. Anne noted that development was not a thing that should be measured by a series of short-term projects, but something which requires long-term insight and long-term strategies.

Judith Ulirsch (German Development Agency – GIZ) noted the absence of conflict settlement, the existence of poverty and weak states as key indicators of drug production, summing up that alternative development or drug supply reduction policies should not just address crop reduction but the overall frameworks that govern the states where drug production takes place.

Dag Endal (FORUT) argued that development deserves a more prominent role in the drug policy discourse and that drugs needed a more prominent role in the overall development discourse. He noted the connections with the Sustainable Development Goals (Goals 3 and 3.5) in terms of promoting healthy lives and well-being and how this links clearly to drugs. He noted the changes in language and terminology from crap eradication towards crop substitution, then to integrated rural development and alternative development.

He highlighted that successful community development would require sustainable livelihoods, engagement of local citizens, good governance, basic health and social services as well as a strong civil society.

He noted that prevention should be the main paradigm of drug policies and that harm reduction could play a role as an element of this but not as an overall paradigm. In terms of priorities, he highlighted indicators for drug use prevalence, processes to access essential medicines, abolishment of capital punishment, strategies underpinned from a child's rights perspective and community mobilisation with national coordination.

Audience Participation:

- Thomas Clausen said that he believed research needed to be a larger component of development work, to ensure that there are more reports and research about what actually works and that these reports needed to be shared widely between European funding partners

- Other delegates highlighted their support for Alternative Development to emerge as the key theme of the UNGASS process but highlighted that they would like agencies such as UNDP playing a more joined up role in the process

Panel Five: Human Rights and Drug Policy: How can drug policies best sustain the rights for all of society?

Elsa Maia (European Commission) thanked Actis and the Norwegian government for today's event and said that many of her points would echo Astrid's points made at the beginning of the conference. She noted the different realities that are currently happening in Europe in regard to drug policy, such as social clubs in Spain, Czech Republic allowing for recreational use and the approach of the Netherlands to cannabis. The current EU approach is that the UN Conventions and frameworks are the cornerstone of global drug policy but that there is still a lot of flexibility within them.

One of the key aspects that the EU will be calling for is an evidence based approach with clear instruments. On what refers to public health, she said that they have already somehow tackled this issue, including the recognition of drug use is a very complex condition and not only approached from a criminal approach but from a health perspective and in that sense, one of the EU key points is advocating for harm reduction interventions. In 2009, the EU wanted a clear message on harm reduction but this wasn't accepted at that time because of a few countries.

She concluded that human rights is a key issue for the European Union. The EU has been a major donor of UNODC and funding 22 projects and most of them refer to drug trafficking and some tackle human rights. The understanding is that we have to tackle human rights broadly, not on only one or two topics, however of course they will be working on the abolition of the death penalty, the criminal justice system, access to controlled medicines and access to treatment.

Whatever the findings on UNGASS, we want them action oriented to ensure there is a continuity of the debates until 2019, as it would be dangerous to stop after 2016.

Fay Watson (EURAD) provided a broad overview of human rights laws and potential violations under the themes of right to life, right to treatment and healthcare, right to non-discrimination, right to a fair trial and the right of children to be protected from the drug trade and drug supply. Fay echoed back to a comment made by Torbjorn Brekke at this

year's CND in that "human rights should never be applied when appropriate, they should always be applied".

Fay then showed a video of how civil society organisations can support human rights in the drugs field, by showing a video of how EURAD's member organisation, San Patrignano provides alternatives to incarceration.

Audience Participation:

- A delegate from Reprieve asked Elsa from the European Commission, how the Commission can ensure that funding it provides for drug programmes to countries who still issue the death penalty are not supporting or even funding capital punishment and asked for funding to be conditional and that there should be a discussion about whether any funding should be given to those countries which breech human rights laws.

Closing Remarks: Mina Gerhardson

Mina thanked all delegates for attending and emphasized Actis' commitment to follow and report on the UNGASS process as it progresses. She announced that Actis will be hosting another seminar on 15th December, on the topic of Mental Health and Cannabis.

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Written Input Received For Consideration

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1. Martin Haraldsen, General Practitioner, Norway

Now is the time to learn from different EU countries and Norway by studying the trends of overdose deaths in different countries because there are so extremely big differences in the results. It is also important to know that Norway uses by far most resources in the world on substitution (with too much controls and restrictions) and useless trials of detoxification in institutions. With high expenses many people earns a living from it and become directly affected if it will be ended. It is therefore nearly impossible to change it, if EU doesn't make clear guidelines for the treatment.

