Media Information Pack

'Cannabis and International Drug Policy'

The World Federation Against Drugs (WFAD) - a multilateral community of non-governmental organisations and professionals - is pleased to invite media personnel to utilise this resource and to make direct contact with Board members present at the CND in Vienna.

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Side event on

HOW CANNABIS CAN NEGATIVELY AFFECT YOUNG PEOPLE: A DISCUSSION OF THE SCIENTIFIC EVIDENCE

jointly organized by San Patrignano, Word Federation Against Drugs, Europe Against Drugs and European Cities Against Drugs

Tuesday, 12 March
9:00 to 9:50 am
Conference Room M7

Invited Speakers:

Prof. Sir Robert Murray, Kings' College London, UK
Prof. Daniela Parolaro, Insubria University, Italy
Kevin B. Sabet, Drug Policy Institute, University of Florida, USA

Cannabis
Overview of Facts

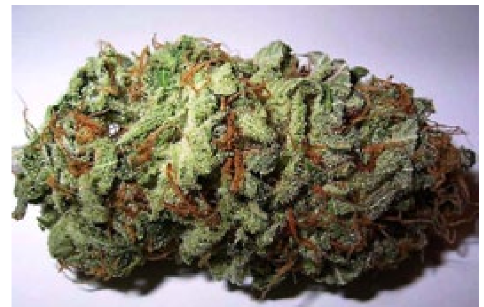
Cannabis is the term most frequently used to refer to the drug deriving from the plant Cannabis sativa and it is the most commonly used illicit drug in the world. About half a percent of the world's adult population use cannabis daily and between three and four percent has used cannabis at least once the past year[1].

Cannabis is generally found in three forms (marijuana, hashish and hashish oil) all of which contain delta-9 tetrahydrocannabinol (THC) as the main psychoactive ingredient. It is absorbed through inhaling its smoke or its inclusion in cakes or cookies and is very slowly metabolized by the body as it becomes deeply absorbed and entrenched in the body's fatty tissues, with the brain as a primary target. The complete elimination of a single dose from a user's system may take up to thirty days[2] and its acute effects can last several hours.

Cannabis dependence is the most common type of drug dependence in many parts of the world after tobacco and alcohol. It is estimated that 1 in 9 cannabis users overall will become dependent. Those who begin using the drug in their teens have approximately a 1 in 6 risk of developing dependence[3].

A Gateway Drug - The term "gateway drug" is used to illustrate the tendency of cannabis to introduce the user to other illicit drugs. Consistent evidence has shown that cannabis use almost always precedes the use of other illicit drugs, including cocaine, methamphetamine, hallucinogens, illegally obtained prescription drugs and opiates. Very few users try illicit drugs other than cannabis without prior use of cannabis[4] . For example, the National Center on Addiction and Substance Abuse (CASA) at Columbia University found that children who use drugs, including cannabis, are up to 266 times more likely to use cocaine than those who do not use any of the gateway drugs identified (cannabis, tobacco and alcohol). More frequent use and younger age of initiation to the drug strengthen this relationship.

Increased Potency - Of particular concern in recent years is the cultivation of high potency cannabis. This increase in potency refers to increased THC concentrations which may cause users to develop heightened responses to the drug. There is a proven dose-response relationship between cannabis and its related drug-induced psychosis, where the greater the amount of cannabis consumed correlates to a higher degree of risk of psychosis[5] which means that this increase in potency is absolutely critical in any assessment of cannabis harms.



The images above show a piece of hashish, a marijuana bud and hashish oil.

1. EMCDDA, 2012 Annual report on the state of the drugs problem in Europe, Lisbon

2. Cabral, Dove Pettit, 1998. Drugs and immunity: cannabinoids and their role in decreased resistance to infectious disease. 1998:83(1-2): 116-23

3. Wagner, 2002. From first drug use to drug dependence; developmental periods of risk for dependence upon cannabis, cocaine, and alcohol. Neuropsychopharmacology 26, 479-488.

