Drug Policy in the United States:

A Presentation by John P. Walters, Director,
White House Office of National Drug Control Policy

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Official transcription

Michel Perron: Good afternoon and welcome. My name is Michel Perron and I am the Chief Executive Officer of the Canadian Centre on Substance Abuse, the CCSA. It is indeed a pleasure on my behalf and the CCSA to welcome you, Director Walters, to Ottawa. I would also like to thank all of you who turned up today, some travelling a considerable distance to be among us.

Mr. Walters, you should know that this is indeed an august audience that's been composed here today of leading representatives of Canadian government, academics, policing, political and professional bodies and policy groups. There is no question that this group, however, spans a broad range of ideological views and opinions and I expect that to be reflected in the questions that will follow your remarks.

I should mention that I was in your capital last week and it was very much the same temperature as it was here today, attending a roundtable meeting on addiction and mental health convened by Canada's Ambassador to the United States, The Honourable Michael Wilson. In particular the roundtable focused on the many advances in neuroscience, on the keen interest on leading organizations such as Canada's Institutes of Health Research, the U.S. National Institutes of Health, NIDA, and others to formalize a bilateral partnership aimed at working together in the field of addiction and mental health. What struck me most as I listened to the Canadian and U.S. scientific leaders was their borderless conceptualization of the issue and the means to address it...frankly, a perspective many of us would say is not as apparent in the policy level. In many respects the language of neuroscience transcends ideology and perspective and application of its future findings will continue to reshape our views on this issue. Indeed, the scientific language spoke of an appreciation of learning from each other and humbly accepting that they might not have it entirely right, right now. It spoke also of the clear respect of each other's views and opinions whether they be American or Canadian, scientists or not. It is very much in this spirit that I hope your visit will unfold in Canada and indeed why CCSA is pleased to be a part of this process.

Today's lunch is hopefully but among the first steps in bridging ideological gaps, focusing on issues of consensus rather than division, of committing to listening and actually learning from each other and with respect, that is indeed a two-way street. We acknowledge that it is indeed our respective responsibilities to do things in a manner we decide is best for the populations we serve. CCSA believes that one of the most important roles is to facilitate exactly this type of dialogue so that we may move beyond rhetoric and actually focus on reducing the tremendous harm caused by substance abuse

to individuals, families and communities across our land. We also strongly believe in the value of experience and evidence in shaping our actions. We are committed to learning useful lessons from the many and varied approaches to substance abuse adopted by our global neighbours, whether they be in the U.K., Australia, Europe and the U.S. and in turn sharing our experiences and successes with the world. Indeed, I look forward to the discussion today.

Just before lunch is served, to give a sense of how it will unfold today, I would like to say a few words about the question and answer period that will follow Director Walters' remarks. We've reserved approximately 20 minutes for Q&A from the audience. Given the number of participants and the number of questions we anticipate following his remarks, we are going to, in the interest of time, ask that each of you write your question on a card that has been provided to you at the table here. Ideally if you can make it legible that will make my reading of the question all the better. We will however try and pool the questions where there are common themes so that we can actually get as many questions to the director in the time available. In the spirit of transparency, however, we are going to ensure that a full transcript of the proceedings, in addition to all the questions and answers will be posted to the CCSA website. Those that are not answered, ONDCP, the Office of National Drug Control Policy, has agreed to provide a written response, so we'll make sure that we cover all the questions that are tabled and ultimately it will be all on the Web.

At this point we're going to begin serving lunch. Bon appétit. For those of you who have just arrived, please I encourage you to take a seat. We'll allow about 20 minutes for lunch then I'll introduce Director Walters for his remarks. Thank you.

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Michel Perrron: Welcome to those who arrived a few minutes after my introduction. Again, thank you for joining us here today for what I'm sure will be a very stimulating presentation and discussion afterwards. Again just to remind you, given the tight timelines that we have for the Director and our discussion purposes here, we're asking people to write their questions on cards and Enid Harrison from our staff along with Brooke Bryce will collect the cards both during Mr. Walters' remarks and immediately afterwards. They will be brought up here and I'll read the questions from there, which Director Walters will answer. Those questions that we don't get to will be answered afterwards by the ONDCP staff in Washington. All of this, including the transcript of the proceedings today, will be put on the Web.

