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DRUG POLICY DEVELOPMENTS WITHIN THE EUROPEAN UNION

The Destabilizing Effects of Dutch and Swedish Drug Policies

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This paper examines the course of drug control within the European Union (EU). The individual policies of both the liberal Netherlands and the more repressive Sweden are explained in detail, and the effects they have on the EU as a whole are discussed. In order to understand these effects more fully an inspection of recent drug legislation developed in the fight against drugs is undertaken. Current trends relating to the drug problem that can be identified throughout the member states are presented and evaluated with respect to the policies of both the Netherlands and Sweden. A division within the EU centring around the different policy styles of these two nations is discussed and possible solutions to the division are raised. Finally, the positive effects that this battle has resulted in are noted.

Since the formalization of the EU, with the signing of the Maastricht Treaty in 1991, the problem of drug control has presented significant difficulties for policy makers. This problem of drug control can be said to be relatively similar in all member states of the EU. Regardless of actual official statistics and recorded numbers it is a fact that in all EU member states certain drugs are illegal and yet are used and possessed by a number of people within each country. Each member state therefore has to deal with those who use and possess drugs as well as those who supply, cultivate and/or traffic drugs. Issues such as dealing with drug-related deaths, curbing drug-related street level crime and organized crime networks, finding appropriate treatment for those addicted to drugs and suppressing public nuisance and open drug scenes connected with drug taking, face each EU member state to a greater or lesser extent. With regard to this problem individual member states have developed their own, often significantly differing, national policies in which 'prevalence of both cannabis and hard drug use bears little relationship to type of policy in operation in any particular country' (Reuband 1995). More recently, harmonization of drug-control policies has become increasingly important with a developing emphasis on international cooperation in the fight against drugs and particularly in an effort to curb large-scale drug trafficking crime organizations. However, in acknowledgement of the entrenched nature of many member states' national policies, the emphasis has remained on countries working together rather than having identical drug-control policies. Before 1995, the national drug policy of the Netherlands, with its tendencies towards liberalization and tolerance, was distinctive when compared with the drug policies of other member states. Originally highly criticized, policy measures adopted in the Netherlands were beginning to make an impression elsewhere within the EU, and a general shift towards a more pragmatic solution to the problems of drug control could be identified elsewhere. However, in

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1995, Sweden entered the EU and brought a strictly repressive policy approach to drug control. Their national policy is severely prohibitive and has caused a backlash within the EU leading to a generally more punitive attitude towards the problem of drug control. There now exists a serious divide within the EU between the tolerant policies favoured by the Netherlands and the repressive policies followed in Sweden. In the face of this divide, the EU must find a middle road between prohibition and legalization if its centralized aims of cooperation and harmonization are to be met.

Dutch Drug Policy

Dutch drug policy is based on normalization: drugs are seen as a normal problem affecting society in general, rather than a problem facing the abnormal and therefore isolated individual user (Van Vliet 1990). In turn, drug addicts have always been regarded as patients in need of help, rather than as criminals requiring punishment. These underlying conceptions have led to a national drug policy for the Netherlands generally regarded as being liberal and tolerant. The foundations for such a pragmatic policy can to some extent be traced to the early involvement of the Netherlands in the legal trade of coca and opium, and their financial dependence on this trade (De Kort and Korf 1992). The first Opium Act in 1919, adopted largely due to pressure from abroad, made transporting and dealing in drugs illegal, but it was not until the 1960s that drug addiction was viewed as a social problem, and not until 1976 that the Opium Act was revised in order to make provisions for drug addicts. The main aim of this revised opium act was to 'protect [the] health of individual users, people around them and society as a whole. Priority must be given to vulnerable groups' (Netherlands Ministry of Foreign affairs, 1997: 1).

In order to achieve this aim the Dutch, as a nation, have consistently practised a policy of harm reduction with regard to the drug problems they have faced. The principle of harm reduction is encapsulated by an understanding that a drug addict suffers primary harm from the effects of the drugs that they are taking and also aims to reduce any secondary harms the addict may be in danger of suffering as a result of their addiction. Excessive repression and the American 'war against drugs' are seen, in the Netherlands, as being counterproductive in that they cause more pain to the drug user without successfully making headway against drug problems. Dutch government officials have decided that it is an unrealistic aim to completely eradicate drugs from any society—it is far more realistic to contain the damage caused by them (Korf *et al.* 1999). It is this principle which has led to Dutch initiatives such as needle exchanges, the free testing of ecstasy pills for purity, reception rooms where users can take drugs without making a nuisance of themselves on the streets and methadone programmes in which those addicted to heroin receive free methadone in an attempt to control their addiction. The Netherlands, along with Britain, are also one of the first countries to get involved with running trials of marijuana treatment in patients with multiple sclerosis (Sheldon 2002). These practices have resulted in a situation in which Dutch drug addicts are relatively visible to the authorities and far more of them come into contact with care and treatment than in countries with more repressive regimes.