4. Kandel et.al. , 1992. Stages of Progression in Drug Involvement from Adolescence to Adulthood: Further Evidence for the Gateway Theory. J Study Alcohol 1992:53(5):447-457

5. Ramaekers et.al. 2006. High-potency marijuana impairs executive function and inhibitory motor control Neuropsychopharmacology 31: 2296-2303

Cannabis
Health Consequences

It is undeniable that cannabis affects the brain; conclusive evidence shows that heavy marijuana use for five years or more will impair memory and slow cognitive function. The short-term effects of cannabis use on brain function can include things such as problems with memory and learning, difficulty in thinking and problem solving, loss of coordination. Long-term effects include permanent memory impairment and overall slower cognitive function.

Psychosis and Schizophrenia - Severe mental disturbances, such as momentary short-term psychosis or the long-term illness of schizophrenia, have been linked to cannabis use and especially so when cannabis use begins in adolescence. Studies show that that early cannabis use may damage the dopamine receptors in the brain permanently, leaving a young cannabis user at a much higher risk of developing schizophrenia or experiencing psychosis[6].

Depression and Amotivational Syndrome - A mental health issue frequently associated with cannabis use is depression and numerous studies support the connection. A 16-year study of individuals in Baltimore, Maryland USA showed that individuals who initially did not suffer from depression, but who then frequently used cannabis, were four times more likely to develop depression at follow up[7]. Cannabis use can also induce amotivational syndrome, a mental state characterized by apathy, an inability to carry out plans, deal with frustration or concentrate for any length of time[8].

The Adolescent Brain is More Vulnerable - The adolescent brain, while still under development, is particularly vulnerable to the ill effects of substance abuse[9]. In August 2012 a study was published which greatly strengthened the evidence that regular cannabis use beginning in adolescence and continuing throughout young adulthood causes a decline in IQ. In this study, the researchers assessed IQ and other mental abilities at age 13 (before cannabis was first used) and again at age 38, and asked participants about their cannabis use throughout adolescence and young adulthood. They also collected other related data. Researchers found that early and persistent cannabis users showed an eight-point decline in IQ compared to those who had not used cannabis. More detailed analyses pointed to cannabis use being the most plausible explanation for this decline[10].

An American research team performed imaging studies on 14 young men from a residential drug treatment center in New York State, as well as 14 age-matched healthy controls[11]. Performing a type of magnetic resonance imaging scan on participants, the study showed that heavy cannabis use leads to changes in the part of the brain that develops during the late adolescent years, especially in the temporal and frontal lobe.

The results of this study support the hypothesis that heavy cannabis use during adolescence may affect the trajectory of normal brain maturation.
In another important study, cannabis smokers were compared to a control group of non-smokers [12]. Participants' brains were examined with MRI and DTI-techniques while they were administered a number of problem-solving tasks. Cannabis smokers made more mistakes overall and failed in solving some of the tasks compared to non-smokers. The most interesting result was, however, that the cannabis smokers partially used other parts of their brains than the control group, demonstrating that there has been a change in the frontal brain function.
Based on the evidence of these and other recent studies it has become clear that cannabis has both short-term and long-term effects on both the intellectual and the emotional ability of the brain.

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6. Di Forti, Murray, 2005. Cannabis consumption and risk of developing schizophrenia: myth or reality? Epidemiol Psichiatr Soc. 2005;14 (4):184-187.

7. Bovasso, 2001. Cannabis abuse as a risk factor for depressive symptoms. The American Journal of Psychiatry 158:2033-2037.

8. Cohen, 1982. Cannabis: Effects upon Adolescent Motivation. In: Marijuana and Youth: Clinical Observations on Motivation and Learning.

9. Pistis et.al. 2004. Adolescent exposure to cannabinoids induces long-lasting changes in the response to drugs of abuse of rat midbrain dopamine neurons‖ Biol Psychiatry 56:86-94

10. Meier et al. 2012 Persistent cannabis users show neuropsychological decline from childhood to midlife. PNAS August 27, 2012

11. Ashtari et al. 2009. Diffusion abnormalities in adolescents and young adults with history of heavy cannabis use. Journal of Psychiatric Research 2009; 43:189-204.