EMCDDA warns against comparing different countries because of some difference in the registration methods, but advices to study the trend in each country. I also argue for some comparison as Norway has 32 times as many overdoses per million inhabitants as Portugal and four times the EU average.
Sweden and **Finland** has doubled overdose numbers the last 10 years, also with restrictive methods.

My own experience from a town in Norway with 40.000 inhabitants and 100 hard opioid addicts is that buprenorphine (**Subutex**) made heroin to disappear completely from the streets for many years. I treated against the official, restrictive system (encouraged by the good French results after 1996 when Subutex could be liberally be prescribed by GPs, with no pay for consultations and Subutex; with 79% drop in overdose deaths during 5 years). (I lost my job as GP because of this treatment against the system.)

Buprenorphine is partly antagonistic, which doesn't match with the parallel use of **heroin** or **methadone**. This causes either abstinence or less effect of heroin/methadone. Methadone can easily be combined with heroin.
Subutex has less side-effects than methadone, and much less dangerous. It could be given out with only a short initial supervised intake (only days)
and then be given for one week at a time to be taken at home. Even if some of it should leak to other addicts that will help them to come off heroin. The price of illegal Subutex will fall drastically as more and more get it directly from the GP.

Suboxone (buprenorphine+naloxone) is increasingly used on behalf of Subutex, but has more side-effects, and should not be used with liver failure. Sadly this is the drug of choice in Finland, which has unregistered Subutex. The Suboxone drug company works hard to persuade other countries to do the same.

Conclusion: My experience is then that low threshold treatment with **Subutex displaces heroin,** and if many countries see this the heroin problem in the world would decline.

Pacini Editore & AU CNS

Letter to the Editor

Heroin Addict Relat Clin Probl 2015; 17(2-3): 59-62

HEROIN ADDICTION & RELATED CLINICAL PROBLEMS
www.europad.org
www.wftod.org

Is Agonist Opioid Treatment (AOT) best done by GPs or in a specialized setting?

Martin Haraldsen

General Practitioner, Sandefjord, Norway

TO THE EDITOR: There are two ways of starting Agonist Opioid Treatment (AOT) with opioid addicts, most often in a specialized manner (in 17 of 28 EU countries) or by letting GPs contribute to it (in the other 11 EU countries). Within the second group of 11 countries, GPs can prescribe both buprenorphine and methadone in seven: Denmark, Germany, Netherlands, Belgium, Italy, United Kingdom and Croatia, and buprenorphine alone in four: France, Czech Republic, Portugal and Cyprus [2]. GPs tend to start medication early, without any unnecessary delay, in an intimate, individualized setting. The personal contact creates responsibility and resilience. By getting a patient's needs covered in this decentralized manner, compliance is improved, as the link to co-addicts becomes much less important.

A major reason for seeking other addicts and drug sellers is to get a supply of benzodiazepines (BZDs). Based on several sources I will advocate reasonable access to BZD through prescriptions by GPs.

I will also look into the issue of whether GPs need a special training programme before they can write BZD prescriptions.

Based on EU overdose numbers and population statistics for the years 1987-2011, I drew population-related (per million inhabitants) overdose curves for 19 EU countries, plus Norway (Figure 1) [2, 4, 5]. I thereby omitted Bulgaria, Cyprus, Greece, Hungary, Latvia, Luxembourg, Malta, Romania and Slovakia.

For each country included in Figure 1, the year ('m') in which agonist opioid medication was started is indicated, together with an annotation (D+ or D-) to show whether a GP was able to initiate AOT [3].

One of the main aims of compiling Figure 1 was to separate out the ten countries where GPs are allowed to start AOT, so as to be able to compare them with the others. I then summed the average overdose numbers of these two groups of countries.

During the first period there were rather more deaths in the b-group (Figure 2); around the year 2000, this gradually changed, creating a significant difference in favour of 'b'.

There is an interesting contrast between the developments taking place in Norway, a high-threshold-country, and in France, which had a low threshold for the prescription of buprenorphine, which I have marked out. France achieved a 79% decrease in overdoses from 1995-1999 through its aggressive policy of facilitating prescriptions [6] (see Figure 1). The countries that permitted prescriptions by GPs show clearly better results, although there was some spread. Since the start of the programme in 1998, Norway has had overdoses four times above the EU average, whereas France and most other countries that were implementing the GP model had rates well below the EU average. Before 1990 all these countries had about the same overdose level.

