PROHIBITION OF HARD DRUGS IS HARMFUL TO PUBLIC HEALTH


SUMMARY:

The prohibition of addictive intoxicants, the so called hard drugs, is not founded on public health arguments, but on a mixture of moral and ideological considerations, on prejudice, erroneous thinking and a lack of factual knowledge, and last but not least, on irrational fear.

In contrast to general opinion, the responsibility of governments should lie in the prudent regulation of production and distribution of all addictive drugs, precisely because the stated aim is the protection of vulnerable individuals. Handing over the regulation and provision of hard drugs to organised crime has proved harmful to public health and damaging to the very fabric of democratic society.

The disastrous developments in most countries with respect to drug addiction and AIDS demonstrate that the policy of law enforcement has failed. In the Netherlands the spread of drug addiction and of AIDS is better contained by a policy of harm reduction, that promotes the health and social position of drug users, than by one that promotes repression. There is an urgent need to further develop this normalization policy, which is, without justification, obstructed by international treaties.

After a careful and gradual transition to legalization of hard drugs, public health problems may be expected to be both acceptable and containable.
For several years there was a solid political consensus in the Netherlands concerning the Dutch drug policy. All political parties agreed that the policy should be directed at the prevention and minimization of social and public health problems, and at the creation of a distinction between the use of hard and soft drugs. Of late, however, drug policy has returned to the national political forum in Holland and there are two main reasons for this.

Firstly, despite the acknowledgment that the consumption of cannabis has remained stable for more than ten years and caused few problems, the present drug policy has come under pressure from within the Netherlands itself. As you may already know, the consumption of cannabis in Holland is illegal but condoned. Because this de facto legalization has resulted in a number of 'social contradictions', the situation has even led to calls for the legalization of cannabis and to this end, the NIAD, the Netherlands Institute for Alcohol and Drugs, has suggested a bill similar to the liquor licensing act to demonstrate that legalization is technically possible.

In contrast to consumption, the trade in marihuana and hashish is still illegal and this has led to practical problems, with owners of coffeeshops that abide by the informal rules, making lots of money but being denied the possibility of investing or spending their profits legally. Coffeeshops selling cannabis are often perceived as attracting criminality and as a source of annoyance for residents in the immediate environment of the coffeeshops, and the official separation of the trade in hard and soft drugs is not always strictly adhered to, mainly because the police have other priorities.

Furthermore, in regions near the borders (with Germany and Belgium), drug tourism causes additional problems. These negative aspects of the present drug policy have led the Christian-Democratic party in Parliament to propose a firmer course of action: in their opinion, the number of coffeeshops selling soft drugs should, at the very least, be reduced. Local government however, as well as the police, feel that the extent of the problem does not warrant a change of policy: they would rather spend their limited resources more usefully.

A second reason for the revived debate is the forthcoming European integration. Supporters of the liberal standpoint fear that integration will force the Netherlands to comply with the more repressive policies enforced by the rest of Europe. Ironically, this takes place at the same time as the Dutch policy gains more and more respect in some European countries. One of the many examples of this recognition is Frankfurt, a city that has recently remodeled its health care program for addicted persons with the help and advice of the Amsterdam Municipal Health
In Rotterdam, a few months ago, a group of hard drug addicts who use to hang around the railway station were chased away by a group of soldiers, causing a national political scandal. The Mayor of Rotterdam, the Chief of Police and the Public Prosecutor proposed to reduce the nuisance caused by the addicts by starting an experiment in the supply of hard drugs. The Minister of Justice reacted with the stereotypical statement that because of the unacceptable health risks the prohibitive sanctions should be applied more firmly. In contrast, the Ministry of Health publicly favors liberalization of drug policy, and recently a top official held a plea for the legalization of cannabis.

A more recent incident is the overt disagreement between the French Minister of Internal Affairs Ouiles and the Dutch Prime Minister Lubbers. At the 'Trevi talks', at the beginning of this month, Quiles criticized the liberal drug policy in the Netherlands with a view to hindering the establishment there of Europol. In reaction, Premier Lubbers - for the first time in public - defended the Dutch drug policy by retorting that the French Minister was evidently misinformed, and that the Dutch policy was, in striking contrast to that of the French, remarkably successful. Specifically, he mentioned the low number of drug-related deaths in Holland and the satisfactory control as to both the number of addicts and their health conditions in general, with particular reference to AIDS.

This account of the recently revived controversy in the Netherlands provides a brief sketch of our approach and serves as an introduction to the point I would like to make.

In debates about the legalization of hard drugs, the decisive argument has always been that the health risks of these substances are unacceptable. I, on the contrary, would argue that precisely because of the health risks, the state is socially and morally obliged to regulate the production and distribution of all addictive intoxicants, including hard drugs. In this paper, I will discuss the public health aspects of the use and abuse of intoxicants. The specific psychiatric aspects deserve separate discussion, and are therefore beyond the scope of the present paper.