12. Gruber, Yurgelun-Todd, 2005. Neuroimaging of marijuana smokers during inhibitory processing: a pilot investigation. Cognitive Brain Research 2005;23:107-18.

Cannabis

Physical Harms

Respiratory and Cardiovascular System - Because cannabis is frequently smoked, bronchial and lung diseases are common. A large number of toxic chemicals have been identified in the smoke of cannabis, including carbon monoxide, carcinogens and irritants. These all greatly affect the body's respiratory and cardiovascular systems in a similar manner to the known effects of smoking tobacco.

There is research to support the connection between cannabis use and cancer of the digestive and respiratory tracts[13 14]. Aldington found that long term cannabis use specifically increased the risk of lung cancer in young adults, particularly in those who started smoking cannabis at a young age[15].

We still do not know the long term effects of exposure to cannabis smoke on the cardiovascular system over extended periods, but experience with the problems of tobacco smoke should urge caution. There are enough similarities between THC and nicotine's cardiovascular effects[16].

Cannabis and Pregnancy - There are also important research studies on the effects of cannabis use during pregnancy on newborns, with THC readily crossing the placenta. Studies have shown that there is an increased risk of the child getting neuroblastoma[17] and leukemia[18]. There is also strong evidence for multiple abnormalities in physical appearance, size, weight and hormonal functions.

The risk of miscarriage of ectopic pregnancy of women smoking cannabis in the early stages of pregnancy has also been highlighted in recent research[19].THC was found to mimic anandamide and its control over embryo development, disrupting the process and creating cell abnormalities in mice. It has also been shown that pre-natal exposure to cannabis use is related to some common neurobehavioral and cognitive outcomes, including symptoms of ADHD such as inattention and impulsivity, decreased general cognitive functioning and deficits in learning and memory tasks[20].

The effects of cannabis smoking on the respiratory and cardiovascular systems are comparable to those induced by tobacco smoking.

13. Berthiller et.al. 2008. Cannabis smoking and risk of lung cancer in men: A pooled analysis of three studies in Maghreb. Journal of Thoracic Oncology 3, 1398-1403.

14. McKallip, Nagarkatti, 2005. Delta-9-tetrahydrocannabinol enhances breast cancer growth and metastasis by suppression of the antittumor responseǁ J Immunol 2005:174(6):3281-9.

15. Aldington et.al, 2008. Cannabis use and risk of lung cancer: A case-control study,ǁ European Respiratory Journal issue:2008:31(2) 280-86 2008.

16. Jones, 1984 Cardiovascular effects of cannabinoids. In Harvey et.al. Marijuana '84: Proceedings of three Oxford Symposium on Cannabis, Ox ford: IRL Press

17. Bluhm et.al. 2006. Maternal use of recreational drugs and neuroblastoma in offspring: a report from the Children's Oncology Group. Cancer Causes Control 2006:17(5):663-9 (ISSN: 0957-5243).

18. Robison et.al. 1989 Maternal drug use and risk of childhood nnonlymphoblastic leukemia among offspring. An epidemiologic investigation implicating marijuana. Cancer, 63, 1904-1911.

19. Day et al, 1994. Effect of Prenatal Marijuana Exposure on the Cognitive Development of Offspring at Age Threeǁ Neurotoxicology and Teratology 1994:16(2): 169-75..

20. Huizink, Mulder. 2006.ǁMaternal smoking, drinking or cannabis use during pregnancy and neurobehavioural and cognitive functioning in human offspringǁ Neurosci Biobehav Rev 30(1) 24-41.