The year of introduction of agonist opioid treatment in the various countries (i.e. the way 'm' differed year by year from 1967 to 2001) was unrelated

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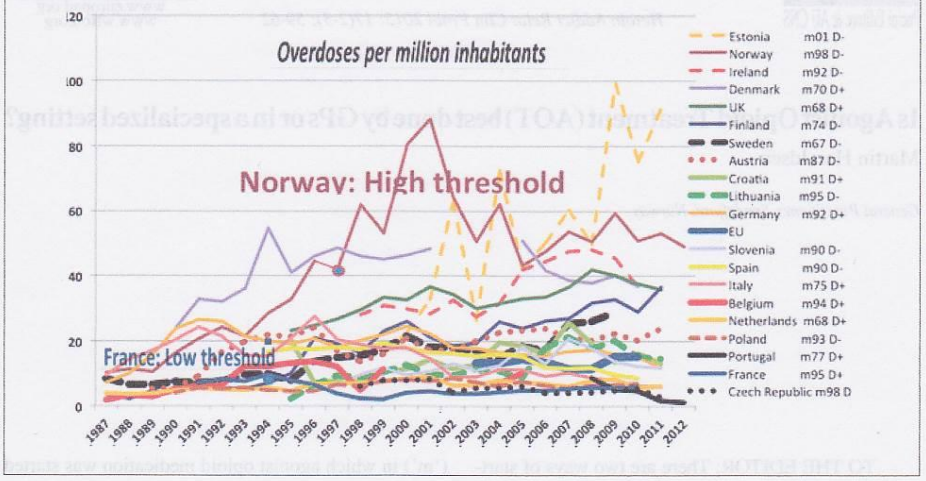
Figure 1: EU numbers of overdoses per million inhabitants (1987-2011) [2, 4, 5].

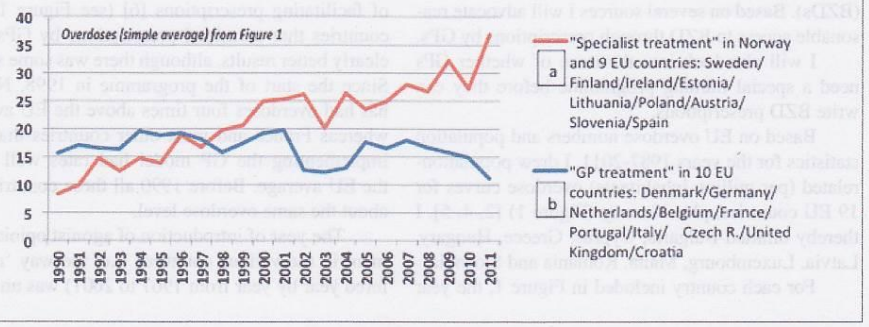


to the outcome.

By now it seems clear that the GP's office is the best setting for AOT treatment in all its aspects. This is good news, as that setting is by far the simplest and cheapest for opioid treatment. One result of spreading this treatment over as many GPs as possible is that it reduces the opportunities for meetings between patients sharing the same problem. All GPs should be able to contribute to this treatment, without any training. Within the EU only Germany demands this – a 50-hour course in addiction medicine, "which may be a disincentive" [8].

'One interesting feature of Figure 1 is its demonstration that the three countries which allow GPs to start prescriptions exclusively with buprenorphine are those with the least frequent overdoses (Czech Republic, Portugal and France). Buprenorphine is a much safer drug than methadone. A report from France gives a good explanation for this [6]: "For 1995 to 1998, the risk of death attributed to methadone was more than 10 times higher than that attributed to buprenorphine"; "Comparing data on the number of deaths related to methadone misuse and the number of deaths related to buprenorphine misuse, buprenor-

Figure 2: Comparison of overdoses per million inhabitants in the two groups of EU countries (plus Norway), differentiated by whether AOT treatment could be started there – either a) by a specialized body only, or b) by a GP (in prescribing at least buprenorphine)



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phine appears to be associated with a lower risk than methadone". The report explains why: "Buprenorphine's pharmacology makes it theoretically unlikely to be a substance of abuse among regular opiate users because of its mixed agonist-antagonist action, slow onset, and ability to precipitate withdrawal among users of pure μ opiates." On the issue of the safety of the treatment, it states: "In France, buprenorphine maintenance treatment for problem opiate users was feasible and safe through office-based prescriptions in a relaxed regulatory environment" and "with dispensing in community-based pharmacies happening in a relaxed regulatory context" and "the buprenorphine patients were more likely to inject their own prescribed buprenorphine, whereas those methadone patients who injected were more likely to inject heroin and cocaine".