In my opinion, the prohibition of drugs has increased instead of diminished the public health risks. It has proved advantageous only to criminals, who profit exceedingly by the lucrative trade in drugs, and to those organizations and persons involved in the legal production and trade of alcohol, tobacco and tranquilizers. The main argument for prohibition is that the public health risks of intoxicants oblige the government to protect the population from them. This argument is
illogical. True, there are certain health risks to intoxicants, but these should be considered in relation to the social context in which they are used and moreover, in relation to the effects of prohibition - which are by now common knowledge. No matter how harmful the effects of irresponsible drug use may be in individual cases, it is of much greater importance to study which course of action can prevent, contain or reduce the health risks most efficiently for society in general.

In addition, it is not all that certain what the exact causes of the aforementioned health risks are. It is usually assumed that these are simply a direct result of the drugs, but this is not correct, because as mentioned, the social context is of primary importance. This statement may seem a remnant from a long out-dated anti-psychiatric standpoint, but in reality it is the current, official view of the Dutch Ministry of Health and of the majority of international drug experts. History as well as academic research provides numerous indications that the extent and gravity of substance abuse in a society are predominantly socially determined, whereas the media keep repeating the allegation that crack has turned the American inner cities into ruins, as if it is a chemical property of crack/cocaine to stimulate users to rob and kill.

It should be admitted that this is one of the more difficult aspects of the discussion on drugs.

For instance, one gets the impression that crack turns a large number of addicts into dangerous and unpredictable psychopaths (the international film and television industry would not know how to survive without these themes), and some supporters of the legalization of hard drugs are even inclined to make an exception for cocaine and crack, which they consider too addictive and too dangerous. But if this were true, why then does crack present far less problems in the Netherlands, where it also available, than in the United States? Various studies (e.g. by Peter Cohen in 1989) have demonstrated that the vast majority of people who use cocaine are able to control their consumption and even stop using it altogether.

Then again there are other experts who argue that not cocaine and crack but heroin should be excluded from the legalization of drugs. It is well known however, that few real problems arose from what often amounted to widespread use of opium in both England and the Dutch Indies between the middle of the nineteenth century and the middle of the twentieth. And a study by Robins (1980) demonstrated that 88 percent of the American soldiers who became addicted to heroin in Vietnam had stopped using after 3 years. Other examples are that speed presents the most serious problems in Sweden, but not in other countries, and that the Indians in Middle and South America know very well how to control their use of coca leaves, psilocybine and mescaline, but not alcohol. In turn, psilocybine and mescaline are prohibited in the Netherlands, but the population has learned how to use alcohol and cannabis.
The damage caused by these intoxicants is considered socially acceptable, while in other countries even cannabis is still seen as a dangerous substance. (You may recall that the name 'hashish' is derived from the French word assassin, which means murderer. This was based on the conviction that the substance stimulated murderous inclinations.)

It is obvious that the explanation for these differences in use and abuse cannot simply be found in the chemical characteristics of the drugs. The behavior of drug users is not directly and exclusively determined by their drugs, but strongly influenced by the social and cultural context in which they live. When drugs are prohibited and users persecuted, drugs and users become entangled in criminal circuits, and these are conditions in no way conducive to the development of safe consumption patterns.

Physicians, and health care professionals in general, are insufficiently aware of these cultural determinants. They claim medical expertise and are therefore awarded a decisive vote with respect to drug policy, but their evaluation of epidemiological questions is biased by the nature of their work, in which they only can see a particular section of the population (and only in a specific context). Of course, when doctors are asked whether heroin and cocaine could cause serious health problems to people who become addicted, they cannot help but answer: "Yes, these substances may cause serious health problems to a number of addicts." But if this same question is asked with respect to the use of alcohol or tobacco, the answer will be exactly the same. Notwithstanding the medical dangers for individuals, alcohol and tobacco are not prohibited in most countries, and rightly so, because we know that the social and recreational use of these substances is unproblematic for the population in general. With regard to drugs, data concerning the recreational, unproblematic consumption is scarce, and to draw a parallel, you have to imagine a policy on tobacco that is determined only by purely clinical-medical data on lung cancer, coronary heart disease, delirium tremens and the Korsakov syndrome. This would unquestionably be repressive in every sense.

Unproblematic, controlled use of heroin and cocaine does exist.

Moreover, the population of unproblematic consumers is probably quite large, and the extent of the demand may be inferred from the supply of these substances. From time to time, the police report the discovery of a shipment of drugs worth hundreds of millions of dollars or guilders. But surely we cannot be so naive as to assume that the couple of thousand addicted persons known to the authorities and to health care professionals are capable of rounding up such a large amount of money?
In addition, because it is obvious that an even larger part of the drug traffic escapes the attention of the police, we may safely assume that both the supply and the demand are in reality much larger.

An important element in the opposition to legalization is the fear that easier access will lead to an increase in the incidence of addiction. But although it seems probable that the number of users would increase with legalization, this does not automatically imply an increase in addiction. When use of a substance is forbidden, most people will indeed stop using it (and some will switch to another intoxicant). This is easier for people whose use is recreational than for those who have become dependent. A plausible interpretation of the history of Prohibition in the United States is as follows: during Prohibition the consumption of alcohol on the whole was lower than before and after Prohibition, but it was primarily the social use that decreased: alcoholics continued drinking, and got into an increasingly perilous situation.