Medical Marijuana

The idea of cannabis as medicine has become increasingly popular around the world. WFAD believes that it is important to distinguish between certified medicines and so called “medical” marijuana. WFAD regards the non-medicinal use of narcotic substances as a severe public health problem which results in major problems for society. At the same time, narcotics can have important medicinal uses and must therefore be available to the health services. Some constituents of cannabis, including THC, are available today in pill form and some synthetic mimics of those constituents are also available and used as medicine, approved by appropriate authorities. The whole cannabis plant material, on the other hand, has thousands of unknown and carcinogenic components that have not been accepted by scientific and medical authorities as medicines. Authorities that approve medical products (such as FDA in the US and MPA in Sweden) has high demands on the products before they are approved. For example:

- The substance has to be well-defined and controlled; the same amount should give the same dose.
- It should be safe and effective.
- The side-effects should be well documented and described.
- The substance must have been tested, on laboratory animals and humans, in several steps.
- The production should be controlled
- The side-effects should be well documented and described.

The so called “medical” marijuana does not fulfill any of these demands and is therefore not accepted as a medical product

It is important to distinguish between so called “medical” marijuana and certified cannabis based pharmaceutical drugs.

About the World Federation Against Drugs

The World Federation Against Drugs (WFAD) is a multilateral community of non-governmental organizations and individuals founded in 2009. The aim of WFAD is to work for a drug-free world.

A Global Network of Organizations

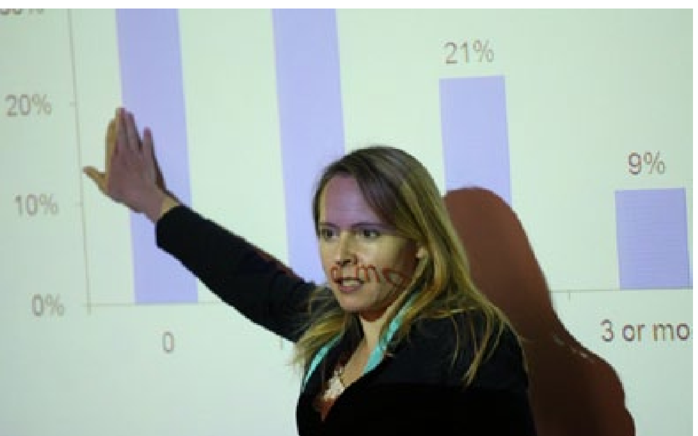
WFAD marks the launch of a global network of organizations which are united behind the UN's narcotics conventions. Countries have worked together for more than one hundred years in order to prevent the problem of abuse of narcotic drugs. Much has been achieved, but much more can be done in the future to prevent young people from experimenting with illegal drugs and thus exposing themselves to the risk of becoming addicted.

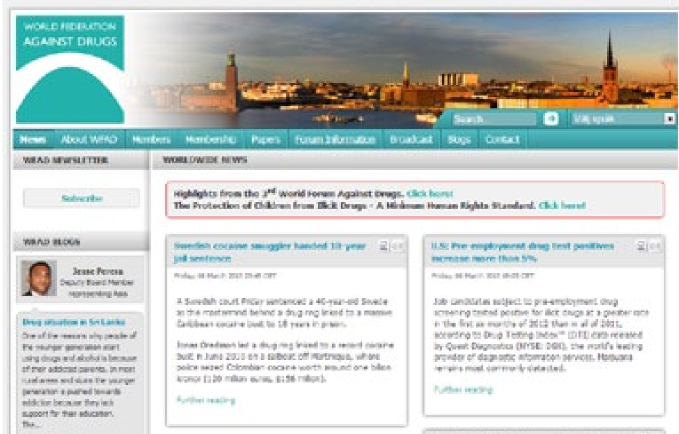
WFAD believes that it is important to identify and promote good examples of policies and programs that are efficient and make a difference to reduce drug abuse. Every day of the year, in all corners of the world, people do important work to prevent drug abuse. It is important for those involved to get to know each other, exchange experiences and establish networks across borders and between continents. WFAD welcomes all individuals and organizations that are campaigning to achieve a society free from the abuse of illicit drugs. The path to achieving this goal is long and beset by problems, which is why unrelenting efforts to gradually reduce drug abuse, step by step, are so important.