So without further ado, allow me to introduce our keynote speaker today. John Walters is the Director of the Office of National Drug Control Policy. He was sworn in on December 7, 2001 as the nation's drug czar. Director Walters coordinates all aspects of federal drug control program and spending. Many of you have already heard him speak and understand the many different programs in which he works, including national youth anti-drug media campaigns, anti-drug coalitions at the community level, in addition to access to recovery treatment initiatives. He has also worked internationally on a number

of very high-profile issues along with the Colombian cultivation of coca and production of cocaine. Working with U.S. authorities, Mexico has demonstrated an unprecedented resolve to dismantle violent drug cartels and of course the U.S. have been working in close cooperation with the United Nations Commission on Narcotic Drugs on a number of issues, including pseudoephedrine. Prior to returning to ONDCP, Mr. Walters served as president at the Philanthropy Roundtable. Previous to that he served at the ONDCP as chief of staff and deputy director for supply reduction and worked in the U.S. Department of Education and the National Endowment for the Humanities. Mr. Walters.

John Walters: Thank you Michel for that kind introduction, thank you all. I know that some of you came a long way so I appreciate and thank all the members of CCSA for their sponsorship of this lunch and the team and other board members, thank you. There are a number of distinguished people I know in the audience. I want to recognize them as well. I won't try to name everybody because I will leave somebody out. For those who are distinguished and I don't know, thank you for honouring me by coming here and listening to these remarks.

Also, I want to thank Canada. As some of you may know I have family here; my father was born in Toronto and I was the beneficiary of the education that the University of Toronto gave me as a graduate student. It's a great pleasure to be back; I don't get a chance to visit very often in my job, but I'm always reminded about the terrific country this is and wonderful neighbour and I'm glad it's part of my family personally as well.

I am very optimistic; I know that some people consider me excessively optimistic, but I'm very optimistic about the future of what we can do about this problem for the better. The reason is that I think we have tools at our disposal that have not been exploited fully, that allow us to use the science and what we have learned more effectively. I think also that there is in fact a growing consensus, although it's boisterous and not everybody will be going in the same direction, about how we can really combine things to maximize progress. What we've tried to do and the Bush administration at the President's direction is take the knowledge of the past – the President's direction to me was – and use what we know to more effectively make the problem smaller. His confidence, having been a governor, having obviously been aware of these issues in politics as well as in governing as well as in his own life, was that we can do a better job by combining what we've learned of the painful experience over 30 years or more on controlling supply and demand. That we need balance and we sometimes struggle with what I would call a cartoon picture of people who are either on the demand side and are indulgent or on the supply side and harsh, that the growing awareness of the need to combine both supply and demand in effective ways to see progress as critical.

We began with not only an emphasis on balance but also an emphasis on reinvigorating confidence; we can do something about this, because I think cynicism and some of the pain this problem has, in real terms, caused has led people to lose confidence that our institutions and our own actions can be able to effectively reduce these sources of suffering. So he set with a goal in 2002, the first announcement on policy, strategy and budget, the goal for teen drug use for 25 percent decline in five years. That was pegged

to one of the number of surveys we have, the results of which we got for that five year interval in December which showed in fact a 23 percent decline over five years of teenage use. Why do we focus on that apart from, well, obviously we care about young people. As many of you know working in this field, but particularly as it applies I know from the information in the United States and it may be different in other countries, if you don't start using drugs of abuse, illegal drugs, alcohol, cigarettes during the teenage period, multiple studies longitudinally showed you would have a much reduced risk of using after the teens and if you do start using after the teens you have a much reduced risk of becoming dependent. So we changed the trajectory of individuals for being victims of this by simply doing what common sense tells us: don't expose our kids and adolescents to dangerous, addictive substances as they pass from childhood to adulthood. Easy to say; hasn't been so easy to do.