Low-threshold AOT treatment by GPs is safe, and buprenorphine is the preferred drug, rather than methadone. What about benzodiazepine (BZD) prescriptions in the GP setting? This is the other bothering medication question with these patients, as about 2/3 of opioid addicts are addicted to BZD too [7]. My experience is that the GP office can be considered the optimal place for finding the right treatment for this combination, as GPs have a broad, individualized approach that includes steadily tapering to a low or zero dose. In my view, BZD prescriptions appear to be the least dangerous form of 'side-abuse', and they prevent the more dangerous and expensive ones, such as illegal BZDs and the other street drugs, not least alcohol. I find support for this in an Irish article published in this journal [7]: "MMT (Methadone maintenance treatment) patients who also use BZDs often present a more complex clinical picture with a greater number of needs. A link has been made in some studies between this cohort of MMT patients and poorer treatment outcomes. However, in general this association has not been found to be significant. Longitudinal studies of up to 36 months in length in Australia, America and Germany found no significant relationship between BZD use and MMT outcomes"; "When examining consumption it appears that those who use prescribed BZDs alone have a lower level of consumption. Those who use prescription BZDs only, use less than 5 tablets on a normal day and no one in this category used more than 10 tablets per day. In comparison those who use illicitly sourced BZDs take more than 10 tablets on a normal day."

This study of overdoses in 19 EU countries (plus Norway) shows that countries that allowed the simplest treatment by letting GPs start AOT with at least – in some cases by prescribing only – buprenorphine (not methadone) obtained by far the best results, with average overdoses below the EU average. This was in contrast to the specialized models adopted in countries that had a frequency of overdoses above the EU average. Norway has an extreme, expensive variant of specialization with top overdoses, in parallel with Estonia. In a routine way, trials of detoxification and far too much control have proved to be counterproductive. An article in this journal from Switzerland concurs with the advantages to be gained by allowing treatment in the GP setting: "Methadone can be prescribed by all licensed physicians in all 26 cantons. No special training in addiction medicine is required"; the conclusion was: "This study adds evidence for the effectiveness of opioid maintenance treatment in primary care" [1].

I argue similarly that the (ab)-use of benzodiazepines should be actively treated by GPs.

References

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2. Stale Nygard, Independent Writer, Norway

Racist drug policy - Norway
Disparities - 2005-2008:
- 4.2 percent of all male African immigrants were jailed.
- 5.1 percent of all male Somali immigrants were jailed.
- 1.2 percent of all male Norwegians were jailed.
- 6.3 times as many Somalis as Norwegians were sentenced for a drug offense and had 5.5 times as likely to be in prison at all times compared to Norwegian men.

45.3 per cent of inmates for drug offenses are foreigners. Foreigners convicted of drug crimes now account for 13 percent of all inmates in Norwegian prisons. [2]

Stigmatization
- "Sellers are African"
- "Criminals pigs"
- "Effort against West Africans"
- "Must face harsh reactions"
- "Assholes"
- "Asylnark"
- "Treat them in a much rougher way,
and crime will go away "
- "Targeted actions over a long time"
- "Indicates the need for asylums"
- "Send Nigerians faster out.
Guaranteed crime prevention effect."
- "Ten times longer in prison for violating entry ban"
- "Hire prison capacity abroad. They are going out anyway"
- "Criminal asylum seekers"
- "Do not deserve to be taken with soft gloves"
- "Pushes someone to death"
- "The police must crack down hard on organized criminal drug trade in Oslo"
- "Torture in the street" [3]

The Norwegian Government states that Norway wants to develop a knowledge-based and effective drug policy that can maintain the rights of all people.

The problems of disparities, injustice and stigma related to minorities, ethnicity and color of skin is one of the most serious negative effects of Norway's drug policy.

There are documented disparities and injustice in our criminal justice system and in our drug control regime.

It has been implemented police operations, directly and exclusively targeting young, poor West African men over a period of many years (Operasjon Touch Down) in combination with a very dangerous stigmatization used as a social-psychological process.

Norway, 4.6.2015: "The Government does not consider that there are grounds to appoint a committee to review and document the impact of current drug policies. The government believes that to have a ban on drugs, in itself is one of the most important instruments of the current drug policy." [4]

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Norway must review, document and analyze these effects, protect these people, and include this situation as part of our drug problem in order to develop and contribute to a knowledge-based drug policy that can maintain the rights of all people.