Aims

The members of WFAD share a common concern that illicit drug use is undercutting traditional values and threatening the existence of stable families, communities, and government institutions throughout the world. The work of WFAD is built on the principles of universal fellowship and basic human and democratic rights. We believe that working for a drug-free world will promote peace, human development and dignity, democracy, tolerance, equality, freedom and justice.

WFAD recognizes that civil society has the right to fact-based information about the risks and damage caused by drugs. All people have the right to be protected from the harms created by drug use. WFAD supports and is guided by the 1961, 1971 and 1988 UN narcotics conventions and the resolution resulting from the 1998 UNGASS-meeting. WFAD also supports the UN Convention on the Rights of the Child, which stipulates in Article 33 that children have the right to be protected from the abuse of illicit drugs.





Stockholm Declaration

WFAD adheres to the Declaration signed at the World Forum Against Drugs signed in Stockholm, Sweden in September of 2008. Here you can read more about what WFAD stands for and its aims.

To Achieve a Drug-Free World WFAD Declare

1. We support the UN Convention on the Rights of the Child, which stipulates in Article 33 that children have the right to be protected from drug abuse. All people, governments, and organizations should commit themselves to preventing drug abuse among young people. For example, we can do this by ensuring that schools are drug-free.

2. We all have the right to be free from drug abuse. Drug abuse and drug trafficking violate the human rights of the most vulnerable individuals – those whose free will has been compromised by addiction. Drug dependence is a modern form of slavery that robs drug users of their free will, condemns them to crippled lives and often premature deaths, creates massive social burdens and spreads drug-using behavior. All people have the right to expect their governments to protect them and their families from drug abuse and to have a life free from drug abuse.

3. A balanced policy of drug abuse prevention, education, treatment, law enforcement, research, and supply reduction provides the most effective plat form to reduce drug abuse and its associated harms.

4. We support and are guided by the 1961, 1971 and 1988 UN Drug Conventions and the resolution resulting from the 1998 UNGASS-meeting. The UN Conventions provide a good platform for international cooperation in fighting drug abuse.

5. We urge all people to work with their governments to strengthen, support, and encourage the UN drug control system that includes the Office of Drugs and Crime, the International Narcotics Control Board, the Commission on Narcotic Drugs, the Economic and Social Council, the World Health Organization, and other bodies, in order to reduce the global demand for and supply of illicit drugs.

6. The work of the UN Office of Drugs and Crime (UNODC), the Commission on Narcotic Drugs (CND) and the International Narcotics Control Board (INCB) are positive and essential in international drug demand and supply reduction.

7. We support the INCB statement in its 1993 report that drug demand reduction activities are crucially important in international drug policy and we call on governments to consider demand reduction as one of their first priorities in the fight against drug abuse.

8. We support the INCB statement that “harm reduction” programs are not substitutes for demand reduction programs and should not be carried out at the expense of other important activities to reduce the demand for illicit drugs, such as drug prevention activities.

9. All forms of differentiation between so-called “soft” and so-called “hard” drugs must cease. Extensive research confirms that the use of cannabis is detrimental to health, causes crime, and is addictive. Cannabis, and certain other drugs regarded in some countries as “soft” should be viewed in the same way as other types of illicit/psychotropic drugs when it comes to control policy, rehabilitation and preventive measures.

10. Commercial outlets for illicit/psychotropic drugs, including coffee shops, and other open drug markets or drug scenes in Europe, must be closed immediately.

11. The so-called “medical” projects for distribution of heroin to drug addicts as a means of “harm reduction” are nothing but an attempt to legalize drugs through the “back door.” This must be prevented by authorizing the United Nations to withdraw all import licenses for heroin intended for use by drug addicts.

12. We oppose so-called “shooting galleries” or injection rooms, where drug abusers can administer drugs. This practice violates the UN Conventions. It provides for the congregation of addicts, facilitates illicit drug trafficking, and promotes drug abuse. The so-called “medical trial” of injecting rooms is yet another example of trying to

legalize drugs covertly. As an alternative, we call on governments to provide appropriate evidence-based treatment for drug abusers.