What's the greatest single force of evidence for this? My generation, the baby boomers. We had as a cohort the largest involvement in illegal drug use of any teenage cohort prior to our generation and we are carrying those with the higher levels of substance abuse all the way through into our 50s and 60s. So just as with my generation, the susceptibility to this problem is made much greater by involvement in adolescence. Today's generation, the decline we've seen of almost 840,000 in actual numbers of teenagers between 2001 and 2006 involved, means that for the rest of their lives they will gain a measure of reduced risk as a result of not being exposed as teens. That's important because it creates the ability to have durable and lasting change.

In addition, what we've tried to do is not only talk about balance and focus, but we've tried to exploit a couple of key things; strengthening prevention, trying to be clearer and more direct. Michel mentioned the media campaign that we have to try and reinforce lessons that obviously come first and foremost from parents, educators, other adults closer to children. To put out there in the media information that we think can help to buffer both blind spots and some of the reasons that young people give us for using or that we know from the history. In addition, we know that the drug problem depends on addiction. Drug business fed by dollars can't exist as it exists today without the kinds of high volumes that are only generated by those who are dependent. We have in this book, it gives you a kind of summary; I'm not going to go through it, but there are a lot of questions and I'm not going to pretend to be able to do a complete resume here, but if you are interested in some of the information we also looked at, what you see with alcohol, what you see with cigarettes, what you see with drugs and abuse, the same phenomena: the heaviest users use vastly greater quantities of the substance; they produce the dollars so that when a problem gets rooted in a community the enormous draw of demand is rooted in that addicted population. So first we want to try and create obviously a barrier of prevention that we've followed as a common sense measure for a number of years, but we also need to dry up the addicted demand.

The President asked to do some innovative things about treatment. We provide about $2 billion at the federal level to states and localities in the United States for treatment. He asked for additional monies; we ended up getting abut $100 million, to both add capacity for particular needs—and we made grants to 14 states and one Native American group to

do that—but in addition, we took the science that tells us we need a continuity of care. Some people, not you in this room, but a lot of common sense notions in this are misleading sometimes. Treatment is kind of like a washing machine. You come in addicted, you get clean and you come out and you're better…if the washing machine works. Of course that's not the way it works and one of the reasons that we know we need to make some modifications is we need to have recovery support. We need to support people in reintegration whether they come out of jails or prisons, whether they come through referral in the health care system or the criminal justice system or simply through community or through private sources, family, employers and others. We need to support where their lives have been damaged most extensively. We need to support getting them into follow-on counselling, housing, education, employment. Many times we need to get them help resituated in the community that's away from the patterns of self-destruction they had before.

So we provided this money in a way that provided support for a continuity of care, brought more institutions in, many community-based institutions, some faith-based institutions, some providers of employment support and others. So what we had was the management of an individual to optimize the likelihood that their recovery would be supported, and if they failed in their recovery – as we all know, I think, many people do in the course of getting to recovery – that they are helped to get back into recovery as rapidly as possible because we know that also increases effectiveness. We are also funding reimbursement for services. Sometimes our system has funded slots or capacity, but the capacity is mismatched with the individuals. So we provide greater efficiency; we're funding actual services to individuals and we increased the provider base with this and we also allow ability to measure quality. In addition, between the poles of prevention and treatment, we believe one of the most powerful and promising long-term areas is what I would call the category of intervention. You have seen this in terms of things like diversion programs and drug courts. People who come into the criminal justice system, not because they're a violent, predatory criminal, but because they are addicted, because their addiction leads them to theft or leads them to prostitution or leads them to other kinds of self-destructive behaviour to themselves and others. We know those people will continue to become a problem to themselves and others, usually if their dependency is not treated. The courts become a way of under supervision getting them into treatment and supporting them in recovery. So we've seen these expand greatly, both because they're humane, because we see the benefits and we're increasingly tying mental health services to that kind of court-supervised rehabilitation, but also because they're cost effective.

Obviously the cost of incarcerating an individual is great and we know sometimes people will offend and re-offend and spend their lives both harming others in their communities, themselves and their families, but also being an enormous destructive force in society generally. We want to turn that around. But in addition to the more, I think, somewhat established notion of diversion programs in the criminal justice system, we try to expand this in the health care system. Again all these I think are based on—and I think the most powerful things that are promising and make me more encouraged—is the way we can re-conceptualize and help to redirect our understandings in ways that are productive.