The second major strand of Dutch drug policy is the principle of the separation of markets. In the Netherlands, as in many other countries, a distinction is drawn between 'hard' and 'soft' drugs. 'Hard' drugs are those such as heroin, cocaine, crack cocaine and

amphetamines which are judged to present an unacceptable risk to society. In comparison, cannabis and marijuana products are categorized as 'soft' drugs and are thus assigned a far lower risk status. It has been suggested often and in many contexts that becoming involved with soft drugs leads to an introduction to harder drugs, and thus that cannabis is a 'gateway' drug leading to cocaine and heroin addiction. By permitting the establishment of coffee shops which sell cannabis and marijuana in a controlled, semi-legal environment, the Dutch have effected a separation of the markets for soft and hard drugs. This is a major difference in drug policy between the Netherlands and other countries. The sale of drugs in coffee shops is tolerated in parts of the Netherlands so long as the shops themselves adhere to a set of carefully laid down rules. No hard drugs may be sold in coffee shops; there can be no advertising, no sales to minors and no nuisance caused to neighbours. Trade stock cannot exceed 500 grams and each customer can buy up to only 5 grams per day (Van Dijk 1998). Therefore, in the Netherlands, there now exists a situation in which it is possible to obtain cannabis products without coming into contact with any more potentially dangerous drugs. Cannabis itself remains illegal but such a situation can be justified by employing the expediency principle: while it would be possible to prosecute people for the possession or consumption of small amounts of cannabis it would not be in the interest of society in general to implement such repressive action. Although coffee shops themselves are legal they are dependent on an illegal market to supply them and this creates a paradoxical situation in the Netherlands (De Kort and Cramer 1999). Coffee shops are officially approved to sell small amounts of cannabis but not to grow it in large amounts or import it. Nevertheless, the Dutch generally regard their separation of markets policy as being successful and it is so deeply entrenched in their society that it would be difficult to make any significant changes at this stage.

The one area in which repressive measures are strongly enforced is that concerning trafficking in drugs. The Netherlands have declared that they will cooperate in and actively support any action against trafficking in drugs, and indeed have a relatively strict policy in this area themselves. Other than this, their liberalized twin policies of harm reduction and the separation of markets has led to a situation in which drug addicts in the Netherlands are highly visible, have easy access to treatment and thus can be extensively monitored by the authorities. Needle exchange programmes and other harm reduction initiatives are successful in that they have led to a lower drug-related death rate without causing an increase in the overall number of users (Netherlands Ministry of Foreign Affairs, 'Prevention and Care': 1-2). Dutch drug policy, in the past, has taken severe criticism from other countries, but it is increasingly true that schemes initially seen as too radical are now being adopted by other countries. Two examples are the decriminalization of cannabis possession in Germany, Belgium and Portugal, and the provision of methadone programmes in Switzerland (Lemmens and Garretsen 1998). In the eyes of the Dutch, a drug-free society is not a realistic outcome. They recognize their drug problem as being dynamic and have implemented a dynamic, innovative and flexible drug policy as a result (De Kort and Cramer 1999).

To some extent a drug policy such as that employed in the Netherlands relies on the tolerance of its national neighbours. Dutch drug policy can be viewed as an anti-prohibitionist style of controlling drugs which does not enjoy support everywhere. Criminal law is employed only against large-scale drug traffickers while users and small-scale dealers are tolerated and/or treated. The United States has a diametrically

opposite prohibitionist policy in which users, dealers and traffickers are all treated punitively, and it has become routine for senators, such as General McCaffrey, to publicly castigate the Dutch approach (van Solinge 1999: 517). Although the United States is an undeniably powerful foe to have, the legitimacy of their criticism can be brought into question by the fact that they have arguably the worst drug problem in the world with laws that have 'served mainly to create enormous profits for drug dealers and traffickers, overcrowded jails, police and other government corruption . . . predatory street crime . . . and urban areas . . . terrorized by violent drug gangs' (Inciardi 1991). With the current state of the American drug situation and its unfavourable comparison with that of the Netherlands this criticism loses a lot of its influence. The United States-fuelled 'war against drugs' provides a vehement criticism of Dutch drug policy but in terms of the EU there are many critics much closer to home.