13. We denounce so-called “medical marijuana” policies where marijuana is used as a “medicine”, contrary to the Conventions, without such use first being approved by the competent regulatory authority of a nation and its usefulness recognized by the medical community.

14. We oppose all forms of legalization of illicit/psychotropic drugs because such policies do not withstand critical evaluation, tend to run contrary to general experience and violate the Conventions. The term “legalization” can have any one of the following meanings: *Total Legalization:* All illicit drugs such as heroin, cocaine and marijuana would be legal and treated as commercial products. No government regulation would be required to oversee production, marketing, or distribution. *Regulated Legalization:* The production and distribution of drugs would be government regulated, with limits on the amount that can be purchased and the age of purchasers. There would be no criminal or civil sanction for possessing, manufacturing, or distributing drugs unless these actions violated the regulatory system. Drug sales could be taxed. *Decriminalization:* Decriminalization eliminates criminal sanctions for drug use and provides civil sanctions for the possession of drugs.

15. All drug abuse treatment should have the goal of helping drug users become drug-free. Treatment aimed at the drug-free standard should be expanded and readily available. Programs that permit addicts to continue non-medical drug use violate the human rights of addicts.

16. We condemn “drug zones” in cities where the drug laws are not enforced on small amounts of drugs for personal use.

17. We urge that governments and charities provide resources for drug abuse treatment for drug users, drug addicts, and their families.

18. We urge that governments and charities provide resources to make schools drug-free and that school administrators work with parents to make schools drug-free.

19. We urge that governments, charities, and businesses provide resources to make workplaces drug-free and that business management work with labor unions to make workplaces drug-free.

20. We urge that governments provide resources to reduce drug-related crime, including drugged driving. We also urge that the criminal justice system use criminal sanctions, when appropriate, to deter drug use and use alternatives to incarceration such as drug treatment courts, when appropriate, to deter and treat drug abuse.

21. We support an increase in advocacy work to increase funding and policy and legislation changes that support drug demand reduction and interdiction efforts.

22. We support the launch of a global network of organizations which are united behind the UN Conventions.

23. We support the organization of regular, global drug-free world conferences in the future.

24. It is important to state that drug abuse greatly harms developing countries. Drug abuse and drug trafficking destroy local cultures and hinder political and economic development. Drug abuse and drug trafficking impact most heavily on some of the poorest countries. The developed countries must reduce the demand for drugs and assist the developing countries in the fight against drug abuse and drug trafficking.

> "States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties and to prevent the use of children in the illicit production and trafficking of such substances"

The UN Convention on the Rights of the Child, article 33

The Basic Principles of the World Federation Against Drugs

a. We support the UN Convention on the Rights of the Child, which stipulates in Article 33 that children have the right to be protected from drug abuse.

b. All people have the right to expect their governments and civil society to help them and their families to be free from drug abuse.

c. A balanced policy of drug abuse prevention, education, treatment, law enforcement, research, and supply reduction provides the most effective platform to reduce drug abuse and its associated harms.

d. We support the UN Drug Conventions of 1961, 1971 and 1988 because they provide for a unified and cooperative effort in fighting drug abuse.

e. All drug abuse programs should have the goals of preventing drug use and helping drug users become and stay drug-free. “Harm reduction” programs should not be carried out at the expense of other demand-reduction and deterrence and prevention programs.

f. The misinformed classification of drugs either as “soft” or “hard” must cease. Extensive research confirms that the use of cannabis, or any other illicit drug, is detrimental to health, causes crime, and has the potential to be addictive.

g. We oppose all forms of legalization for illicit/psychotropic drugs as such policies do not withstand critical evaluation, tend to run contrary to general experience, and violate the international U.N. Drug Conventions of 1961, 1971 and 1988.

h. Drug abuse and trafficking greatly harms developing countries. The demand for drugs must be reduced throughout the world. Assistance must be provided to reduce drug use, abuse and trafficking in developing countries.

i. Women have equal rights to be free from drug-related harms as they experience drug- related gender-based violence and other harms as a result of drug use. Women who seek treatment for drug use should have equal ability to gain access to and benefit from treatment.