A dishonest Norwegian government.
November 2014, Norway was elected for the new Presidency of the Pompidou Group (2015-2018). Mrs Heiberg said that there “are no indications that the availability of drugs will decline” and countries will “face new ways of distribution” that call for strong international cooperation. In Norway Astrid Nøklebye Heiberg told the Norwegian civil society that the current drug policy Norway supports of achieving a ‘drug free society’ is a success.

In the West few politicians have been ready to admit the drug war’s failure. They need to be honest with their own voters about the misery it has caused. Only then can they make a good case to the rest of the world.

13.3.2014, UN: State Secretary Astrid Nøklebye Heiberg: «Is this acceptable, does it indicate more of the same or do we see a need for change? – is it a success or a failure?«

8.9.2015, Oslo, Norway: At a seminar senior advisor at the Foreign Ministry Lars Meling and State Secretary Astrid Nøklebye Heiberg told the Norwegian civil society that the drug policy Norway supports is a success.

State Secretary Astrid Nøklebye Heibergs dishonesty is a threat to the ‘health and welfare of mankind’. Mrs Heiberg does not consider that there are grounds to review and document the impact of current drug policies. Astrid Nøklebye Heiberg support current racist policy in Norway - more of the same - and believes the current drug strategy Norway supports of achieving a ‘drug free society’ is a success.

Norway should stand up for a drug policy that can maintain the rights of all people. The current strategy of achieving a ‘drug free society’ is not such a policy.

Mrs Heiberg needs to be honest with her own voters about the misery the drug war has caused. Only then can Norway make a good case to the rest of the world. Only then.

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3. FORUT, Norway

Preamble : Issues recommended for consideration

FORUT urges the inclusion of a strong statement about the severity and social and economic costs of substance use in the Preamble to the UNGASS Outcome Document. In addition, FORUT recommends that the preamble of the document addresses the following issues, among others:

The third way in drug policies

Drug-policy development, including the UNGASS process, is currently hampered by focussing on the false dichotomy of drug legalization on the one hand and fighting an endless, unwinnable “war-on-drugs” on the other. That debate is counterproductive for the UNGASS process and for drug policy development in general, for three reasons: the stark contrast dramatically compresses the policy space between the portrayed extremes, limiting the discussion of useful alternative approaches; it constrains the many nuances normally present in policy discussions and promotes simplistic solutions; and it wrongly identifies many effective prevention interventions as part of the much-maligned ”war-on-drugs” policy argument. In reality, plenty of middle ground exists. That “third way” is already in use by most governments and comes highly recommended by NGOs all over the world. Many effective policy options are available in the large space between the two extreme positions, and their support or implementation require no fundamental changes in UN drug conventions or in most national legislation.

UN drug conventions provide flexibility

The UN drug conventions are non-prescriptive and flexible in providing guidance to national and local governments on how to prevent drug problems and enforce the general global ban on the use of narcotic drugs. Governments have wide latitude to manoeuvre within the framework of the three UN drug conventions. Although, for the most part, countries meet their international responsibilities, many have failed to implement adequate national policies suggested by the wide-ranging conventions. A broad, balanced and humane drug policy The UN drug conventions provide substantial guidance and latitude for countries seeking to design broad, balanced and humane drug policies that are consistent with the principles of human rights. The drug conventions allow a broad range of different strategies and measures that can be adopted and/or adapted for a country’s particular circumstances. The best national drug strategies provide balance, using policy elements that both achieve their specific goals and also complement the facilitation of related policy interventions. Such a comprehensive policy would be humane, because it is an effective and sustainable way to

reduce human suffering to a minimum. The most successful policy approaches to reducing drug-related harm involve the balanced integration of several key intervention strategies, including demand reduction, supply reduction, early intervention, treatment, rehabilitation, social re-integration and assistance with acute health problems.

Understanding and reducing the availability of drugs is a key factor in prevention

Recognizing how the availability of drugs affects the levels and forms of drug use in a society is a vital element of tackling drug issues – and designing effective prevention programmes to reduce drug related harm. The complex concept of "availability" needs to be understood and addressed in a comprehensive manner, such as that described in the book, "Drug Policy and the Common Good." That work points to four components of availability: a) the supply of drugs (physical availability); b) the real price of drugs (economic availability); c) the attractiveness of drugs (psychological availability); and d) the social acceptance of drugs within the user's primary reference groups (social availability).

