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Response

Cannabis control: the model of the WHO tobacco control treaty☆

Eddy L. Engelsman *

Bezuidenhoutseweg 353, 2594 AR Den Haag, The Hague, The Netherlands

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There is a growing acceptance of the so-called harm or risk reduction approach. Accessible care primarily directed at drug user's physical and social functioning, without requiring abstinence (or at least not immediately), persuading users to quit, including needle exchange programmes and the prescription of methadone and other substitute drugs, has increasingly become a realistic modality in the provision of care for drug users. And it has positive results. The Council of Health Ministers of the European Union (EU) adopted in December 2002 specific Recommendations encouraging this risk reduction approach. (Council of the European Union, in press). Whichever way you look at it, the acceptance of this pragmatic approach is contrary to the slogan 'A Drug Free World—We Can Do It' adopted for the United Nations General Assembly Special Session (UNGASS) 1998. Obviously the seriousness of the actual problems in the EU is stronger than the doctrine.

Emphasis on law enforcement

Although health ministers have demonstrated open-mindedness and pragmatism in the demand reduction field, their realistic approach does not go hand in hand with a similar realistic view on supply reduction among their law enforcement colleagues. On the contrary, since the present supply reduction approach proves not to be effective enough, the ministers of Justice and Home Affairs of the EU urge for strengthening police and justice measures. The proposed Framework Decision on setting a legally binding European minimum for maximum penalties for drug sales and trafficking may illustrate that. The Netherlands has blocked the adoption (requiring unanimity) of this Decision at the December 2002 session of the EU Council of ministers for Justice and Home Affairs, because it found that the Decision could put its cannabis policy in jeopardy.

This gap between health people and law enforcement people may grow. The reason is that with regard to the nature and scope, law enforcement activities differ from demand reduction activities. Cross border drug trafficking and the resulting cross border law enforcement co-operation and co-ordination by police, customs, military and prosecution departments lend themselves far better to international co-operation and henceforth to harmonisation 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 is able to increasingly reinforce itself. It leads to greater dominance in the UN drug control system, to the detriment of the public health influence. Undoubtedly the conviction of the rightness of prohibition makes them reluctant to evaluate the UN drug treaties. Nadelmann (1992) provides us with powerful reasons for taking seriously the alternatives to drug prohibition. He argues that drug prohibition has proven relatively ineffective, increasingly costly, and highly counterproductive in many ways.

In present drug policy making, government drug officials come and go. Even if they would want to bring something up for discussion it's too dangerous for the rest of their careers. Newly starting politicians who not always have a clear vision and picture of the real drug problems are more or less forced to accept the present drug policy. They jump on a bandwagon. It requires a strong political will to bring the issue up for discussion. Usually they adopt existing views and fictions in drug policy without ever looking back to the public health aspects of the drug control treaties. They neither ask themselves whether these instruments are effective to solve health problems. The methods are self-evident; the question of the why seems not debatable.

☆ This article does not necessarily reflect the opinions of the Netherlands government.

* Tel.: +31-70-3474302; fax: +31-70-3819664.
E-mail address: eddyengelsman@cs.com (E.L. Engelsman).

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Effects of drug policy

Strong moralistic views and emotions determine drug policy. Facts and results of research are only remotely relevant. Knowledge of the pure physical (health) effects of drug use is almost unavailable. In our efforts to reduce the supply of drugs because of their harmful (primary) effects, we confront both drug users and society with numerous additional physical and social problems, induced by the illegal set and setting in which drug use takes place. It is overlooked that problems of drug users are to a large extent the products of this counter-effective control-of-supply policy: drug-related crimes, prostitution, social degradation, and increased health risks such as overdose, AIDS, tuberculosis and hepatitis. On the society level there are problems of organised crime, erosion of the judicial system and enormous costs for police, justice, customs, the military and the prison system. The nature of the problems has blinded the view of the 'original' effects of drug use, which are much less serious than other drugs such as alcohol and tobacco.

The major obstacle to any change in drug policy is that the (primary) effects of *drug use as such* are not distinguished from the effects of a well-intentioned *drug policy based on prohibition and illegality*. Paradoxically, this blindness has made the fight against drug trafficking and criminality becomes the main reason and focus of drug policy in general.

Cannabis controlled?

In this Journal Fazey (2003) and Bewley-Taylor (2003) show very thoroughly that there are many political, legal and practical obstacles to overcome where one were to reform UN drug treaties. The complicated routes to amend, denounce or simply disregard or ignore the UN drug treaties have been realistically set out. Fortunately, the authors present passable routes to break the impasse. The strategy that only a credible alliance of like-minded states and other stakeholders like NGOs outside the formal setting of the UN Commission on Narcotic Drugs may, over time, may create sufficient momentum to trigger a regime change. A sufficiently weighty 'denouncers' group may be able to not only withstand UN and USA pressure, but also apply significant pressure itself.

