

Successes and new challenges for Netherlands' drug policy;

Cannabis to be regulated in the WHO Framework Convention on Tobacco Control

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Introduction

Total abstinence from drugs is the best way to avoid trouble.

In a *perfect* world I'd say: yes, absolutely!

But we all know that this ideology has made drugs illegal. Since 100 years the 'drugs' issue has been a moral issue. The illegality has caused substantial harm to those who don't resist:

- drugs become more potent and contaminated,
- drug use becomes more hazardous,
- and people who use drugs are marginalized.

So, in the *real* world we always need a fallback strategy for those who won't refrain from using drugs.

The Netherlands has opted for a realistic approach.

Although the Netherlands is party to all the UN drug treaties it is steering a *middle course* between repression and a completely

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liberalized situation. Since the beginning of the seventies of the 20th century the central aim of drug policy has been the protection of public health:

It is tried to minimize the risks for the user, the immediate environment and society as a whole as much as possible.

Rob Samsom, who is in the audience today, was one of the pioneers of this approach.

Care to drug users

Since the eighties, and following this risk reduction principle, the care for drug users has been pragmatic.

The aim has been improving drug user's physical and social functioning, by offering easily accessible care, in outreach facilities. Methadone maintenance buses were a widespread phenomenon in the eighties. Detoxification and abstinence were and are not required.

When the HIV/AIDS pandemic started, needle and syringe exchange programmes were also developed and funded.

Only by doing so the HIV outbreak among drugs users could be contained.

The approach, laid down in policy documents, was highly criticized by most other countries. Because it was contrary to the more prominent abstinence-only ideology: 'If you give up your habit, we will help you. If you won't, you may die, but don't blame us.' 'User accountability' was their leading principle. But why exactly? Generally in health care, we've never been that stringent. For example: for many years physicians have been prescribing blood pressure lowering medication to people with hypertension.

Why should *that* be allowed?

Instead, physicians could require those patients to reduce their salt intake and to change their lifestyle fundamentally by doing more

physical activity, instead of throwing pills to them. Because *physical activity* may lower blood pressure. Patient accountability, one could say.

Moreover, the World Health Organization (2008) estimates that being physically *inactive* causes, amongst others, around 25% of breast and colon cancer, 27% of type II diabetes and about 30% of ischaemic heart disease burden.

Well, if physical *inactivity* does so much harm to people and society, why did our criticsasters not introduce the prohibition of inactive lifestyles?

What happened since the beginning of the eighties?

In spite of all the criticism in the beginning the Dutch approach, the so-called risk or harm reduction approach, has become a realistic modality in the provision of care for drug users in many countries. Although some countries still boycott the word 'harm reduction' (e.g. Russia and Japan) there is a growing acceptance of this risk reduction approach. It includes needle and syringe exchange programmes and the prescription of methadone and other substitute drugs, even heroin. The Netherlands set an example here.

Under Jan van Ree's chairmanship of the Central Committee for the treatment and care of heroin addicts, and thanks to Wim van den Brink's and others' commitment, such as of Els Borst (former Minister of Health) and Fons Vloemans who are also here today, this form of treatment could be developed to what it is now: a well-designed, controlled and evaluated, and successful and therefore internationally respected modality in drug dependence treatment.

Last year it was a milestone that WHO issued its document entitled: Guidelines for the Psycho-socially Assisted Pharmacological Treatment of Opioid Dependence.

Already in 2004 the WHO published the review on the 'Effectiveness of sterile needle and syringe programming, in reducing HIV/AIDS among injecting drug users'. That was a milestone as well. The

overall conclusion was that the availability and utilization of sterile injecting equipment by intravenous drug users reduces HIV infection substantially. In addition to the effectiveness, no evidence could be found of negative consequences.

Last year the International Harm Reduction Association (2009) reported to the UN Commission on Narcotic Drugs that there are now 84 countries that support harm reduction, laid down in policy or in practice:

- * 377 have needle and syringe exchange programmes;
- * 10 countries, among these Iran, even have needle and syringe exchange in prison;
- * and in 65 countries there is opioid substitution therapy as maintenance, so not for detoxification only;
- * even 37 countries, of which Indonesia, Malaysia and Sweden have opioid substitution therapy as maintenance and detoxification in prisons.

There are even clear signs of a new drug policy in the US. Most striking are the acceptance of needle exchange and of medicinal cannabis, and a shift in budget allocation from supply to demand reduction.

There is no room for complacency, but perhaps we may conclude that thanks to the leading role of the Netherlands a growing number of countries have made the protection of public health their central focus.

Emphasis on law enforcement

It is time that the law enforcement community will acknowledge this changed focus. Because the open-minded and pragmatic approach of the health ministers does not go hand in hand with a similar realistic view on *supply reduction* among their law enforcement colleagues.