WFAD Board Profile

Sven-Olov Carlsson, International President
Sven-Olov Carlsson has been the International President of IOGT International, a worldwide community of NGOs working in the field of alcohol and drug policy and prevention, since 2002. Mr. Carlsson is a member of the Board of Eurocare – the European Alcohol Policy Alliance, Global Alcohol Policy Alliance (GAPA) and International Council on Alcohol and Addictions (ICAA).

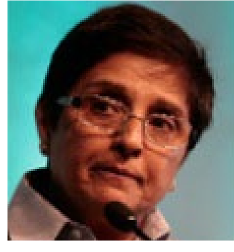
Josephine Baxter, Vice president (Oceania)
Ms Baxter entered the Alcohol and Drug sector as CEO of Life Education in South Australia in January, 2000. In her current position as Executive Director at Drug Free Australia she oversees strategies in capacity building, project management and community development, focusing on drug prevention. Ms Baxter is a past member of the Australian National Council on Drugs (ANCD) and a current member of the International Taskforce for Strategic Drug Policy.

Mr Per Johansson, Secretary of the Board (Europe)
Per Johansson is Secretary General of RNS (National Association for a Drug-free Society) in Sweden. He was educated to be a teacher but has committed himself to work with drug policy since 1979. He started off by working as a volunteer but since the early 90s he has been involved professionally and is now a leading figure in the drug debate in Sweden. He lectures on drug policy and role of the public opinion in forming a balanced and restrictive drug policy.

Rogers Kasirye (Africa)
Executive Director, Uganda Youth Development Link, board member of WFAD. Mr. Kasirye has undertaken several consultancy positions as a technical Coordinator, he is also a consultant with Mentor foundation UK. He is the local expert advisor to UNODC in Eastern Africa and is actively involved in capacity building of NGOs and Communities in Drug Demand reduction activities. Mr. Kasirye is a researcher on the global study on gender and alcohol studies coordinated by WHO

Robert L. DuPont (North America)
Robert L. DuPont, M.D. has been a leader in drug abuse prevention and treatment in the US for more than 30 years. He was the first Director of the National Institute on Drug Abuse and was the second White House Drug Chief. In 1978 Dr. DuPont became the founding president of the Institute for Behavior and Health, Inc. and in 1982, with his longtime colleague, Peter Bensinger, he founded Bensinger, DuPont & Associates. Dr. DuPont maintains an active psychiatric practice specializing in addiction and anxiety disorders, and has been Clinical Professor at the Georgetown University School of Medicine since 1980.

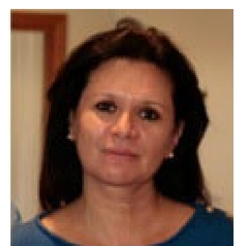
Mina Seinfeld de Carakushansky (Latin America)
Mina Seinfeld de Carakushansky is the president of BRAHA (Brazilian Humanitarians in Action) and General Director of Prevention of ABRAD (Brazilian Association on Alcohol and Drugs) as well as the International Coordinator of the Program Forging Leadership for Drug Demand Reduction in Latin America. She has developed numerous drug prevention programs and has authored texts and articles about Drug Prevention, Legalization, and Preventive Cities.



Kiran Bedi (Asia)
Kiran Bedi is one of India's most famous women due to her involvement in social activities and police work. She received the woman of the year award in 1981 for her lifelong commitment to equality and justice. Kiran Bedi is the founder of two NGOs dealing with crime prevention as well as drug abuse prevention and child welfare. She is known for her rhetorical skills and motivational speeches. Kiran Bedi was voted "India's most admired woman" in 2002 and "India's most trusted woman" in 2010.

