Foreword

In a few months, the international community will commemorate 100 years of international drug control.

A hundred years ago, substances that are internationally controlled today were unregulated and widely abused. The consumption of opiates in China alone was estimated to be more than 3,000 tons in morphine equivalent, far in excess of global consumption, both licit and illicit, today. In the United States, about 90 per cent of narcotic drugs were used for non-medical purposes. As drug abuse spread, an increasing number of people became familiar with the wretchedness, misery and evil connected with that affliction.

The International Opium Commission, convened in Shanghai in 1909, brought an end to decades of indifference towards drug problems and is rightly regarded as having laid the foundation for the current international drug control system. From it, an international treaty system was created and expanded over the decades that followed. Today, the three main international drug control treaties form the foundation of that system: the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances of 1971 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988.

With over 95 per cent of Member States being parties to the international drug control conventions, multilateral drug control should be considered one of the greatest achievements of the twentieth century.

For its part, the International Narcotics Control Board has managed, for the past 40 years, a global control system that has continuously expanded. The number of internationally controlled substances has increased from a few dozen to more than 200 today. In addition, national legitimate requirements for narcotic drugs and psychotropic substances have soared.

Despite the ever-increasing scope of the international drug control system, diversions of narcotic drugs from the licit to the illicit market are virtually non-existent. While diversions of psychotropic substances occur, the implementation of the 1971 Convention has resulted in a substantial reduction in the prescription of barbiturates and other hypnotics. The success of international cooperation in controlling the licit manufacture of and trade in narcotic drugs and most psychotropic substances has forced traffickers to resort to illicit drug manufacture.

However, to pretend that challenges do not exist would be to deny reality. One such challenge is ensuring the availability of narcotic drugs used for medical purposes. For years, the Board has called on Governments to fulfil that treaty obligation and make the availability of drugs a priority public health issue. Nevertheless, large discrepancies in the consumption of those medicines remain. As a result of the underutilization of these drugs in many countries, the World Health Organization (WHO) estimates that perhaps as many as 86 million persons suffer from untreated moderate-to-severe pain each year. The problems behind this phenomenon are complex and defy simplistic solutions. Together with WHO, the Board has developed the Access to Controlled Medications Programme, which addresses the causes of the problems and assists Governments in their endeavours to prevent

unnecessary suffering. I encourage Governments to make use of the Programme to improve the availability of drugs for medical purposes, where appropriate.

The treatment of addicts remains a difficult medical task. Such treatment should be carried out in line with sound medical practice and should not be used as an instrument to establish or maintain social control. Much attention has been paid recently to drug substitution programmes, which were initially developed as a last resort for those drug abusers who, for a variety of reasons, had not succeeded in overcoming their dependence through the use of other treatment modalities. While these programmes have their place in drug control policy, they should not necessarily be regarded as the ultimate goal but as an interim stage that would eventually lead to the development of a healthy, drug-free lifestyle. Moreover, drug substitution programmes should be supported by psychosocial care. The Board agrees to the use of substitution therapy in the treatment of drug dependence, always providing that this is delivered with appropriate medical supervision and can be reconciled with adequate measures to prevent abuse and diversion. Governments must also seriously address the other questions of demand reduction, particularly drug abuse prevention. We should recall the clear message of the twentieth special session of the General Assembly, held in 1998: drugs represent a danger for our societies, and drug control, control of both demand and supply, is the shared responsibility of all nations.

The international community may wish to review the issue of cannabis. Over the years, cannabis has become more potent and is associated with an increasing number of emergency room admissions. Cannabis is often the first illicit drug that young people take. It is frequently called a gateway drug. In spite of all these facts, the use of cannabis is often trivialized and, in some countries, controls over the cultivation, possession and use of cannabis are less strict than for other drugs.

Drug regulations are not a panacea. Regulations alone cannot eliminate illicit drug trafficking and abuse. I can therefore understand that the following question is often raised: Would it would be more economical to do away with all drug regulations and leave it to market forces to regulate the situation? I believe that this is the wrong question, similar to questioning whether it is economical to try to prevent car accidents or to treat infectious diseases. History has shown that national and international control of drugs can be effective and it is therefore the choice to be made.

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