There used to be a view that while science was showing us parts of this phenomenon that was disease, that if we talked about it as a disease there was a fundamental opposition to talking about responsibility. Responsibility was needed to support prevention and law enforcement and if you gave that up by talking about it as a disease, you would lose the ability to have powerful tools you needed. In addition, if you just talked about it as responsibility, you lose the ability to treat, people were antithetic. We don't believe that. We believe that we can take the science of this as a disease, a disease we can image the changes of the brain as you go from voluntary to addictive use, that we believe we can use that science to help both in prevention and care. One of the ways that I think is most powerful is to build it into our health care delivery system. We have done enormously beneficial things in both of our countries and in much of the world that has developed a health care system now through screening for diabetes or hypertension or even conversations from medical personnel about smoking and diet. It's not perfect but it does a proven contribution. It makes a proven contribution to reducing the phenomena early on before the full-blown manifestations of pathology and disease manifest themselves. That's what we're trying to build into our health care system. We've just got codes for the Medicaid and Medicare reimbursement system that will allow states to pay physicians for the screening costs and brief intervention costs. We're working to make sure people are trained in these measures and we're working to get those similar codes for our private paid insurance system through the AMA code system in the next month. These will be enormously powerful tools we believe to reduce the number of people who start and end up unfortunately on a path that leads them to dependency and abuse.

We have funded some initial programs in major hospital systems, Cook County in Chicago, Ben Taub in Houston and Harborview in Seattle. What they have found, because those are frequently public-pay systems, is every dollar they spend on screening and brief interventions or referral to treatment, they save $2 to $4 in downstream costs because of illness, disease, continued readmission to shock trauma centres for continued consequences of addiction and substance abuse. So this is not only humane, it's not only consistent with science, it's not only consistent with what we think we should do and know we should do for medical practice, it's also consistent with saving public dollars for focus on the variety of other threats we see.

In addition, what we have talked about doing is greater screening in the form, as the President mentioned in 2004 State of the Union, in random testing. Random testing in the United States I believe, although I won't claim to know in the necessary detail in Canada, is fairly extensive—or more extensive than in Canada—in the workplace and obviously we also have this in the transportation safety industry, in the military, law enforcement. It's been not only an enormous benefit to reducing accidents and other kinds of problems when people are dependent; it's an enormous prevention tool. In talking about using random testing in schools, we know this is controversial. We know that it's been something nobody wants to talk about because they see it as an enforcement and punishment tool. We've had this tested at the Supreme Court level. Random testing in schools may not be used to punish. It has to be used confidentially with the student and the parent to get help to kids who need it and not have them become dropouts, throw outs. It gives affirmative obligation to the community when it finds a child that has a

problem or a family that has a problem to tie support to that problem. We're not mandating this, we are providing some money. We have about 1,000 schools, just recently Dallas, Texas, the school system of Dallas, has adopted this and will start this fall.

How powerful a tool can it be? Well, we've seen some schools with results and they've seen declines. It varies in some degree on how this is implemented and the frequency of tests that underline the problem. We're looking at some of those results and, we're making available the information to schools that want to do it. I think this is something we have to talk to somebody twice about. The first time they find it too controversial and they see all the objections. But I tell them to remember this the next time they hear about a child dying of an overdose death, when they die behind the wheel of a car or as a passenger of a car of someone who is drunk or high; and remember it doesn't have to be, we don't have to lose kids this way. Why is this something I think we can adopt, and it's not too controversial? First of all, when we start thinking of this as a disease we begin to see that, as many of our states, how do we think of tuberculosis tests which are a condition of coming to school in the United States? We don't see that as an infringement of rights. We don't see that as an unacceptable burden. We see that as an important and necessary means of reducing the spread of childhood tuberculosis because one, we know that tests will find children that can be treated and if left untreated will get sicker, and two, they'll communicate that disease to their friends and to those around them. We have changed dramatically the cost of childhood tuberculosis by testing and it allows us to begin – when we think of these as a disease – to use other public health measures that have changed the face of suffering in other areas of disease control and pathology.