Deputy Board Members

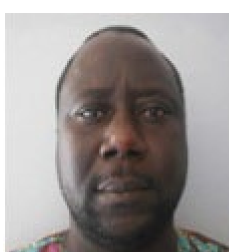
Jesse Perera (Asia)
Jesse Perera is a certified life coach who is teaching skills development training for youth, drug addicts & other addicts. He has been in the drug rehabilitation and youth development field for more than 12 years. Jesse Perera provides trainings in, for example, leadership and prevention. He is well experienced in teaching re-integrating into society, acceptance and strategies on how to obtain sustainability of sobriety.



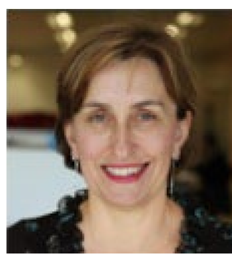
Carmen Fernández Cáceres (Latin America)
Carmen Fernández Cáceres is the author and editor of several publications dealing with drug and alcohol with a gender perspective. She is the coordinator-general and professor of the Master Degree in Therapy Family in Addictions at the Autonomous University of Tamaulipas (UAT) and of five Certificates in Gender, Addiction and Domestic Violence with official recognition by the National Autonomous University of Mexico (UNAM) and other Mexican universities. She has been teaching in the School of Economic and Social Studies of Mexico city and in the National Institute of Public Health (INSP).

Calvina Fay (North America)
Calvina Fay is the executive director of Drug Free America Foundation, Inc. and Save Our Society From Drugs (S.O.S.). Professor Fay has been an outspoken advocate against the legalization of drugs for over 20 years and is considered a pioneering expert on workplace drug abuse prevention programs. Professor Fay has served as an advisor to the Whitehouse's Office of National Drug Control Policy as well as several political leaders, including President Bush, on drug policy issues.

Mike Sabin (Oceania)
Mike Sabin is a former Police-detective and founder/managing director of drug education group Methcon. Mike is a nationally and internationally-recognised expert and authority on methamphetamine and drug policy. Mike is a foundation member of the Fulbright New Zealand Alumni Association and deputy Board Member, Oceania Region, World Federation Against Drugs.



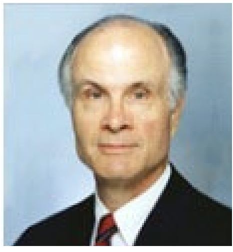
Abdoulaye Diouf (Africa)
Abdoulaye Diouf is a sociologist of formation, manager of the Center of Sensitizing and Information on Drugs Jacques CHIRAC of Thiaroye in Dakar in Senegal. Mr Diouf is formative trainer on drug abuse prevention in Senegal and a member of West African local experts' network and founding member of the Sub-Saharan NGO's coalition against drug abuse. He is also a deputy Board Member of World Federation Against Drugs.



Moncia Barzanti (Europe)
Since 1986 Ms. Barzanti has been organizing international events in San Patrignano, in addition to participating in conferences in Italy and abroad on the theme of drug dependence. She also acts as a liaison for University students wishing to incorporate information on the San Patrignano Community in research papers or University theses. Since 1998 she has coordinated visits to the Community by schools, volunteer groups, social workers, policy makers and people working in the addiction field, both Italian and foreign.

Special Advisors

Torgny Petersson
Mr. Peterson has been the Head of the social section at the Maria Clinic for young people in Stockholm, Director of HNN and the European Cities Against Drugs. He has written numerous articles about drugs and hosted and spoken at several national and international conferences on money laundering, organized crime, motorcycle gangs, research on drugs, prevention and treatment. Mr. Petersson is a member of the International Task Force on Strategic Drug Policy, the Global Institute on Drug Policy, and the Swedish Narcotics Officers Association. He is currently Director of ReactNow.se.



David G. Evans
David G. Evans is the Executive Director of the Drug Free Schools Coalition and is a practicing attorney. The Coalition is an organisation of school officials, teachers, counsellors, parents, and students dedicated to helping schools to become drug-free. Mr. Evans has written several books dealing with substance abuse and the law, including books on designing effective drug-free workplace programs and on children, drugs and the law.