The vast majority of people globally do not use drugs

According to the World Drug Report 2015, an estimated 95 per cent of the world's population, and almost all the children of the world, do not use illicit drugs. The prevailing norm of non-use keeps drug problems in check and represents a powerful force in the global struggle to stabilize and reduce drug related harm. Maintaining and strengthening this key asset of social capital must be a central target for follow-up after UNGASS2016, by governments and civil society alike.

Non-users suffer substantially from others' drug use

A substantial part of the harm resulting from substance use is typically inflicted on persons other than the users themselves. Those "third-party" effects are now widely recognized as a critical issue in the field of alcohol prevention; unlike previously, when individualistic and medical paradigms attracted the most attention -- at the expense of more social and cultural approaches. The drug field would be well-advised to avoid many of the mistakes made in the alcohol field during past decades.

Legal drugs cause more harm than illicit substances

Despite the relatively low prevalence of drug use worldwide, drug taking ranks 19th among significant health risk factors reported in the Global Burden of Disease study. In comparison, the two legal and widely accepted substances, tobacco and alcohol, are ranked as health risks number two and five, respectively. In 2010, 32 per cent of the world's adults consumed alcohol, with staggering negative effects for public health and safety. Recent global estimates (Global Burden of Disease study) for 2012 attribute some 3.3 million deaths to alcohol consumption. In contrast, 183.000 persons died of drug-related causes.

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Prevention is by far the most effective strategy for harm reduction

Broad, population-oriented interventions, for example, demand- and supply-reduction policies that aim to keep drug-use prevalence and the social acceptance of such use at the lowest possible levels, represent harm-reduction of the highest order, because they operate to prevent harm from occurring in the first place. They also address incipient problems at the earliest possible stage of development. Early interventions prevent huge amounts of human suffering, both for drug users themselves and for the many people around them. From a policy perspective, prevention is cost-effective; it is sustainable and people empowering; and it is the most humane policy option, particularly in the context of assuring the best interests of the world's children. Effective prevention methods exist and are widely implemented throughout the world.

Harm-reduction interventions, although important, should be but one element among many in a much broader anti-drug strategy

Harm reduction, understood as the provision of health and social services to active drug users, can never replace primary prevention and treatment/ rehabilitation as the main strategy in global, national and local drug policies. Harm reduction initiatives fail to address the bulk of drug-related harm, but are nonetheless essential to assist drug users with their acute problems. Users are as entitled to health and social services as other groups in society, and receiving aid with acute problems contributes directly to recovery from drug addiction among those who seek it. Harm reduction for problem users helps assure better outcomes for addiction treatment by establishing and maintaining a link between the users and the health care system and by helping to contain co-morbid conditions such as the spread of communicable diseases through contaminated needles and syringes.

Recommendations for action points in the UNGASS Outcome Document

A variety of other issues have been raised during the preparatory process for UNGASS 2016. Here FORUT provides a catalogue of some of those issues, and our thoughts about how they should best be addressed in the UNGASS Outcome Document based on our experience as an international development NGO.

Key indicator: Drug use prevalence

The outcome document from UNGASS should identify drug use prevalence (regular drug use as well as experimental use) as the key indicator for monitoring progress in reducing drug-related harm. Using this indicator provides an important, population-level measurement of how many people are exposed to the risks of using narcotic drugs, both directly and indirectly. It also provides a good estimate of the social and psychological availability of drugs within a given population. Keeping drug use prevalence at the lowest possible levels

should be the primary goal of Member States' follow-up of UNGASS 2016, globally, nationally, and at the local community level.

Community mobilization with national coordination

UNGASS should encourage local communities all over the world to join in a global mobilization of concerned citizens and public authorities to confront illicit drug issues. UNGASS should call upon national governments to establish national systems for the support and coordination of local initiatives. UNODC should establish a "certificate of excellence" programme that can make annual awards to those local communities that have demonstrated outstanding or innovative, effective interventions to address drug problems. Coordinated efforts by a broad coalition of community stakeholders have proven to be an effective prevention strategy, one that has been thoroughly tested in many countries. Schools, parents' groups, sports clubs and faith-based organisations, youth and children's organisations, law enforcement associations, medical professionals, and others can all contribute to prevention by promoting anti-drug messages within their constituencies, by offering drug-free environments, and by mobilizing concerned citizens. Health, social and welfare services in local government have other channels to reach the population. The coordination of these complementary activities – by local authorities and civil society – offers a potent mix for effective prevention.