In addition, I think the example of the workplace is powerful. Again, the workplace is different from schools. I just gave an award to the Department of Defence in the United States a couple of months ago for their workplace testing program. Some of you are no doubt experienced enough to know that a predecessor to my job was actually created by President Nixon during his administration when the troops were coming back from Vietnam with opium and heroin addictions. It was unacceptable obviously that people who had risked their lives for their country would come back to their families with addictions. The government really became much more involved in treating the whole drug abuse problem at that time triggered by that phenomenon. It's a different military; it's a different war, a different time. It wasn't a voluntary military at that time, but we now obviously, as you know, we have men and women serving in Afghanistan where 95 percent of the opium in the world is today cultivated. We haven't had one positive opium test of the men and women serving in Afghanistan, not one. Now that's the power of testing, I think, not simply as let's find somebody who is at risk; it's a prevention tool to stop the risk from coming in. Some people sometimes object, well, if testing is going to show us we've got a lot more kids to treat than we have capacity…the answer is yes, it may certainly, but one, it will get you treating at a rate you're not treating now and two, you're forgetting the prevention part of this. It is an enormous way to stop the number of kids who are reaching the point of needing intervention from reaching that point. Again, I think these are ways that we can not only change the dynamic of use, but we can keep them and change institutionally and in our societies in durable and permanent ways.

On the supply side – I'll close with this and take your questions – we have tried to understand this just as with the disease side and the epidemiological insights that gives us, we have tried to understand the supply side as a business that requires certain things that businesses do. I know there tends to also be in a cartoon world the view that just as you can't stop people from suffering victimization of substance abuse at the rates they now do, which is demonstrably wrong, on the supply side these are businesses that, unlike other businesses that are always worried about government damaging their profitability or driving them out of business, these are businesses that know no amount of effort can change their ability to inflict harm through the substances they bring into our society. That's also not true. We've seen dramatic changes when we do things in a more sensible and focused manner. We have worked, just as I know Canada has, on an amphetamine problem, for example. We've seen enormous declines through efforts that work, production systems that have migrated to small toxic labs around the United States to the control of over-the-counter medications that were precursors. We have seen dramatic declines. Some of the most effective states, Oklahoma, Oregon have seen drops of 60, 70, 80, and 90 percent in the small toxic labs and we've seen declines in the workplace testing as a result in some of those places. We need to follow through. We've also seen part of the decline, we've seen in teenage drug use, one of them is 50 percent or more declines in LSD, meth and ecstasy use by teens. That, we believe, is a combination of not only prevention messaging to explain dangers, but also a supply control addition: cutting off some of the key ecstasy routes that were coming from Europe at that time; in the case of LSD (and) the take-down of a large lab, production was much more centralized than we thought and had an effect; and obviously with regard to meth, that same kind of phenomena that I talked about with regard to the larger meth markets.

Again, does that mean that we can always control all of these forces? Obviously not, but the real issue is, does it make sense to be balanced in the way we focus on it? My argument is that is the fundamental thing that we need to reach an insight on. Secondly then, how do we conceive of both demand control and supply control? I would argue that the insights that allow us to be optimistic now are the ability to mix disease and epidemiological understandings into both demand and the business model that we look at on the supply side and focus our efforts in areas where there really are needs. This is not a uniform phenomenon so I'm very big on things like mapping and finding and seeing spread and propensity of changes to both give us a sense of what's working, but also to give us a sense of where our obligations are to work. We at government, especially when you look at the national level, want to do, and have an obligation sometimes because of equity, to do something everywhere. These phenomena are not everywhere. We don't have the resources to do everything everywhere, so where do we focus? Can we take information that will allow us to essentially put out the fire by putting water on the fire and not spraying the entire city? That's what I think is an important key, to do certain kinds of strategies that have broad protective or beneficial buffering effects and then specific things that allow us to find and to work with individuals.

Now I won't claim to have done justice to the time you've given me, but I'll stop there in order to take some of your questions and as I mentioned earlier, we'll try to answer any of the other ones electronically so you can get those questions answered as well.

Thank you.