In the 1980s, German authorities expressed criticism against Dutch drug policy as large numbers of Germans were crossing the border to purchase drugs in the Netherlands. However, it was felt by Dutch commentators that Germany's repressive drug policy was pushing German drug users into the Netherlands more strongly than the liberal Dutch policy was actually pulling them there (van Solinge 1999). More recently Germany's drug policy has become less repressive and has focused more strongly on the treatment and understanding of addicts resulting in far fewer Germans going to the Netherlands for drugs. In 1995, President Chirac of France accused the Netherlands of being the chief supplier of drugs to the French market and became vocally very critical of Dutch drug policy. Chirac spoke out at several European summits and won the support of German Chancellor Kohl and British Prime Minister Major (van Solinge 1999: 518). Chirac even went as far as threatening to close the border with the Netherlands—impressive fervour even if, in the real world, the two countries do not share a border. Concerns of countries actually bordering the Netherlands have been aggravated by the 1985 Schengen Agreement which largely removed border controls between Belgium, the Netherlands, Luxembourg, Germany and France. In order to deal with these concerns, the Netherlands have undertaken to ensure that any effects their domestic drug policy may have on other countries will be anticipated and dealt with by themselves. The police and customs officials of the relevant countries are now working together to control large-scale drug trafficking organizations operating across these borders.

Through signing the Maastricht Treaty, all countries in the EU have committed themselves to the fight against drugs, and they continue to commit themselves by supporting various UN drug conventions. Although each individual member state has been given free reign to develop its own policy, no country has managed to develop a policy which has succeeded in curbing drug use. Perhaps because of this, the pragmatic Dutch approach has recently enjoyed increasing popularity. Austria, Denmark, Italy and Portugal are now becoming more liberal in line with Dutch-style policy, and are placing increasing emphasis on social needs (Blom and van Maastricht 1994).

Swedish Drug Policy

Unlike many other European countries which reject the total abolition of drugs as an unrealistic objective, the main aim of current Swedish drug policy can be identified as a bid to entirely free society of illegal drugs and the problems they cause. During the 1960s

and 1970s the Swedes operated a relatively liberal drug policy not dissimilar to practices in the Netherlands today. However, during the late 1970s, a far more repressive policy began to be implemented (Johansson 1998). Previously, it had been judged not to be in the interest of the public to prosecute in the majority of cases of possession of narcotics, but by 1980 the law was changed to ensure that every incidence of possession of illegal drugs was taken to court. Throughout the 1980s, campaigners fought to introduce laws against even the consumption of illegal drugs, and in 1988 this was passed into the legal framework. By 1993 the police were allowed to do blood and urine tests in order to determine whether illegal drugs had been consumed, and, in the event that such tests apparently demonstrated that they had been, to prosecute from this evidence alone. Three basic laws regulate Swedish drug control: The Smuggling of Goods Act (1960), The Narcotic Drugs Ordinance (1962) and the Narcotic Drugs Act (1968). Revised versions of these laws have drastically increased the original maximum sentence of two years for drug offences in Sweden. Serious drug offences now carry penalties of between two and ten years in prison, and possession of any amount can now be punished by up to six months' imprisonment. Only sentences for murder, aggravated robbery and aggravated arson are harsher than those for serious drug offences (Solarz 1989). These repressive changes have taken place in the space of no more than 20 years. When Sweden entered the EU in 1995 they paralysed the general trend towards liberalism that had been developing. Unlike the policy in the Netherlands that had been gaining in popularity elsewhere, Sweden does not distinguish between measures to limit supply and measures to reduce demand. While other countries have focused their drug-control policy on large-scale drug traffickers (leaving small scale users and dealers in relative peace) Sweden believes that every user and dealer should be targeted in an attempt to create a totally drug-free society. Neither does Sweden differentiate between soft and hard drugs; in Sweden even cannabis is regarded as causing psychological damage, making people irresponsible, being addictive and is charged as a gateway leading to other, potentially more damaging, drugs (Westerberg 1994). The Swedes thus view Dutch drug policy as a direct threat to their aims for a drug-free society, and have condemned their liberalized approach as 'giving up'.

Sweden has always been a country with a strong temperance culture. For example the consumption of alcohol has long been strictly controlled, and regarded as extremely dangerous (Gould 1988). In addition to this, conformity is important and liberalism is viewed very negatively (Daun 1989). Within such a national paradigm it is hardly surprising that drug policy has become, in recent years, so repressive. Tham (1995) describes how the drug problem in Sweden has become entwined with forming a national identity and fighting against outsiders. Citizenship is very important in Sweden and the life of the drug abuser is held up as the antithesis of the life of a good citizen. Drugs are seen as being part of a hippie, decadent culture that 'normal' people would wish to eradicate from society. In this way it is claimed that a strict drug policy has widespread support from the general population of Sweden. This is emphasized by the many pressure groups that show support for a repressive drugs policy. These groups are not all government controlled. Others are run by parents, Parents Against Drugs (FMN), or by groups of volunteers, the Workers Temperance Association (Verdandi) and the National Association to Help Addicts (RFHL) (Gould 1988). As policy has become more repressive drugs have become a problem that supersedes party political interests. Instead they are seen as a problem that has come from outside Sweden and as such constitute a

threat to the Swedish lifestyle. In the words of an eminent Swedish drug researcher: 'drugs have no place in Sweden and have been brought in from the outside—they are an attack on the kingdom of Sweden both culturally and territorially' (Tham 1995: 120). This is an opinion that is often expounded in the national press which reinforces many elements of the restrictive policy and gives little consideration to liberal alternatives—often linking articles on narcotics with foreign countries (Gould 1996).