The reason is that law enforcement activities differ from demand reduction activities. Cross border drug trafficking and the resulting

cross border law enforcement activities by police, customs, military and prosecution departments lend themselves far better to international co-operation, harmonization and institutionalisation. While on the other hand, prevention, care and treatment are by their nature domestic issues, that do not need cross border co-operation. Consequently, the law enforcement system has increasingly reinforced itself. It leads to greater dominance in the UN drug control system. The conviction of the rightness of prohibition makes them reluctant to evaluate the UN drug treaties. In 1998 they managed to get the slogan 'A Drug Free World – We Can Do It' adopted at the United Nations General Assembly Special Session (UNGASS). Ten years later, in 2008, the problem had only worsened.

The evidence supplied by many organizations that drug prohibition has failed to prevent availability of illegal drugs is now unambiguous. Drug prohibition has proven relatively ineffective, increasingly costly, and highly counterproductive in many ways. Ethan Nadelmann and several others (e.g. Freek Polak, Martin Jelsma, Transform, Beckley Foundation) provide us with powerful reasons for taking seriously the alternatives to drug prohibition and its resulting War on Drugs.

Effects of drug policy

The major obstacle to any change in drug policy is that the direct effects of *drug use* are not distinguished from the effects of *drug policy*. These are the indirect effects.

It is difficult to identify the pure physical (health) effects of drug use. It is overlooked that health and social problems of drug users are to a large extent the products of the control-of-supply policy: drug related crimes, prostitution, social degradation, and increased health risks. On the society level there are problems of organized crime, erosion of the judicial system and enormous costs for police, justice, customs, the military and the prison system.

All these problems have blinded the view of the 'original', pure effects of drug use to a large extent.

This blindness has made the fight against drug trafficking and criminality become the main reason and focus of drug policy in general. Fighting drug crimes has become a goal in itself. That is why the police and justice guys have taken the lead.

In order to be able to consider alternatives to drug prohibition we first need to unravel the direct and indirect effects of drugs.

Cannabis for example.

I do acknowledge that cannabis has adverse effects, although these effects have been heavily debated.

The Beckley Foundation's Global Cannabis Commission Report (2009) provides us with useful information. It reviewed a number of studies that have attempted to rate the harm of cannabis.

The conclusion is that despite of some risks, such as the risk of dependence, being around 9% for regular users, cannabis was constantly found to be less harmful than most other widely recreational substances, legal and illegal.

Other studies identified a number of issues that question the association between cannabis smoking and the risk of later mental problems, such as psychotic symptoms and schizophrenia.

One example: in the Netherlands since 2003 medicinal grade cannabis is provided on prescription through pharmacies.

Growing, processing and packaging of the plant material are performed according to pharmaceutical standards and are supervised by the official Office of Medicinal Cannabis (OMC).

The Office compared cannabis samples obtained from randomly selected coffeeshops to medicinal grade cannabis obtained from the OMC (Hazekamp). They found that all coffeeshop samples were contaminated with bacteria and fungi. Toxins produced by some fungi, from the *Aspergillus* types, may even provoke psychotic symptoms.

Uncontrolled cannabis, acquired from illegal sources, are an underestimated source of neurological toxicity.

One may therefore also be in doubt as to the reliability of at least some research on the effects of cannabis use. The effects of which substances have actually been evaluated?

But whatever harm researchers may find in the future, the political question will always be how to avoid criminal proceedings against users that will cause more harm than cannabis use does.

Cannabis controlled?

Having said this, there is room for a policy change. Why not take cannabis as a first step, as it is already on the political agenda of several states and municipalities (Van Gijzel)?

In spite of the *de facto decriminalization* and consequently *access* to cannabis in the Netherlands, the possession of cannabis for personal use and the sale in so-called coffee shops are still illegal. There is still an illegal cannabis market with all its consequences. In the long run this is an unsatisfactory and untenable situation.

Perhaps, denouncing the present UN drug treaties as regards cannabis may create more acceptance if there is an alternative plan for an even better regulation of substances.

Fortunately, the Netherlands has already some experience with cannabis. The results of a less punitive approach as regards cannabis are not highly speculative. It's not all a leap in the dark.

The Netherlands has not seen an explosion in cannabis use. According to the latest available data last month prevalence in the age bracket of 15 to 65 years was 3.3%. Last month and last year prevalence have been stable since 1997 (Trimbos Instituut).

[In non urban areas last month use was 1.7% and in urban areas: 4.4%]

In spite of the wide availability these are not dramatic figures.

Anyhow, cannabis control policies, whether liberal or draconian, seem to have little influence on the prevalence of consumption. On the contrary, law enforcement and repressive policies *do* have negative side-effects on the content of the substances and on those who use. It is also a comforting thought that US public opinion polls reveal that few Americans believe they would use drugs that are now illicit if they were legally available (Nadelmann).