Michel Perron: Thank you, Director. Well we have a number of questions here and perhaps just to start on the aspect that you closed on, which is in fact some of the balance between the demand reduction and supply reduction, one of the questions is: "You talk about investment between prevention and treatment and the repression or supply reduction and also the investments in housing. Why is it then that most of the money goes, in fact, to supply reduction when the other parts are more important?"

John Walters: Again, I think it's a mistake to talk about "more important". We need to do these things together. I think there is sometimes a kind of counter-productive—we were talking about this at lunch—claim that we don't get money because another part of the effort against drugs gets money. Two points on that: one, as with you, we have a federal system and a lot of the actual spending that goes on in communities, well, the federal government provides a lot of money. I've been in Washington D.C. so long that I don't think of $12 or $13 billion as a lot of money, but we're also a wealthy and big country. We spend over $25 billion on candy in the United States, for example. So compared to what we have and what we should spend, I believe this is a reasonable investment.

In terms of the proportion, there are certain kinds of responsibilities that are funded and carried out by state governments, by local governments, by non-government entities... A lot of our health care is not funded by the national government. A lot of our educational costs, most of them by far, are funded not by the federal government. Most of our law enforcement costs are funded not by the federal government. The federal government provides and has provided, because of the unique need and pressure this has put on people—and I think it's true in Canada—some sectors we have gone further into what have been non-national issues before because they are believed to have national importance. Now, the mix I would also say is partly dependent on how we present it for key strategic decisions, but the usual way this is discussed—and we were talking at lunch—is we could get more treatment money if we'd stop doing border interdiction, but you that are in government and you that are savvy in this room know that's not where the competition occurs. When I ask for more treatment money from our Congress, whether it's Democrat or Republican, it doesn't compete against border enforcement. Border enforcement competes against immigration control, other kinds of fisheries monitoring, everything else because that's where those agencies are. Treatment competes against health care for the aged, care for women with dependent children and other kinds of health and human service priorities. So we are also both trying to provide a defence for resources in an overall and comprehensive way that reflects the balance (and) the fact that not all the resources for that balance come from the federal government, but secondly, we're also trying to make sure—this is the issue we were talking also about earlier—of accountability, that we can show in the competition, where the competition actually

occurs, that this investment is good. One of the problems that many of you working in the field know is that there is a bias that permeates our work about addiction and about aid to people who suffer from this, even though all of our families, I believe, at least in the United States, have witnessed the terrible destruction of alcoholism and addiction. They sometimes know also the shame of that. One of the things that the science liberates us for is to see this as a disease, recognizing a part of this disease is the fact that denial is involved not only by the sufferer, but by people around them. We need to get at that and I think that we can do that not only through policy leadership, but also we're even using that in our prevention campaigns to tell kids this isn't about whether or not you like a certain kind of music or you want to wear a certain kind of clothing, this is a pathway to disease and you need to help to make sure that you don't encourage your friends or you yourself don't enter that pathway.

Michel Perron: Thank you. The next question is, "The U.S. National Drug Strategy Report deals with intervening and helping America's drug users and the importance of a public health approach. The report, however, does not mention the importance of public health measures such as needle exchange programs and supervised injection sites, despite the evidence that these measures reduce the transmission of HIV and Hep C and save lives. Can you please tell us how your strategy will prevent the tens of thousands of new HIV infections through injection drug use this year?"

John Walters: This has been quite a controversy, I think, in both countries frankly as to what kind of measures do we use and how do you judge the evidence on different measures of, quote, harm reduction or other kinds of efforts to control especially related health problems or societal concerns. Again, I don't say we've settled this kind of debate, but I would say the way we have settled it is at the federal level we have adopted a policy that is based on something that is clear and not debated. The best and most comprehensive way to stop the spread of HIV or Hepatitis C is to take someone who is an IV drug user and get them to recovery. If we can do that, we have the lowest chance of them becoming either infected with Hepatitis C or HIV. Again, I recognize that some people believe that you can't get some people there or that in the interim we need to do other kinds of prophylactic measures, but our view has been we can get them there in greater measures, that especially the scarcity of resources requires us to put the resources on where we think the most far-reaching benefit can be done. We believe that outreach to treatment, intervention and recovery support is where that should be.