Like the Netherlands, although not on the same scale or for the same reasons, the Swedish method of dealing with the drug problem has attracted criticism from the outside. Liberal drug policy makers have criticized repressive policies for breeding large-scale rings of organized crime drug traffickers, isolating individual drug users and being counterproductive to aims of reducing drug-related deaths. Swedish drug campaigners such as Olsson (1998) refute these lines of thought as ideological theories paying no attention to the practicalities of the situation. Continuing this debate in an article for the *Scandinavian Journal of Social Welfare*, Gould (1994), criticizes Swedish policy for reducing its welfare and treatment options while at the same time increasing control measures. He condemns the aim of a drug-free society and denounces the Swedes for placing a higher emphasis on a drug-free environment than the rights of individual integrity. New and increasingly repressive policies are described as 'dangerous and extreme'. Westerberg (1994) replied to these claims in the same journal issue. He cites the fact that most Swedes agree with the repressive aims, and the fact that drug policy is not political but part of general social policy, as defence against Gould's criticisms. He charges Gould with inhumanity for his refusal to believe in the ideal of a drug-free society, and further defends Swedish policy by claiming that they are committed to international cooperation but also recognize the European wide right to pursue their own national policy within international aims. Up to date statistics on the drug problem within Sweden have also been cited as criticism of the repressive policy. Yates (1998) reports an increase in serious drug addicts from 12,000 in 1980 to 22,000 in 1998. A government report (CAN 2000) supports Yates's findings by claiming that although drug seizures are up by 50 per cent, and prosecutions are up by 66 per cent since 1990, the level of drug abuse among young people is the same as in the 1970s. Further, drug-related deaths have increased from 50 per year in the 1970s to 250 per year in 2000 and are said to be the highest in Europe (Yates 2001), and availability of illegal drugs is at an all time high.

As the situation stands, the respective drug-control polices of Sweden and the Netherlands are so opposed it is difficult to imagine a situation in which the two countries could work together to combat the drug problem that faces them individually and the EU as a whole. The policies of each country are so entrenched in their differing national values and so supported by their differing societal structures that the possibility of them embracing each other's ideas in an effort to achieve harmonization is extremely unlikely. The situation is further complicated by the fact that Sweden used to be a relatively liberal country in terms of drug policy, but has written this period off as a disaster in terms of drug control. It is ironic that both Sweden and the Netherlands have declared a reduction in the number of young cannabis users in recent years, and each country has claimed the reason for this trend is due to the success of their respective, and very different, drug policies.

It would be possible to compare the extent of the drug problem in Sweden and the Netherlands on the basis of available statistics relating to matters such as the number of problem drug users recorded in each country or the number of young people who report

recent cannabis use. However it is highly debatable as to whether such comparisons constitute any useful information. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) states in its 2000 report that 'there are differences across countries in methods of data collection, sampling sizes and frames, which could influence the precision and validity of estimates. Until these issues are solved, direct comparisons between levels of use in Member States should be made with caution'. In addition, whereas Sweden's drug users are largely a hidden population, due to policy which drives them into isolation, in the Netherlands numbers of drug users seem relatively high since they can be readily identified through their use of benefits and services and because they need not fear government recrimination.

The Problem of Drug Control within the European Union

In order to assess fully the impact of these two such different drug policies on the EU as a whole it is important to look in detail at the existing position of the EU itself on matters of drug control. As issues of drug control have become increasingly important over recent years, several organizations have been set up in order to facilitate international cooperation, amass data and compare new ideas and experiences. The first working group to be set up was the European Committee to Combat Drugs (CELAD) in 1989 which brought together the national coordinators in this field from different member states. It also provides legal bases for EU action in internal and external affairs. During the first half of 1995 the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was established. The Centre's main objective is to collect and analyse information relating to drugs and to make this information available to a wide audience including academics, policy makers, journalists and the general public. Surveys, studies and pilot projects are carried out by the Centre and the exchange of information between specialists is facilitated (EMCDDA 1998b). The priorities of the EMCDDA have been identified as the reduction of the demand for drugs, international cooperation, the control of trade and an examination of the implications of the drugs phenomenon for producer, consumer and transit countries (EMCDDA 2001).

One of the most consistently raised themes by the new groups formed to combat the drug problem is the necessity of international cooperation. A state of cooperation is expected to flow from the work of the EMCDDA, and an important tool in the pursuit of this aim is the European Information Network on Drugs and Drug Addiction (REITOX), created in 1993. REITOX is a computer network at the heart of the collection and exchange of drug information and documentation in Europe which stores national statistics on drugs from each member state of the EU. Finally, a further tool in the fight against drugs was envisioned in July 1995 by the establishment of a European Police Office (Europol) which was actualized on 1 October 1998. This new body was designed to provide a structure for 'developing police cooperation between member states in preventing and combating serious forms of international crime, including terrorism and drug trafficking' (SCADplus 1998a: 2). Before it became fully operational in July 1999, a temporary Europol Drugs Unit (EDU) was established to combat drug trafficking and associated money laundering, with powers to take effect immediately. Europol took over the duties of the EDU with effect from January 1999, and is particularly helpful in organized crime investigations.