When Prohibition was lifted, social drinking increased and alcoholism also, but to a lesser degree. Experience after the de facto legalization of cannabis in Holland has learned that both the incidence and prevalence of cannabis use among young people have remained lower than in Germany, where cannabis use is strongly repressed. There is no reason to expect a significantly different development pattern after legalization for cocaine, heroin or any other addictive substance.

At this point in the discussion someone invariably yells:

"You can't compare crack-cocaine to alcohol!" (Or: ".. to cannabis!")

The answer to this should be: "The comparison is valid, because we know by now that it is not the substance itself that determines the spread of use and the seriousness of addiction problems, but social conditions."

Almost always the debate has at this stage become so emotional that this answer is not heard and for this reason it is necessary to discuss the basic arguments separately.
In principle, controlled use is always possible - even of the illicit drugs - and when a person has difficulties with control there should be a suitable and accessible treatment facility.

None of the illicit drugs is addictive to such a degree that the need for prohibition outweighs prohibition's harmful consequences; but it is not easy to explain this to people who are continuously fed with misleading information about drugs. Television shows us daily how innocent children are lost to drugs after a single dose, and the fear of the power of addiction is such that most people believe all of the stories depicting its irresistibility. This fear boils down to the thought that one's 15-year old daughter or son might take a drug without knowing it, for instance in a soft drink, and that this will result in a lifelong, hopeless addiction. But this "instant addiction" is a myth, constructed and continually reinforced by the media with dramatic power.

The prime argument against the prohibition of hard drugs is the non-validity of the health arguments upon which it is founded. In this official position, isolated health arguments are adduced and no distinction is made between the biochemical-pharmacological or sociocultural causes of the damage to health. Furthermore, the damage caused to public health by prohibitive law enforcement policy is either ignored or depicted in a falsely favorable light.

People who are inclined to accept this line of reasoning are immediately faced with moral, legal and practical questions which seem insurmountable. Confining myself here to health and practical problems, it would seem that an immediate change to legalization could lead to uncontrollable developments, and the important question is: will it be possible to implement a prudent, gradual and correctable transition to legalization, with acceptable social and public health consequences?

I shall attempt to answer this question.

It is obvious that the transition must be both gradual and flexible, because the spread and acceptance of safe patterns of use takes a number of years (as has been the case in Holland with cannabis). When access to hard drugs becomes easier, we have to be prepared to face problems arising in at least three risk groups: marginalised and socially deprived young people, some groups of psychiatric patients and those addicted people who have become dependent on an institution for their methadone or other prescribed drug. In each case, appropriate measures and care programs have to be prepared for these groups and for implementation, evaluation
and further development of the program, a transition period will be needed of probably ten to fifteen years.

In the Netherlands, because of the particular and individual nature of our culture, we find ourselves in the fortunate situation of being able to undertake large-scale social and cultural changes even when these involve actions that are to some extent quite literally illegal.

Instead of saying: "It's the law and it has to be executed", we say: "Maybe this law is no longer adequate. Let us take our time and see how things develop before changing it." Recent examples can be found in the socially sensitive areas of abortion, euthanasia and homosexuality. In the last twenty years public opinion concerning these issues has undergone far reaching changes, whereas the social and legal framework has followed these developments at a distance and step by step. In this way the Dutch legal and social system allows for the optimal (=minimal) steerage of social change.

In the same way the Dutch can tolerate and explore the use of officially illegal drugs, in order to promote and facilitate the natural and relaxed development of safe patterns of use. For alcohol and nicotine these rituals and social customs have been operating for centuries, and the Dutch policy has permitted them to come into existence with respect to cannabis and to be reasonably integrated into society in general. It is my firm conviction that a similar normalization can be attained with respect to the so-called hard drugs, provided that we are no longer restrained, without good reason, by other countries.

If the Dutch drug policy had been allowed to follow its natural and academically tested course, a variety of experiments would already have been conducted in the dispersion of hard drugs. (Assessing plans for the dispersion of hard drugs in a medical regime, one has to appreciate that medical dispersion is no goal in itself, but a necessity in the transition phase between prohibition and legalization.)

However, we have been obstructed by international treaties of often dubious origins, that do not concur with scientific knowledge and experience.

No country in the world, on the basis of the results of its drug policy, is in a position to tell the Dutch that their policy is irresponsible. On the contrary, it is irresponsible that our policy has not
been allowed to follow its natural course - in the direction of further normalization of the use of intoxicants and with the aim of promoting the health of users. All the more so, as the countries most actively fighting the 'war on drugs' experience a situation far more miserable than ours. The rest of the world, and certainly Europe, should allow the Netherlands to continue its policy, and give us the opportunity to demonstrate - with verifiable data - that toleration will not necessarily lead to unacceptable harm

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1. No selling of hard drugs or alcohol, no selling to minors (under 18 years), no publicity and no nuisance in the neighborhood. When these rules are breached, the police can close the coffeeshop.

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