I also think most of the people I've talked to that even support some of the harm reduction measures and are working in those areas don't debate that it would be important to get people to get to recovery. Addiction is not good for your health any more than HIV or Hepatitis C are. There also is very little debate, I think, from the common sense citizen. If you had your son or daughter or your brother or sister, you would like to get them into treatment and recovery rather than into a safe injection site if you could do that.

Michel Perron: Perhaps I'll segue way into another question just because I know there is an interest of time; you can speak to this sort of tangentially. The question: "Do you

anticipate that the Bush administration will ever extend its support to science and evidence-based policy to these areas? I think the point you make with respect to going to recovery, I think, there is very little controversy to that objective. It's the getting to and ultimately the interim stage between use and ultimately recovery, and I think some of the policies that flow from harm reduction-like programs. How would you reconcile that along with the use of science and evidence-based policies to guide your actions in that area?"

John Walters: Well, again, I don't think the argument about how science has not been used or been used is all on one side. I don't think that the data that we are seeing from looks at various harm reduction strategies and their consequences or how much what they're targeting has influenced conversion rates for HIV or Hepatitis C... There have been a variety of studies in different places that do not, I believe, have a uniform conclusion. I recognize reasonable people have some differences about this and sometimes unreasonable differences are stated about this. Again, I don't think we're closed to the science here, but I also think, look, we all live in, we both live in democracies. We have to convince people about what's good for them as well. We can partly educate them, but we also have what we can get support for. I think we get the biggest basis of support by saying we're going to get people to treatment and we're going to get them intervention where we have consensus. I regret, I think in this area wherever we have unnecessary conflict we reduce the amount of public support both for funding and for public programs and the way we create a consensus in society. Now, we're going to have differences because we are free societies, but my goal is to maximize the points of consensus and to build powerful support for programs and budgets on that basis. It may be different and I know it's different in parts of Europe and others about where you can build that consensus, but I think we do not have either a consensus that's antithetical to science, nor do we have a consensus that's weaker. We're spending significant resources, I think we're spending them better and I think we're getting traction on these programs and I think that's going to cause both addiction and use to continue to go down. That's where we all want to be.

Michel Perron: Okay, two last questions and we'll make them snappy because I'm getting all kinds of signs from the back that we have to move on. "You've repeatedly stated that Canada is a significant supplier of cannabis to the U.S. Several major studies, international, Canadian, American have concluded that Canada supplies only a very small proportion of the U.S. market. Can you explain the conflict and who is correct?"

John Walters: I'm not quite sure what studies were referred to there. There are basically three major sources of cannabis in the United States. The United States, and we have been actually under this administration stepping up our efforts to eradicate on public lands where this has migrated as well as indoor grows. Mexico, which has been and continues to be a source which we are working with the Mexican government and our own law enforcement to control. Then, in the last five or ten years the effort by largely Asian-organized crime groups to produce high potency marijuana in western Canada. We've had a great relationship with law enforcement in Canada. The RCMP and others have worked with us to attack this trade. We are trying to do it obviously in ways that

allow our continued and mutual interest in allowing the border to move goods and people freely without encumbrance while protecting us from these threats. But there is no question that a significant amount of high-potency marijuana comes into the United States, but again we're also attacking that in a balanced level. I sometimes get criticized for focusing on marijuana. Marijuana is one of the blind spots we don't have consensus on. It's a soft drug; we should tolerate it, and so forth. We have more people seeking treatment for marijuana now partly because the potency seems to be related to the greater problems it causes with health and addiction. We need to stop that and we need to alert people to that so they take appropriate measures to correct their misunderstanding. But a lot of people in my generation, people who had the most involvement with marijuana…it's still the largest source of any illegal drugs abused by teens, but it's also the largest source of putting teens into treatment. It's even ahead of alcohol now.

Michel Perron: The final question is, "You've emphasized the need to maximize the use of what we know works and specifically in the area of treatment, then—a merge question of sorts—are we doing enough and what else can we do. In that context, will the U.S. encourage Canada to continue to support well-designed scientific evaluations of innovative addiction and prevention such as a supervised injection site in Vancouver?"