Perhaps, denouncing the present UN drug treaties may create more acceptance if it is accompanied with a concrete alternative plan for an even better regulation of substances. There are hopeful opportunities. And the alliance will receive even more appreciation if the scope would be limited. At this stage, for strategic reasons, we should limit ourselves to cannabis (hashish and marijuana) as it is already on the political agenda of several states. For example: since 2001 ministers of Belgium, France, Germany, the Netherlands and Switzerland have been holding several conferences on cannabis policy. Most Parties to the conventions still have a long way to go before they catch up with the Netherlands and other states in pushing the boundaries of international law with regard to cannabis policy. In implementing this policy they can learn from Netherlands' experience. It is not at all a leap in the dark. Netherlands' cannabis policy has erroneously been accused of being lenient, tolerant or indulgent. On the contrary the health risks have never been denied nor minimised. The political question is rather how to avoid criminal proceedings against users that will cause more harm than cannabis use does. The public health approach simply offers better opportunities.

The results of a less punitive approach as regards cannabis are not highly speculative. There has not been an explosion in cannabis use. In 2001, lifetime cannabis use in the Netherlands was 17.0% and last month use 3.0%. For the age group of 16–19 years, lifetime use was 28.4% and last month use 8.6% (Abraham, Kaal and Cohen, 2002). These are not dramatic figures in spite of the wide availability. The US public opinion polls reveal that few Americans believe they would use drugs that are now illicit if they were legally available (Nadelmann, 1992).

In spite of the de facto decriminalisation in the Netherlands the possession of cannabis for personal use and the so-called coffee shops are still formally illegal. There also remains an illegal cannabis market with all its consequences. In the long run this is an unsatisfactory and untenable situation. Some might think that there is much room for improvement.

WHO framework convention on tobacco control

Cannabis like other illicit drugs is so-called 'controlled drug'. 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. Neither is the use. All this is a threat to public health. Fortunately, there is an alternative at hand.

It is acknowledged that cannabis has some harmful effects, although these have been heavily debated. But the question is whether the limited *direct* hazardous effects legitimate such a repressive answer. Let's compare cannabis with other, legal addictive substances. Violence and crime are highly correlated with alcohol. But, society is obviously able to cope with these huge problems without emotional overtones and fear that the survival of our civilisation is at stake.

In terms of morbidity and mortality tobacco clearly outweighs cannabis. Tobacco use is one of the major causes of death and causes annually millions of deaths world-wide. Mortality by cannabis is so low that data are not available (WHO, 2002). The association of cigarette smoking with lung cancer, chronic respiratory diseases such as bronchitis and emphysema, arteriosclerosis, coronary heart disease, stroke and impaired circulation is well known. There is growing evidence that passive smoking, even occasionally, may damage non-smokers. 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 (WHO, 2002). Therefore, smoking can not only be seen as a self-inflicted habit, but smoking tobacco often leads to, or at least is associated with, the use of other drugs. It, and not cannabis, can be regarded as a gateway drug. Cigarettes are often smoked at the same time as other drugs are taken, or other drugs are mixed with tobacco. The well-known Shafer Commission (US Commission on Marijuana and Drug Abuse) reported this relationship in 1972 (Shafer, 1972).

There is a change in thinking about tobacco, both in the world and at the EU level. Since 2000, the World Health Organization (WHO) is negotiating its first treaty on tobacco: the Framework Convention on Tobacco Control (FCTC) (WHO, 2002). It is foreseen that the FCTC will be adopted at the World Health Assembly in 2003. If we were to bring ('schedule') cannabis under the FCTC it would offer room for a shift from *prohibition* to *regulation and control*. In other words: decriminalisation can be compensated by a regulatory regime.

In the FCTC a great number of items are likely to be incorporated, such as: price and tax measures; protection from passive smoking; regulation of contents of tobacco products; regulation of tobacco disclosures; packaging and labelling of tobacco products; education, training and public awareness; banning advertising, promotion and sponsorship; measures concerning tobacco dependence and cessation; 'tracking and tracing' of tobacco products in order to eliminate illicit trade; and elimination of tobacco subsidies and government support. Surprisingly during the negotiations none of the 190 Parties to the WHO has ever proposed or suggested prohibiting cultivation, trade or use of tobacco. If the forthcoming WHO tobacco convention is considered to be an adequate instrument for controlling such a dangerous substance, especially in developing countries, why could not 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.

Since the Netherlands government takes the harm caused by tobacco smoke very seriously it has one of the most restrictive tobacco control laws of the EU. In its legislation it anticipates future EU tobacco legislation and the WHO FCTC (WHO, 2003). The EU has a product and labelling regulation (European Communities, 2001) in place setting standards for the percentages of tar, nicotine and carbon monoxide, and tobacco manufacturers are, as a first step, obliged to disclose the used—chemical—additives. In December 2002 the EU adopted a regulation to ban tobacco advertisement, sponsorship and promotion as of July 2005 (European Communities, 2002). If we were to schedule cannabis in the FCTC it would, paradoxically enough, also serve the health objectives of the current drug treaties.

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