This emergence of drug-control problems as a priority for the EU is also evidenced in new legislation. The Amsterdam Treaty, signed in October 1997, has as a main aim to 'enable the EU to deal with the globalization and evolution of the International situation' (SCADplus 1998b: 1–2). Within its broad objective to ensure freedom, security and justice, the fight against drugs is given special attention. Prior to the signing of the Amsterdam Treaty, the main piece of legislation stipulating guidelines for the control of the drug problem had been the Maastricht Treaty signed in November 1991. Regarding the regulation of drug control, this treaty was largely unsatisfactory as it failed to lay down sufficient provisions for international cooperation, and for effective methods for fighting the drug problem in Europe. Individual member states were left to fight international crime relatively informally—much as they had been doing for the previous 20 years. The implementation of the Amsterdam Treaty reshaped international cooperation and introduced effective methods of reaching this cooperation in the fight against international crime and control of the drug problem within Europe.

Since the Treaty of Maastricht, the EU has been organized on the basis of three 'pillars' as described by van Solinge (1999), each of which has relevance to the problem of drug control. The first pillar deals mainly with the traditional economic policy of the EU. However, Article 129 of this pillar stipulates a responsibility of the EU to deal with the 'prevention of diseases, in particular the major health scourges, including drug dependence', although it is left up to the individual member states to coordinate their own policies and programmes to achieve this objective. The second pillar covers cooperation in external relations and deals with drugs in terms of supply reduction and the fight against drug trafficking. The third pillar regulates cooperation in justice and home affairs and therefore deals with many of the important decisions that are now being made on drug issues. Drug issues can therefore be said to come under all three pillars, which has made regulation somewhat difficult. In order to combat this problem a horizontal drug group was set up to coordinate drug issues across the three pillars. The Treaty of Amsterdam has, however, gone some way towards reorganizing drug issues within the EU. Title IV of the Amsterdam Treaty now deals with checks at external borders and judicial cooperation in criminal matters. It aims to make freedom of movement easier while at the same time building up effective international cooperation. Title VI also deals with drugs in terms of trafficking and building up an international network of cooperation between police, customs and judicial authorities. This new organization has focused more on international cooperation and may allow more effective methods of drug control to be developed. A closer examination of the statistics gathered by agencies such as the EMCDDA and REITOX allows an insight into the extent of the drug problem in Europe, and into the solutions developed to overcome it.

Current Trends in Drug Use within the European Union

The EMCDDA report on Trends in Drug Use (1999) creates a clear picture of the current situation regarding the use of illicit drugs within the EU. Cannabis is identified as the most widely used illicit drug having been used by 40 million people across the EU. It is the main drug to be involved in arrests for drug offences, although most of these arrests relate to use of the drug rather than trafficking. It is not associated with any particular social or recreational context or with any particular situation suggesting that its use is

prevalent across all sections of society. Amphetamines are the second most widely used drug and show particular association with young people. Levels of cocaine and ecstasy use are moderately but steadily rising, heroin use remains relatively constant and crack cocaine use is still a relatively limited phenomenon. Solvents are consistently popular but only among adolescents and conversely misuse of medicines such as benzodiazepines is rising among adults. In health terms, the levels of reported AIDS cases are levelling out but hepatitis cases are rising at a serious rate. Drug-related deaths are stable or decreasing in most countries. Law enforcement measures show that police arrest mostly for drug use, and the proportion of arrests for trafficking is not generally increasing. Rather worryingly, a fairly high proportion of the prison population in every country are drug users, even though they are not necessarily imprisoned for drug offences. In many countries within the EU community work is being considered increasingly important in the prevention of drug use. Problematic drug use has been consistently linked to social exclusion and therefore prevention and treatment options are becoming more comprehensive. It has also been noted that the borders between licit and illicit drugs are blurring in terms of treatment and development.

As well as these fairly specific statistics relating to current trends in drug use, the EMCDDA also collects data on methods of drug prevention and control within the EU, and these are presented in the EMCDDA General Report (EMCDDA 1998a). The EMCDDA General Report evaluates the extent of cooperation to date, and identifies where it is most needed. The findings show that across Europe cooperation between agencies within member states appears to be increasing. Cooperation between the criminal justice system and health and social sectors is also developing resulting in increased use of schemes for drug using offenders and projects for imprisoned drug users. The report also looks in detail at the preventative position adopted by the majority of member states and current trends in repression or liberalization in terms of drug-control policy.