Essential medicines

UNGASS2016 should commit the UN and its member states to developing a global plan of action to secure universal access to essential medicines for pain and palliative care by 2025. The plan should be ready for adoption by Member States in 2019. In anticipation of the plan, the UN should establish an expert group to identify possible barriers to universal access, as well as to suggest mechanisms for preventing the diversion of medicines into the illegal market and for non-medical use. Recommendations from this group should form the basis for the new plan of action. UNGASS should also stress the importance of strong protocols for national testing and approval of narcotic medicines. Those protocols should avoid excepting some drugs, as has been occurring in some countries with regard to so-called "medical marijuana."

Illicit drugs as a development issue

The UNGASS outcome document should carefully address a number of development perspectives in international drug policies: In many developing countries, where the health service systems are severely burdened by potentially deadly and costly diseases such as TB, malaria and hiv/aids, prevention and early intervention represent the only viable core strategies for combating illicit drug problems. The international community should provide increased technical and financial support to countries that have become transit points for illicit drug smuggling. UNGASS should urge government development agencies in donor countries to include drug prevention in their alternative development portfolios. Alternative

development programmes have much to learn from mainstream development work in order to enhance results. Successful local development requires an integrated use of various strategies, including the promotion of good governance, anti-corruption measures, building and/or strengthening of civil society, mobilization of community-based organisations, provision of health and education services, etc. The correct sequencing of these changes is essential for a sustainable outcome. The heart of development depends on the strong involvement of the local population in identifying and defining problems and solutions at the start of any new programme.

Alternative sanctions

The UNGASS outcome document should recognize that many countries already have developed and are using alternative approaches to imprisonment and fines for minor, non-violent users. UNGASS should urge governments to start using or increase the use of alternative sanctions for minor drug offences. In general, the overall aim of all policies must be to keep young offenders out of prisons and instead offer them support, treatment and rehabilitation programmes designed to increase their chances for recovery from addiction or a criminal lifestyle. UNGASS should appeal to governments and NGOs to share their experiences with existing alternative sanction programmes at the international level. UNGASS should commission UNODC to establish mechanisms to facilitate the dissemination of those experiences.

Harm reduction can never replace prevention and treatment/rehabilitation as the main strategy in global, national and local drug policies.

It is essential that the UNGASS outcome document recognizes that a harm reduction approach must operate in a broader context. Harm reduction initiatives will never be able to address the bulk of drug-related harm. Therefore, harm reduction cannot replace primary prevention, early interventions, and treatment/rehabilitation as the core strategies underlying global, national, and local drug policies.

Capital punishment

UNGASS2016 should appeal to all Member States to abolish capital punishment, not only for drug offences but for all types of offences.

The child rights perspective

The outcome document from UNGASS should recall the Convention of the Rights of the Child's principle (Article 39) that children and young people shall be protected from the illicit use of narcotic drugs and thus aided in achieving their greatest potential. The UNGASS Outcome Document should declare that a top priority in national drug policies should be to promote drug-free environments for children and adolescents.

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New psychotropic substances

The UN should create an expert group to suggest how the international community can more effectively combat the development and distribution of new psychotropic substances.

Health Care Systems should offer a variety of treatment options

Health-related problems are a significant result of substance use, but not nearly the only potential negative consequence. Many people with drug problems suffer from a variety of other social and psychological conditions, some of which date back to experiences in early childhood and adolescence. The UNGASS outcome document should emphasize the need for treatment programmes to be designed to approach clients in a holistic manner, while offering assistance for the entire spectrum of problems drug addicts often have. The treatment sector must offer a wide range of therapeutic options that take into account individual needs and reflect the diversity of people with drug-related problems.

Social re-integration - the key to successful treatment

Returning to a regular life and living drug-free after treatment for drug-related issues tends to be even more complicated than the de-addiction/recovery process. The real challenges begin when the specialized treatment programme ends and life begins anew: finding a job and generating income; seeking a home and starting a new household; establishing new social networks; choosing leisure time activities, etc. Treatment programmes must aim to assist former addicts during this difficult transition period. Universally, those needs are routinely ignored, resulting in a failed recovery and an enormous waste of human resources and money.

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FORUT is a Norwegian development NGO, specialized in the field of Alcohol, Drugs and Development, that actively engages with civil society partners and governments in selected countries in Asia and Africa.