John Walters: I don't think a supervised injection site per se is treatment. You may want to reach out to people and refer them into treatment, but I think even people that I've talked from harm reduction, it's an interim step and it's something to limit certain kinds of consequences, but in and of itself is not treatment. I would think we want to be very clear about what is and is not treatment. We want to get more people to treatment. If you want to use certain harm reduction methods as a way of reaching out to those who are dependent and bringing them in, let's not leave them in a way station that's not really where we want to get to; let's get to the goal line. The goal here, I think, is also to establish the competence in treatment. I will tell you from my own view, talking to Europeans especially, some of the times when I talk to them about harm reduction what's underneath this is a profound cynicism about treatment. They believe that there are people that are lost and the best we can do is not let them cause more trouble for other people. Maybe not for themselves, but let's put them in some place in our community where they don't rob us and we don't have to look at them when we walk to work and we don't have to spend more money on them than is necessary. That's corruption in my view. That is a society that is not treating its citizens equally. I believe that we can reach out to these people no matter how long they've extended their addiction and get them recovered. I meet people who have been through that night. Can we save everybody, no, I'm not trying to make that argument. But I am saying that the usual view that is not spoken, not by everybody but by some whom I've talked to in Europe, is the secret underneath all this is these people are lost and the best thing we can do is to manage them so they don't cause problems. I believe that's wrong. That is not a policy statement that I think is required, that I think is a matter about what do we mean about ourselves as people. I think when people are suffering from addiction, our position is we have an obligation as a society to help them get well from that disease and that we can do that. We have more and more powerful tools from pharmacological and behavioural. We're putting resources in this and I think we can put more resources into it. We're trying to

stop it before it becomes the most acute forms, but we're also going to deal with the most acute forms and we're going to make an obligation on ourselves not to just watch and look the other way. We have a denial problem in society. We want to address that and frankly the President has made that a matter of most priority since he began. He does not believe we have to watch our family members and our fellow citizens get hurt, to continue to suffer. I think that's the most important catalyst for a balanced strategy, for more money for treatment, for energizing prevention and I think frankly even for law enforcement because of the obligation it has to protect the innocent and to save those who are suffering. That gives the maximum basis for public support and I appreciate frankly this opportunity to talk to you and I know that many of you are engaged in this and I appreciate your taking time from your important work to be with me today and thank you for what you're doing and thank you for the friendship of Canada. We stand in a number of areas together not only on the border, but in far away places like Afghanistan and I hope you know on behalf of my government we are aware that there again in a conflict to help make the world safer we have mixed the blood of your men and women with the blood of our men and women and we are profoundly grateful.

Thank you.

Michel Perron: Thank you, Director. I'm just calling on Chief Barry King, Chair of the CCSA Board of Directors to provide some closing remarks.

Barry King: Thank you very much, Director. It was a very compelling presentation. I don't think anybody could fail to be impressed by the progress that your country is starting to make on reducing some of the drug use especially among the young people since 2001. I congratulate you on that. Particularly appreciate the emphasis that the U.S. strategy is placing on a balanced approach because that's been exactly what we've advocated for Canada. Prevention, treatment, enforcement and we also add in education as well. As a soon to be retired police chief I can attest that neither enforcement nor prevention nor treatment alone or individually is going to solve this problem; it has to be balanced. It also has to be intentional, it has to be a strategy and it has to be resourced. I also concur with your remarks about the importance of research, evidence and experience in the formulation of drug policy. It was through evidence and research that we've learned the importance of delaying the onset of drug use among young people and the value of screening, brief interventions and the referral to treatment. Canada and the United States share the longest undefended border in the world; you're our neighbours and we appreciate the remarks that you made with reference to Canada. It's vitally important for us all to support each other in the quest for a healthier and a safer society while maintaining still our respective individuality and our own sense of community. With that in mind, I'm encouraged by your positive view of our country and our cooperation and for your generous remarks. Thank you very much. For everyone else that attended, thank you for attending. There is some snow coming we understand so have a safe trip home. Thank you.