The principle of therapy instead of punishment has been adopted in the general guidelines of drug policies in a growing number of countries. Some member states have consolidated social and medical support towards drug-addicted offenders, and increasingly the first contact with law enforcement authorities is being used as a door to treatment or counselling activities. The EMCDDA interpret this as a sign that the EU is gradually moving away from repressive responses to the drug problem and focusing more on prevention and treatment in an effort to reduce the risks caused by drug use. Further evidence of this is provided by new projects aiming to give legal, professional and political recognition to a range of activities such as needle exchange, injecting rooms or substitution treatment which have been implemented in many countries. This can be interpreted as an attempt to reduce the health and social damage often caused by drug addiction. However, it is still most definitely the case that prohibition of possession and use of drugs is the basic precept followed by all EU countries. Legalization is not currently considered an option in any member state, although there is consistent evidence of awareness that prosecution and imprisonment of individuals with drug problems can cause escalations of their problems. Drug consumption in general seems not to be prosecuted in most European countries. However, debate continues on how to deal with consumers in possession of small quantities of drugs for personal use, or who commit petty crimes because of their drug dependence. To sum up it can be said that developments in European drug policies and new legal approaches towards illicit drugs show a

shift towards decriminalizing some behaviour linked to consuming and possessing drugs for personal use. However, most member states reject extreme solutions, such as full legalization or harsh repression, but continue to prohibit drug consumption while modifying the penalties and measures applied to it.

The European Union Action Plan to Combat Drugs (2000–04)

The most recent document outlining the position of the EU on drug control is the current EU Action Plan to Combat Drugs (2000–04) which outlines the methods and policies to be put into practice regarding dealing with the problem of drug control. This is a document which must attempt to reconcile the positions of Dutch liberalism with Swedish repression if it is to have any success in implementing the objective stated in almost every piece of EU legislation: to encourage international cooperation and harmonization in the fight against drugs. It builds upon the 1995–99 drug plan which aimed to work on demand reduction, supply reduction and the fight against illicit trafficking, as well as on international cooperation and coordination at national and EU level. The 2000–04 action plan develops further aims in the fight against drugs and defines more carefully the role of international cooperation. Each member state is expected to develop their own individual policy, but participate in interaction with the policies of other member states. 'Not everyone has to fight on the same fronts at the same time but coordination and interaction of players and approaches must be ensured to reach maximum efficiency' (European Union 1999: 2). The EU is publicly declaring its support for both the Swedish and the Dutch models of drug control, but it remains to be seen how interaction between these two opposed styles of drug control will be effectively implemented.

The action plan emphasizes the importance of collecting, analysing and disseminating data on the drug phenomenon in the EU. In the area of demand reduction two specific aims over the next five years have been defined: to reduce significantly the prevalence of illicit drug use among young people under 18 and to reduce substantially the number of drug-related deaths. In addition several new challenges have been determined. One of these new challenges deals with the area of amphetamines and ecstasy and the other with urban delinquency. The plan focuses on fighting the production and abuse of increasingly popular drugs like ecstasy and amphetamine especially among young people. Efforts will be made to curb the increasing number of juveniles involved in criminal groups and in the sale of illicit drugs in general. Other new areas of concern that are outlined are polydrug use, drug use in prisons and alternatives to punishment for drug users. Finally the new action plan to combat drugs makes preparations for the enlargement of the fight against drugs.

A Divided European Union

Despite the official prolific cooperative measures implemented by the EU, the current position held on matters of drug control remains, in reality, very much divided. Several countries are embracing the pragmatic approaches of the Netherlands and are gradually introducing some of them to their own national drug policies. However, other countries

are joining Sweden and the United States in their strict adherence to repressive measures. Complicating the situation further is the fact that this division in methods of drug control is not just an international phenomenon: some countries are also internally divided. For example, in Germany where drug control is a federal matter but implementation of policy is left up to individual states (Länder), Northern states have increasingly adopted a liberal position matching that of the Dutch while Southern states are still very much pursuing repressive policies (Albrecht and van Kalmthout 1989). Even the European Parliament, which should be sending out a consistent message regarding drug control, reflects the divisions seen elsewhere.

The European Parliament has organized and headed two drug reports: one headed by Stewart-Clark and known as the Stewart-Clark report (1986) and one headed by Cooney and known as the Cooney report (1991). Both reports are discussed in an article by Blom and van Maastricht (1994) and demonstrate divided opinions and relatively inconclusive findings. Stewart-Clark, a British conservative, headed the 1986 report which ended in a majority/minority divide of positions within the group. Overall the group members agreed that large-scale dealing should be treated with a strict enforcement policy but agreement ended here. The majority position held that a repressive approach should be maintained in drug-control problems while the minority position linked large-scale organized drug trafficking to repressive policies and allowed for the possibility that legalization could be an effective tool in controlling trafficking. The majority group cited brief periods of legalization in Spain and Sweden as a failure resulting in an increased number of drug addicts. It also criticized the contradictory policy currently operating in the Netherlands whereby trade and supply in cannabis is illegal but sale and small-scale possession is legal. Conversely, the minority position found that Dutch policies made sense and favoured the decriminalization of use, possession and small-scale dealing. They found it incomprehensible that some drugs, such as alcohol and nicotine, are legal but others are not. The European Parliament judged the findings to be inconclusive and, ignoring the main debate surrounding prohibition versus legalization, recommended the implementation of educational programmes, the establishment of research centres and the improvement of national and international coordination.