What is the current international legal situation?

Cannabis, like other illicit drugs is a so-called 'controlled drug', because it has brought 'under control' of the UN drug treaties.

A closer look makes clear that these drugs are in fact far from being 'controlled'. The cultivation, trade, transport, wholesale distribution, sale, and above all the unsafe composition, potency and quality of the products are not controlled at all. Fortunately, there is an interesting alternative at hand. That is the WHO Framework Convention on Tobacco Control (FCTC) of 2005.

WHO Framework Convention on Tobacco Control (FCTC)

Tobacco clearly outweighs cannabis in terms of morbidity and mortality. Tobacco use is one of the major causes of death and causes annually millions of deaths world-wide. Half of all regular smokers will be killed by tobacco prematurely, losing an average of 16 years of life. The association of cigarette smoking with a lot of diseases is well known. There are chronic respiratory diseases such as bronchitis and emphysema, arteriosclerosis, coronary heart disease, stroke and impaired circulation .

I limit myself to the increased risk of several cancers: lung, oral cavity, oesophagus, pharynx, stomach, breast, larynx, liver, pancreas, bladder, prostate, kidney, uterus, cervix, ovary, colorectum, and leukaemia.

Does tobacco only hurt the smoker?

No, smoking tobacco can not only be seen as a self-inflicted habit.

There is also evidence that passive smoking, even occasionally, may damage non-smokers. Second hand smoke increases the risk of ischaemic heart disease by about 25%. Smoking by parents may lead to childhood leukaemia. Smoking during pregnancy leads to an increased incidence of stillbirths, significantly reduces birth weight of children, and increases the likelihood of the sudden death of infants.

Short term effects: after public smoking bans in bars and restaurants Ireland and Italy emergency admissions in hospitals because of heart attacks decreased dramatically.

So, smoking tobacco can not only be seen as a self-inflicted habit, with only long term effects. The claimed non-existence of these facts are often considered to be the major difference between tobacco and also alcohol² on the one hand, and illicit drugs on the other hand.

The observation is very clear: society is obviously able to cope with huge tobacco, and alcohol, problems without emotional overtones and fear that the survival of our civilisation is at stake.

In 2005 the Framework Convention on Tobacco Control (FCTC) (WHO, 2005) entered into force. This tobacco convention is the first treaty negotiated under the auspices of World Health Organization. As such it is a turning point in the promotion of public health and provides new legal dimensions for international health cooperation.

Surprisingly during the negotiations from 2000-2003, at which I represented the Netherlands government, none of the 190 member states of the WHO has ever proposed or even suggested prohibiting cultivation, trade or use of tobacco.

Now, after five years of its commencement, the treaty is already one of the most widely embraced treaties in history of the United Nations.

² Due to limited time for this presentation alcohol problems have not been discussed. Alcohol problems are huge, both on individual and societal level.

If we were to bring ('schedule') cannabis under the FCTC we would shift from *prohibition* to *regulation and control*. In other words: decriminalisation can be compensated by a regulatory regime.

To this end I launched a proposal in an article, in January 2003, entitled: 'Cannabis control: the model of the WHO tobacco control treaty'.

Since then this proposal was supported by many others, such as the Beckley Foundation's Global Cannabis Commission of 2009, as mentioned before. A draft was presented. This Commission opted for an adaptation of the Tobacco Convention as a model, by also taking over the strong provisions regulating the legal trade in opiates and other medications of the Single Convention on Narcotic Drugs. The Commission also added the provision that the Cannabis convention takes precedence over free trade and equal-treatment provisions of the World Trade Organization' and other trade agreements. This issue was, for political commercial reasons, explicitly omitted from the Tobacco treaty.

In the FCTC a great number of items are incorporated, such as:

- price and tax measures (tobacco taxes are the most effective way to reduce its use);
- protection from passive smoking;
- regulation of quality, contents and composition of tobacco products;
- regulation of tobacco disclosures, which means that the industry has to tell us which substances are in tobacco products;
- packaging and labelling of tobacco products;
- banning advertising, promotion and sponsorship;
- education, training and public awareness;
- measures concerning tobacco dependence and cessation;

- 'tracking and tracing' system of tobacco products in order to eliminate illicit trade;
- elimination of tobacco subsidies;
- and government support.

The WHO tobacco convention is considered to be an adequate instrument for controlling such a dangerous, even lethal substance. So, why could this tobacco treaty not in the same way serve as a public health instrument to 'control' cannabis better?

It does not solve all the problems and a lot has to be worked out, but the cannabis problem can be brought back to its real, 'natural' proportions. If we were to schedule cannabis in the FCTC or draft a new Framework Convention on Cannabis Control the *health* objectives would be better served than by the current drug treaties.

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