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4. LUHM, Norway

I'm writing to you because in a form I got at Actis seminar "En bedre global narkotikapolitikk (A better global drug policy)" the participants at the meeting were encouraged to submit feedback about the seminar and suggestions for you, as the Western European representative on The Civil Society Task Force (CSTF) for the UNGASS 2016 process.

I attended the meeting because it said that it would give me the opportunity to give input to UNGASS from the civil society in Norway. I do so on behalf of "Folkeaksjonen lovlige utsalgssteder for hasj og marihuana (LUHM)" a campaign requiring legalisation and regulation of cannabis for recreational use. LUHM has for several years participated with newspaper articles, television debate, hearings and other contributions to the political discussion in Norway.

Cannabis account for most of the overall market for illicit trafficking of drugs. Globally there are almost 200 million consumers. It was not intended that the global prohibition policy would lead to major problems such as war, violence, racism, terrorism financing, human rights violations, corruption, money laundering and weakening democracies. All drugs have potential for harms, but the illegal market is more harmful than the use itself. Prohibition for recreational use is a strategy that entails enormous problems.

Astrid Nøklebye Heiberg, who attended the Actis seminar as a panellist, said in the UN 2014: "What really concerns is the high homicide rates and widespread violence some regions have faced due to drug trafficking. These countries are paying a disproportionate high price. Is this acceptable, does it indicate more of the same or do we see a need for change? – is it a success or a failure? Based upon this grim picture, it necessary to discuss more thoroughly how we analyze and consider this situation for the way forward."

Nøklebye Heiberg said at the Actis seminar "that it is important to find out what it is about policies that do not work."

One of the other panelists at the seminar, Lars Meling who is senior advisor at the Ministry of Justice, said about UNGASS that Norway already have taken a stand to the UN conventions (cannabis): "It is said that the policy is a failure. My answer is no. It is knowledge based and successful because it is relatively low use in Norway." About human rights he said: "It implies the right to be free from drugs, and it must be included more in the academic debate."

It is a lie that it is low use of cannabis in Norway, moreover the UN conventions are an

international framework.

I asked him: "Is the Government's stance based on a cost-benefit analysis, and where can we possibly find it? Meling answered: No, it's not on the basis of a cost-benefit analysis."

Forut, an organization from the Norwegian temperance movement says that "cannabis should not be legalised and regulated for non-medical use, but tested and approved through the ordinary systems used in the development of medicines". They also say that "an important element of the anti-drug strategy involves reintegrating marginalized segments of society and bolstering their respect for the law".

That a small group of people getting legal access to cannabis does not reduce the global problems associated with the illicit market.

Forut and Actis says that it is not only two options; legalisation/regulation or prohibition, but a third option; alternative sanctions. "The prosecution - or management - of minor drug offences should focus on rehabilitating drug users". They recommend it as a solution to the global problems. But alternative sanctions is not a third solution, it means that the prohibition framework maintain and those getting caught for use can choose between fine/administrative fee or "voluntary" rehabilitation. Punishment for production, trafficking and sale will be the same. In Norway we are about to get a prison industry like in the US, and "Touchdown" have similar consequences as "Stop and frisk" who are also criticized in the US.

Few people have problems with their cannabis use. Here is one example about alternative sanctions that is being used in Norway: A young man being caught for smoking a joint, he lives at home with his parents while he is studying and has no income. He gets an offer of alternative sanction. The parents say they can not afford to pay the fine and says that he should choose other penalties because then he also avoids to get remarks on the record. He goes along with it, but he will not stop even if he "agrees" to go to treatment, and he changes his drug habits from cannabis (which can be detected in tests) to NPS (which can't be detected in tests). EMCDDA says that there is a correlation between the increased use of NPS and forced treatment. Also in Norway it is registered deaths due to the use of NPS.

Some choose alternative punishment to avoid remarks on the record, perhaps to retain driver's license, maybe even not to lose their children. For whatever reason, it is unethical and a waste of society's resources to treat people for problems they do not have. Those who have problems with use of cannabis should be helped in the same way as with legal drugs. All use is not abuse.

Moreover, it is not a solution that will do something to the illicit market/economy. The

really big problems will persist, and the emergence of new problems.

LUHM strongly recommend that cannabis for recreational use should be legalised and regulated, and those countries that want to produce, export, import and sell cannabis for recreational use must be allowed to do so.

Sincerely

Anita Nyholt
Folkeaksjonen lovlige utsalgssteder for hasj og marihuana

For more information see LUHMs webpage: http://luhm.no

actis

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Photographs From The Event

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