In 1991, the Cooney report was published and focused particularly on the problems associated with illegal drug trafficking. Again opinions were divided, but this time the majority group was more in favour of liberal methods and it was the minority group that remained dedicated to repressive measures. Dutch policies had been more closely researched and this time were judged in a much more favourable light. The distinction between soft and hard drugs, the high priority placed on prevention projects, the general assistance of addicts and, in particular, programmes implementing free treatment, needles and substitute drugs were upheld by the majority group. They were also impressed by the growing view that drug problems should be seen as a public health problem and possession of drugs for personal use should not be regarded as a criminal offence. However, they did maintain that legalization should be rejected as the EU must follow the United Nations in their aim to minimize the use of drugs. Meanwhile, the minority group protested that possession should stay illegal and the illogical policy adopted by the Netherlands (legalizing sale and small-scale possession of drugs in an overall system where trade and supply is still illegal) should be eradicated. It is a measure of the success and spreading implementation of Dutch drug-control policies that such a

turn around in opinion can be observed in the five years separating these reports. However, when the second report was presented to the European Parliament, the majority view was rejected and the minority one upheld—possibly due to the condemnation of the report by the United States (Blom and van Mastrigt 1994). Obviously, opinion within the European Parliament is incredibly divided between support for Dutch style liberalism and Swedish style repression, but a predominantly prohibitionist front has been presented which is not encouraging to those opting for the spread of the Dutch model.

Another area in which the diverse ethics of the Swedish and Dutch drug policies can be seen emphatically is in the establishment of two diametrically opposed European city networks as described by Kaplan and Leuw (1996). In November 1990, the Frankfurt resolution was signed forming a network of European cities devoted to the problem of drug control known as European Cities on Drug Policy (ECDP). Originally, this agreement was signed by Amsterdam, Frankfurt am Main, Hamburg and Zurich who all agreed to work towards the principles of 'legalization, liberalization and harm reduction'. These cities subscribe to a Dutch-style drug policy committed to reintegrating addicts into society and treating rather than punishing them. Drugs are a problem to be shared equally by the police and welfare groups, and the legalization of cannabis is a goal that is being worked towards.

In response to this experimentalist network the Stockholm resolution was signed in April 1994, forming the network of European Cities against Drugs (ECAD). The founder members (Berlin, Dublin, London, Paris, Madrid and Stockholm) were later joined by 19 major European cities in signing this resolution and thereby dedicating themselves to 'prohibition, zero tolerance and a war on drugs'. ECAD adopt the Swedish style aim of freeing Europe from all kinds of drugs. Both networks aim to unite European cities in an attempt to control the drug problem but they have conflicting aims and strategies both of which have attracted considerable support. The development of these networks has shattered hopes for a united European front against drugs. It is a considerable challenge for the EU to develop these networks in such a way that they can interact and cooperate with each other.

*Bridging the Divide: Up to Date Strategies for Dealing with
the Problem of Drug Control within the European Union*

As can be seen from the reports presented to the European Parliament, and the city networks developing within the EU, it is proving difficult to find a middle road between the contrasting policies of prohibition and legalization. Most recently the European Parliament can be described as focusing on individual policy measures judged to be successful in controlling drugs, rather than dwelling overly on the fruitless debate of liberal against repressive measures (Diez-Ripolles 1989). The European Parliament has pledged to continue to intervene in all stages of the drug problem, from production to consumption, and will continue to underline the illegality of drugs in general. However, they will hold regular conferences to evaluate all the implications and effects of new projects designed to tackle the trafficking, dealing, possession and consumption of drugs whether they are prohibitive or repressive. This rather vague general objective allows the

Parliament to side step the issue of which policy style is inherently better, instead introducing the idea of embracing any policy measure which proves successful. More specific individual aims are also professed by the Parliament. They will continue to fight against criminal organizations and put pressure on drug-producing countries with regard to their crop cultivation programmes. Effective measures with regard to controlling money laundering will be adopted, and extradition agreements and the freezing and confiscation of the assets of large-scale traffickers will be facilitated. Finally, preventive education will be improved throughout member states as will rehabilitation and treatment programmes. Essentially the Parliament is backing all the ventures it has previously supported in an environment which proclaims to be repressive but also makes provision for the more successful of the liberal approaches. Within the generally repressive parameters there is thus a definite emphasis on using education, information and rehabilitation to reduce the demand for illegal drugs.

Albrecht and van Kalmthout (1989) describe the various models that have been suggested in recent years for the liberalization of the drug-control problem. The first model would be total legalization in which all kinds of drugs are totally decriminalized and it would not be considered an offence to buy, sell, possess, consume or traffic in drugs of any sort. The second and third models suggest partial decriminalization. This could be partial in the sense of drugs being categorized due to their high or low risk value and then implementing the removal of prohibition with respect to the lowest risk drugs. Alternatively partial decriminalization could refer to the decriminalization of the possession and consumption of very small amounts of any drug. Finally, a fourth model suggests keeping drugs predominantly illegal but to identify seriously addicted users and allow them a controlled amount of illegal drugs through the medium of a legal prescription. None of these models has been, or indeed is likely to be, implemented across Europe in the near future. However, it is indicative of the new, more open, environment which surrounds the drug debate that such models can even be discussed. The entire topic of legalization with reference to illegal drugs used to be one of total taboo. It is now the case, as conflicting ideas about the best way to deal with the drug-control problem abound, that there is much more scope for debate.

Concluding Remarks

It is fairly obvious that Dutch drug policy has had a significant effect on the drug policies in other European member states. Principles of harm reduction and differentiating between hard and soft drugs as well as specific measures such as needle exchange programmes and shooting galleries have spread to an increasing number of countries e.g. as shown earlier Germany and Switzerland. A general regime of tolerance and liberalization regarding drugs seems to be hitting many European countries with new policy initiatives that are influenced by developments in Dutch drug policy. For example the European Legal Database on Drugs (ELDD) (2001) reports that in April 2001 a law passed in Luxembourg decriminalizes cannabis consumption, as well as its transportation, possession and acquisition for personal use and in Portugal the decriminalization of possession and use of all drugs has been effective from the 1 July 2001. In other countries specific laws have not yet been passed but regimes can be nevertheless be

described as becoming more liberal. For example in January 2001 Belgium expressed the intention to modify their main drug law in order to make non-problematic use of cannabis non-punishable and in Britain since October 2001 moving cannabis from a class B drug to a class C drug has been extensively and seriously debated. Sweden's influence is more subtle and perhaps less impressive. However, since they joined the EU in 1995 they have provided a powerful opponent to Dutch-style policy and do not allow this regime of tolerance to reign unchecked. The success and popularity of European Cities Against Drugs (ECAD), initiated by Sweden, is a direct setback for the Dutch born European Cities on Drug Policy (ECDP). Any radical, liberal initiatives attempted to be implemented by the ECDP now face a direct challenger and members of the ECDP must now realize they have rivals in the ECAD who will fight them all the way on new policy initiatives. While Sweden does not have as many drug policy 'converts' as the Netherlands it does have allies and there is evidence that some countries are moving closer to a Swedish-style policy. Finland and Norway, which together with Sweden make up part of the Nordic Council, are also strongly repressive towards drug users, dealers and traffickers with no policy of separation between hard and soft drugs and little differentiation in penalties between drug users and dealers. Denmark, which is also part of the Nordic Council, has in the past displayed a relatively liberal policy towards drugs allowing the free city of Christiania in Copenhagen to flourish despite openly selling and smoking cannabis in hash markets. This situation was tolerated as a social experiment but the Danish government has been cracking down recently on drug users and the current policy in Christiania as a response to considerable criticism for their policies from the rest of the Nordic Council. An article published in the Copenhagen Post (10 March 2002) reports the government's intention to close down Christiania unless all drugs and drug dealers are got rid of.

The opposed styles of drug control seen in Sweden and the Netherlands have made it nearly impossible for a harmonized approach to be adopted throughout the EU. This may be viewed negatively by EU policy makers who are hoping for an immediate Europe wide united front on dealing with drugs or positively by those who are not convinced that either Swedish style total repression or Dutch style liberalism are the order of the day and think that a drug policy considering the positive aspects of both sides of the argument is the way forward. What they have done is significantly contribute to the prioritization of the drug problem for the EU. The division between tolerant Dutch style policies and prohibitive Swedish-style measures has ensured an increasing focus on the drug problem. In an effort to bridge the division the EU has implemented many invaluable research tools and has improved legislation dealing with the control of illegal drugs. As a result the nature of the problem and the solutions available are now much more widely understood. While the aim of the EU to achieve harmonization of approaches to the drug problem has not been met, they are now in a much stronger position to manage drug use. No one style of control has been singled out as being morally better or inherently more successful, but the split has allowed a more diverse range of methods to be developed as each member state devises their own national policy within the parameters of legalization and prohibition (Boekhout van Solinge 2002). No single policy is likely to be universally adopted, but the battle centred around Sweden and the Netherlands has ensured that drug-control policy will remain a priority for the EU and increasing numbers of possible solutions to the problem will become available in the near future.

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